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Cultural Competency Training in Primary Care: A Pilot Project for Improving Culturally Competent Care

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Cultural Competency Training in Primary Care: A Pilot Project for Improving Culturally Competent Care

Submitted in partial fulfillment of requirements for the Doctor of Nursing Practice at Eastern Kentucky University

By

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Abstract

As America grows increasingly diverse, there is a recognized need for increased cultural competence in Nurse Practitioners (NPs) and other healthcare workers. Research has shown that when health care providers are not attentive to providing culturally competent care, there is a subsequent negative impact on the quality, safety and cost of patient care. Cultural competency is a recognized and popular approach to improving the provision of health care to racial/ethnic minority groups in the community with the aim of reducing health disparities in racial/ethnic minorities. The project sought to improve NPs' and other health care workers' abilities to provide culturally competent care through a one-hour cultural competency educational training program. Cultural competency of NPs and health care workers was evaluated with a pre- and post- training using the Cultural Competence Assessment (CCA) tool at a primary care clinic serving a large minority population.

Keywords: cultural competence, cultural competency, nurse practitioners, cultural competence assessment, primary care

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By

Diane Riff

DNP Project Advisor	Date
DNP Project Team Member	Date
DNP Coordinator	Date
Dept. of Baccalaureate & Graduate Nursing Chair	Date

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Cultural Competency Training in Primary Care: A Pilot Project for Improving Culturally Competent Care

The population in the United States (U.S.) is increasing in diversity. The total minority population in the U.S. will increase by 108% from 116.2 million people in 2012 to 241.3 million people in 2060 (U.S. Census Bureau, 2012). As the population becomes more diverse, it is increasingly important for Nurse Practitioners (NPs) and other healthcare workers to address health disparities by improving cultural competency. Disparities in health and health care not only affect the groups facing disparities, but also limit the quality of care and health for the broader population and result in unnecessary costs (Smedley & Nelson, 2002). The purpose of this project was to improve cultural competency among NPs and other health care providers.

Problem Description

Cultural competency is a broad concept used to describe a range of interventions that seek to improve the effectiveness and accessibility of health care services for people from racial and ethnic minorities (Troung, Paradies & Priest, 2014). Research has shown that when health care providers are not attentive to providing culturally competent care, there is a subsequent negative impact on the quality, safety, and cost of patient care (Smedley & Nelson, 2002). Racial and ethnic minority patients and patients with Limited English Proficiency (LEP) are more likely to suffer adverse events when compared to English speaking patients (Horvat, Horey, Romios & Kis-Rego, 2014; IOM, 2003).

Higher quality, patient centered, and culturally based care can occur when the patient, family, and community expectations are in alignment with the health care provider's knowledge and cultural competency (Doorenbos, Schim, Benkert, & Borse, 2005). Empirical evidence

supports the implementation of a cultural competency training program as an effective strategy in improving the cultural knowledge, attitudes, and skills of health care providers (Beach et.al, 2005; Horvat, et al., 2014; McClimens, Brewster, & Lewis, 2014). Additionally, research has supported the implementation of cultural care training programs for healthcare providers as an effective method for improving patient health outcomes and reducing disparities in healthcare (Troung, Paradies & Priest, 2014).

Literature Review

A review of the literature was completed and summarized to synthesize significant studies to utilize results to improve clinical practice. Three main data bases were used to find applicable studies and included using Cumulative Index of Nursing and Allied Health Literature (CINAHL), PubMed and PsychINFO. Key search words used included the MeSH entry terms cultural competency, cultural competence, Nurse Practitioners, and educational programs. The search was limited to adult populations. A total of five studies were selected that investigated the use of cultural competency training to improve culturally competent care.

Debiasi and Selleck (2017) used a mixed method design to assess the cultural competence of eight NPs before and after the implementation of a one-hour online PowerPoint cultural competency training program. This study took place in two NP run primary care clinics in a large metropolitan city in the Southeast United States. Both clinics served uninsured or underinsured clients. Participants in this study completed the 25-item Likert scale Cultural Competence Assessment (CCA) self-assessment survey that measures cultural awareness, cultural sensitivity and cultural behavior (Schim, Doorenbos, Miller & Benkert, 2003). The NPs completed the CCA pre-training and three weeks post-training. Surveys were anonymous and a

matched pair analysis was not completed. Pre-training and post-training results were compared in SPSS for effect size estimation. There were two areas where the Cohen-d values reflected a large effect size *(d* =.08). NPs reported an increase in cultural assessment documentation and decreased stereotyping. All NPs reported the training as valuable. Four NPs reported in-person training would be more valuable than an online training session.

In a similar study, Elminoski (2015) explored the impact of a three-hour cultural competency workshop on the cultural knowledge and cultural competency in a convenience sample of 18 NPs in a Western New York heath care clinic. The workshop content included steps to culturally competent care, considerations of cultural care, communication barriers and use of interpreters. Kleinman's (1980) Patient Explanatory Model of Illness was also presented to the participants. The NPs completed the CCA prior to and eight weeks following the program. Pre-test and post-test data were analyzed using a paired *t* test. Results of the data analysis were statistically significant (p=.004), indicating the workshop had a positive impact on cultural awareness, cultural sensitivity and cultural behaviors of the workshop's participants.

Schim, Doorenbos and Borse (2006) studied the effects of an educational intervention aimed at expanding cultural awareness, sensitivity and competence with a multi-level team of 130 multidisciplinary hospice workers in the community setting using a quasi-experimental longitudinal design. The educational intervention consisted of a one-hour session including cultural diversity, cultural awareness, cultural sensitivity, and cultural information for specific populations served in the community agency. The CCA survey was utilized to measure cultural competence at three intervals (pre-intervention, immediately after intervention, and three months post-intervention). Findings revealed cultural competence scores were significantly

greater immediately following the educational presentation *(p*=.034). The three-month post-intervention CCA scores were higher than the pre-intervention scores but were not found to be statistically significant.

