Are Medical Support Staff Provided with Sufficient Diversity, Equity, and Inclusion Training?

Margareth Alvarado

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Faculty Mentor: Dr. Christine Connolly. Ph.D.

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Abstract

Purpose: This study was conducted to determine the need for workforce development and training of diversity, culture, and inclusion in small healthcare offices in Rhode Island. **Method:** This study utilized phone interviews from participants in twenty-one primary and specialty care offices throughout Rhode Island. **Results:** Findings suggested the need for more workforce development and training of DEI within small offices. More education is needed to understand and define the meaning of diversity, culture, and inclusion in these smaller primary care and specialty care settings. **Conclusions:** A repeat study should be conducted to allow for additional data collection. The geographical and hidden biases that surfaced in this research study should be taken into consideration when gathering date for future studies.

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Are Medical Support Staff Provided with Sufficient Diversity, Equity, and Inclusion Training?

As the population grows the diversity of cultures within the United States is also growing. The healthcare system is becoming more technical and diverse with growth and change, impacting clinician/patient interactions. Most studies on diversity and inclusion are based on clinicians (doctors and nurses) and medical students. There is little research available to address training needs or what has been done in the past for medical support staff, such as medical secretaries. The need for cultural diversity education is important not only in the United States, but also other countries.

The need for understanding and comprehension of cultural competence is an essential factor for healthcare. Cultural competence and diversity can be defined differently and can be misunderstood, “careless use of the term can lead to stereotyping and misunderstandings, while deeper reflection on the term’s meaning offers the chance for better understanding and improved interaction with all patients” (Mews et al., 2018 p. 3). The clarification and education for cultural competence and diversity is part of the need for a regular training and continued education on all levels of healthcare.

It is essential to understand culture and diversity in healthcare to eliminate the barriers that are created for patients of different cultures. Many people from non-dominant cultures have not gone to a doctor in years or all their life, because of the lack of understanding or language barriers. Huot et al. 2019, found “language was identified as a barrier to healthcare access since the vast majority of healthcare providers in Northern Indigenous communities are non-Indigenous and do not speak the local indigenous language.” (p. 5) Huot et al., conducted the study in Circumpolar North, but

demonstrated the problem that is also present here in the United States for the groups of different cultures.

In the United States, cultural diversity continues to grow. “By 2050, it is estimated that 50% of the US population will consist of minorities and unfortunately, today’s model of healthcare has been noted to have persistent racial and ethnic discrepancies.” (Nair and Adetayo, 2019, p.1). With these predicted numbers, how the healthcare system is run in the US will need to change and adapt to resolve these concerns. If the lack of education and training for minority groups are not analyzed, understood, and addressed, serving these populations appropriately will impact effective and efficient treatment for healthcare nationwide.

As a country we also need to look at medical student education and how this affects the medical support staff. While diversity among healthcare professionals exists, the number of medical students does not reflect the proportion of diverse individuals within our society. “Between 1980 and 2016, the proportion of black or African American medical school matriculants rose only slightly from 6% to 7%, and the proportion of Hispanic matriculants rose from 5% to 6%.” (Roberts, 2020, p. 661). This may contribute to healthcare workers not fully understanding issues of diversity and culture and negatively impacting both clinicians and medical support staff.

The purpose of this study is to collect data from smaller offices, mainly primary care providers (PCP’s) and specialist’s offices to gain insight on workforce development needs regarding diversity and culture. This study hypothesizes that there will be a lack of training in diversity, equity, and inclusion (DEI) in PCP and specialty care offices. The data collected from this study is intended to provide a better understanding of the

training provided and needs/gaps in training for medical support staff such as, medical secretaries, receptionist, human resources, and office assistants.

Literature Review

Diversity is being invited to the party; Inclusion is being asked to dance" (Stanford 2020, p. 247). During the past few years, training has progressed in the areas of diversity and inclusion. But the review of the literature demonstrated that there is much we still do not know. The subject has raised even more concerns within the medical field because of the patient populations changing so rapidly. "The Hispanic population is projected to expand from 55 million in 2014 to 119 million in 2060, an increase of 115%. In fact, 29% of the United States is projected to be Hispanic by 2060" (Abrishami 2018 p. 441). This solidifies the importance of the need for diversity and inclusion training and guidance within the healthcare field.

Providers and Medical Training

There is much research targeted at physicians, medical students, nurses, and nursing students receiving education and training to better understand cultural diversity. "Few studies globally, have explored the perceptions of (other) professionals on cross-cultural education initiatives in healthcare." (Shepherd et al., 2019 p.2). However, this literature review showed that there is not sufficient research for medical support staff. As the United States population keeps changing, companies are expected to provide necessary training and materials for staff.

According to Curtis et al. 2019, a study done in Māori, New Zealand to observe the need for cultural diversity competence within healthcare for health equity purposes. "Māori are consistently and significantly less likely to: get understandable answers to

important questions asked of health professionals; have health conditions explained in understandable terms; or feel listened to by doctors or nurses." (p. 2) These insight to the changes that are needed in smaller countries are also reflected in the United States.

