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It's All About Trust and Respect: Cultural Competence and Cultural Humility in Mobile Health Clinic Services for Underserved Minority Populations

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Abstract: **Objectives**. To explore participants' perceptions of cultural competence and cultural humility in mobile health clinic (MHC) service delivery, using the Cultural Competence Model (CCM) as an organizing framework. **Methods**. We conducted five focus groups with an ethnically diverse group of English- and Spanish-speaking men and women, ages 20-67, residing in five underserved neighborhoods in a Southeastern U.S. city. Data analysis followed a thematic approach and iterative qualitative content analysis. **Results.** Participants expressed a desire for well-trained and caring staff who practice cultural humility. **Conclusions.** By applying the CCM's five-pronged constellation of cultural abilities, health care personnel could ultimately be more responsive to ethnically diverse clients. There is a need to reinforce compliance with Culturally Linguistic and Appropriate Service (CLAS) standards and to develop programs to

increase providers' cultural awareness, knowledge, and skills that ultimately would potentially reduce the amount of non-emergent Emergency Room visits and their associated costs.

Key words: Mobile health clinic, cultural competence, cultural humility, vulnerable populations, CLAS standards.

Research[1] has shown that the U.S. falls short in delivering effective primary and secondary prevention for patients with chronic conditions, and that patients face barriers in accessing effective primary and secondary prevention services. Due to these access barriers, Americans seek a significant amount of non-emergent care in emergency departments (ER), with long waits to be seen[2], and associated high costs for uninsured or underinsured patients. The Affordable Care Act (ACA) includes a mandate to practitioners to focus on "developing approaches to engage and monitor patients outside of the office."[3 [p.537]] Mobile Health Clinics (MHCs) are a viable mechanism for reaching out to patients outside of formal health care settings. MHCs are "transportable health care units that enable the provision of community-based care off-site from institutions and health care agencies to under-serviced populations that may otherwise be hard to reach."[4 [p. 351]] MHCs can provide psychological advantages over health care options that take place outside one's neighborhood.[3,5] They are a visible reminder of the importance of addressing one's health care needs, as the presence of a MHC locally encourages residents to engage in self-care provided through mobile screening.[6] MHCs increasingly serve a diverse population. Research indicates that in 2013, 35% of MHC visits were by individuals identifying as non-White, while 45% of visits were by individuals identifying as Hispanic or Latino.[7]

The increased diversity in health care provision is promoting a growing interest in the design and delivery of culturally and linguistically appropriate health care services. Betancourt and colleagues argued that a "culturally competent" health care system is defined as "one that acknowledges and incorporates—at all levels—the importance of culture, assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs." [8 [p. 294]] In the context of a culturally competent health care system, providers must foster respect for the

cultures of individuals from diverse backgrounds, as well as promote efforts to understand the needs of the population they serve. [9] Another related concept, cultural humility, incorporates a lifelong commitment to self-evaluation and self-critique in order to redress the power imbalances in the patient-physician dynamic and to develop a mutually beneficial relationships.[10] The National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care[11] include a standard for health care staff to provide services in a manner that is compatible with clients' cultural health beliefs and practices and preferred language (for a more detailed discussion of cultural competence and cultural sensitivity, see Spector[12]).

We used the Cultural Competence Model (CCM)[13] as an organizing framework to report our study findings about community members' expectations regarding the cultural competence of health care personnel working at a MHC. The CCM is composed of five constructs: cultural awareness, knowledge, skills, encounters or interactions, and desire. The model assumes there is a direct relationship between the competence of caregivers and their ability to provide responsive services. By applying the CCM's five-pronged constellation of cultural abilities, health care personnel could ultimately be more responsive to ethnically diverse clients.[13]

A recent (2016) literature review[14] of 1,204 studies on cultural competence that included 13 studies containing empirical data on cultural competence outcomes revealed that the constructs of the CCM framework have been applied to a variety of health care contexts, and that cultural awareness, cultural knowledge and cultural skills have been replicated across cultural competence models. This review also revealed that cultural desire and cultural encounter/interaction were incorporated in several conceptual models and assessment tools.[14] Another literature review[15], which included research conducted in clinics and hospital settings, examined the effectiveness of Patient Care Centered models (PCC) that incorporate a Cultural