Ohana and Mash (2015) investigated the correlation between the different perceptions of physicians and patients' perceptions of the physician's cultural competence. The study population included 90 physicians working in a hospital's outpatient clinic and 417 adult patients. Four to six patients were surveyed per physician. This study utilized two different questionnaires to gather information on the main study variables: the physicians' perception of their own cultural competence and the patients' perception of the physicians' cultural competence. A significant correlation was seen between general satisfaction of the medical care and the following variables: patients' perception of the cultural knowledge and cultural ability of their physicians (r=97, P<0.01 and r=.94, P <0.01, respectively). Therefore, the more patients assess their physicians as culturally competent, the more satisfied they are with their medical treatment.

The final study utilized a nonrandomized control study that evaluated the effectiveness of a patient centered cultural competence training program for 76 dental health practitioners using assessments of standardized patients (Prescott-Clements et al., 2012). The treatment group received two cultural competency, four hour, training sessions and the control group did not. Both groups had the same amount of prior patient contact. The training sessions included standardized patient scenarios and facilitated small group discussion. Cultural competence was evaluated before and four months after the training sessions using a 10-point interval rating scale. Higher scores indicated a higher level of culturally competent behavior. Interrater

reliability was established. Practitioners who had received the cultural competence training had statistically significant higher scores than the control group ($p < .01$).

Synthesis of Literature

Five quantitative studies were selected to guide this project based on the quality of the evidence determined by Melnyk's Hierarchy of Evidence for Intervention Studies (Melnyk & Fineout-Overholt, 2015). All five reviewed studies support cultural competence training to enhance cultural awareness and cultural behavior resulting in improved patient satisfaction and enhanced patient provider relationship. Three studies supported the use of the CCA as a reliable instrument to measure cultural competency (Elmonoski, 2015; Debiasi & Selleck, 2017; Schim, Doorenbos & Borse, 2006).

Evidence supported the use of cultural competency training programs to improve the cultural competency of NPs and other health care providers (Debiasi & Selleck, 2017; Elminoski, 2015; Prescott-Clements et al., 2012; Schim, Doorenbos & Borse,, 2006). An additional benefit of cultural competency training is improved patient satisfaction. One study concluded the more a patient views their provider as culturally competent, the more satisfied they are with their medical treatment (Ohana and Mash, 2015).

Standards of Practice

The U.S. Department of Health and Human Services (HHS) and the Office of Minority Health (OMH) developed the National Standards for Culturally and Linguistically Appropriate Services (CLAS) to provide practical guidelines for health care providers and organizations to improve culturally competent care (OMH, 2013). The principal standard in the National CLAS standards is to "provide effective, equitable, understandable and respectful quality care and

services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs." (OMH, 2013, p.1).

Conceptual Model

Conceptual models are cornerstones to nursing development and convey a "set of interrelated concepts that symbolically convey a mental image of a phenomenon" (Fawcett & Alligood, 2005, p.228). The Cultural Competence Model (CCM) provides a guiding framework that gives structure and guidance to planning and development of a cultural competency educational intervention (Campina-Bacote, 1998). The purpose of the CCM is to offer health care providers a framework for developing and implementing culturally competent care. The CCM has been used in research conducted across many disciplines including nursing, medicine, psychiatry and anthropology (Campina-Bacote, 2002). This model is appropriate in seeking to improve the cultural competence of health care providers and will be used to support a practice change in this project.

The CCM views cultural competence as an ongoing process and not a one-time achievement. In this process, health care providers continually seek to become culturally competent in the care of the individuals, families and communities by integrating cultural awareness, cultural knowledge, cultural skills, cultural encounters and cultural desire (Campina-Bacote, 2002). The building blocks of the CCM are cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire. To better describe and define this model each construct is defined. A cultural encounter is the experience of **a** health care provider engaging with a client from a culturally diverse background. Cultural desire is the willingness of the health care provider to engage in becoming more culturally aware. Cultural desire is defined

the “want to, rather than the have to, engage in the becoming culturally aware and culturally knowledgeable” (Campina-Bacote, 2002, p.182.). Cultural desire includes a sincere desire to learn to be open and learn about others by demonstrating the ability to listen to everyone and see each person as a cultural informant**.** Using the CCM as a guide in developing the cultural training program it is important to note the key emphasis of the model on intentionally seeking to learn, engage, and listen to patients on each patient encounter.

Implementation Strategy

The Plan-Do-Study-Act (PDSA) Model was used in the implementation of the project to improve culturally competent care (IHI, 2016). This model is effective in its use in planning and facilitating sustainable change in the ambulatory care setting (Baker, Lefebyre, & Sevin, 2017).

In the first step of this process a cultural competency training program was planned, program objectives were developed, a timeline created, and predictions made related to the impact of the implementation of a cultural competency educational program. In the second step, or the “do” step of the cycle, the cultural competency training program was implemented and data collected. The third and fourth steps reflected the “studying” and “acting” steps of the project. These steps included completing analysis, or studying, the collected data along with comparisons to the proposed outcome to decide if changes are needed prior to offering future educational training sessions. The “act” step of the cycle involved revising the project and preparing for the next PDSA cycle (Baker et al., 2017).

Specific Aim

The specific aim of this DNP project was to improve cultural competency among NPs and other health care providers in a NP-led clinic that serves a highly diverse population. The project sought to improve NPs' and other health care workers' abilities to provide culturally competent care through a one-hour cultural competency educational training program.

Methods

Setting

The project took place at a not-for-profit primary care clinic in an urban area of the Southeastern United States. The clinic is staffed by three Adult Nurse practitioners (ANPs) two Family Nurse Practitioners (FNPs) , one Women's Health Nurse Practitioners (WHNP) and one Psychiatric Mental Health Nurse Practitioner (PMHNP) to promote comprehensive care at one location. The clinic serves low-income, uninsured or under-insured clients. Approximately 70% of the client population is Latino (personal communication, D. Hayden, October 1, 2017).