This research necessitates exploration into organizational policies for required guidelines. Many healthcare associations were created, in part, for this reason, and these associations established requirements and reporting regulations for hospitals and healthcare facilities alike. Stanford, (2020) discussed the importance of diversity and inclusion in the health care workforce and provided in-depth research and knowledge on the importance of Liaison Committees on Medical Education (LCME), like the guidelines provided by the American Medical Association (AMA). It is important to consider community groups, national groups, and medical associations, like the Association for Healthcare Administrative Professionals (AHCAP), that provide support for leaders in the medical field and identified specific tools and seminars for cultural diversity and inclusion education. These leadership organizations have established standards to encourage communication between communities, healthcare directors, state officials in public health and health offices. These standards are crucial to creating a better understanding of what is needed as a whole and how to address equity concerns in health care.

The literature also analyzed the perceptive differences between minority and non-minority medical students, to determine if race impacted practice choice preferences, when caring for a patient? Wilbur et al., 2020 found that, "the probability of a medical resident choosing primary care as their specialty was nearly four times greater for a black resident then a white resident." This article explored medical

students that have knowledge of diverse cultures and understood key differences in diverse populations. Wilbur's findings concluded that the possibility of having more diverse staffing for medical clinicians provided a better understanding of culture and diversity and may provide a step towards better outcomes for training and workforce development in more healthcare facilities.

Nursing/Nursing Schools

This literature review provided continuous themes about the importance of diversity and inclusion and showed disparities within different sectors of the healthcare office or hospital. In nursing there is the National League for Nursing (NLN). "Nursing and diversity are both built on core values such as caring, integrity, inclusion, and excellence." (Malone, 2020, p.1). This league provides nursing students and professionals in the field with a strong sense of how important it was to have diversity and inclusion understanding for the membership. Integrating mandatory cultural diversity and inclusion training (with materials) integrated into office practice was deemed essential.

Majda et al's studied emergency room competency of culture, diversity and inclusion and showed that "among all respondents, lower cultural skills were associated with the perception/awareness of problems in inadequate intercultural training and a lack of practical care experience among a diverse population." (Majda et al., 2021, p.9) This study also concluded the need for more competency training for nurses.

International

Lindenmeyer (2016) studied physicians working directly with migrants from different countries all over the world. The research emphasized how the physician

offices would help the migrants adapt to a new country and language but also, pointed out what some physician offices thought about adapting to migrants instead of migrants adapting to them. This study included a total of 10 practices, where 7 had a high level of diversity within their patient load. Lindenmeyer (2016) found that in very diverse areas, small practices often perceive migrant populations as contributing to crisis and overload. In small to medium practices where diversity levels were low, staff talked about lack of experience with engagement of unfamiliar groups, entitlements needed, or preparing for the arrival of new migrants of unknown origin. This was eye-opening and showed the inexperience of providers when dealing with a diverse group. The need for continuing education and training on diversity and inclusion was identified as imperative for this type of situation.

The awareness of the lack of diversity and cultural training was seen in many different elements of healthcare. But it was unclear if this commitment to enforce this training and continuing education came from providers or executive leaders within an organization? In Canada, "accountabilities are defined and shared across the organization including mechanisms for raising and addressing diversity, inclusion, and equity (DEI) issues. For example, at Osler, senior leaders from patient experience, legal, human resources, health equity and inclusion, and ethics collaborate and provide consultation on issues related to Performance, Accommodation, Harassment and Human Rights (PAHHR)." (Gill et al., 2018, p. 2-3) The United States could benefit from Canada's model to address DEI in the health care workplace.

The studies done on clinicians have been broad and done in many different areas. In Petterson et al., 2021, a study conducted with healthcare professionals in

Sweden used surveys in a primary care setting. In the study, 279 participated were included and 74% were registered nurses. They were asked about diversity and inclusion and the lowest scores were found in the domain of workplace support, where 37% of the healthcare professionals reported low perceived workplace support for DEI. Even though the healthcare professionals were initially trained, continuing support from the organizations was not present. For medical support staff, training was not provided. Comprehensive training is needed for all.

Cultural Competency

The conceptualization of competence regarding culture and diversity was a recurring theme that required one to understand these concepts in order to teach them. Every culture and person are different, as is the change in population and the importance of being able to understand and consider what is important for each patient and what needs to be accomplished. “Cultural competence has also been defined as the complex integration of knowledge, attitudes, and skills that enhance cross cultural communication and effective interactions with others.” (Henderson et al., 2018 p. 591). Without a key understanding of what training and continued education entails, patients and medical support staff cannot have good communication and understanding of patient needs.

Henderson’s (2018) comparative article provided an analysis of findings from other scholarly journals to determine what the definition of cultural competence was for each individual journal. Each definition was different. The journals studied included mental health, nursing, cultural competence models, social work, and general medical practice. The journals understood that concept of cultural competence was an attribute

and knowledge was an antecedent of the study discussion. While many fields were included in this study, it was noted that support staff was not studied.

