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# Promoting cultural proficiency in researchers to enhance the recruitment and participation of minority populations in research: Development and refinement of survey instruments

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## Abstract

A community assessment instrument (CAI), to assess community attitudes and beliefs about research and services of the local medical establishment, and a cultural competency instrument (CCI), to assess the cultural knowledge and competence of clinical investigators, were developed to address the need for culturally competent researchers by the minority community that the Omaha health care system (especially Creighton University) serves. The instruments also investigated the minority community's knowledge of medical research and benefits. The CAI and CCI questionnaires were administered by trained interviewers to members of ethnically and racially diverse groups in Omaha and to a group of researchers and clinicians at Creighton University. Respondents identified questions that were difficult, not clear and/or controversial. Modifications to the CAI and CCI were made for use in subsequent focus group studies. This publication reports a pilot study intended to develop and refine the instruments.

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## 1. Introduction

Despite the overall improvement of health in the American population, studies have shown that there are disparities in the health and health care of certain racial and ethnic groups (Blue, 2003; Brach & Fraser, 2000; Brant, Ishita, et al., 1999) and disparities in the delivery of culturally and linguistically competent care (Cross, Bazron, Dennis, & Isaacs, 1993; Edgar, Patton, & Day-Vines, 2002).

Because many of the determinants of well-being span the boundaries of healthcare and medicine, eliminating health disparities calls for new and non-traditional partnerships with diverse sectors of the community. This requires a new approach to research, especially if the subjects are of a

diverse groups and/or cultures that experience health-care disparities. The effort also calls for a fundamental change in how research is designed, conducted and disseminated in collaboration with diverse racial and ethnic communities (Francis, 2001; Glenn-Vega, 2002; Hanley, 1999; Jackson, 2002; Mason, 1995a, b). We believe it also calls for the engagement of communities in the development of clinical research protocols that address health disparities.

## 2. Background

The Creighton University Medical Center (CUMC) has undertaken a program of research that addresses health disparities in minority populations of Omaha, Nebraska. It is well known that some, maybe most, minority populations harbor a distrust of the health care establishment and are reluctant to participate as subjects in clinical research projects (Dominick & Wimmer, 2003; Freimuth, Quinn, &

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Thomas, 2001; Madriz, 2001; Shavers, Lynch, & Burmeister, 2000; Talone, 1998; White, 2000, 2002). In order for CUMC clinical scientists to conduct research in this area, it is essential that they develop trusting relationships with minority communities. This requires that CUMC investigators understand the cultures they study and that minority populations understand and appreciate the value of participating in research.

With the intent to develop educational programs addressed to clinical investigators and community members, we developed two assessment instruments: a community assessment instrument (CAI) (Online Appendices 1–4) and a cultural competency instrument (CCI) (Online Appendices 5 and 6). The CAI is intended to assess the knowledge, perceptions and attitudes of the minority communities that Creighton University serves and the minority communities' knowledge of medical research and its benefits. The CCI is intended to assess the level of cultural proficiency among CUMC medical researchers, clinicians, and other healthcare providers.

This report details the pilot study and the modifications made to both the CAI and CCI before administering the instruments to the focus groups selected for the larger studies. Pilot study and the main study were approved by the Creighton University Institutional Review Board.

### 3. Materials and methods

#### 3.1. CAI pilot study methodology

The CAI was developed to answer five research questions that were formulated to assess the need for culturally proficient health-care providers and three research questions formulated to assess the minority community knowledge of health care issues. The research questions are:

##### 3.1.1. Need for culturally proficient providers and researchers

*Research question 1:* To what extent are people of color satisfied with health care in the Omaha community?

*Research question 2:* To what extent are people of color able to communicate with health care providers in the Omaha community?

*Research question 3:* To what extent do people of color prefer to be treated by health care providers who are of the same ethnic, racial, and/or cultural background?

*Research question 4:* To what extent do people of color practice folk medicine?

*Research question 5:* To what extent do people of color feel pressured to assimilate?

##### 3.1.2. Knowledge of health-care issues

*Research question 6:* To what extent have people of color participated in a health care study or/and do not want to?

*Research question 7:* To what extent do people of color know the benefits of participating in health-care study?

*Research question 8:* To what extent do people of color know the leading cause of death for people in their ethnic/racial group?

Fifty-one survey items were developed to test these 8 research questions.

*Research question 1—dissatisfaction with health care in the Omaha community* was measured by: rating of health care providers, visiting another health-care provider for the same condition that was not a referral, not wanting to see the same health-care provider on returning to the health facility for another illness episode, and whether respondent received medication or an injection during the visit.

*Research question 2—not able to communicate with health-care providers*—was tested using: not being able to complete paper work or forms at health care facility, doctor not asking patients what s/he thought caused illness, no discussion with patient about treatment, not asking about alternative medical providers, not asking about family and friends perception of illness, need for an interpreter, health-care providers use of language, gestures, and visual aids to communicate, whether the health care providers communicated at the client's level, and whether health-care provider communicated effectively.

*Research question 3—people of color preferred to be treated by health care providers of the same ethnic, racial, or cultural background*—was rephrased in question format and asked of respondents along with the question of whether certain illnesses or conditions are better treated by someone of the same ethnic, racial, or cultural background.

*Research question 4—people of color practice folk medicine*—Respondents were asked if there were cultural practices that they performed before going to a health care provider. *Research question 5—feeling pressured to assimilate*—was tested with feeling uncomfortable because they talk, dress, or look different; are pressured to accept treatment or therapy that may go against their cultural beliefs or practices; and being pressured to change gender role behavior.

*Research question 6*—people of color have never participated in a health care study and do not want to, *Research question 7*—people of color do not know the benefits of participating in a health care study and do not know anyone who has participated in a health-care study, and *Research question 8*—people of color do not know the leading cause of death for people in their ethnic/racial group—were rephrased in question format and asked of respondents.

A pilot study was conducted to measure the efficacy of these items and to clarify and refine the draft CAI before administering it to the larger community. Twelve persons, a cross-section of the Omaha minority community, were recruited from organizations representing members of the African American, Hispanic American, Native American, and Sudanese refugee populations. Community organizations were contacted by telephone or visited by a study representative. The only requirement for participation was that the participant be a person of color, proficient in

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