Congruence of DNP Project to Organization

The project goal to improve the cultural competency of the NPs and health care workers through a cultural competency training program was congruent with the mission of the primary care clinic setting. The mission of the clinic is to provide holistic, patient-centered care, which includes health education and prevention, as well as health screenings and disease management. An additional mission of the clinic is to provide students, including nurse practitioner students, Spanish language students, pre-nursing, pre-medicine and medical students, as well as dental residents, the opportunity to improve patient care while advancing their skills. High quality patient centered culturally based care can occur when the patient family and community

expectations are congruent with the health care providers' knowledge and cultural competency (Doorenbos, et al, 2005).

Description of Stakeholders

Stakeholders included the patients served by the clinic, the administrative director of the clinic and volunteer staff. Financial stakeholders were those who and contribute to the private welfare fund that financially supports the clinic. The NPs working at the clinic held a significant stakeholder position. The more the NPs increases in cultural competency, the greater the postivie impact on patient care.

Intervention

A one-hour cultural competency educational intervention was developed based on the prior literature review. Following Institutional Review Board (IRB) approval (Appendix A) from the university and agency approval from the clinic director (Appendix B), the PL posted the recruitment flyers (Appendix C), emailed the recruitment cover letter requesting participation in the project at a given date, time and location (Appendix D). The PL retained the email addresses of those who expressed interest in participating in the project for future communication and for providing reminders of the scheduled educational training. Informed consent was included in the preamble of the CCA survey and was obtained by all volunteer participants.

One week and three weeks prior to project implementation, participants received an email reminder related to the program time and location. Prior to the cultural competency training program, participants drew a random survey number out of a manila envelope marked "survey numbers" in order to ensure anonymity and allow for statistical analysis (Appendix E).

The one-hour cultural competency educational program was provided by the PL at the clinic site on a day that the clinic was routinely open. It was conducted in a large open classroom at the clinic at a time prior to patient visits (10:00-11:00 am). The consent to participate in the project was reviewed. The pre-training CCA survey data were collected prior to the start of the program. Instructions for post-training data collection via mail four weeks following the program was provided and envelopes provided.

The training program (Appendix F) was inclusive of the CLAS Standards (OMH, 2001) and included cultural case studies. The first case study was of a 16-year-old male migrant laborer who presents with muscle pain and the second case study is a 42-year-old female migrant laborer who presents with stomach pain and anxiety. Both cases represented common patient presentations to the clinic. The PL presented the case studies to the participants and guided a discussion applying Kleinman's (1980) model that emphasized the need to understand the client's explanation of his or her illness. The Explanatory Model identified questions for understanding illness episodes from the patient's point of view. These questions included:

1. What do you call your problem? What name does it have?
2. What do you think has caused this problem? Why do you think it started when it did?
3. What do you think your sickness does to you? How does it work?
4. How severe is it? Will it have a short or long course?
5. What do you fear the most about your illness?
6. What are the chief problems your sickness has caused you?
7. What kind of treatment do you think you should receive?
8. What are the most important results you hope to achieve from this treatment? (p.106).

Measures

The post-training data were collected via mail four weeks following the program. All participants received two email reminders to complete the mailed post-program survey at four weeks and five weeks after the program. In the emails, participants were asked to not discuss their

responses to the survey with their peers to decrease risk for bias. To evaluate changes in NP and heath care worker's cultural competency, data were collected at baseline and at four-five weeks after the training was completed.

The CCA (Appendix G) was used to measure cultural competency in the project. Permission to use the CCA instrument was obtained from the author via an email (A. Doorenbos, personal communication, October 17, 2018). Within the CCA instrument are two subscales: The Cultural Awareness and Sensitivity (CAS) subscale and The Cultural Competence Behaviors (CCB) subscale. The CAS subscale measures cultural awareness and sensitivity and is measured with seven-point Likert like responses: strongly agree, agree, somewhat agree, neutral, somewhat disagree, disagree, and strongly disagree. The higher the CAS subscale score, the higher the cultural awareness and sensitivity. The CCB subscale measures culturally competent behaviors and has response categories of always, very often, somewhat often, often, sometimes, few times, never, and not sure. Higher CCA scores indicate higher levels of knowledge, more positive attitudes, and greater frequency of culturally competent behaviors (Doorenbos et al., 2005).The internal consistency and reliability for the overall CCA have been reported to have a Cronbach's alpha reliability score =.92. Cronbach's alpha for the CCB and CAS subscales were reported at .93 and .75, (Doorenbos et al., 2005; Schim et al., 2003). No specific training was required for use of the CCA tool.

Study of Interventions

Data were entered into the Statistical Package for Social Science (SPSS) Version 25. Statistical significance was set at < 0.05 (Polit, 2010). Descriptive statistics were summarized and paired t-tests were computed on mean pre-and post-intervention scores on the CCA survey including the subscales CAS and CCB.

Results

A convenience sample (N= 11) of members of the clinic staff participated in the training program. Only nine (82%) participants completed the descriptive and CCA surveys. data and the study participants' responses to the 25-item CCA (Schim et al., 2003). The descriptive statistics included, age, race and educational training. There were six participants (56%) with a graduate or higher degree. Only one participant identified as Hispanic (11%) and the remaining eight participants were Caucasian. The ages of the participants ranged from 20-67 years of age with a mean of 40.2 years of age.

A paired samples t-test was conducted to evaluate the impact of the one-hour Cultural Competency Education Program on the total CCA Scores (Table 1), the CAS Subscale scores (Table 2) and the CCB Subscale scores (Table 3). Participants' mean CCA scale scores increased significantly from pre-session (M =9.91, SD ± 1.81) to post-session (M=11.59, SD ± 1.47), *t(*4.70), *p*=.002), two-tailed. Participants' mean CAS scores increased significantly from pre-session (M=5.67, SD ± .63) to post-session (M=6.33, SD±.42), *t*(5.20), *p*=.006, two tailed). The mean increase in the CCA score was .73 with a 95% CI ranging from .36 to .95

Table 1

Paired t-test Comparison of CCA Scores

	N	Mean ± SD	t	df	p
Pre-test	9	9.91 ± 1.81	4.70	8	.002
Post-test	9	11.59 ± 1.47			

Note: The magnitude of the change in effect size was large at 1.56.