Leader-based research demonstrated that cultural competency and inclusion are the responsibility of leaders, for inclusive cultural and diversity training to occur at all levels. A study based out of Canada utilized the LEADS framework: lead self, engage others, achieve results, develop coalitions, and systems transformations, to assure inclusion, diversity, equity, and accessibility (Mullin et al., 2021). “The LEADS system identified five pillars and concentrated on the following competencies: (i) uphold justice, fairness, and ethical standards; (ii) exhibit and support flexibility, open-mindedness, and ability to manage change; (iii) enable and uplift talent; (iv) develop and model a high standard of excellence; and (v) demonstrate accountability for results” (Mullin et al., 2021 p.2). Even with this framework there were disparities within the training and few real results were seen because the training itself was not fully understood or developed.

Another group of articles observed the difference between cultural competence and cultural humility. “Together with the concept and embodied practice of deep *cultural humility,* the study provided health educators and other public health professionals with some of our most important tools in working with diverse individuals, groups and communities in today’s complex world.” (Greene-Moton and Minkler, 2020. p.3). This article showed controversy for health professionals regarding the importance of having cultural competency or have cultural humility. Both seem to be vital to the understanding of the culture training with both humility and competency. The concerns within this article demonstrate the importance of both understanding and education needed for cultural diversity and inclusion.

Abrishami (2018 p. 442) provided several models of cultural competence. One example is the *Bennet Model*: "Milton Bennet's viewed as an anthropologist, introduced a continuum model of cultural competence that started with denial and avoidance." The models provided a broad spectrum of how a person's competency moved towards cultural competence. However, it was unclear which methodology were more beneficial to an office.

Medical Support Staff

Cultural and diversity understanding does not affect just the staff or clinicians but may also affect patients due to the lack of understanding from medical support staff. For example, medical assistants may have to give a vaccine to a patient and possibly the patient cannot be given a vaccine because of religious beliefs, or the patient does not understand fully why the vaccine is needed. Medical assistants have clinical skills but are a medical support for doctors and nurses and often do not receive training. "Beliefs about disease, approach self-management, and medications can be influenced by history, culture, family experiences, and individual preferences, and may involve complexities beyond the risks and benefits that are typically discussed during the patient encounter." (McQuaid and Landier, 2017 p.201-202) This brings into perspective language barriers, communication between provider and patient, implicit biases, and diversity understanding. Even the medical support staff need to be included in the research to determine what they know or understand about the importance of culture and diversity, especially regarding the patients. It is necessity for all staff, especially including medical support staff, to receive continuing education and implement the knowledge gained from this education

Patient

The effectiveness and implementation of trainings like cultural diversity and inclusion also play an important role in research. Stanford (2020 pp. 248) stated, "Approximately 50% of department chairs responded and approximately 75% reported having a plan for diversity, which targeted racial, ethnic, gender, lesbian, gay, bisexual, and transgender, disabled, and social class groups." Very often, methodologies are in place to formulate a plan for cultural diversity and inclusion within the workplace. Even though the plans were in place, according to 75% of department chairs, the plans needed to be tested, reviewed, documented, and implemented.

Implementation of education seminars are key to providing the best outcome for staff and patients alike. While studies for hospitals and larger medical facilities were in abundance less research was available for primary care and specialty offices. "Providing diversity training may create awareness on how to work with patients and colleagues from diverse backgrounds (Kumra et al., 2020 p. 10)." This would help open the door for more training and continued education with more awareness and understanding of what might work for that office.

Summary

This literature review provided themes and insights into training opportunities and needs identification for providers, nurses, other clinicians, and medical school students. Findings demonstrated that there was training and teaching of cultural diversity, and varied analyses of the definition of cultural diversity and the understanding of its meaning for different organizations. There was very little information on medical support staff such as secretaries, medical aides, human resource, and case managers.

It is still unknown how much training or continued education they receive, if any. In small offices of primary care and small specialty clinics there is little research. It is essential to have a better perspective of what is currently being done and what is needed. If there is lack of funds and little to no education, do these offices and clinics have a patient population that is inadequately served?

The theme that emerged throughout the literature review showed that leadership obligations for training do not always trickle down to the medical support staff. If clinicians obtained basic diversity and inclusion education in medical school and repeated continuing education in the workforce; shouldn't the same be provided to a medical secretary? There was very little in the literature that addressed training for medical support staff.

This research study compared organizations and facilities providing vital information and described how and when diversity models and training programs are being applied. The goal was to obtain a sense of patient population within each office, the process of training for staff, and what materials were provided for the patients, if any. McCalman et al. 2017 asserted, "Cultural competence has been identified as one strategy to address racial and ethnic disparities in healthcare by providing services that meet clients' cultural, social and communication needs (p.2)."

Given that so little is known about training done or needed for medical support staff, this research study will focus in-depth on cultural competence, mode of training, plan implementation, understanding, and other necessary views for workforce development in healthcare. This study will collect data to assess if training in DEI is

occurring in Rhode Island for smaller medical offices and specialty practices by surveying health care support staff and presenting any disparities identified.

