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SUPPORTING CULTURAL COMPETENCE: PRACTICES OF MANAGERS AND LINE WORKERS IN A HEALTH SERVICE

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This paper examines approaches and practices of managers and line-workers to support and delivery culturally competent health services. The aim is to explore the connections between managerial and professional practices that sustain or hinder cultural competence. We conducted a case-study of a large health service, located in a central Italian Region, with diversity initiatives underway. We involved four managers and six family planning counselling providers. Data came from interviews with managers and one focus group with the staff. Findings showed organizational commitment toward cultural competence and the perception of mutual support at multiple levels. Also, an evolution toward participation and community-based approaches of cultural competence was found. Data revealed the importance of intra- and inter-organizational communication in order to sustain cultural competence implementation. The main perceived barriers concern the risk of precariousness and resistances, while evidence of inequities, innovative and patient-centered culture emerged as facilitators.

Keywords: Cultural competence; Organizational commitment; Migrants; Health services; Inequities.

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Evidence of inequities in migrant health and minority groups demands health services to adapt in order to effectively provide for diverse populations and needs. "No public health without refugee and migrant health" is the subtitle of the first report on the state of health of migrants and refugees in the European region published by the World Health Organization (2018) that like the Ucl-Lancet Commission on Migration and Health's publication of the same year (Abubakar et al., 2018), collected evidence on the state of health of migrants and refugees dispelling some established myths (i.e., "they bring disease"), highlighting the seriousness of conditions of some groups (i.e., asylum seekers and undocumented migrants), and proposing recommendations with relevant scientific and political implications. Promoting migrants' health requires cross-sector responses and reorientation of health service practices to meet health needs of migrants and remove barriers in access and quality of care. The health of refugees and migrants is extremely complex and there is enormous diversity within these groups. Migrants' health is diverse and dynamic because of numerous interacting influences and risks associated with the migration process (pre-departure, travel, arrival). Refugees and migrants may show remarkable health strengths and resilience, but also may face specific determinants of health such as perilous journeys, violence and exploitation, new lifestyles linked to acculturation, unhealthy living and working conditions, and others determinants linked to social exclusion and discrimination (World Health Organization, 2018). They may also face certain challenges including financial,

administrative, language and cultural barriers impacting access and quality of care — diagnostics, medication, medical follow-up, hospital visits and admission — as well as patients' adherence to treatment.

It is now shared that equity in healthcare requires a "different care" rather than a "one size fits all" approach to service provision that discriminates those whose needs differ from the majority (Browne et al., 2016; World Health Organization, 2020). A key concept is cultural competence (CC), which spread in the United States as a response of the health system to racial and ethnic inequalities evidently witnessed in the 2000s (Office of Minority Health, 2001; Nelson et al., 2002). In the literature, definitions and operationalizations of CC vary referring to different scopes, contexts, and types of diversity (Kirmayer, 2012; Seeleman et al., 2015). So, in the absence of a consensus on its definitions in the medical field, organizations have implemented CC in various ways depending on the local context and their own views (Aggarwal et al., 2016; Bhui et al., 2007). Uncertainty remains among front-line health practitioners and administrators about what CC entails in everyday practice and how to implement it (Mollah et al., 2018; Ng et al., 2017).

Despite advocacy for a systems-level approach to CC, that integrates practices throughout the organization's management and clinical subsystems, the primary focus in the literature and implementation in health care remains on professional strategies, that is, workforce development (McCalman et al., 2017).

The purpose of this article is to complement the existing literature by exploring the perception in healthcare on CC and its practices, considering different organizational levels. In doing so we present the result of a study conducted in Italy, where there is only sparse literature reporting how health services can achieve CC to promote migrants' health.

Cultural Competence: Definitions and Key Dimensions

Cultural competence can be considered an umbrella term for a variety of approaches to make healthcare services more responsive to "diverse" and underserved population: cultural sensitivity, cultural humility, cultural safety, diversity responsiveness. CC is a multilevel and systemic concept that entails the understanding of the importance of social and cultural factors and their interaction at multiple levels of the healthcare delivery system (e.g., at the level of structural processes of care or clinical decision-making) for devising interventions that take these issues into account to promote quality of care (Betancourt et al., 2003).

The most recent development in the concept of CC calls for "diversity responsiveness" targeting vulnerable groups including ethnic and cultural minorities and other related to gender, age, socioeconomic status, religion, sexual orientation (Cattacin et al., 2013; Chiarenza, 2018; World Health Organization, 2020). It called into doubt the very centrality of the concept of culture itself and of ethno-cultural diversity alone, arguing instead for the adoption of an intersectional approach that focuses on the dynamic intersection of all variables that can lead to marginalisation, social exclusion, and disempowerment (Mock-Muñoz de Luna et al., 2015).

Indeed, CC has often been criticized in the literature for relying on a narrow/trait-based conception of culture that treats groups as homogeneous and for the inadequate recognition of the "culture of medicine" (Thackrah & Thompson, 2013) that may lead to stereotyping and focusing on the "otherness" of patients.

Health workers and systems are now urged to take into account all aspects of a person's social context and position in society, avoiding over-focusing on culture. Recent approaches emphasize the need to respond to multidiversity — see the concepts of hyperdiversity (DelVecchio Good & Hannah, 2015; Hannah, 2011) or superdiversity (Vertovec, 2007) — and intravariability within groups. They incorporate patient-centered principles that reinforce the need to acknowledge that people should be treated as individ-

uals (Betancourt et al., 2014; Saha et al., 2008). Indeed, to make CC effective the literature now agrees in using a process-oriented approach of culture which sees it as a dynamic process through which all people make meanings of health and illness, as proposed in the concept of cultural humility (Tervalon & Murray-Garcia, 1998). It recommends self-critique at individual and institutional level and mutually nonpaternalistic clinical approaches, seeing the patient or client as a collaborator.

CC is therefore strictly linked to a participatory approach. Designing and implementing inclusive healthcare and CC practices requires addressing power imbalance at different levels and the involvement of all groups of beneficiaries and stakeholders to build collaborative relationships for increasing quality and access (De Freitas et al., 2014; Ingleby, 2011; Napier et al., 2014).

Implementing Cultural Competence in Health Services

Effective implementation of CC requires a systems approach: an *integration* of values and principles, behaviors, attitudes, policies, and structures that enables healthcare organizations and professionals to work effectively (Cross et al., 1989; McCalman et al., 2017). CC encompasses addressing sociocultural issues at the clinical, programmatic, institutional, or societal level in a thoughtful and integrated way:

> For example, a clinician, regardless of training, may not be able to provide culturally competent care in a program and an organization that do not support diversity. Organizations and programs, in turn, may encounter barriers in improving their cultural competence without accompanying advocacy work at the systemic level to improve policies and legislation, funding, and other systemic social inequities (Fung et al., 2012, p. 167).

CC practices and strategies involve multiple domains: organizational commitment, empirical evidence on inequalities and needs, a competent and diverse workforce, access for all users and responsiveness in care provision, patient and community participation, cooperation with other organizations and across sectors to promote equity (Seeleman et al., 2015). For example, CC practices could include the training of staff, diversification of the workforce, use of cultural mediators and interpretative services, adaptation of protocols (Freeman et al., 2014; Handtke et al., 2019). Developing CC is described as an ongoing effort. Cross and colleagues' (1989) model defines CC as a continuum from cultural destructiveness to cultural proficiency where diversity responsiveness is a high priority, guides all endeavours, and is integrated in multiple domains. Similarly, Fisk and colleagues (2019) proposed 4 typologies of CC in organizations — compliance based, disengaged, ad hoc, inclusive — which differ in the level of commitment and support to diversity management and the degree of institutionalization that makes CC practices more or less permanent, deep, shared, or integrated. In the first case, the organization performs the minimum amount of actions necessary to be compliant with a policies or legal requirements on diversity management; in the second one, it may have well-established programs and initiatives, but little integration among other programs; in the third one, it is likely characterized by staff members, who pursue voluntary diversity management programs without formal organizational support or access to resources. Finally, the inclusive type makes deep and systematic efforts to improve its cultural competency and to institutionalize the related programs and values (e.g., it has a strong relationship with a variety of minority groups and programs in place to nurture future leaders) and is cognizant of its organizational climate related to diversity.

Embedding cultural competency in organizational managerial practices can facilitate change within organizations and in clinical subsystems. Providers may be influenced by their organizations' commitment and actions in relation to cultural diversity and vice versa (Truong et al., 2014). In particular, a sys-

tematic review of organisational approaches to improving CC found that organisational commitment, user participation, and delivery across multiple sites were key principles for implementing systems approaches (McCalman et al., 2017).

Following this approach, some studies have investigated the role of organizational levers for implementing CC, such as leadership and organizational climate. Dauvrin and Lorant (2015) found evidence that CC of the healthcare staff was associated with the CC of the leaders, while Guerrrero et al. (2017) highlighted the importance of organizational climate in maximizing the influence of transformational leadership on employees' CC practices in health care. However, previous studies showed that organizations have better performance in patient-related cultural competency practices, such as data collection on inpatient populations, interpreter services, and clinical cultural competency practices but tend to lag in integrating cultural competency into management practices, such as leadership and strategic planning, community representation or cross-sector collaboration (Chiarenza et al., 2020; Cunningham et al., 2014; Weech-Maldonado et al., 2002, 2012, 2018; Whitman & Davis, 2008).Various studies interested in exploring perceptions about CC through a systems approach have shown how the difficulties professionals' have are related to the lack of organizational support (Taylor & Alfred, 2010) and that managers and line workers have different, and sometimes conflicting, perceptions about the meaning of diversity and CC (Adamson et al., 2011; Aries, 2004). Managers may show little understanding of culturally competent clinical practices or show individual visions of CC (Adamson et al., 2011). Poor integration and communication between levels and departments results in inconsistency with which culturally competent care, including translation services, is offered. In addition, most administrators define CC through group-based, demographic traits compared to person-centered definitions (Adamson et al., 2011; Aggarwal et al., 2016), and staff may show resistances that can also hinder the delivery of CC practices in a consistent way. Some authors reported additional institutional and systemic challenges to CC, such as limited inter-professional relationships and financial resources, time and technological pressures, lack of state governement funding, and anti-immigration policies (Aggarwal et al., 2016; Suphanchaimat et al., 2015).

Aims of the Study and Methodology

Based on these previous studies, the aim of the study is to explore the implementation of CC in healthcare by looking at the integration between managerial and front-line practices in the delivery system and to understand how CC can be supported. The following broad questions guide this investigation:

- What are the meanings attributed to CC as an organizational and service strategy?
- How is CC translated into organizational practices and supported? What role do participatory practices play?
- What are the barriers and facilitators to CC?

The research design was qualitative, with a case study approach (Yin, 2005), an approach that, according to Mertens (2005) "represents a depth of information rather than breadth" (p. 345). In this study, conducted in 2018, the case was a particular health care organization. Specifically, the selected sites for the study were organizational contexts with diversity initiatives underway.

Following a systemic approach, we explored the following two levels: the *corporate/institutional level* and a *health-service level*, here considering both middle management and staff. At the first level, the organization was selected with the contribution of key informants expert in this research field. It is a large local healthcare organization, ASL[1], divided into three administrative areas, located in ethnically different

communities, and situated in a region in the Center of Italy. It represents one of the rare cases in Italy with a formalized leadership on migrant health in top management. At the second level, within this organization we identified, through interviews with managers, a health service renowned for its commitment to migrant sensitive care. The health service is a family planning counselling service located in a medium-sized city in the same region in the center of Italy.

We used a purposive sample: participants included, at the institutional level, managers and personnel who had the lead responsibility for CC implementation (n = 4) and, at the health-service level, the manager and a sample of the family planning counselling staff (n = 6). Data collection included individual and group interviews.

At the institutional level, we interviewed the head of the migrant health division, the health director, the past manager of cultural mediation of the communication sector and an informal leader on CC, a speech therapist from the mental health department who promoted CC projects. At the health-service level, we interviewed middle management, that is, the family planning clinic director, and we conducted a focus group with front-line workers: a gynaecologist, a midwife, a nurse, a cultural mediator, and a social worker (see Table 1). Using a semistructured guide, participants were asked about efforts to reduce health inequalities, community participation, diffusion of CC in the organization and support available to deliver such care, barriers and facilitators of CC, and suggestions for improvements. For the interviews and the focus group the same areas of investigation were defined to favor the comparison between levels, but the questions were tuned to the professional specificities.

TABLE 1
Participants and instruments

Participants				Instruments
Gender	Organizational role and duties		Division	
F	Managerial	Head of the Migrant Health Division	Health Direction-Promotion and Health Etics	Interview
F	Managerial	Socio-Health Director	Socio-Health Direction	Interview
F	Managerial	Past interpretation service manager	Communication Division	Interview
F	Staff, with informal leadership on CC projects	Speech therapist	Mental health program	Interview
F	Middle Management	Gynaecologists, Family clinic director	Family planning clinic	Interview
F	Staff	Midwife	Family planning clinic	Focus group
F	Staff	Gynaecologist	Family planning clinic	
F	Staff	Social worker	Family planning clinic	
F	Staff	Cultural mediator	Family planning clinic	
F	Staff	Nurse	Family planning clinic	

The interview was aimed at exploring in depth the management practices connected to CC and its implementation, "with respect to the interpretation of the meaning of the described phenomena" (Kvale, 1983, p. 174). The focus group was conducted with a "natural group" and was chosen to encourage the emergence of shared practices and meanings around CC implementation, in the idea of having access to the

organizational culture that supports CC within a service. In fact, we consider professional practices, and thus CC professional practices, as deeply shaped by the team behavior and norms. Unlike the individual interview, the data collected through the focus group, which is thought as a "social space," is the result of a discussion between several people (Kitzinger, 2006).

Since in Italy the terms CC is not widespread, we did not use or operationalize it. Also, we wanted respondents to define their practices within the context of their own work. The average length of interviews was 60 min (minimum 30 – maximum 75); the focus group interview lasted 90 mins. All of them were taped and transcribed.

Data was analysed using thematic analysis (Braun & Clarke, 2006) and managed in NVivo version 11. The relevant material was selected and was subsequently encoded according to themes emerging from the data set. Identified themes captured important aspects of the data in relation to the research questions. The credibility of analysis, as criterion for the qualitative research, was assessed through supervised sessions to check the coding strategies and to review the interpretation of the data, by discussing any reason of variation (Barbour, 2001). Rival configurations of themes were ultimately modified (Patton, 2002) and quotes were selected that best illustrated themes from the participants' perspective. All participants gave written informed consent and authorized and approved the use of anonymous data for publications.

RESULTS

The data has been organized into different sections that represent the main themes of the analysis. They are first presented by describing the common subthemes and then the specific ones of the levels considered: the institutional one and the health-service one. Textual citations of the participants are referenced by the number of the cited interview, from I.1 to I.10, and the professional role (manager, middle-manager, staff).

Migrants' Health and Diversity

According to the interviewees, dealing with diversity poses challenges due to the socio-cultural barriers, access and quality of care, and to the presence of health inequities. Although they reported the presence of multiple ethnic groups, interviewees mainly focused on the Bangladeshi community (the second biggest group in the area) and the newly arrived asylum seekers often called and recognized as Nigerians.

They talk about "diversity" in a way that tends to limit the "othering" (Johnson et al., 2004) of migrants users, recognizing at different degrees the role of supply-side factors such as their own biases in the clinical relationship — "I personally had this thing, this cultural barrier" (I.8, staff) — the unpreparedness of professionals and services to cultural or linguistic needs — "uncorrected diagnoses, inability, incompetence in bilingualism" (I.1, manager) — and the role of exclusion mechanisms or social determinants on health. However, sometimes they referred to ethnic communities and cultural groups as homogeneous.

At the institutional level, some managers described some migrant groups as particularly vulnerable because of social factors: an interviewee reported that inequalities derive from the "sanitization" of social problems, or underlined the intersection between gender and ethnicity to explain health inequality. Managers, by referring to the variety of ethnic and migrant groups, illustrated specific and prior health inequities (i.e., access, voluntary termination of pregnancy, diabetes, learning and intellectual disabilities in

bilingual children) that the epidemiological analysis and need assessment interventions had shown in the served area (see the Section "Migrant-Sensitive Healthcare Practices").

At the service level, the manager and the front-line staff spoke more specifically about the difficulties of confronting with diversity because of the linguistic and cultural barriers in the clinical relationship. Some participants underlined the frustration of misunderstandings — "we had the feeling that the information was not coming across correctly" (I.5, middle manager) — and noncompliance in the clinical relation. They seemed fatigued by the change in user population caused by the recent arrival of asylum seekers, for the higher perceived cultural gap, lower health literacy, and for cultural health problems (i.e., female genital mutilations). Even if front-line staff spoke sometimes of foreign users referring to "ethnic groups" and cultural habits, the middle manager and some staff seemed to recognize their role in creating communication barriers or building cultural differences. In fact, they stressed the difficulty of not categorizing users for their origin and the middle manager described the relationship with diversity as improvable over time.

Sustaining Migrants' Health as Priority: Drivers and Approaches

There was a shared perception, among the participants, of the current organizational commitment to support CC on one hand and on the other, at the same time, of a patchy diffusion of culturally sensitive practices across departments. The organization indeed was sometimes described as a "trailblazer" in the area and the family planning clinic was valued as a role model.

The goals of reducing inequalities and promoting equity in access and quality of care — "not to exclude groups" (I.5, middle manager) or "give the same opportunities" (I.2, manager) — were mentioned as drivers for implementing CC at different levels. Managers, in particular, associated culturally competent practices with the aims of promoting health, preventive healthcare, and cost-effectiveness.

For all participants, developing CC required tailoring practices to different migrant groups and their cultural, linguistic and social needs, flexible intervention to local needs — "there isn't a recipe" (I.2, manager); "there isn't an expert of migrants" (I.1, manager); "there isn't one best way" (I.5, middle manager) — and supporting the participation of migrants' communities and stakeholders.

Developing CC was seen as a long process of continuous learning and innovation. At the institutional level, implementing CC meant "intercultural support" in the whole organization and avoiding "special services." A senior manager in particular described the organizational objective as promoting a "preventive infrastructure" (I.2, manager) for helping providers in the clinical relation with migrant patients, establishing shared organizational practices, providing linguistic and cultural mediation services and collaboration with communities and social services.

At the health-service level, for many practitioners developing CC required a "reflective attitude" to respect diversity — "keep the warning light on" as a provider said (I.8, staff) — questioning organizational, specific professional practices, and "cultural understanding."

A great deal of uncertainty was prevalent on what constitutes appropriate culturally competent practices — culturally competent practices were cited as "attempts" — especially in relation to the change in the served population: "Things change quickly, everything changes; this is the most difficult thing: once you seem to have understood . . . it is no longer the right thing to do" (I.5, middle manager). Some participants stressed the need of developing "cultural understanding" that means differentiating practices by mi-

grant groups and at the same time avoiding stereotyping, by recognizing everyone's diversity, following a patient-centered perspective in the clinical relationship.

As previously discussed, supporting the participation of migrants' communities and stakeholders is described as one of the most important drivers for CC implementation. Most participants recognised that listening to patients as well as to communities is critical to deliver CC care. Some managers value building partnerships with communities' representatives and organizations as a way to enhance trust and access, others as way to lead CC development.

Family planning clinic practitioners value not only community's participation but also patients' involvement as a way of *tailoring* practices to cultural needs instead of requiring adaptation. For the middle manager engaging communities facilitates to overcome an ethnocentric perspective and "negotiate" cultural practices. Otherwise, they also underlined the complexity of patient-centered access and the need of negotiating between the organizational values, as efficiency, and the cultural values of the patients, such as in the case of scheduling of appointments. Someone, in addition, discussed the concerns of creating ghettoization by implementing interventions for specific groups.

Migrant-Sensitive Healthcare Practices

Managers spoke about current organizational efforts to integrate CC in their practices. Epidemiological analysis and data collection were primary strategies for developing organizational commitment and defining priorities. Evidence of inequities has favoured the establishment of a Division in the Top Direction dedicated to the promotion of migrants' health, during last year, for coordinating CC implementation within the organization and with external stakeholders — i.e., the regional center for migrants' health, prefecture, some migrant associations. Referents of migrants' health were also appointed for each organizational area, following a regional policy. Then a need assessment has been implemented, also to define an organizational plan: the migrant's health division manager held meetings with some departments and experts, to share data and perspectives on migrant health and to access and collect good practices. Further efforts concerned managing and obtaining financial resources or external funding or inserting some planned interventions in the organizational policies. In addition, to sustain involvement the division manager promoted the participation of some migrant associations in the consultation forum.

In the following subsections, we will present some specific strategies implemented both to promote access and quality of care, and migrants' participation.

Promoting Access and Quality of Care

At the institutional level, managers illustrated efforts to institutionalize already developed practices and projects and implement new interventions in specific departments (e.g., mental health department) or through intraorganizational collaboration. A cultural mediation comprehensive strategy was established to provide cultural mediators — both in-house to support teams in some services, and with external service provider — and "health community educators" (HCE). In the mental health service, by following an Asylum, Migration and Integration Fund (AMIF) project, it was planned to supervise the teams to develop CC and, for the assessment of learning disorders for bilingual children, to introduce specific clinical tools. For sustaining intraorganizational collaboration, an integrated care pathway was

planned for promoting access and preventive care for refugees, and initial meetings were held to define procedures to guarantee entitlement.

In the family planning clinic, participants mainly described communication practices in clinical relations and in health promotion interventions for screening and maternal care with specific ethnic groups, and, to a lesser extent, practices to facilitate entitlement. Line workers believed that collaborations with other services need to be improved such as sharing and evaluating CC practices. Also, it seemed useful to develop further interventions to address specific targets' health problems (e.g., sexual education for adolescents). The in-house cultural mediator (who speaks Bengali), as part of the team, was described as a "great achievement" for supporting professionals and access, narrowing the gap with communities. Front-line staff discussed the help of professional mediators for doctor-patient communication and for understanding cultural differences (e.g., eating habits). They also expressed satisfaction for the institutional linguistic service, even if the telephonic interpretation was seen as less used and too impersonal. An interviewee described her effort, in a three-way communication, to establish a relationship of trust with patients by speaking in English and using the mediator as supervisor. She also explained her effort in doing similitudes between different medical systems to address patients' low health literacy. A central strategy — which has been present for 10 years — is the pre-birth course with the cultural mediators for users who speak Bengali or Hindi. The interviewees valued the training events that address "sentinel events or critical issues": for example, the recent on-the-job training, a pre-birth course conducted under the supervision of an anthropologist, for tailoring practices to the needs of female asylum seekers.

Participative Practices

Participants described practices for involving migrants' communities by using community health educators, according to an outreach approach to promote access, as the middle manager expressed: "it's time to go to their homes" (I.5, middle manager). Moreover, they reported collaborative relationships that have been developed with nongovernmental organizations (NGOs) with expertise on migrant health and institutions such as schools and organizations of the reception system for refugees. These relations were seen as essential for co-planning CC interventions like health promotion projects and training.

At the institutional level, they talked about the institutionalization and support to some participative practices. For instance, the role of health community educator was introduced in organizational policies, as seen above; a convention was stipulated with the the Italian Asylum Seekers and Refugees Protection System (SPRAR); and in the mental health department a project was co-planned with a migrant association for the after-school service for bilingual children.

At the health-service level, participants valued two projects, proposed by a local NGO, for implementing the health community educator. On these occasions, cultural mediators and providers were trained to carry out collaborative research and health education in the service and in the places where the migrant communities used to meet. The interviewees underlined consequent benefits for access (reaching a high number of people, activating informal peer education processes) and for their professional practices:

> That was a true opportunity to gather important information, and it is really interesting because the method of working with the community was really innovative for us. So we then re-proposed it with the Nigerian women, asylum seekers . . . In my opinion, this was not only the use of mediation, but precisely about giving a voice to the needs of the community by building paths within the community. (I.6, staff)

Not only this, they also presented the pre-birth courses as an opportunity to listen to health needs and to explain, with the cultural mediators, the informed consent to labor analgesia. It has emerged, also, how relationships with different stakeholders were used for intercepting and understanding migrants' health needs: "The educators are telling me that they [asylum seekers] asked where to do the FGM [female genital mutilation]" (I.5, middle manager).

Supporting CC Implementation: Barriers and Facilitators

It was possible to identify the main common barriers and facilitators to CC. The former ones concern low organizational commitment, resistance to change, racism, and low migrants' participation. The latter ones concern the support of management and of the team, a patient-centered and innovative organizational culture, plus external drivers.

Barriers

In relation to organizational support, participants spoke about leadership, economic resources, and the long-term effects of interventions. Some managers expressed concerns about the risk of the precariousness of the actions implemented for the future change of the Health Director or the non-formalization of some CC role and practices in the services. Furthermore, one manager pointed out that the network of migrant health referents was still ineffective and the management of external funding very onerous.

At the service level, staff believed that the lack of structural financial resources is an impediment for developing new CC practices for other migrant groups and projects are at risk of becoming one-time efforts. For this reason, they expressed the need for more support on the evaluation of interventions:

> The return of what you do, that is if it works, if it doesn't work . . . That is, we made this project, what came out of it, that is, someone who gives us back the results in a slightly more complete and complex way. (I.7, staff)

Everyone, and especially managers, recognized that CC development can be hampered by resistance to change, notably in health services with lack of financial or organizational resources, or by prejudices or systemic racism. Some participants talked about differences in the sensitivity to CC and the risk of delegation among colleagues or services. The middle manager talked about the difficulty when speaking openly about discriminative behaviors and of creating intraorganizational collaboration. The anti-immigration climate and policies at the national and local level, for managers and middle manager, pose the risk of media controversy and can negatively affect access. Participants mentioned, as an additional impediment, the closure of a municipal intercultural services, central in the area, due to a political change in the municipal administration.

Some managers reported difficulties in guaranteeing migrants' representation for the high number or the informality of migrant associations; one, in particular, discussed the risk of tokenism, that is, of making only a perfunctory effort in involving communities. Front-line workers focused on some difficulties of identifying members of the communities for engaging users in health education intervention. Participatory practices with migrant users and with the wider community appeared not systematic in the

organization. Some interviewees outlined the difficulty to find effective ways to involve migrant users and greater barriers for newly arrived groups.

Facilitators

There was a shared perception of organizational support among the different levels — top and middle management and professionals — in a reciprocal way in terms of responsiveness and collaboration. For managers and middle manager, training, recognition of inequalities, and evidence of CC cost-effectiveness seemed to have a facilitating role to support CC among professionals and reduce resistances and burnout. Besides, a shared culture of patient-centered and innovation were felt as a lever to invest in CC practice. While managers valued more the sensitivity of the top management and the Health Director, in the service also the support of the team was heightened. Below there is a representative comment of a front-line worker:

> The manager responsiveness and the willingness of managers to make us participate, to get involved, and to change practices . . . to continually rethink them, that is, a liveliness here […] and surely the desire to work a little on this issue as a group, however, is also given by a need, because we aren't the best. A need to address an inequality. (I.6, staff)

Some regionals policies and organizations, such as the regional structure for the health of migrants or a local ONG, are cited by managers as drivers for the development of CC, but at the same time, someone at different levels expressed the need to improve coordination among the different institutions which care CC diffusion and implementation.

DISCUSSION

This article has analyzed CC meanings and practices and related barriers and facilitators according to a systems-level approach that considers the integration between managerial and professional practices and emphasizes the role of community participation.

Data confirms that there are multiple and diversified views on CC and highlight the dynamic ways in which the multiple organizational stakeholders contribute to delivering culturally competent care. The meanings attributed to CC may vary based on the role and perspectives on diversity, but unlike previous findings that attested tremendous differences (Aries, 2004), we have found some convergences on the central aspects of CC. More specifically, data showed that, although perceived as unsystematic and to be improved, participatory practices and collaborations with stakeholders are central aspects of managerial and professional practices for sustaining inclusive healthcare. If in part these results may be related to the type of sampling that we used in this research (since we selected contexts with diversity initiatives underway), they can also be explained by the positive relationship between the institutional and the service levels.

The study contributes to understanding the implementation of CC not only by looking at the type of CC practices implemented, but also at the role of organizational commitment and the interaction between different levels and systems. The results of the study photographed the organizational characteristic in a phase of new investment toward CC, showing at the same time the commitment to the development of interventions and the continuous challenges encountered in the implementation of CC. Many interviewed showed great commitment to CC, demonstrating interest in our research, asking questions about what other organizations were doing, and manifesting their personal commitment to support development in this area.

Referring to Fisk and colleagues' model (2019), it can be said that the organization is in a phase of transition from the "ad hoc" typology, where staff members at the service level pursue voluntary diversity management programs without (or with little) formal organizational support, toward the "inclusive" one, that is characterized by systematic efforts, sustained by top management, to ensure the sustainability of CC over time.

Our results show the positive role in supporting CC implementation of organizational and managers' support, especially from middle management, which enhances staff participation, innovation, and patient-centered values, and thus "CC climate" in the work group. Data allows us to understand the specific barriers and facilitators of the organization in its transition toward the "inclusive" typology.

Organizational commitment is visible at all levels and is felt as a reciprocal support, confirming previous literature (Guerrero et al., 2017; Truong et al., 2014), while part of the barriers to CC implementation seems to concern the little internal and external diffusion of CC practices and their unsystematic nature. In particular, data shows that middle managers and staff may experience an uncertainty about the meaning and enactment of diversity management (Irizzarry & Garrant, 2006). This uncertainty can be exacerbated in the absence of intra- and inter-organizational references (Dogra et al., 2009) and by the hyper-diversity (Hannah, 2011; DelVecchio Good & Hannah, 2015) of users. Indeed, CC was perceived as a continuous process of learning and of innovation, that requires habitual practices to be reconsidered. Team support facilitated CC development, but at the same time, middle managers need support for promoting equity values in the team and specifically for dealing with discriminative practices.

The health-service makes proactive efforts to develop migrant-sensitive care and there is a good degree of institutionalization for a few programs on one hand and low intraorganizational collaboration on the other hand, which highlights the risk of isolation and the importance of top management support.

A key point is that organizational commitment relies on a systemic approach that allows viewing CC not only as a result of professionals' responsibility (Aries, 2004), but also of the continuous organizational support. To support CC at a managerial level, our data highlight the importance not only of integrating CC into managerial practices through formalized data analysis, leadership, strategic planning, and financial resources but also intra-organizational communication strategies and policies as reported in the previous literature (Aries, 2004; Fung et al., 2012; Harper et al., 2006). For example, the need assessment linked together with data on health inequities promoted a shared vision on migrant health problems, thus reducing the risk of disconnection due to the complexity and the size of the organizations (Taylor & Alfred, 2010). In this way, CC senior managers could be cognizant of the organizational climate toward CC and could support good practices already developed at service level. In this sense, the role of middle management or informal leaders in transforming forms of organizational disharmony into learning opportunities for the teams is vital, otherwise, managers may experience exacerbated change resistances. In addition, data suggest to invest in the evaluation of interventions' effectiveness, to make CC more systematic, and to reduce uncertainty about the implementation, as reported by frontline staff.

Another main axis of intervention for leaders is the development of participatory practices for planning and delivering CC interventions, despite the difficulty of promoting a participative leadership model that requires a change in organizational values. For example, at the managerial level initial steps were taken to involve migrant associations in consultation bodies.

According to a systems-level approach, it is also important to pay attention on one hand to the influence of anti-immigration policies and the climate on the development of CC practices, and on the other to the importance of developing managerial skills in advocacy and care of the organizational image in order to manage media controversies or resistances to CC and value intervention efficacy.

Our results contribute to the identification of the key elements that constitute CC. Commitment to CC is based on the aim to contrast health inequities: at all levels, CC means also tailoring interventions for different groups based on ethnicity or migrant status. As previous scholarship outlined, CC requires, through participative processes, flexible responses to local needs and diverse groups at the organizational level (Freeman et al., 2014, Truong et al., 2014) and individualized practices at the professional one. However, the data has shown that understanding diversity remains complex, so the concept of hyperdiversity (DelVecchio Good & Hannah, 2015; Hannah, 2011) and the importance of integrating different perspectives and approaches between levels seem useful to avoid essentialization, that is, reducing the overfocusing on culturalist explanations, ignoring individual needs and the structural factors behind inequities. We found differences depending on one's role in the organization and conceptions of diversity for the focus on social, cultural, or individual needs and on the intravariability among groups (Aggarwal et al., 2016). Sometimes migrants were addressed as cultural groups and repeated use of the ethnic term could underlie an understanding of culture as static. At the service-level dealing with cultural and linguistic diversity seems central and some participants defined culturally competent professional practices through a patient-centered approach, based on a process-oriented vision of culture. These data, consistent with previous findings (Adamson et al., 2011; Aggarwal et al., 2016), can be explained as the results of CC training implemented in the service and the daily interfacing with different patient populations.

The evoked dimensions of self-critique and negotiation are consistent with those CC definitions that emphasize the deconstruction of medical expertise and the participation of the patient and communities (Muntinga, et al., 2016; Tervalon & Murray-Garcia, 1998). Reflective and participatory dimensions are essential to develop the "cultural understanding," that is, the ability to consider diverse needs avoiding stereotypes (Irizzary & Gallant, 2006; Johnston & Herzig, 2006) and to address asymmetries of power by implementing group-based practices (Suphanchaimat et al., 2015).

Adapting practices, structures and policies aims to reduce linguistic and cultural barriers and to promote access and entitlement, health promotion, and participation. Consistent with a systems-level approach, workforce development interventions, such as on the job training and staff supervision, support team's practices and reflexivity, as suggested by recent literature (Chiarenza et al., 2019; Jongen et al., 2018), avoiding CC to be seen as the responsibility of a specific staff (Adamson et al., 2011). In relation to multiple perceptions on CC, it seems that an effective mediation and interpretation service is central as well as a patient-centered approach to reduce the intrinsic risk of a categorial approach to CC at the clinical level, that is, the risk that mediators become the main interlocutors by assuming conversational dominance or reinforce their role as experts on the patients' cultures thus disempowering patients (Dell'Aversana & Bruno, 2017, 2018, 2020; Verrept, 2019). Data shows an evolution toward community-based approaches — which aim to mobilize the health resources that communities already possess in a way that benefits health services and communities. Thanks to the relationship built up over time, the collaborative processes now concern few ethnic groups, but given the barriers highlighted, further support is needed to reach other migrants groups and not only a well-organized community but also smaller or marginalized groups.

Practical implication, Limitations, and Future Developments

In relation to practical implications, data makes a contribution to the operationalization of CC, not only in terms of front-line strategies, but also in terms of managerial strategies that are less explored in literature. While considering the specificity of local contexts, data suggests in particular to developinng intra-

organizational communication and monitoring practices. Differing perceptions about the meaning of diversity need to be reconciled. It also highlights some implications for CC training in health services: training needs to be context-specific and practices-based and should be specific to the different professional levels, taking into account the competencies and difficulties of the professional levels. As for the managerial level, training should address the issues of CC as a systemic construct, the role of organizational support, participative practices, and barriers in implementation processes.

The in-depth nature of the case-study limited participation to a small number of participants. A more detailed survey of health services would likely identify additional strategies and barriers to the implementation of CC in the whole organization. Collecting evidence of the efficacy of the strategies was beyond the scope of this study, but further research could include a more systematic investigation of strategies in different types of services and the impact of these strategies from the point of view of staff and service users.

NOTE

1. Italy's health care system is a regionally based national health service. At a national level it is responsible for ensuring the general objectives and fundamental principles of the national health care system. Regional governments, through the regional health departments, are responsible for ensuring the delivery of a benefits package through a network of population-based health management organizations (Azienda Sanitaria Locale, "local health enterprises," ASL) and public and private accredited hospitals. https://www.euro.who.int/en/countries/italy

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