Table 2

Paired t-test Comparison of CAS Subscale Scores

	N	Mean ± SD	t	df	p
Pre-test	9	5.67 + .63	5.20	8	.001
Post-test	9	6.33 ± 4.3			

Note: The magnitude of the change in effect size was large at 1.73.

Table 3

Paired t-test Comparison of CCB Subscale Scores

	N	Mean ± SD	t	df	p
Pre-test	9	4.24 + 1.37	2.93	8	019
Post-test	9	5.26 + 1.31			

Note: The magnitude of the change in effect size was large at .98.

Participants' mean CCB scores also increased significantly from pre-test (M=4.24, ±SD=.63) to post-test (M=5.25, ± SD 1.37), *t*(2.93), *p*=.019, two tailed). The mean increase in the CCB score was 1.12 with a 95% CI ranging from .21 to 1.82. Cohen's d test was used to calculate the effect size of the change in means form pre-session to post-session results. The magnitude of difference in all three means were large in the CCA, the CAS and the CCB (1.56, .1.73 and .98 respectively), suggesting that the magnitude of the change in effect size was large in all three cultural scores that were measured.

In previous studies researchers found participation in prior cultural diversity training and age in years were each directly related to greater cultural competence behaviors, and greater cultural competence awareness and sensitivity scores (Schim, et al, 2006). In this project the cultural competence scores were not related to prior cultural training or age. A Pearson's product moment was computed to assess relationships between the participant's educational level, prior cultural diversity training and Cultural Competency Scores. No positive correlations were noted between any of these variables.

Limitations

Limitations of the project design include a small sample size and convenience sampling.. Although the four weeks follow up post-test indicated knowledge retention, it may be beneficial to evaluate the retention of cultural competency awareness and behavior again at 4 months to assess for the retention of CCA and CCB behaviors. Time constraints limited the recruitment process, the length, and frequency of program implantation.

Sustainability

Several action steps were implemented to promote the sustainability of this cultural competency education project. The clinic has recently begun an annual continuing educational program to provide updates for primary care providers. Plans are being made to include a program on cultural competency in the yearly continuing educational day. To further promote the sustainability of the project, laminated signs of Kleinman's (1980) Explanatory Model questions (Spanish and English) used in the educational program were placed in each exam room on the walls above the provider's desk as a visual reminder of a cultural competence assessment tool.

Summary

The one -hour evidence-based cultural competency educational program conducted and evaluated in this project was shown to be an effective strategy in improving cultural competency attitude and behaviors among a multidisciplinary team in a primary care setting. These results are consistent with prior programs and evaluations (Brewster, & Lewis, 2014; Debiasi & Selleck, 2017; Horvat, et al., 2014; Schim et al., 2006). Feedback from participants immediately after the program were overwhelmingly positive and participants noted the multidisciplinary team discussion of the case studies were the most helpful component of the program. Thus, implementing a cultural competency training program for NPs and other health care providers is a recommended routine practice for health care delivery in a primary care setting.

Conclusion

An evidence-based cultural competency educational program was designed and implemented to increase the cultural awareness, sensitivity, and competence of a multi-disciplinary primary care team. Findings from this project have shown that even with a modest

one-hour face -to face cultural competency educational program, cultural competency scores were significantly greater after the educational intervention. Limitations and insights gained from this project suggest further examination of the impact of program design and continued competency training in multidisciplinary groups.

References

Beach, M. C., Price, E. G., Gary, T. L., Robinson, K. A., Gozu, A., Palacio, A., … Cooper, L. A. (2005). Cultural Competency: A Systematic Review of Health Care Provider Educational Interventions. *Medical Care*, *43*(4), 356–373.

Brunett, M., & Shingles, R. (2017). Does having a culturally competent healthcare provider affect the patients' experience of satisfaction? A critically appraised topic. *Journal of Sport Rehabilitation*, 1-10. http://dx.doi.org/10.1123/jsr.2016-0123

Campinha-Bacote, J. (2002). The process of cultural competence in the delivery of healthcare services: a model of care. *Journal of Transcultural Nursing*, (13), 181–184.

Campinha-Bacote, J. (1998). *The process of cultural competence in the delivery healthcare services: A culturally competent model of care* (3rd ed.). Retrieved from http://www.transculturalcare.net)

Castro, A., & Ruiz, E. (2009). The effects of nurse practitioner cultural competence on Latina patient satisfaction. *Journal of the American Academy of Nurse Practitioners*, *21*, 278-286. http://dx.doi.org/10.1111/j.1745-7599.2009.00406.x

Center for Disease Control and Prevention. (2012). United States life tables by Hispanic origin. Retrieved from www.cdc.gov/nchs/data/series/sr_02/sr01-12.pdf.

Debiasi, L. B., & Selleck, C. S. (2017). Cultural Competency Training for Primary Care Nurse Practitioners. *Journal of Cultural Diversity*, *24*(2), 39-45. Retrieved from

Doorenbos, A. Z., Schim, S. M., Benkert, B., & Borse, R. (2005). Psychometric evaluation of the cultural competence assessment instrument among health care providers. *Nursing Research*, *54*, 324-331. http://dx.doi.org/10.1097/NNR.0000000000000266

Elminowski, J. (2015). Developing and Implementing a Cultural Awareness Workshop for Nurse Practitioners. *Journal of Cultural Diversity*, *22*(3), 105-113.

Fawcett, J., & Allgood, M. (1988). Influences on advancement of nursing knowledge. Nursing Science Quarterly, 18(3), 227-232.