Competence perspective in improving health outcomes among culturally and linguistically diverse patients. Renzaho's literature review[15] showed evidence supporting the effectiveness of cultural competence and PCC training in increasing cultural knowledge and awareness; two of the constructs included in the CCM model.[13] While some MHCs have integrated recommendations from the Institute of Medicine's Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care,[16] the authors of the present study were unable to find literature reviews that included studies that explicitly explored cultural competence in the context of MHCs.

We report on the efforts of a large hospital system in the southeastern United States to explore residents' attitudes and perceived needs pertaining to MHCs. The hospital system recognized that implementing an on-site, community-based MHC could expand primary and preventative care to vulnerable communities and by doing so, could potentially reduce the frequency of ER visits among residents from five underserved neighborhoods whose low-income residents are considered high rate ER users, according to hospital-generated data. The MHC was a critical step for addressing the health of underserved populations served by this hospital. This paper reports on participants' perceptions and expectations of health care providers' services by identifying quotes that the authors considered to reflect and/or relate to the five constructs included in the CCM model[13], including cultural awareness, knowledge, skills, encounters or interactions, and desire.

Methods

This study used a descriptive qualitative design[17,18] with focus group interviews to determine residents' general opinions about and preferences for a MHC.

Sample selection and participant recruitment. The XX Health System Institutional Review Board approved this study in October 2015. Purposive sampling was then used to select

an ethnically diverse group of English and Spanish-speaking women and men ages 20 to 67, who, at the time of the study, resided in one of five underserved neighborhoods in the hospital's service area. These settings were considered "underserved neighborhoods" as residents living within these settings had increased emergency department use for non-emergent and treatable primary care services at the local hospital. Other study inclusion criteria were: (a) being uninsured, underinsured, or enrolled in government health insurance programs (Medicaid, Medicare, or the federal marketplace); (b) being functionally able to attend and participate in a focus group; and (c) having an ability to speak and understand English for the designated English-speaking focus groups or Spanish for the designated Spanish-speaking focus group. Exclusion criteria included: (a) being 68 years of age or older; (b) having a hearing impairment without an assistive device; and (c) having job-based or private health insurance. The demographic characteristics of the focus group participants are summarized in Table 1.

Table 1. Demographic Characteristics of Focus Group Participants (n=35)

	#	*%*
Gender		
Male	7	20.0
Female	28	80.0
Race/Ethnicity		
African American/Black	24	70.6
Caucasian/White	2	5.9
Latino/Hispanic	8	23.5
Age (Years); Mean= 44.8		
20-29	7	20.1
30-39	8	22.8
40-49	6	17.1
50-59	5	14.2
60-69	9	25.7
Education		
Junior HS or less (1st-8th grade)	3	9.1
Some high school	6	18.2
Graduated high school or earned GED	9	27.3
Some college/ technical school, no degree	10	30.3
Two-year college degree	4	12.1
Four-year college degree	1	3.0
Employment		
Working full-time	5	14.3
Working part-time	8	22.9
Self-employed	1	2.9
A homemaker	6	17.1
Out of work for more than a year	2	5.7
Out of work for less than a year	1	2.9
Retired	2	5.7
Unable to work	10	28.6
Income		
Less than $10,000	16	47.1
$10,000-$19,999	9	26.5
$20,000-$29,999	2	5.9
$30,000-$39,999	3	8.8
$80,000-$89,999	2	5.9
Choose not to answer	2	5.9

Note: Not every focus group respondent answered every item on the questionnaire, and one participant did not complete the second page of the questionnaire, which included information about racial/ethnic group identity.