Methods

This research study was conducted using a telephone survey tool (Appendix A). Questions from this survey were validated as they were taken from the journal, *Cross-Cultural Perceptions of Health Care Professionals* and were tested and used for other populations. Thirteen questions in total were used including the comment/suggestions question. During this process, COVID-19 restrictions were still in place and the researcher had to follow those restrictions for the safety of the participants. The COVID-19 restrictions were as follows: no face-to-face contact, all deliverables were strictly electronic, and the IRB required a COVID plan for the research study to take place.

The materials were created by the researcher starting with the flyer (Appendix B) and verbal scripts (Appendix C). The flyer was created for the use of promoting the study and provided details of the research study, raffle information, contact information, and specific requirements for participation in the study. Verbal scripts were also created by the researcher to provide guidance on the telephone survey process and assurance of the clear, concise, and sequential ordering of questions. This was done to ensure consistency with each question asked. The ordering of question was also consistent to assure reliability. To ensure accuracy, questions were written on the form and each person was asked the question using the exact same words. Variations from this would have impacted validity.

The researcher created an email response (Appendix D) for the purpose of tracking those interested in participating and who needed follow-up. The email provided

concise information so any person with interest would receive the same response. For all participants, a consent form was provided (Appendix E) and emailed directly to the interested party. The consent form provided detailed information of what the survey entailed and who was conducting the survey. The name of the faculty mentor was also provided. The consent form clearly stated that any participant may opt-out at any moment of the survey with no questions asked. The contact information for both the researcher and faculty mentor were made available on the consent form for any questions or concerns. Every consent form also provided a list of resources for counseling centers if necessary for any participants. Once the consent form was signed, an appointment for the telephone survey was made and then the survey was conducted on the arranged date. The consent from was separated from the actual surveys so individuals could not be identified. Each survey was coded with a number to protect the confidentiality of the participants.

The researcher investigated online doctor's offices to create a list of specialty and primary care provider offices in Rhode Island excluding clinics affiliated with major organizations like Lifespan and Care New England. The reason for this exclusion was because larger facilities often have more training in place and the point of the study was to determine if diversity resources were available for smaller, stand-alone offices. The study process was started by placing phone calls to various offices in Rhode Island for any interested frontline staff. Flyers were also emailed to any office willing to print the flyer, for placement in the office areas for those interested in participating.

The researcher also used word of mouth for anyone currently working in the medical field who might know of interested parties including students at Rhode Island

College who may work as medical support staff. No surveys were conducted to family or friends of the researcher but, family and friends could share the information/flyer with medical facilities. Once a candidate confirmed interest in the research study an email was sent to the candidate with the attached consent form. Resources for counseling were also sent to each participant. If they were upset after taking the survey, this would provide a place for them to reach out confidentially.

All candidates interested in participating in the study were informed within the email that no survey would be conducted without the consent form. The consent form needed to be received prior to scheduling a time for the telephone survey. Once the consent form was received and reviewed by the researcher, the participant would be scheduled for a date and time for the telephone survey. The survey would be conducted on the date and time agreed upon by both the researcher and the participant. During this process the participant was reminded once again of the right to opt-out at any moment from the survey or could choose to not respond to any question. Once the survey was completed all participants would be entered into a raffle for a $25.00 Starbucks gift card. All surveys were stored in a secure area where only the researcher and faculty mentor had access.

Findings

PCP and Specialists offices were the focus for this study to provide insights on the understanding of training available within smaller offices. The survey questions 1-4 provide the demographic information for the survey. This research study collected 21 surveys in total with one survey omitted because the participant opted-out and refused to participate after the initial telephone survey was started. The participants included 19

female and 2 males; gender was not taken into consideration because only two males participated. As for office type, the research study had a total of 12 PCP offices and 9 Specialists offices. The variety of the participants were from varying positions of medical support staff including 7 medical secretaries, 2 medical assistants, 2 office assistants, 3 human resource personnel, and others who identified as medical support staff.

Participant age is also broken down into brackets for the survey purposes from 18-24, 25-34, 35-44, 45-54, and 55+ years of age. In the category of 18-24 there were 5 participants, 25-34 had 7 participants, 35-44 had 5 participants, 45-54 had 3 participants and 55+ had 0. One of the participants age was unknown because the participant did not want to give age in survey. During the data analysis, those in the age bracket of 25-34 was the highest number of participants in the survey respondent and the age category above and below this represented most of the other respondents.

Within the demographics of the survey, the number of years working in the field was included. To participate participants had to have the minimum of one year. Categories were created as follows: 1-2 years with 6 participants, 3-6 years with 9 participants, and 7+years with 6 participants. These categories were chosen to represent employees new to the field, employees with some work experience, and people who have much experience and were trained years ago. Survey questions 5-13 are summarized in Table 1 and discussed below.

Table 1

Survey Questions 5-13	*Yes*	*No*	*Unsure*	*Mixed*
5. Is cultural awareness important in providing best-practice health care. Why or why not?	17			3

6. Do you think it is important to learn about different cultures as part of your practice? Why or why not?	13	1	1	5
7. Do you think learning about different cultures improves service delivery with multi-cultural patients? Why or why not?	15	2	3	
8. Do you feel that your organization could do a better job at accommodating the needs of patients from diverse cultures? If yes, how?	14	3		4
9. Do you think other cultural models of health are useful to complement conventional health care approaches?	5	7	8	
10. How often do you treat patients of color?	15	5		
11. What areas of cultural awareness/cultural competence do you feel that you or your organization perform well?				
12. Did your health care training include a cultural awareness/competence component?	20			
13. Any comments or suggestions?	15	5		

Note: These questions were reprinted from Shepherd, S. M., Willis-Esqueda, C., Newton, D., Sivasubramaniam, D., & Paradies, Y. (2019, February 26). *The challenge of cultural competence in the workplace: Perspectives of Healthcare Providers - BMC Health Services Research*. BioMed Central. Retrieved October 22, 2022, from https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-019-3959-7

Question 5 asked if cultural awareness was important in providing best-practice health care. Why or why not? This question was meant to determine if participants felt that cultural awareness mattered. Out of all 21 asked, 3 had “mixed feelings” or thoughts about this concept. One participant stated *“I have been working in the field for years, I really like it. I think all this cultural concern have been coming out about now because before it was not too important. It depends on which office setting you are working from because the patients change in each setting.”* The response describes mixed feelings and two others made similar statements. Another similarity was all three

respondents with mixed feelings were in PCP office settings. This question also showed survey responses varied based on experience in the field. There were 6 participants that had 7+ years of working in the field. Those longer in the field, with greater experience identified that they had not heard much of cultural awareness until recent years. In this question the rest of the 17 answered “yes,” it is important to have cultural awareness and discussed why. This suggests that there is more cultural diversity now in this country and times are changing as we move forward. In one survey, from someone working in a specialist’s office, the participant believed that this was not a priority for the office with the belief that since people are in this country, English and American culture should be followed.

Question 6 asked if participants thought it was important to learn about different cultures as a part of their practice? Why or why not? Within the 21 surveys there were 5 surveys where participants stated they had “mixed feelings” and were unsure if this was needed or not needed. Out of these 5, the “mixed” answers were similar. One of the participants stated: “*I have mixed emotions regarding this because as I said I was not used to hearing how important it was for the healthcare field to learn culture. In addition, my patient population is not so diverse since we are not located in the city. However, it may be important in other areas of Rhode Island.”* All 5 participants with mixed feelings worked in a PCP office and were in the older age bracket (one was unknown age but as she stated that she was “under 65 years of age).” Thirteen survey respondents answered “yes” when asked about the need to learn about different cultures. One participant was unsure if it was needed, and one answered no, that it is not a priority for the office in her opinion.

Question 7 asked participants if learning about different cultures would improve service delivery with multicultural patients. Why or why not? Three individuals stated that they were unsure. The survey had 2 PCP offices and 1 Specialist office that responded "unsure." One of the participants answered: *"I cannot say since I don't have many patients that are colored. I do know that in other parts of the state this is more relevant and specialized."* All 3 participants had a similar response for this part of the survey and felt that this concept did not relate to the office where they were employed. The question had 2 respondents that stated "no," 1 from a PCP and 1 from Specialist. The rest of the participants all had similar answers stating the importance of implementing culture into service delivery and showed in their responses a need for training and a concern for the patients. For the bulk of the answers, the responses trended toward implementing cultural training to improve patient service delivery. An interesting observation on this question was that people interpreted "different cultures" as "colored." Cultural diversity started to become defined by some as physical differences.

Question 8 asked do you feel that your organization could do a better job of accommodating patients from diverse cultures? There were 4 answers that stood out. All were from PCP offices. One answer was, *"the organization does ok. I think we manage."* This answer was short, but others expressed similar responses. The answer also was like the previous finding that training only needed to occur when there was a necessity needed within the office. These individuals felt that because of the non-diverse patient population served in that facility, they did not require training for the staff. Three respondents felt their organizations did not do well in this area and answered

“no,” 2 specialist and 1 PCP. Those responding “no” also responded similarity to the previous group and their answers included statements about not really serving a diverse patient population.

Question 8 gave participants the opportunity to explain how they thought their organization can do better. In total there were 14 who felt their organizations could do better, 7 for PCP and 7 for Specialist. The answers all had suggestions for organizational improvement including translation services, patient materials in different languages, and better understanding the cultural background of a patient. One voiced concern that doing better might help patients understand and that education to the patient could possibility prevent the patient refusing needed treatments.

Question 9 asked participants if they thought other cultural models of health are useful to complement conventional health care approaches? Due to the wording of the question, there was some feedback indicating confusion. The question was referring to the cultural models of health and the ability to integrate them into conventional health care approaches. There were 8 responses of “unsure.” One answer was: *“I think it can, it just needs to be analyzed and studied more for a plan on how to complement the current health care approach.”* The participants answers were not specific, and no clarity was given as to whether a culture model to training would be helpful. One of the participants suggested combining both cultural models and traditional approaches to healthcare. Another was confused and was unsure what the question meant and stated that he/she was unsure. There were only 5 “yes” responses for this question and two of those responses also indicated that the question was unclear. One was a PCP office, and one was a specialist office.