Horvat, L., Horey, D., Romios, P., & Kis-Rigo, J. (2014). Cultural Competence education for health professionals. *Cochrane Database for Systematic Reviews*, 1-82. http://dx.doi.org/DOI: 10.1002/14651858.CD09405.pub2

Institute for Healthcare Improvement (2016). *Science of Improvement: Testing Changes. Retrieved from* http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementTestingChanges.aspx

Institute of Medicine. (2003). *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Retrieved from https://doi.org/10.17226/10260

Kleinman, A. (1980). *Patients and Healers in the Context of Culture.* CA: University of California Press.

Lie, D. A., Lee-Rey, E., Gomez, A., Bereknyei, S., & Braddock, C. H. (2011). Does cultural competency training of health professionals improve patient outcomes? A systematic review & proposed algorithm for future research. Journal of General Internal Medicine, 26, 317-325. http://dx.doi.org/10.1007/sll606-010-1529-0

McClimens, A., Brewster, J., & Lewis, R. (2014). Recognizing and respecting patients' cultural diversity. *Nursing Standard*, *28*(28), 45-52. http://dx.doi.org/doi:10.7748/ns2014.03.28.28.45.e8148

Melnyk, B. M., & Fineout-Overholt, E. (2015). *Evidences-Based Practice in Nursing & Healthcare* (3rd ed.). Philadelphia: Wolters Kluwer.

Ohana, S., & Mash, R. (2015). Physician and patient perceptions of cultural competency and medical compliance. *Health Education Research*, *30*, 923-934

Office of Minority Health. (2013). National standards for culturally and linguistically appropriate health care services. Retrieved from https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53

Prescott-Clements, L., Schuwirth, L., van der Vleuren, C., Hurst, Y., Gibb, E., & Rennie, J. (2012). The Cultural Competence of Health Care Professionals: Conceptual Analysis Using the Results from a National Pilot Study of Training and Assessment. *Evaluation and the Health Professions*, *36*(2), 191-203. http://dx.doi.org/10.1177/0163278712454137

Polit, D. F. (2010). *Statistics and Data Analysis for Nursing Research* (2 ed.). New York: Pearson.

Schim, S. M., Doorenbos, A. Z., & Borse, N. N. (2006). Enhancing Cultural Competence Among Hospice Staff. *American Journal of Hospice and Palliative Medicine*, *23*, 404-411. http://dx.doi.org/10.1177/1049909106292246

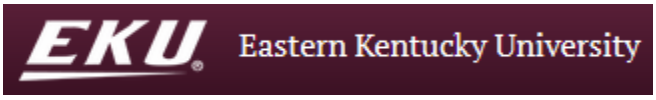
Smedley, B. D., & Nelson, A. R. (2002). Institute of Medicine Committee on Understanding and Eliminating Racial Disparities in health and healthcare. *Unequal Treatment; Confronting Racial and Ethnic Disparities in Health Care*.

Truong, M., Paradies, Y., & Priest, N. (2014). Interventions to improve cultural competency in healthcare: a systematic review of reviews. *BMC health services research, 14*, 99. doi:10.1186/1472-6963-14-99.

U.S. Census Bureau. (2012). Population estimation. Retrieved from http://www.census.gov/popest/national/national.html

Appendix A

IRB Approval Letter



December 18, 2018

Hello Diane Riff,

Congratulations! The Institutional Review Board at Eastern Kentucky University has approved your IRB Application for Exemption Certification for your study entitled, "**Cultural Competency Training for Healthcare Providers in Primary Care: A Pilot Project for Improving Culturally Competent Care**" as research protocol number 2049. Your approval is effective immediately and expires three years from the approval date.

Exempt status means that your research is exempt from further review for a period of three years from the original notification date if no changes are made to the original protocol. If you plan to continue the project beyond three years, you are required to reapply for exemption.

Principal Investigator Responsibilities: It is the responsibility of the principal investigator to ensure that all investigators and staff associated with this study meet the training requirements for conducting research involving human subjects and follow the approved protocol.

Appendix B

Eastern Kentucky University
Department of Baccalaureate and Graduate Nursing
Doctor of Nursing Practice Program

Statement of Mutual Agreement for DNP Project

The purpose of a Statement of Mutual Agreement is to describe the agreement between a designated clinical agency and the DNP student regarding the student's DNP project.

I. General Information

Student Name: Diane Riff MS, RN, APRN-C, DNP student

Project Title: Cultural Competency Training for Healthcare Providers in Primary Care: A Pilot Project for Improving Culturally Competent Care

Agency: Kentucky Health Racing Services Center

Agency Contact: Dedra Hayden, Clinical Director, Kentucky Racing Health Services Center

II. Brief description of the project

- A cultural competency training program that is based on current evidence is proposed as an intervention to increase the cultural competency of Nurse Practitioners and other health care workers in a primary care clinic that serves a culturally diverse population.
- It is hoped that participants in the program will gain an increased knowledge of ways to provide culturally competent care. The DNP student will attempt to have the results of the study published and will present the results of the study as a requirement for obtaining a Doctor of Nursing Practice degree. There are no expected products to come from the study. The DNP student, Diane Riff, owns the intellectual property rights of this project.
- The DNP student will act as the primary investigator and the facilitator of the cultural competency training program. Emails will be sent to the potential participants one month and one week prior to the program. The emails will include details of the project implementation plan will be described. In addition, participants will be notified by email that individual participation is voluntary.
- The one-hour cultural competency educational program will then be provided by Diane Riff at the clinic site on a day that the clinic is routinely open. Participants will be conducted in an open classroom at the clinic at a time prior to patient visits (8:30-9:30 AM). The post-training data will be collected via email and online survey during the three weeks following the program.

III. Agreement of written and oral communication

- In the DNP student's academic work, project and agency details may be used. However, in publications and presentations outside of the student's academic work, references to clinical agency and project participants will not be used. Formal agency approval needed for any publicly shared findings.
- Formal agency approval is required to publish or present the project findings in which the agency is named. No formal agency approval is required to present or publish the findings without identifying the agency or participants' names.

Fall 2017

Eastern Kentucky University
Department of Baccalaureate and Graduate Nursing
Doctor of Nursing Practice Program

- Formal agency approval is required to publish or present the project findings in which the agency is named. No formal agency approval is required to present or publish the findings without identifying the agency or participants' names.