Eighty percent of the participants were women, reflecting the fact that women have more contact with health care service providers than men.[19] Only 6% of the focus group

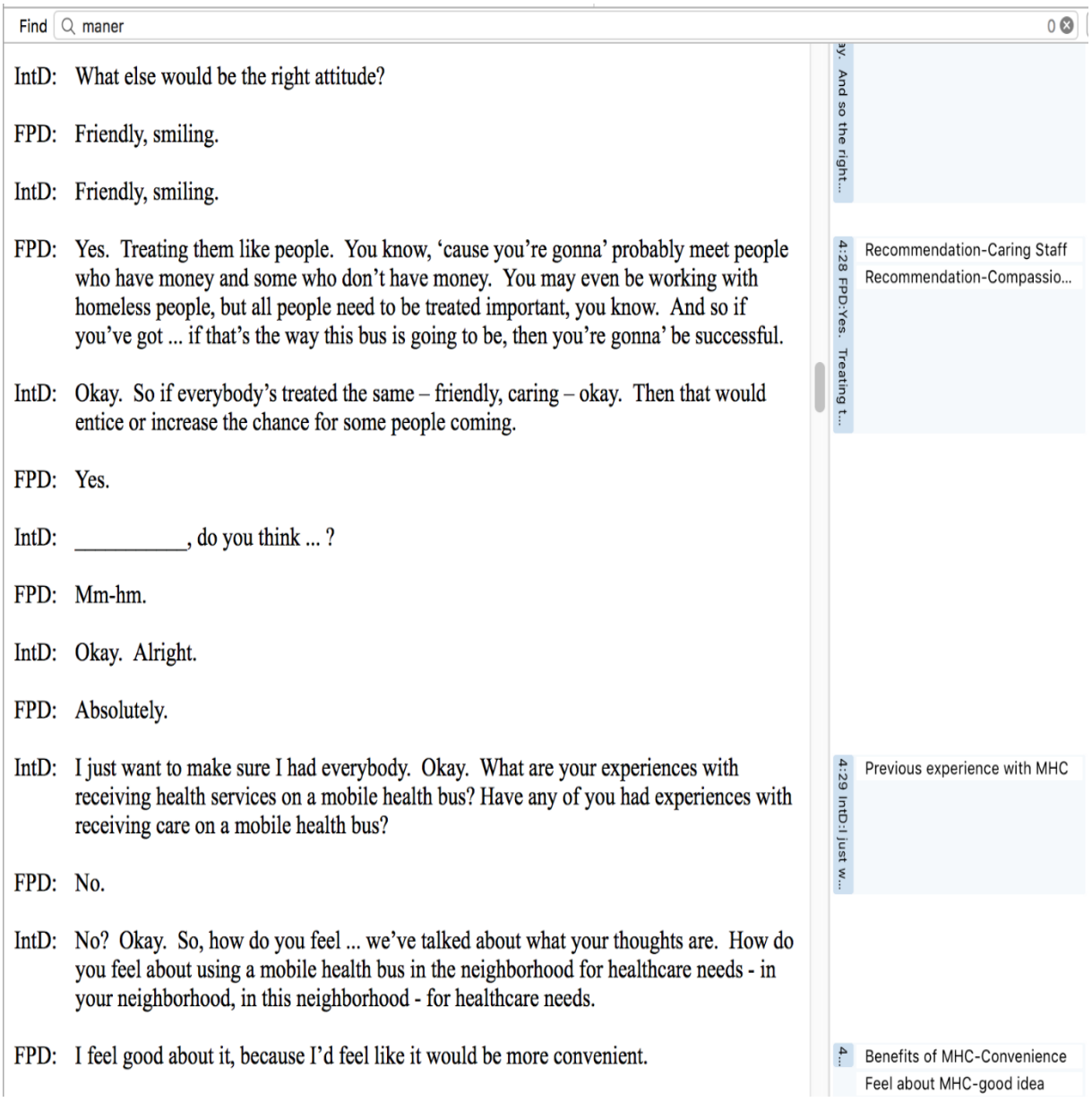
participants identified as White; 70% identified as Black and nearly one-fourth (23.5%) identified as Latino. The mean age of participants was 44.8 years. In terms of education level, 27.3% indicated they had not earned a high school diploma and an equal proportion (27.3%) indicated a high school diploma or GED as their highest level of education. Just over 14% of participants indicated they worked full-time, while nearly 23% indicated they worked part-time, and nearly 29% percent reported that they were unable to work. Nearly three-fourths of participants reported a household income of less than $20,000.