Question 10 asked about the patient population and how many patients of color are treated. There were only 5 that answered "none," indicating that they did not treat patients of color. The other 15 responded "yes", and shared the populations they served - Latin X, Cape Verde, African American, Asian, or Portuguese. Most indicated that their practice contained much diversity. One participant stated, *"all day, our patients are from all different backgrounds of Spanish descent."* This helped to demonstrate the diverse patient population and similarities of the patient populations within each office.

Question 11 asked, in what areas of cultural awareness/cultural competence do you feel your organization does well? Every participant had a different interpretation of the question that affected the answer that was given. For example, one participant stated *"We make ourselves available for our patients if they need us. We try too always be considerate, at least most of us."* Another participant answered *"I feel like there is some lack in this department with a lot of the staff. I think they can do better."* The last quote described what the organization is needing or lacking for their patient population. Due to the confusion in the responses, this question was not counted for the discussion section because of the disparities in answers. Overall, the meaning was unclear.

Question 12 asked, did your health care training include a cultural awareness/ competence component? Every participant stated that they did receive some initial training for cultural awareness. Eleven participants stated that the basic training given by the organization ranged from a presentation to a video with questions. The participants with the most basic training had more than 5 years working with the organization. Ten participants indicated that a PowerPoint was shown and that was all. This was all the training that occurred for more than half of the group.

The last survey question (Question 13) allowed participants to provide any comments or suggestions. Five participants stated "no," they did not have additional comments or suggestions. All of them were from PCP offices and all were in the age group 19-26. For the participants that did want to comment, all felt that more training was necessary. One participant stated, *"More training and knowledge is needed and should be given."* This was reflected in most of the participants who responded with suggestions. From this question it was clear that medical support staff felt that more training was needed to assist them with their job responsibilities.

Discussion

This study was mainly used to collect data based on workforce development need for DEI training of new hires and current employees in Rhode Island. This study was condensed and limited to primary care and specialists' offices that were not owned by any major corporations or companies, such as Lifespan or Care New England. The first observation is the limited diverse population. There were some offices, both primary care and specialist offices, that expressed that training was not needed because of the lack of diverse population in the area they served. The impression is that they do not need it or worry about the understanding and comprehension of diversity and culture within that community, clinic, or office. It is unclear if these were less diverse communities or if the lack of cultural competence and feelings that diversity training was unnecessary shifted where patients choose to received care. These clinics may not see a diverse pool of patients because they are not providing culturally sensitive treatment and therefore patients are choosing other clinics to receive services. The need for training is still important because the population can change at any moment and

become more diverse. Being educated on the changing cultural needs will allow more sensitive treatment.

A second observation is related to the training in the workforce for new hires and current staff. Many participants expressed the need of more funding for their healthcare workplace for the ability to provide more training and tools. Lack of sufficient funds for medical support staff may be because of the lack of importance placed on medical support professionals or the lack of importance placed on DEI in these clinics. Training on this subject is need but may not be prioritized. Even participants working in a very diverse office stated that the funding they have is not enough for the training needs of the office.

This study involved office support staff and was primarily completed by females. It would be interesting to see if male responses would be different. There are less males in medical support staff roles, but it is unclear if perception by males would impact the results. Also, asking patients in these clinics the same questions would also be very insightful and would provide understanding of what their perceptions are. The perceptions of patients could then be compared to the responses of the medical support staff. This may reinforce the need for more training and may highlight the specific training that is needed.

A final observation relates to the training model or approach. The survey had a couple of questions correlated with the training models and many participants expressed that only a generic training approach was used. This meant that the training included the basic Power Point presentation along with a few follow-up questions. Responses by participants indicated the need for more ongoing, hands-on training,

longer time on the subject, and more in-services. Also, participants indicated that some of the training models are dated and provide older information based on diversity and culture within healthcare.

Finally, both the literature review and the participant comments indicate the lack of support for regular training and lack of research for what medical support staff need and what works. There is a need for more research on this topic to determine on a larger scale what is being done, is it effective, and what are next steps to assure that all staff in the clinics have received comprehensive diversity, equity, and inclusion training and have had opportunities for discussion about this information so they can best serve a diverse growing patient population in a way that is welcoming and shows understanding and appreciation of cultural differences.

Study Limitations

This study focused on the workforce development training for medical support staff in small primary care provider and specialists' office. The study was performed during the COVID-19 pandemic. This limited data collection strictly to telephone interviews only. Also, the timeline for data collection was limited to three months, as this was intended as a semester study and not more comprehensive. The study was advertised by word of mouth both in the academic community and professionally. Because of COVID, there was not direct access to more broad advertising within clinics. Phone calls were made to several clinics but often it was difficult to get a person to call back or someone willing to participate due to voice mail and increased business during the COVID epidemic. Another limitation was having a dense female gender pool. Most

medical support staff are female in medical offices, so responses were made largely from a female perspective. Only two males participated in this study.

Conclusions

The results of the data collection highlighted that only the most basic DEI training is provided for new hires. There have been some changes in training requirements more recently. This was visible with the comparison of medical support staff of greater than 7 years or less than 7 years in the field. Those in the field longer had less training on DEI overall and their training was more basic. Those with more than 7 years in the field were not open to more training or had doubts about the benefit. When seeking to learn about those wanting more training, the younger age group of participants was open to more DEI training than the older age group. Also, those who worked in the field longer were less open to training.

Another theme that emerged was that regardless of the group, many of the participants who perceived that they did not work in communities where there was diversity felt that training was not needed but those that worked with individuals from different cultures expressed the need for more comprehensive training. Future studies need to explore if those who feel the training is “not necessary” are really in communities where there is not diversity or if the clients in those communities do not feel comfortable with those clinics based on biases and prejudice or lack of understanding of their cultural needs. Research is needed to explore this further.

Recommendations

The necessity for a repeat study should be done to gather more data on medical support staff. The timeframe for this study was short to be able to collect more data and

there was no ability to access clinic staff face-to-face due to COVID-19. There are also some underlying perceptions regarding diversity and inclusion that should be studied and analyzed, as this may affect the results of future studies conducted related to DEI. The next recommendation would be a statewide study to determine if differences exist in trainings of medical support staff in different geographical areas of the state. In addition to looking at areas where there are higher rates of ethnic diversity, studies could look at demographics within communities, urban vs rural area, economic differences, etc. This might provide clearer insights and more specific training needs. Lastly, identifying funding for smaller medical offices throughout the state might help to increase training opportunities. Some clinics are privately owned by one or two clinicians, and they do not have the same funding as a corporate medical office or hospital. With the collection of additionally data, the study can grow and demonstrate the significance gaps in DEI training and can help provide better information on healthcare training needs for medical support staff within the United States.

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Appendix A

Interview Survey

Survey Number:

Survey for Research Project- HCA

1. Is your organization a specialist or PCP office? What is your position?

2. What is your age?

3. What is your gender?

4. How long have you worked in this office or clinic?

5. Is cultural awareness important in providing best-practice health care. Why or why not?

6. Do you think it is important to learn about different cultures as part of your practice? Why or why not?

7. Do you think learning about different cultures improves service delivery with multi-cultural patients? Why or why not?

8. Do you feel that your organization could do a better job at accommodating the needs of patients from diverse cultures? If yes, how?

9. Do you think other cultural models of health are useful to complement conventional health care approaches?

10. How often do you treat patients of color?

11. What areas of cultural awareness/cultural competence do you feel that you or your organization perform well?

12. Did your health care training include a cultural awareness/competence component?

13. Any comments or suggestions?

Survey Questions From:
https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-019-3959-7

Appendix B

Research Promotional Flyer

Participants needed for study of cultural diversity workforce development

We are searching for medical support staff, such as medical secretaries, front office staff and human resource personnel.

Cultural Diversity Workforce Development Training Assessment

This study will consist of a survey with the opportunity to give statements and suggestions on how the office is providing training for cultural diversity and inclusion. The study will take 20-30 minutes and the consent form will be sent via email and **MUST** be returned before the survey can be conducted.

Participants will receive:

- All participants will be eligible for a $25 gift card to Starbucks and the winner will receive the gift card via email.

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Location

- Due to the COVID-19 pandemic this study will be conducted by telephone.

Are you eligible?

- Must be age 18-64
- Must be working in a Primary Care Provider or Specialist office for a minimum of one year.
- Must provide email for consent form and **MUST** return consent form before survey can be conducted.

If you're unsure if you meet the requirements email the researcher directly:

Margareth Alvarado
Rhode Island College
Undergraduate Student-Healthcare Administration
MAlvarado_1059@emai.ric.edu

Appendix C

Verbal Script for Telephone Interview

Verbal Scripts for Telephone Interview

Verbal Script: Recruitment First Contact

Hello! My name is Margareth Alvarado from Rhode Island College. I am conducting a research study on cultural diversity and inclusion workforce development and training within medical practices. Participation will take 20-30 minutes through a telephone interview. If you are interested, please provide your email and I will send an email with the consent form. There are minimal to no risks involved in this research and all participants will be added to a raffle for a $25 gift card to Starbucks. If you have any questions, you may reach the investigator at MAlvarado_1059@email.ric.edu.

Verbal Script: Follow-up Recruitment Contact (If needed)

OPENING:

Hi! My name is Margareth Alvarado from Rhode Island College. You expressed interest in participating in the research study on cultural diversity and inclusion workforce development and training. Participation would involve you doing an interview survey with me through telephone that will take about 20-30 minutes. There are minimal to no known risks involved and participation is voluntary. All participants will be entered into a raffle of $25 gift card to Starbucks. Are you still be interested in participating?

CLOSING:

Do you have any questions you would like answered now?
You may contact the researcher at MAlvarado_1059@email.ric.edu and faculty mentor Dr. Christine Connolly at CConnolly@ric.edu.

Reminder Message: Research involving participation to occur at a specific time/location.

This is a reminder that you have signed up to participate in a research study about cultural diversity and inclusion workforce development and training. You are scheduled to complete the study on [date] at [time]. The study will be conducted via telephone. If you have any questions, please contact Margareth Alvarado at MAlvarado_1059@email.ric.edu or Dr. Christine Connolly at CConnolly@ric.edu.

Appendix D

Communication Emails

<Date>

To Whom It May Concern:

This email is being sent to you because you have shown interest in participating in the survey study of Cultural Diversity and Inclusion Workforce Development. This survey will be conducted by telephone and the survey will be done Margareth Alvarado, Undergraduate Student at Rhode Island College, under the advisement of Dr. Christine Connolly, faculty mentor.

Within this email you will find the attached consent form, which needs to be returned before conducting the survey/interview. After the consent has been received, I will schedule a time convenient for the participant to interview and the interview itself will take about 20-30 minutes.

Please complete the consent form and email back to malvarado_1059@email.ric.edu. If you have any questions regarding the consent form, please do not hesitate to contact Margareth Alvarado for further assistance.

I look forward to speaking with you and again thank you for your interest in participating in this study.

Sincerely,

Margareth Alvarado
Undergraduate Student—Rhode Island College
Healthcare Business Administration

Appendix E

Consent Form

RHODE ISLAND COLLEGE

CONSENT DOCUMENT

Rhode Island College

"Healthcare Support Staff Workforce Development Sufficiency in the Subject of Cultural Diversity and Inclusion"

You are being asked to be in a research study about your training in the subject of Cultural Diversity and Inclusion. Participation in this study is voluntary and it is anticipated that you would be involved for 20-30 minutes amount of time. You are being asked because you currently work in a primary care provider's office or a specialist office as healthcare support staff. Please read this form and ask any questions that you have before choosing whether to be in the study.

Margareth Alvarado, undergraduate student in Healthcare Administration, is conducting this research in collaboration with her faculty advisor Dr. Christine Connolly, Associate Professor at Rhode Island College.

Why this Study is Being Done (Purpose(s)

We are conducting this study to obtain more information on training and workforce development techniques within primary care and specialists offices.

What You Will Have to Do (Procedures)

If you choose to be in the study,

- First, I will ask you survey questions relating to current, and any previous training obtained for workforce development in the subject of cultural diversity.
- Second, I will ask of you would like to share any comments or opinions that you may have regarding the subject of cultural diversity in workforce development. This will take about 20-30 minutes.

Risks or Discomforts

This study is minimal to no risk. We think the questions would be like the kinds of things you talk about with family and friends. If you find that answering some questions is upsetting, you can skip any questions you don't want to answer, and you can stop the

interview at any time. If you want to talk to someone about feelings you're having from the study, we have provided with a list of counseling agencies you can contact privately and directly. They may take insurance or charge a fee for their services which would be your responsibility.

Benefits of Being in the Study

Being in this study will not benefit you directly.

Compensation

If you participate you will be entered into a $25.00 raffle for a gift card to Starbucks.

Deciding Whether to Be in the Study

Being in the study is your choice to make. Nobody can force you to be in the study. You can choose not to be in the study, and nobody will hold it against you. You can change your mind and quit the study at any time, and you do not have to give a reason.

How Your Information will be Protected

Because this is a research study, results will be summarized across all participants and shared in reports that we publish (specifically my honors project) and presentations that might be given. Your name will not be used in any reports. We will take several steps to protect the information you give us so that you cannot be identified. Your name will not be used for this interview, your information will be given a number code which will be the identifier for the researcher and faculty advisor. The information will be kept in a locked office file and seen only by myself and the faculty advisor who works with me. Also, if there are problems with the study, the records may be viewed by the Rhode Island College review board responsible for protecting the rights and safety of people who participate in research. The information will be kept for a minimum of three years after the study is over, after which it will be destroyed.

Who to Contact?

You can ask any questions you have now. If you have any questions later, you can contact Margareth Alvarado at MAlvarado_1059@email.ric.edu and Dr. Christine Connolly at CConnolly@ric.edu.

If you think you were treated badly in this study, have complaints, or would like to talk to someone other than the researcher about your rights or safety as a research participant, please contact the IRB Chair at IRB@ric.edu.

You will be emailed a copy of this form to keep.

Statement of Consent

I have read and understand the information above. I am choosing to be in the study "*Healthcare Support Staff Workforce Development Sufficiency in the Subject of Cultural Diversity and Inclusion*". I can change my mind and quit at any time, and I don't have to give a reason. I have been given answers to the questions I asked, or I will contact the researcher with any questions that come up later. I am between 18-64 years of age.

Print Name of Participant: ____

Signature of Participant: ________________________________Date: __________

Name of Researcher Obtaining Consent:___________________________________