IV. Required Signatures:

Student	Date: 9/20/18
DNP Project Advisor	Date
Agency Representative: Dedra Hayden, APRN-BC	Date: 9-26-2018

Appendix C

Recruitment Flyer

VOLUNTEERS WANTED FOR A PILOT PROJECT

Cultural Competency Training in Primary Care: A Pilot Project for Improving Culturally Competent Care

I am seeking people aged 18 and over who work or volunteer a minimal of three days per year in providing care for the patients at the Kentucky Health Racing services Center. I am a Doctoral Nursing student at Eastern Kentucky University conducting a project to implement and evaluate a cultural competency training program.

Participation involves filling out 2 confidential questionnaires (20 minutes per questionnaire) and attending a one-hour educational training program on cultural competency. (For a total of one hour and 40 minutes time commitment).

Please contact Diane Riff APRN at 502-262-0043 or diane.riff106@gmail.com if you are interested in participating in this scholarly project.

This research is conducted under the direction of Dr Nancy Owens, The Department of Baccalaureate and Graduate Nursing, Eastern Kentucky University
Email: ***nancy.owens@eku***.edu; Phone: 859-622-1971

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Diane.riff106@gmail.com (502)-262-0043

Appendix D

Recruitment Letter

Cultural Competency Training in Primary Care: A Pilot Project for Improving Culturally Competent Care
Diane Riff, DNP student
Eastern Kentucky University Department of Baccalaureate and Graduate Nursing

Hello,

I am Diane Riff, a Doctor of Nursing Practice (DNP) student at Eastern Kentucky University in Richmond, Kentucky. As part of my graduation requirements, I am completing a pilot study aimed at helping to improve cultural competency in healthcare providers and healthcare workers. I would like to invite you to participate in this study. The purpose of this DNP project is to implement and evaluate the effectiveness of a one-hour cultural competency educational program and its impact on participants' cultural competency.

As part of my project, I will conduct a one-hour training program prior to or during clinic work hours. A questionnaire will be given prior to and after the training program, to measure the cultural awareness, cultural sensitivity and culturally competent behaviors.

The questionnaires are anonymous. Only group (aggregate) data with no personal identifiers will be used in written or oral presentations of the study results. The study is voluntary and withdrawal from the project is permitted at any time. There will be no penalty for non-participation. This study poses no foreseeable risks to you or your position within this institution.

Your participation will be greatly appreciated! If you have questions or concerns about the project, you may contact me by telephone at (502) 262-0043 or by email at diane_riff@mymail.eku.edu. You may also contact the faculty advisor for the pilot project Dr. Nancy Owens, DNP, by telephone at (859-622-1971) or by email at Nancy.Owens@eku.edu.

Respectfully,

Diane Riff MS, APRN, NP-C
DNP Student, Eastern Kentucky University

Appendix E

Project Implementation Steps

- Once IRB approval is received, PL will email the recruitment cover letter to potential participants and will post the recruitment flyers at the Kentucky Racing Health Services Center.
- PL will email the responding potential participants with detailed information on the location and time of the cultural competency training at the Kentucky Racing Health Services and request confirmation of participation.
- One week and three weeks prior to project implementation, participants will receive an email reminder about the program time and location.
- Prior to the cultural competency training program, PL will request participants to draw a random survey number out of a manila envelope marked "survey numbers". Participants will be asked to write that number on the face sheets of both a pre and post-program CCA survey.
- PL will request participants to complete the paper and pencil pre-program CCA survey.
- PL will request and assign a volunteer participant to collect the pre-program surveys and place them in a manila envelope marker "pre-program surveys".
- PL will request participants to place the blank post-program survey in a self-addressed stamped envelope.
- PL will request the assigned volunteer collect the post-program surveys in the self-addressed envelopes and place them in a folder marked "post-program surveys".
- Instruct participants that the post program survey will be mailed to their addresses 4 weeks after the program. Request participants to mail back the program in the self -addressed stamped envelopes after completion.
- PL will conduct the Cultural Competency Education program.

Appendix F

Cultural Competency Training Program Outline-One-hour workshop

Part 1: Introduce program objectives: After completing the workshop, participants will be able to define determinants of health, and principles of culturally effective care, describe how culturally effective and collaborative care leads to better outcomes, identify strategies to improve culturally competent care, apply principles for culturally competent care to a case study.

State expectations as to what to expect in the next hour of the program-(Presentation, cases studies and discussion)-**5** minutes**.**

Part 2: Why Cultural Competence is important. This content will be delivered by PL verbally in a classroom in a workshop format. Delivering care in a culturally and linguistically appropriate manner is a strategic way that you can help improve quality of care for diverse patients. Culturally and linguistically appropriate services (CLAS) are shown to improve the quality of services (Beach et al., 2004; Goode, Dunne, & Bronheim, 2006), increase patient safety and boost patient satisfaction (Beach et al., 2004). In describing the need for cultural competency, the National Center for Cultural Competence (Goode, Dunne & Bronheim, 2006), identified six primary areas of cultural competency education as follows: To respond to current and projected demographic changes in the United States. **10** minutes.

- To eliminate long-standing disparities in the health status of people of diverse racial, ethnic, and cultural backgrounds
- To improve the quality of services and primary care outcomes
- To meet legislative, regulatory, and accreditation mandates
- To gain a competitive edge in the market place
- To decrease the likelihood of liability/malpractice claims

Part 3: Define Cultural competence, cultural competence self-awareness and health disparities related to minorities. **10** minutes

Part 4: Present strategies to improve cultural competency and models for cultural competence. Describe specific strategies for delivery of culturally competent care. Content from this area comes from the CLAS standards Kleinman's Explanatory Model of Illness (Kleinman & Benson, 2006).-**15** minutes

Part 5: Present case study of a patient presenting at the clinic. Lead the group in discussion of home to assess the patient and implement a holistic plan of care related that reflects the standards of cultural competency -**15** minutes.