Data collection. Focus groups were held in December 2015, at conveniently located community centers and churches in the host communities. The fourth author was moderator of the three English-speaking focus groups and the first author moderated the one Spanish-speaking focus group. The principal investigator took field notes throughout the meetings. The focus groups included these types of questions: opening, introductory, transition, key, and ending (following Krueger and Casey[20]). Participants signed an informed consent and received an incentive for their participation.

Data analysis. The focus groups were audio-recorded and then transcribed by a professional transcriber. A certified language services person transcribed the Spanish-speaking transcripts, first into Spanish and then into English. The first author, who is a native Spanish-speaking researcher, verified the translated transcript. The third author verified the English transcripts. Qualitative data management and analysis was conducted with ATLAS.ti version 7[21]. The third author, who engaged in the data analysis, has extensive experience using Atlas.ti, a popular and versatile qualitative software package. The authors has used Atlas.ti for numerous other projects. The authors followed Strauss and Corbin's[22] grounded theory approach to qualitative analysis and engaged in inductive analysis. The three-step coding process consisted of open coding (identifying key emergent themes in the focus group transcripts), axial coding

(categorizing the initial themes into the broader themes as they related to participants views of and experiences with MHCs), and selective coding (connecting these latter categories with one another and identifying subcategories within each). Although seemingly a linear process on the surface, this analysis process was iterative, with careful multiple readings of the focus group transcripts to identify the emergent themes. Figure 1 provides a screen shot of a coded portion of one transcript, uploaded to ATLAS.ti.

Figure 1: Screen shot of a coded portion of one transcript uploaded to ATLAS.ti.



Results

Across all focus groups, participants expressed a strong desire for well-trained, compassionate, and caring staff members who practice cultural humility and exhibit evidence of the CCM's five cultural competence abilities: cultural awareness, knowledge, skills, encounters or interactions, and desire. Below, we provide evidence from the focus groups for each of the cultural competence abilities, using the participants' own words to illustrate their desire for these abilities. In accordance with this model's assumptions, although we address these cultural competence abilities separately, they are interdependent with one another. That is, no matter where a health care provider enters into the CCM cycle of care, all five aspects must be incorporated for effective service. We explore this interdependence in the discussion section. (NOTE: Actual quotations from the focus group participants appear in *italics* below.)

Cultural awareness. Cultural awareness is the self-examination and in-depth exploration of one's own cultural and professional background, along with a recognition of one's biases, prejudices, and assumptions about individuals who are different.[13] Therefore, health care providers who lack cultural awareness might provide treatment according to their preconceived notions about their patients—providing different treatment or providing treatment in a different manner depending on the patient's culture—ultimately leading to service provision that would likely have a lingering negative impact on patients. Several participants reported receiving care in the past that was characterized by a lack empathy or concern from their health care providers; the participants expressed ideas that reflected that the health care providers lacked cultural awareness. One participant described the difficulty that many face when seeking treatment from health care professionals: *"I'm in the process of changing my doctor, because when I go in there, I don't act like I'm received, you know, in a friendly manner.* [They] *don't act like they're concerned."* Such negative experiences markedly influenced their subsequent

interactions with the health care system: *"You just get fed up with them pushing you through like it's a drive-through, like it is fast-food time."* Participants thus reflected that no community-based MHC should be staffed with personnel that exhibit these characteristics.

When asked what would prevent them from using a MHC in their community, one participant said, *"If you had a bad experience, if you go the first time and you have a bad experience, you won't come back."* Prejudice and bias could also be related to one's socioeconomic status. Some participants felt stigmatized by some health care professionals because of their socioeconomic status. For example, a participant said, "*if you [have] no insurance, they'll treat you any kind of way…and that they'll kick you off the bus!"*. It is important for providers to be aware of potential socioeconomic-related bias perceived by their patients when they seek health-care services at the MHC.

Cultural knowledge. Cultural knowledge is the process of seeking and obtaining a sound educational foundation about diverse cultural and ethnic groups.[13] Participants expressed certain expectations regarding providers' knowledge about the populations that they serve and the level of professionalism that patients expect in their interactions with health care professionals. A participant, who expected a certain level of professionalism from MHC staff, reiterated this point: *"So people's mood, the presence…they must have the same formality that they have in the hospital."* Participants expected staff to be well trained; such training might include cultural knowledge. In addition, the presence of a higher-ranked medical professional during the visit to the MHC might increase patients' trust in the treatment provided. For example, one participant indicated that while they prefer to see a doctor when visiting the MHC, they would accept *"the apprentices"* if a doctor was present during the actual appointment. Thus, the perceived providers' scientific and cultural knowledge might increase patients' level of trust in the service provided.

Obtaining knowledge about clients' health-related cultural beliefs and values involves understanding the clients' worldviews.[13] One participant suggested that the staff receive training to work with diverse patients and to deliver compassionate care. She recognized that the MHC staff will be working with people from "*different walks of life,*" a theme echoed by another participant: "*…'cause you're gonna' probably meet people who have money and some who don't have money. You may even be working with homeless people. But all people need to be treated* [as] *important."* Another participant suggested that MHC staff members be told: "*Don't be judgmental toward people. You're there to help. It's your job."* Because in the end, "*It's* [the health care providers'] *responsibility to make sure people feel comfortable."*

Cultural skill. Cultural skill is the ability to collect relevant cultural data regarding the clients' problems, as well as to accurately perform a culturally-based physical assessment.[13] To exhibit cultural skill, MHC providers should become familiar with the populations they serve and become aware (cultural awareness) of their patients' expectations regarding how they would like to be treated by health care personnel. Indeed, staff should be reminded of the intimate nature of their community-based job: "*You're taking care of people. You could be taking care of somebody else's parents."* Another participant reiterated this theme: "*…Because we're talking about taking care of our loved ones."* They recommended that the facility choose "*nurses or doctors with a good personality, a nice background and education."*

Participants expressed that caring about someone involves showing respect, regardless of racial/ethnic or socioeconomic background. For example, Hispanic participants described being the target of negative stereotypes when obtaining health care through other facilities: "*We cannot deny that some people don't like us."* This participant expressed ideas that reflected her concern about becoming the target of stereotypes and discriminatory behaviors, reflecting that health care providers approach her with the notion that " '*You're this Mexican*

person…I got to come down here because y'all don't know what y'all are doing. Y'all don't have no medical insurance and y'all need to get it together.' "

Cultural encounters or interactions. Cultural encounters or interactions encourage health care providers to engage directly in cross-cultural interactions with clients from culturally diverse backgrounds. Directly interacting with clients from diverse cultural groups will refine or modify one's existing beliefs about a cultural group and will prevent possible stereotyping.[13] A primary theme regarding cultural interactions pertains to the overall demeanor of the MHC staff. Participants do not want to be treated with disrespect: *"I would dislike the staff being arrogant, not being compassionate, or* [not] *having passion to do what they're doing."* The preference for compassionate cultural encounters extends beyond doctor-patient and nurse-patient interactions. Front-desk staff-patient is another important interaction to consider. This is reiterated in a study[20] finding that patients' perceptions about the cultural sensitivity of front desk staff has a significant positive association with patient treatment adherence and that this relationship is mediated by patient health care satisfaction.

Researchers[23] have described the relevance of client-provider relationships in facilitating the introduction of free health screenings in underserved neighborhoods. Participants recognized that people in need of health care are especially vulnerable and should be treated with dignity and respect. In one participants' words, *"When you're sick and you go into a place, you don't need somebody being short with you, being ugly with you."* Another participant reinforced this theme: *"People who aren't feeling well especially need to be treated well…people that don't feel good* [are] *not in the best of spirits. So you've got to be able to deal with this person not feeling good…They're not mad or angry; they don't feel good."*

Another element of cultural encounters and interactions was reflected in participants' recommendations about the desired demographic composition of the MHC health care workers.

Participants expressed the importance of hiring staff who share similar life situations or who can at least understand the residents' life experiences: "*You know, most people out here are single parents, or have a whole bunch of children, so people with experience with children and single* [parents] *in the same situations, they will be good on relating to the community as well.*" Participants also indicated that the MHC staff should reflect the community, or communities, that the MHC serves, if at all possible: "*The more people that* [community members] *see working with them, that look like them…I think that's very important. If you're going to work in an African American community…I think that it should be African American staff. I think that makes people feel more comfortable, too. It's just not like, 'These people coming down here trying to look down on us.' I think it would help draw more people to be willing to come, too.*" Participants recognize the challenges in hiring a diverse staff *"because you have to work with what you have*." None the less, they expressed the importance of striving toward this goal.

Cultural desire. Cultural desire is distinct from the other four elements, as it represents the willing disposition to develop cultural awareness, knowledge, and skills and to participate in encounters with other cultures. Cultural desire involves the concept of caring.[13] Research documents the disappointment that results when, despite advertising, community members are reluctant to access free health screenings at the MHC.[23] When participants were asked what qualities could help individuals overcome their disinclination to visit the MHC, one participant indicated that having "*friendly and outgoing*" staff would be a major factor: *"I think that is definitely important. Because, obviously, it would be very intimidating to have someone that was not welcoming, not friendly."*

Participants want to be "*treated like people"* and to interact with staff who are *"not just treating you as a statistic, but treating you as a human being."* One participant offered the following advice regarding attitude that health care providers should exhibit when coming into

their communities: "*When you go into these communities, you are going to have to act like: 'Okay, I'm not here, you know, being the big I or whatever. I am here with your concerns. I want to know what you are feeling. I am here to support you. I'm here to help you.' If you go in there with the right attitude, you're going to be well received…They will shut you out if you go in there with the wrong attitude."* Participants reported positive experiences with obtaining community-based health care. As one participant noted, sometimes the best services are offered in community-based health care settings such as MHCs: *"Those are some caring people…And they are volunteering. They are there because they want to be. They're not there because they were told."* She contrasted this MHC model of care with her experience receiving dispassionate care through the county health department, where she feels that *"people are just assigned to these places and they just hate this job* [and think] *'I don't want this stinkin' person in my face.'…I think a mobile health unit would be a job where somebody really wanted to make a difference."*

Discussion

Mobile Health Clinics (MHCs) provide an alternative portal into the healthcare system for the medically disenfranchised, that is, people who are underinsured, uninsured or who are otherwise outside of mainstream healthcare due to issues of trust, language, immigration status or simply location.[24] Oriol and colleagues[24] posited that difficulties to obtain accessible, affordable, convenient care for non-emergent conditions that could be cared for in health units like MHCs could potentially determine a significant increase in ER visits.

Mobile Health Clinics (MHCs) provide services to disenfranchised communities, which at the same time might be perceived as well-established communities. Within these well-established communities, residents often have a deep sense of community history and pride. Our participants felt strongly that the MHC should follow certain principles to ensure its success.

Services should be offered consistently and be based on a model of compassionate, connected care. Staff should be highly qualified and culturally competent. Importantly, exhibiting cultural humility and acceptance of cultural differences should be key elements in ongoing service provision. Additionally, service providers should be respectful of patients' privacy and the facility should be sterile and neat. While everyone would likely prefer that their health care providers and facilities exhibit these characteristics, this is especially the case for medically underserved individuals, many of whom are acutely aware of their vulnerable situations and many of whom have received culturally insensitive health care in the past.

Hill and colleagues[25] posited that MHCs could increase the health care system's capacity to help patients overcome barriers to access and can build trusting relationships to reduce disparities, improve health, and reduce costs. In addition to users' benefits, the hospital system would also potentially benefit by a reduction in frequent ER visits by low-income patients. A study conducted by Oriol and colleagues[24] showed that an MHC in Boston produced a return on investment of $36 for every $1 invested in the program.

Previous studies[25] have found that MHCs are a source of trusting relationships between the health system and potential low-income users. These trusting relationships are necessary to ensure that patient-provider communication is culturally and linguistically relevant. As MHCs are generally directed toward communities that are diverse in race, ethnicity, and socioeconomic standing, it is important to more fully consider the importance of cultural competence among health care providers. In our study, participants' responses and comments demonstrate their desire for culturally competent staff that reflects the community served by the MHC. Thus, it is important that the MHC provides culturally tailored health care to the target communities.

Culturally competent health care is characterized by "care that respects the health beliefs, values, and behaviors of culturally diverse populations and individuals."[26 [p. 2]] Such care

is essential for reducing health care disparities, enhancing engagement, lowering linguistic barriers that community residents may face, and ultimately improving health care outcomes.[27] Culturally competent interventions include hiring staff who reflect the diversity of the target communities; using interpreter services or hiring bilingual health care providers for patients with limited English proficiency; offering cultural competency training for MHC staff; using culturally appropriate educational materials; and designing health care settings to be culturally specific.[28] Consistent, respectful, culturally competent and high-quality care that embodies cultural humility should be the foundation of ongoing implementation. This approach complements and reinforces the principle of "knowledgeable neighbors" as foundational for delivering health care through MHCs in underserved communities.[29]

Public health implications. Participants' sentiments reflect their desire for cultural humility among health care providers at MHCs. Such humility implies providers would undertake an active process of self-reflection and self-critique, and would be fully engaged, listening to patients and community partners.[30] Community members should become active partners in designing health care service delivery mechanisms within their communities. To this end, it is important to develop a broader, community-based marketing and engagement strategy to ensure that the MHC has strong community support from the beginning. For instance, a participant in our study suggested that the MHC staff give considerable thought to developing an outreach plan for the MHC that is broad and reaches all segments of the community. Recommendations about outreach strategies like the one provided by this participant reflect the importance of involving community members in a way that the initiative becomes truly community-engaged as opposed to only community-based. Skinner and colleagues[31] used the term "democratic engagement" to refer to a process where the MHC and the community learn to work together for mutual benefit. Studies such as ours can offer community members a

platform to have their voices heard and to contribute to health care service providers in their communities through a democratic process of engagement.

Rowland and colleagues[32 [p. 10]] recognized the urgent need for cultural competence in health care service provision, stating that this concept and practice "should easily flow through every component of teaching, patient care and research like blood flows in the human body." We contend that cultural competency should also be the "lifeblood" of health care service provision in community-based settings, such as MHCs. In this way, patients and their families may well feel their needs are being served and become more proactive in their own health care as a result.

There is an urgent need to incorporate cultural competency education into health care providers' continuing education curricula,[1] as well as to reinforce services' compliance with the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care.[11] The Affordable Care Act includes a 10% payment bonus for qualified primary care physicians and includes a set of provisions, and millions of dollars in additional funding, to support medical education and increase the number of primary care physicians, physician's assistants, and nurse practitioners. Funding through the ACA for primary care providers' education would ideally incorporate cultural competency education as a central component of this curriculum.[1]

There is strong evidence that linguistic and cultural issues contribute to health care inequities and poor health care outcomes among vulnerable populations.[30] Standard 7 of the 2013 CLAS Standards states "Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided."[11 [p. 13]] Reinforcing the importance of compliance with CLAS is a necessity. Although related, linguistic competence—following standard 7—is not the same as cultural competence. Estrada and Messias[33] argued that while linguistic competency is vital, a broader

cultural focus is necessary to reduce health care disparities. Rowland and colleagues[32] recommended that cultural competency should be incorporated throughout the curriculum in medical and health care training schools, so that it is integrated through every component of teaching, patient care, and research. Therefore, MHC efforts also require developing programs that can increase providers' cultural awareness, knowledge, and skills, by fostering partnerships between providers and community members that would result in increased opportunities for cultural encounters.

Equally important as increasing health care providers' cultural competency is the need to ensure that patients are able to engage proactively in their own health care experience. If the MHCs personnel integrate a culturally competent approach, then more residents would potentially obtain their health care through the MHC; this would then potentially result in fewer ER visits, and consequently, lower associated health care costs for both patients and the health care system overall.[24,34] The Affordable Care Act positions patient engagement in health care at the forefront due to its potential to transform the practice of medicine.[35] Engaging patients in their own health care requires that patients understand this process, which is intertwined with health literacy. Koh and colleagues[35 [p. 357]] described health literacy as "the patients' ability to obtain, process, communicate, and understand basic health information and services." The authors call for the incorporation of health literacy themes and tools into the ACA-proposed Care Model (formerly known as the Chronic Care Model).

Limitations. This study relied on a small, purposefully selected sample; thus, the results are not generalizable to the neighborhoods or counties where the participants reside or to the Southeastern United States. However, the results do highlight ways to improve health care delivery through MHCs. Participants may have already been predisposed, one way or another, toward the concept of MHCs, and thus began the focus group with a strong bias about

MHCs. However, that does not seem to be the case here as very few participants had prior knowledge about or experience with MHCs.

Two literature reviews[15,36] on cultural competence models found that most studies analyzed only healthcare providers' cultural competence, but did not evaluate patient and health outcomes. Similarly, the present study only explored patients' opinions that reflected characteristics of any of the five constructs included in the Cultural Competence Care Model (CCM)[13], but did not explore participants' health outcomes.

The results represent both the opinions of the particular individuals who participated, as well as additional opinions and viewpoints that may have emerged due to participating in the focus group.[37] Although the focus group format capitalizes on a social context that encourages participants to reflect on one another's ideas, it may also limit the information any one participant can share, inhibit the expression of minority opinions, or limit the participation of individuals who are not notably confident or articulate. Given the cross-cultural nature of our study, some of the rich data and cultural nuances may have been lost when the Spanish focus group discussion was translated into English.

Despite these limitations, the focus groups included community residents who are generally excluded from or marginalized in the traditional health care system (e.g., by virtue of social class, race/ethnicity, geographic isolation) and thus often do not have the opportunity to express their opinions regarding health care delivery. Studies such as ours allow these individuals' voices to be heard and to potentially influence the design of community-based health care delivery systems. Additionally, qualitative studies can provide a foundation for designing larger-scale studies that involve quantitative techniques (e.g., surveys) that are implemented on a larger scale.

Conclusion. As U.S. society becomes increasingly diverse, it is essential that health care providers more fully consider the importance of cultural competence in health care delivery. Our study of MHCs begins to highlight the benefits and challenges of health care delivery for underserved populations. The participants in our study were asked about their expectations for service delivery through the new Health System MHC, which was due to arrive in their communities in the near future. Their responses reflected the participants' desire for culturally competent health care in their own communities, in particular through this new MHC. Collectively, health care providers' cultural competency education and patients' health literacy education could ignite providers' cultural desire in health care delivery and stimulate a culturally sensitive health care partnership. A health care approach based on the CCM could promote a more efficient health care delivery system, as providers and patients would experience qualitatively different, presumably more positive and respectful, interactions with one another.

We found that the Cultural Competence Model (CCM) is appropriate for exploring the role of cultural competence and cultural humility in improving outcomes for low-income minorities through MHCs. By applying the CCM's five-pronged constellation of cultural abilities, health care personnel could ultimately be more responsive to ethnically diverse clients. The model can also be used to develop interventions that promote these cultural abilities among MHC health care providers.

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