Part 6: Summarize program and comments from the group. Remind participants of the survey mailing in 4 weeks. Answer any questions from participants**. 5** minutes.

Appendix G

Cultural Competency Assessment Survey (CCA)

Cultural Competence Survey

Increasing cultural diversity of people in our communities and workplaces is a fact of life. Diversity among students, co-workers, and organizations is also expanding. Improvements in travel and communication have brought people with different cultures, languages, and customs into contact as never before. A greater variety of people within our communities, schools, and workplaces continues to have an impact on the way that we think, feel, and act.

This survey is designed to explore your knowledge, feelings, and actions when you interact with others in the context of health care and health service environments and in academic settings. *Your answers are strictly confidential.* The researchers will put your answers together with those of others to get an overall profile for group cultural competence and educational needs. We will also use your responses together with those of other people such as yourself to design cultural competency training programs to meet specific needs. Neither your identity nor your individual answers will be shared with anyone.

Questions on this survey are intended to gather information about how you personally think, feel, and act. Some questions may not fit your situation exactly depending on the type of work you do at this time. Please try to answer every question. If you are unsure or have no opinion on an item, use the "No Opinion" or "Not Sure" options. There are no "right" or "wrong" answers.

Completing this survey is completely voluntary. It will take about 20 minutes of your time. You may choose not to participate. You may stop at any time. Your completion of the survey indicates your informed consent to participate in this study.

NOTE: This instrument may only be used with the express permission of the authors. For information contact:

Dr. Ardith Doorenbos (doorenbo@wu.edu)
Or
Dr. Ramona Benkert (ramonabenkert@wayne.edu)

VERSION: 4 NOVEMBER 2009

1. In the past 12 months, which of the following racial/ethnic groups have you encountered among your clients and their families or within the health care environment or workplace? *Mark 'X' for all that apply.*

- ❑ Hispanic/Latino (including Mexican, Mexican American, Chicano, Puerto Rican, Cuban, other Spanish)
- ❑ White/Caucasian/European American
- ❑ Black/African American/Negro
- ❑ American Indian/Alaska Native
- ❑ Asian (Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, or other Asian)
- ❑ Native Hawaiian/Pacific Islander
- ❑ Arab American/Middle eastern
- ❑ Other (specify) _____

2. In your current environment / workplace what percentage of the total population is made up of people from these racial/ethnic groups? *Write in percents to add to 100%*

____ Hispanic/Latino (including Mexican, Mexican American, Chicano, Puerto Rican, Cuban, other Spanish)
____ White/Caucasian/European American
____ Black/African American/Negro
____ American Indian/Alaska Native
____ Asian (Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, or other Asian)
____ Native Hawaiian/Pacific Islander
____ Arab American/Middle Eastern
____ All other groups combined
100 % = TOTAL

3. In the past 12 months which of the following special population groups have you encountered among your clients and their families or within the health care environment or workplace? *Mark 'X' for all that apply.*

- ❑ Mentally or emotionally Ill
- ❑ Physically Challenged/Disabled
- ❑ Homeless/Housing Insecure
- ❑ Substance Abusers/Alcoholics

- ❑ Gay, Lesbian, Bisexual, or Transgender
- ❑ Different religious/spiritual backgrounds
- ❑ Other (specify) _____

4. In your current environment what percentage of the total population is made up of people from these special population groups? *Write in percents; may not total 100%*

   ____ Mentally or emotionally Ill
   ____ Physically Challenged/Disabled
   ____ Homeless/Housing Insecure
   ____ Substance Abusers/Alcoholics
   ____ Gay, Lesbian, Bisexual, or Transgender
   ____ Different religious/spiritual backgrounds

5. Overall, how competent do you feel working with people who are from cultures different than your own?

Very competent	Somewhat competent	Neither competent nor incompetent	Somewhat Incompetent	Very Incompetent
❑	❑	❑	❑	❑

For each of the following statements, put an 'X' in the box that best describes how you feel about the statement.

6. Race is the most important factor in determining a person's culture.

Strongly Agree	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Strongly Disagree	No Opinion
❑	❑	❑	❑	❑	❑	❑	❑

7. People with a common cultural background think and act alike.

Strongly Agree	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Strongly Disagree	No Opinion
❑	❑	❑	❑	❑	❑	❑	❑

8. Many aspects of culture influence health and health care.

Strongly Agree	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Strongly Disagree	No Opinion
❑	❑	❑	❑	❑	❑	❑	❑

9. Aspects of cultural diversity need to be assessed for each individual, group, and organization.

Strongly Agree	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Strongly Disagree	No Opinion
❑	❑	❑	❑	❑	❑	❑	❑

10. If I know about a person's culture, I don't need to assess their personal preferences for health services.

Strongly Agree	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Strongly Disagree	No Opinion
❑	❑	❑	❑	❑	❑	❑	❑

11. Spiritually and religious beliefs are important aspects of many cultural groups.

Strongly Agree	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Strongly Disagree	No Opinion
❑	❑	❑	❑	❑	❑	❑	❑

12. Individual people may identify with more than one cultural group.

Strongly Agree	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Strongly Disagree	No Opinion
❑	❑	❑	❑	❑	❑	❑	❑

13. Language barriers are the only difficulties for recent immigrants to the United Sates.

Strongly Agree	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Strongly Disagree	No Opinion
❑	❑	❑	❑	❑	❑	❑	❑

14. I believe that everyone should be treated with respect no matter what their cultural heritage.

Strongly Agree	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Strongly Disagree	No Opinion
❑	❑	❑	❑	❑	❑	❑	❑

15. I understand that people from different cultures may define the concept of "health care" in different ways.

Strongly Agree	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Strongly Disagree	No Opinion
❑	❑	❑	❑	❑	❑	❑	❑

16. I think that knowing about different cultural groups helps direct my work with individuals, families, groups, and organizations.

Strongly Agree	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Strongly Disagree	No Opinion
❑	❑	❑	❑	❑	❑	❑	❑

***For each of the following statements put 'X' in the box that best describes how often you do the following*:**

17. I include cultural assessment when I do individual or organizational evaluations.

Always	Very Often	Somewhat Often	Often	Sometimes	Few Times	Never	Not sure
❑	❑	❑	❑	❑	❑	❑	❑

18. I seek information on cultural needs when I identify new people in my work or school.

Always	Very Often	Somewhat Often	Often	Sometimes	Few Times	Never	Not sure
❑	❑	❑	❑	❑	❑	❑	❑

19. I have resource books and other materials available to help me learn about people from different cultures.

Always	Very Often	Somewhat Often	Often	Sometimes	Few Times	Never	Not sure
❑	❑	❑	❑	❑	❑	❑	❑

20. I use a variety of sources to learn about the cultural heritage of other people.

Always	Very Often	Somewhat Often	Often	Sometimes	Few Times	Never	Not sure
❑	❑	❑	❑	❑	❑	❑	❑

21. I ask people to tell me about their own explanations of health and illness.

Always	Very Often	Somewhat Often	Often	Sometimes	Few Times	Never	Not sure
❑	❑	❑	❑	❑	❑	❑	❑

22. I ask people to tell me about their expectations for health services.

Always	Very Often	Somewhat Often	Often	Sometimes	Few Times	Never	Not sure

❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑

23. I avoid using generalizations to stereotype groups of people.

Always	Very Often	Somewhat Often	Often	Sometimes	Few Times	Never	Not sure
❑	❑	❑	❑	❑	❑	❑	❑

24. I recognize potential barriers to service that might be encountered by different people.

Always	Very Often	Somewhat Often	Often	Sometimes	Few Times	Never	Not sure
❑	❑	❑	❑	❑	❑	❑	❑

25. I remove obstacles for people of different cultures when I identify barriers to services.

Always	Very Often	Somewhat Often	Often	Sometimes	Few Times	Never	Not sure
❑	❑	❑	❑	❑	❑	❑	❑

26. I remove obstacles for people of different cultures when people identify barriers to me.

Always	Very Often	Somewhat Often	Often	Sometimes	Few Times	Never	Not sure
❑	❑	❑	❑	❑	❑	❑	❑

27. I welcome feedback from clients about how I relate to people from different cultures.

Always	Very Often	Somewhat Often	Often	Sometimes	Few Times	Never	Not sure
❑	❑	❑	❑	❑	❑	❑	❑

28. I find ways to adapt my services to individual and group cultural preferences.

Always	Very Often	Somewhat Often	Often	Sometimes	Few Times	Never	Not sure
❑	❑	❑	❑	❑	❑	❑	❑

29. I document cultural assessments if I provide direct client services.

Always	Very Often	Somewhat Often	Often	Sometimes	Few Times	Never	Not sure
❑	❑	❑	❑	❑	❑	❑	❑

30. I document the adaptations I make with clients if I provide direct client services.

Always	Very Often	Somewhat Often	Often	Sometimes	Few Times	Never	Not sure
❑	❑	❑	❑	❑	❑	❑	❑

Your answers to these last few questions will help us understand responses from different kinds of people who complete the survey. <u>ALL answers are strictly confidential.</u>

Read each item below and decide whether the statement is true or False as it pertains to you personally. Mark your answers with an 'X' in the True or False box.

31. It is sometimes hard for me to go on with my work if I am not encouraged.

True	False
❑	❑

32. I sometimes feel resentful when I don't get my way.

True	False
❑	❑

33. On a few occasions, I have given up doing something because I thought too little of my ability.

True	False
❑	❑

34. There have been times when I felt like rebelling against people in authority even though I knew they were right.

True	False
❑	❑

35. False matter who I'm talking to, I'm always a good listener.

True	False
❑	❑

36. There have been occasions when I took advantage of someone.

True ❑ False ❑

37. I'm always willing to admit it when I make a mistake.

True ❑ False ❑

38. I sometimes try to get even rather than forgive and forget.

True ❑ False ❑

39. I am always courteous, even to people who are disagreeable.

True ❑ False ❑

40. I have never been irked when people expressed ideas very different from my own.

True ❑ False ❑

41. There have been times when I was quite jealous of the good fortune others.

True ❑ False ❑

42. I am sometimes irritated by people who ask favors of me.

True ❑ False ❑

43. I have never deliberately said something to hurt someone's feelings.

True ❑ False ❑

44. In what year were you born? ☐

45. Using the categories below, what do you consider yourself? *(Choose one or more)*

- ❑ Hispanic/Latino (including Mexican, Mexican American, Chicano, Puerto Rican, Cuban, other Spanish)
- ❑ White/Caucasian/European American
- ❑ Black/African American/Negro
- ❑ American Indian/Alaska Native
- ❑ Asian (Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, or other Asian)
- ❑ Native Hawaiian/Pacific Islander
- ❑ Arab American/Middle eastern
- ❑ Other (specify) _____

46. What is your highest level of education completed?

- ❑ Less than high school
- ❑ Diploma
- ❑ High school or GED
- ❑ Associate degree
- ❑ Bachelors degree
- ❑ Graduate or professional degree

47. Have you ever participated in cultural diversity training?

Yes	NO
❑	❑

48. If you have had prior diversity training, which option below best describes it? *(Check all that apply)*

- ❑ Separate college course for credit
- ❑ Content covered in a college course
- ❑ Professional Conference or Seminar
- ❑ Employer Sponsored Program
- ❑ On-line (computer assisted) Education
- ❑ Continuing Education Offering
- ❑ Other diversity training types (Specify) _____

49. Which of the following best describes your current role?
    - ❑ LPN
    - ❑ RN
    - ❑ Clerical Worker
    - ❑ Nutritionist
    - ❑ Therapist (occupational or physical)
    - ❑ Physician
    - ❑ Other _____

Thank you for taking this survey. We appreciate your time and effort!

If you have any questions or concerns about this research, please contact: