# Strategies to Improve Cultural Awareness and Self-Efficacy in a Primary Care Practice

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Abstract

The purpose of this Doctor of Nursing Practice (DNP) project was to develop, implement, and evaluate cultural awareness in a primary care medical clinic using the Culturally and Linguistically Appropriate Services (CLAS) training modules. Providers' cultural awareness may influence the success of treatment, compliance with health promotion behaviors, and barriers that interfere with desired health outcomes. The literature review identified two primary themes. First, a focus on the content of cultural competence training and second a focus on patients' health outcomes and satisfaction with care. Based on the literature review successful strategies include a combination of training and patient outcome elements at both the individual and organizational levels. The project was conducted within a primary care clinic serving female military veterans on the western slope of Colorado. A mixed methodology was used with quantitative and descriptive analysis. Qualitative data was used in addition to a self-assessment checklist because the N is too small for statistical significance. The descriptive analysis was used for the aggregate data using an office resource checklist. Instrumentation includes (a) The Promoting Cultural and Linguistic Competency Self-Assessment Checklist for Personnel Providing Primary Health Care Services (b) The Office Environment Checklist from the CLAS training modules. Participants reported (a) improved understanding of communication models and linguistic competency (b) a desire for more training to increase knowledge about vulnerable populations served (c) improved knowledge about cultural awareness and sensitivity (d) recognition that effective communication skills can lead eliminate barriers that interfere with desired outcomes (e) recognition of strategies to promote a more culturally competent clinic environment and expand culturally competent services with community partnerships. The project may benefit practitioners and the organization by enhancing knowledge about cultural concepts, confidence in delivering culturally competent care, and patient engagement in their own health and patient satisfaction with care.

## Cultural Competence for the Advanced Practice Registered Nurse

Cultural competence (CC) is essential for the advanced practice registered nurse (APRN) to establish trust and rapport, make accurate diagnoses, and provide effective patient teaching (Debiasi & Selleck, 2017). Optimal CC and promotion of delivering a high level of culturally congruent care requires active engagement and ongoing learning (Jeffreys & Dogan, 2012). Lack of CC has consequences as described in Fadiman's poignant book, *The Spirit Catches You and You Fall Down.* Fadiman (2012) tells the tragic story of confusion, over-medication, and cultural clash. Fadiman (2012) identifies the importance of acknowledging and understanding others' belief systems to avoid inefficiency and perceptions of superiority. Fadiman (2012) cites examples of successful CC programs and the potential for improving outcomes of culturally diverse populations.

Sakauye (2015) suggests that culture is most relevant in the treatment plan when there are significant differences in the cultural backgrounds of providers compared with patients. Sakauye (2015) identifies eight cultural issues that affect care. The consequences on patient outcomes are listed in Table 1.

Table 1

*Cultural Issues that Affect Care*

| **Cultural Issue** | **Consequence** |
|---|---|
| Different definition of illness. What is wrong? | Non-acceptance of interventions. |
| Preferences for treatment. What is needed for a cure? | Non-acceptance of treatment. Lack of trust that you are knowledgeable. |
| Relationship to authority, suspicious of strangers. | Difficulty in establishing a therapeutic relationship. |
| Different expressions for distress, different communication styles. | Potential misdiagnosis. |

| | |
|---|---|
| Language barriers. | Potential misdiagnosis. |
| Limited resources and access. | Potential limitation of available interventions. |
| Family, religion, institutions specific to an ethnic group. | Protective factor, stress reducer; should be encouraged. |

*Note.* Retrieved from "Diversity and Cultural Competence; Part 2," by K. Sakauye, 2015, *Psychiatric Times, 32*, p.17.

There are many ways APRNs develop and enhance CC (Engebretson, Mahoney, & Carlson, 2008). Graduate education provides CC training in varying degrees and there are numerous independent CC programs one can pursue (Engebretson et al., 2008). The Board of Nursing in Colorado does not mandate CC training, but it is explicitly addressed in the Doctor of Nursing Practice (DNP) learning essentials [American Association of Colleges in Nursing (AACN), 2006]. The DNP Essentials define elements of the DNP curriculum required by the Commission on Collegiate Nursing Education (CCNE) for accreditation (AACN, 2006). DNP Essentials II and V specifically address CC. DNP Essential II addresses the need for sensitivity to diverse organizational cultures and populations including patients or other providers. This requires the DNP to assume leadership roles within a practice with the goal of improving patient outcomes and reducing healthcare disparities. Essential V requires the DNP to participate in all levels of health policy and to understand that health policy either facilitates or impedes successful delivery of healthcare (AACN, 2006). The AACN (2006) points out that cultural sensitivity, ethics, access to care, and social justice influence healthcare policy and the delivery of healthcare.

While CC training is part of healthcare organizations' mandates, health disparities in diverse populations continue to exist (Like, 2011). Disparities are rooted in poverty, lack of insurance, health status, health risk behaviors, lack of education, and poor living conditions (Like, 2011). CC training has mixed reviews from some healthcare professionals. However,

quantitative data suggest CC training has been positively received by many others (Like, 2011). CC program participants rate organization and presentation of content, educational value, improved knowledge, and usefulness in the work setting highly (Like, 2011). Jernigan, Hearod, Tran, Norris, and Buchwald (2016) report that variations in implementation of CC training programs lead to differences in the quality of training and outcomes. Jernigan et al. (2016) reviewed 18 medical programs offering CC training. All 18 programs included communication techniques and differing beliefs and values. However, the authors note that health disparities, factors influencing health, and epidemiology of population health were not consistently included across the programs reviewed. Jernigan et al. (2016) concluded that healthcare providers must consider all sociocultural determinants of health (eg. race, ethnicity, culture, gender, age, sexual orientation, socioeconomic status, health access, and disability). Studies suggest that formal training for APRNs increases knowledge attainment and improves APRNs' perceived CC. When APRNs understand differences in social and cultural beliefs that influence patients' health and well-being, the provider-patient relationships and health outcomes are strengthened (Elminowski, 2015).

## Description of Problem

In the 21st century, the heterogeneity in the United States (US) is the highest it has ever been. The US population has seen increased diversity in terms of sociocultural determinants of health. Diversity in the US is growing each decade and by year 2055, it is projected that there will be no single racial or ethnic majority (Cohn & Caumont, 2016). Much of this change and growth is driven by immigration. The Asian population is the largest source of immigrants to the US (Cohn & Caumont, 2016). According to US Census Bureau reports, 14% of the population in 2012 was foreign born compared with 5% in 1965 (Cohn & Caumont, 2016; US Census

Bureau, 2013). Projections by Pew Research Center (2016) report that 18% of the population in 2065 will be foreign-born and will be driven by Asian and Hispanic immigration. Ogunwole, Battle, and Cohen (2017) report that small Sub-Saharan African and Caribbean ancestry groups will also grow rapidly. In 2016, the US admitted 84, 995 refugees, the greatest percent from the Democratic Republic of Congo, followed by Syria, Burma, Iraq, and Somalia (Krogstad & Radford, 2017).

Macartney, Bishaw, and Fontenot (2013) report 42.7 million or 14.3% of the population had income below the poverty level in another Census Bureau report. In addition, the US Census Bureau (2016) reports in 2016, there were over 20 million veterans. This changing diversity translates to a variety of languages, religions, ethnicities, education levels, and health behaviors for APRNs to consider. As such, APRNs serving this increasingly diverse group of patients must have flexibility in skill sets to meet individual healthcare needs. APRNs are expected to care for patients from a variety of backgrounds and cultures, often in time-limited visits. Additional challenges are related to health literacy, communication, education, and counseling when caring for patients of different cultures. CC skills and sensitivity have the potential to facilitate the health care encounter with a primary care provider. The provider should have clarity about what the illness means to the patient, the capacity of behavior change, and influences of access to healthcare (Matteliano & Street, 2012).

According to Mesa County Health Department (MCHD) (2017), Mesa County, Colorado includes 89.6% Caucasian residents, 13.6% Hispanic residents, 0.7% African-American residents, 0.7% Asian residents, and 1% American Indian and Alaskan native residents. The most common foreign languages are Spanish, German, and Japanese. The most common birthplace of foreign-born residents was Mexico, followed by Germany and Canada (MCHD,

2017). In Mesa County, 14.7% of the population lives below poverty level. This percentage has been increasing since 2005 (MCHD, 2017). The Hispanic population in Mesa County has a higher percentage of uninsured persons (34%) compared with non-Hispanic persons (19.4%) (MCHD, 2017).

Mesa County was designated a low-income Health Professionals Shortage Area (HPSA) for primary care services, by the US Department of Health and Human Services (HHS) in 2010 and renewed in 2012 (MCHD, 2017). The lack of adequate primary care providers in Mesa County also contributes to the Medically Underserved Area (MUA) designation (MCHD, 2017). Improving access to primary care services was identified as a priority to improve individual and community health outcomes (MCHD, 2017). Barriers to primary care access in Mesa County include lack of insurance, lack of a medical home, waiting periods that delay services, and a shortage of primary care providers (MCHD, 2017).

The National Office of Minority Health (OMH) suggests providing training and education as a standard toward achieving CC care. The National Culturally and Linguistically Appropriate Services (CLAS) Standards include mandates and guidelines that inform, guide and facilitate required and recommended practices related to the provision of culturally and linguistically congruent health services. The Enhanced National CLAS Standards reflect the growth in the fields of cultural and linguistic competencies. The OHM offers a self-directed training course for primary care providers in response to the growing concerns and the need to address sociocultural disparities in healthcare (DHHS OMH, 2017).

CC is required at all socioecological levels (eg. policies and systems, communities, organizations, relationships, individuals). This project will focus on the organizational (primary care) setting. In the primary care setting, CC may influence the success of treatment, compliance

with health promotion behaviors, and elimination of barriers that interfere with desired health outcomes.

## Purpose

The purpose of the DNP project is to develop, implement, and evaluate cultural awareness in a primary care medical clinic using the Culturally and Linguistically Appropriate Services (CLAS) training modules. The project was facilitated by a DNP student within a Veteran's women's primary care clinic on the western slope of Colorado. The CLAS training tool is available to employees, but, according to the VA's nurse educators and clinic manager, the tool was not being used.

The intended outcomes for this project are two-fold. First, strategies to increase cultural awareness within the clinic were identified and then evaluated for their impact on individual staff. Second, a system-wide plan for monitoring the progress of utilization of CC resources within the clinic was defined. This project will monitor for improvements in cultural awareness and self-efficacy for the clinic providers and staff after CC training. Improved self-management of health for the patient and improved patient satisfaction for the practice are additional expected outcomes that the facility may monitor after completion of the project.

Quantifying CC in the primary care setting in a primary care practice is not simple. Matteliano and Street (2015) provide rich qualitative data demonstrating healthcare providers' use of different strategies to provide culturally competent care to diverse patient populations in three different practice groups. Identification of congruent personal characteristics between a provider and the patient was an initial theme identified by the authors. Concordance with ethnic similarities, language, age, gender, family role, or military service experience resulted in higher levels of patient satisfaction and strengthened provider-patient rapport (Matteliano & Street,

2015). Cultural humility is a second theme identified by the authors, and can strengthen the trust between the provider and patient. When providers acknowledge what they do not understand or know about the patient's life experiences it may open the door for sharing of more information. Matteliano and Street (2015) emphasize that CC is not something one fully achieves, but rather a life-long process. Identification of experts within a practice who are most knowledgeable and understanding of diverse groups may help a practice with overall cultural sensitivity. Respectful interactions with patients to develop trust and preserve dignity, another theme, takes time and may seem inefficient to the practice at first (Matteliano & Street, 2015). Providers need to learn more about the patient, the family, the community, and, in some situations, may need to ask difficult questions. This requires patience and a gentle approach, but may lead to stronger patient-engagement in his or her own health. Treating patients with CC may be instrumental in achieving healthier lifestyles for diverse populations (Matteliano & Street, 2015). Jernigan et al. (2016) suggests reflective practices may facilitate increased cultural humility and promote cultural sensitivity. Matteliano and Street (2015) also suggest that teaching CC to healthcare providers should include didactic instruction and real patient experiences.

Lathrop and Hodnicki (2014) point out that increasing access to primary care services and health promotion interventions for disease prevention are important for improving health outcomes. The DNP-prepared APRN has the knowledge and ability to understand the challenges facing diverse communities and patients with different cultural backgrounds, socioeconomic states, and limited education. The culturally competent APRN must be able to provide compassionate, comprehensive, and coordinated care to meet the diverse needs of all patients and families (Lathrop & Hodnicki, 2014).

## Section Two

## Systematic Literature Review: CC in Primary care

Cai (2016) and Fahlberg, Foronda, and Baptiste (2016) define attributes of CC as cultural awareness, cultural sensitivity, cultural knowledge, and cultural skill. Cultural humility is another important concept initially defined by Tervalon and Murray-Garcia in 1998 (Fahlberg, Foronda, & Baptiste, 2016). A desire to want to learn more as one recognizes gaps in knowledge, address power imbalances in the provider-patient dynamic, and value the patient's history and preferences are key to developing cultural humility (Tervalon & Murray-Garcia, 1998). Table 2 defines CC and some of the terms used in discussions about CC in primary care.

Table 2

*Definitions*

| **Term** | **Definition** |
|---|---|
| Culture | The integrated pattern of thoughts, communications, actions, customs, beliefs, values, and institutions associated, wholly or partially, with racial, ethnic, or linguistic groups, as well as with religious, spiritual, biological, geographical, or sociological characteristics (OMH DHHS, 2013). |
| Cultural Competence | Congruent attitudes, knowledge and behaviors that allow healthcare professionals to work effectively in cross-cultural situations (OMH DHHS, 2013). |
| Cultural Humility | A process of life-long learning, self-critique, inquisitiveness, and self-reflection (Tervalon & Murray-Garcia, 1998). |

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| Cultural Sensitivity | An attitude and way of behaving in which a person is aware of and acknowledges cultural differences (Matteliano & Street, 2012). |

*Note*. OMH DHHS = Office of Minority Health Department of Health and Human Services.

Pub Med, Medline, and the Cumulative Index for Nursing and Allied Health Literature (CINAHL) were used in the systematic search of articles. The search terms were "cultural competence training OR cultural competence education AND cultural competence OR cultural sensitivity OR cultural humility AND primary care OR healthcare disparities." The inclusion criteria were articles (a) written in English (b) peer-reviewed (c) published within the past five years (d) focused on primary care, family practice, or primary care sub-specialty groups and (e) directly related to CC and/or CC training or education for primary care providers. Articles were excluded if they were (a) published in languages other than English (b) not peer-reviewed (c) published before 2013 (d) focused on specialty areas outside of primary care (e) not focused on CC and/or CC training or education for primary care providers (f) lacked data due to incomplete study and (g) conducted in a non-English speaking country.

Figure 1 summarizes the article review and selection process using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) diagram and checklist. The Pub Med search yielded 25 articles, the CINAHL search yielded 23 articles, and the Medline search yielded 60 articles. The abstracts were reviewed based on the inclusion criteria. Sixty-nine articles were excluded for failure to meet inclusion criteria. Six articles were excluded because they were duplicates. Thirty-three articles were reviewed in full for inclusion or exclusion criteria. Twenty articles were excluded after full review for not meeting inclusion criteria or meeting some of the exclusion criteria. A total of 13 articles were included in the final literature review.

Figure 1. Summary of Article Review and Selection Process

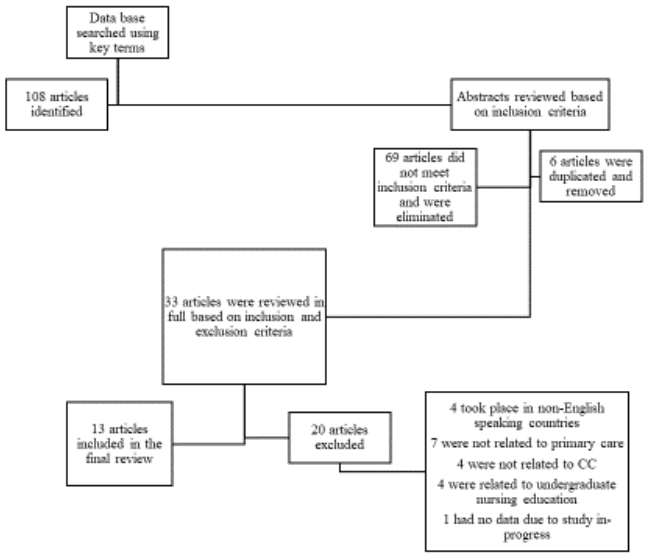


*Figure 1.* Summary of article review and selection process. CC = cultural competence.

## Findings

The literature review identified two primary themes. First, five articles focused on the content of CC training. Second, nine articles focused on patients' health outcomes and satisfaction with care. See Table 3.

The articles in the analysis include articles aimed at CC training and healthcare outcomes at the individual and organizational levels. CC is recognized as an umbrella term used when referring to individual, organization, and system concerns (OMH DHHS, 2013). Engebretson et al. (2008) make a point of distinguishing between organizational and individual CC before translating knowledge to clinical practice. In a systematic review, McCalman, Jongen, and Bainbridge (2017) find that although evidence supports that systems-level approaches to CC improve patient satisfaction and outcomes, which strategies are most effective is unclear. Some of the intervention strategies described are related to quality improvement efforts and include

Table 3

*Summary of articles*

| Author (yr) | Purpose | Study Design | N | U A | Results |
|---|---|---|---|---|---|
| | | | TRAINING | | |
| Kutob, Bormanis, Crago, Harris, Senf, & Shisslak (2013) | A skills-based model, ASCN, was used to train primary care providers about CC diabetes care. | A controlled, posttest-only design. | N = 90; PCPs (n=41 C; n=49 I) | Indv | No sig. differences on mean CCAT scores ($p$ = .154); Sig. + difference between nonjudgmental attitudes & behaviors ($p$ = .004) & sig. difference between cultural self-awareness ($p$ = 0.018); CC training should target non-judgmental behaviors & patient explanatory models; Need more research on assessment tools. |
| Singleton (2017) | To assess the effectiveness of enhancing CC across a DNP-FNP curriculum. | Pre–post paired *t* test, nonex design. | N = 54; DNP student s | Indv | Sig. difference between pre & post-test scores in students' TSE, t = 11(49), $p$ < .001. |
| Fox, Hamilton, Frayne, Wiltsey-Stirman, | Is EBQI the most effective strategy for improving gender | Multi-method, group-level, RCT | N=151 ; 8 groups ; EBQI | Indv | Gender sensitivity increased from M =118.42 to 121.29 ($p$ = .005, r = 0.30); SI participants reported higher gender sensitivity M=120.44 compared to EBQI participants M=117.74 with |

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| Bean-Mayberry, Carney, & ... Vogt (2016) | sensitivity & knowledge for health care staff in a women's VA clinic? | | = 4; SI = 3; (n=46 C; n=101 I) | | marginal sig. ($p$ = 0.09, r = 0.19); Paired sample $t$ tests in the EBQI condition group: increase in gender sensitivity & knowledge (sensitivity: $p$ = .02, r = 0.20); knowledge: $p$ = .01, r = 0.22); SI condition group, gender sensitivity sig. increased ($p$ = .03, r = 0.31); EBQI delivery of the CWV training did enhance gender sensitivity & knowledge; EBQI strategies may improve training for other healthcare employees. |
| Lange, Mager, & Andrews (2013) | To determine staff needs regarding CC training & predominant ethnic groups among HCPs at HBHC and LTC. | Mixed methods | N = 45; NA, allied HCPs. | Grp | CSES results for knowledge of cultural concepts $t$ = 6.03, $p$ = .000, CI = 1.39; Confidence in CC skills $t$ = .000, CI = 1.50; Confidence increased across all subscales for specific racial & ethnic groups (Asian, African American, Caucasian, Russian: $p$ = .000; Latino, Caribbean Island: $p$ = .001); participants' post-test mean scores > non participants; |

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| | | | | | CC training success influenced by culture specific information, flexible scheduling, congruence with agency priorities, & use interactive delivery methods. |
| Yingling, Cotler, & Hughes (2017) | Description of an LGBT specific training module for FNP students. | Review article | N = 5 student cohort | Grp | Student feedback + re: integration of LGBT module into curricula; Teaching methods: Audio-visual materials, case presentations; Topical areas: cultural humility, minority stress, & health disparities. |
| Patient Outcomes | | | | | |
| Calo, Cubillos, Breen, Hall, Rojas, Mooneyham, & ... Reuland (2015) | Explore Latino pts' experiences with registration systems & front office staff. | Qualitative | N = 20; pts | Indv | Themes: confusion about their surname during registration process (n = 12; 60%), language barriers (n = 13; 65%), difficulty understanding written material (n = 19; 95%), & feelings of discrimination based on language, ethnicity, and immigration status, generates mistrust of the office staff (n = 13; 65%). |

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| Kendrick, Nuccio, Leiferman, & Sauaia (2015) | To evaluate the attitudes & perceptions of PCP regarding racial, ethnic, & socioeconomic disparities in HTN control. | 24-item, on-line survey | N = 115; PCPs | Indv | Disparities based on race & ethnicity (33%, n = 38), socioeconomic status (44%, n = 50), pt.-related factors (66%, n = 76); Specifically, pt. adherence to treatment was largest contributor for socioeconomic disparities (71%, n = 82); Second was health literacy for racial/ethnic disparities (60%, n = 69) & socioeconomic disparities (68%, n = 78); Provider or health-system factor identified was miscommunication with pts for racial/ethnic (34%, n = 39) & socioeconomic (26%, n = 30); Provider training in communication & health equity will improve care for minority & low socioeconomic pts. |
| Tucker, Moradi, Wall, Nghiem (2014) | To test first component of PC-CSHC-Model. | Mixed method | N = 298 AA/Bl PCC pts. | Grp | Three dimensions of perceived provider cultural sensitivity had + direct relationship with provider trust ($p < .001$). Perceived provider competence had + direct relationship with provider fairness ($p < .001$); |

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| | | | | | Perceived provider interpersonal skill had + relationship with pt satisfaction ($p < .001$); Fairness or impartiality & trust of the provider has significant + associations with provider care; Practices serving low income AA/Bl pts benefit from CC training. |
| Waite, Nardi, & Killian (2013) | To identify CC attributes of providers & resources at NMHC. | Mixed method | N = 37 | Grp Dir. | CC resources include ongoing resources, books on cultural sensitivity, on-line CC workshops, ethnic specific health educators, interpreter bank, language line, diverse staff, & ethnic specific consultation. Beneficial services identified as ongoing in-services (46.7%, n = 14), CC workshops (43.3%, n = 13) & ethnic specific educators & interpreters (33.3%, n = 10); CC attributes of providers include bilingual personnel that matched populations served, approaches used for non-English speaking pts or ESL pts, & types of CC training offered to |

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| | | | | | providers & staff; Identifying gaps in provider, staff, & organizational cultural knowledge & awareness of cultural sensitivity & CC practices will reduce racial & ethnic disparities which impact outcomes. |
| Joo (2014) | Examine effectiveness of diabetic interventions tailored to Asian immigrants' cultures. | Systematic review | N = 9; Study | Grp | N = 5 RCTs, n = 4 quasi-experimental; All interventions community-based; n = 7 followed National Diabetes Education Program & ADA guidelines; All showed effectiveness of culturally tailored interventions (positive clinical, psycho-behavioral, & satisfaction outcomes). |
| Fahlberg, Foronda, & Baptiste (2016) | Demonstration of cultural humility at end-of-life. | Case study | N = 1 AA family | Grp | Cultural humility at end –of-life based on: inquisitiveness, self-awareness, & awareness of others' beliefs & values, awareness of power imbalances, & willingness to learn from others; Patient & family's beliefs, experiences, & values guide decisions |

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| | | | | | in care; Case study was effective in improving cultural humility. |
| McCalman, Jongen, & Bainbridge (2017) | To identify systems-level CC interventions. | Systematic literature review | N = 15; Study | Grp | Key principles: user engagement, organizational readiness, & delivery across multiple sites. |

*Note.* Yr = year; U A = unit of analysis; ASCN = Ask, Share, Compare, & Negotiate; PCP(s) = primary care provider(s); CC = culturally competent; C = control; I = intervention; Indv = individual; Grp = groups; CCAT = Cultural Competence Assessment Tool; DNP = Doctor of Nursing Practice; FNP = Family nurse practitioner; Sig. = significant; Nonex = non-experimental; TSE = transcultural self-efficacy; EBQI = evidence-based quality improvement; RCT = randomized controlled trial; VA = Veteran Administration; SI = standard web-based intervention; CWV = Caring for Women Veterans; HCP = Health care professionals; HBHC = Home-based health care; LTC = Long-term care; CSES = Cultural Self-Efficacy Scale; Pt(s) = patient(s); AA = African American; LGTB = Lesbian, Gay, Bisexual, & Transgender; PC-CSHC = patient-centered culturally sensitive health care; + = positive; HTN = hypertension; AA/Bl = African-American/Black; PCC = primary care clinic; NMHC = Nurse Managed Health Centers; ADA = American Diabetes Association.

interpreter services, translation of written material, workforce diversity training, promoting national standards, and improving access (Kutob et al., 2017).

Five articles (35.7%) describe CC training and education strategies for either specific ethnicities (Lange, Mager, & Andrews, 2013), chronic conditions (Kutob et al., 2013), vulnerable populations (Fox et al., 2016; Yingling, Cotler, & Hughes, 2017), or healthcare disciplines (Lange, Mager, & Andrews, 2013; Singleton, 2017; Yingling, Cotler, & Hughes, 2017). Three articles addressed CC at the individual level (Fox et al., 2016; Kutob, et al., 2013; Singleton, 2017) while two addressed CC at the organizational level (Lange, Mager, & Andrews, 2013; Yingling, Colter, & Hughes, 2017). The variation in study design, methodology, and tools or instruments used in the different articles makes comparisons difficult. This supports the

conclusion of Kutob et al. (2013) that it is difficult to teach and assess CC. Table 4 lists specific tools, instruments, or program used in prior studies.

Table 4

*Instruments, tools, or programs used in some studies*

| Author(s) (Year) | Instrument, Tool, Program |
|---|---|
| Kutob, Bormanis, Crago, Harris, Senf, & Shisslak (2013) | CCAT<br>ASCN model |
| Singleton (2017) | TCSE tool<br>Jeffrey's CCC model |
| Fox, Hamilton, Frayne, Wiltsey-Stirman, Bean-Mayberry, Carney, & ... Vogt (2016) | CWV Training Program |
| Lange, Mager, & Andrews (2013) | CSES |
| Tucker, Moradi, Wall, Nghiem (2014) | HCJI<br>PSQ-18<br>T-CSHCI |
| Joo (2014) | Amsterdam-Maastricht Consensus List for Quality Assessment |

Note. CCAT = Cultural competence assessment tool; ASCN = Ask, share, compare, negotiate; TCSE = Transcultural Self-Efficacy; CCC = cultural competence and confidence; CWV = Caring for Women Veterans; CSES = Cultural Self-Efficacy Scale; HCJI = Health Care Justice Inventory; PSQ = Patient Satisfaction Questionnaire Short Form; T-CSHPI = Tucker-Culturally Sensitive Health Care Provider Inventory.

Tools used for CC training and education include detailed content, self-discovery exercises, video-based case studies and vignettes, self-assessment exercises, interactive on-line courses, and presentations and handouts (Lang, Mager, & Andrews, 2013). Yingling, Cotler, and Hughes (2016) use similar tools in the development of a FNP module specific to primary care of LGTB people. Fox et al. (2016) describes the web-based Caring for Women Veterans (CWV) program that also includes video scenarios and interactive discussion segments. Singleton (2017) describes several strategies used to enhance CC in a DNP curriculum using Jeffrey's CCC model. The first phase used expert consultants to provide training for the faculty, followed by delivering CC content, exercises, and reflective activities to promote self-awareness. The final phase was the development and implementation of a web-based learning environment that included many of the tools used by others and links to relevant resources and reports.

Patient satisfaction is largely impacted by the patient-provider relationship (Fahlberg, Foronda, and Baptiste, 2016; McCalman, Jongen, & Bainbridge, 2017; & Tucker, Moradi, Wall, & Nghiem, 2014). Training in both CC and cultural sensitivity is important to influence patient satisfaction with care. Patients from diverse groups felt more respected and more trusting when practitioners demonstrate behaviors and attitudes that suggest sensitivity to differences. Joo (2014), in a systematic review, reports findings that culturally tailored diabetes programs for Asian immigrants to the United States demonstrate positive clinical, behavioral, and satisfaction measurements. Tucker, Moradi, Wall, and Nghiem (2014) find that an assessment of racial/ethnic minorities and low-income patient's view of healthcare services and experiences contribute to patient empowerment and provider cultural sensitivity by enhancing patient trust.

Increased provider awareness of racial/ethnic and socioeconomic disparities within their own health setting and improved provider communication skills was an emerging theme in a

study of primary care provider perceptions of disparities in hypertension control (Kendrick, Nuccio, Leiferman, & Sauaia, 2015). Waite, Nardi, and Killian (2014) reiterate the need for quality audits that evaluate dimensions of CC in practices among providers and staff and from an organizational perspective. The authors support the concept of CC as dynamic and the need for continuous evaluation as it relates to patient outcomes.

McCalman, Jongen, and Bainbridge (2017) report that healthcare organizations, at regional and local levels, are recognizing CC as an organizational strategy to address the needs of diverse client populations. The authors note that some primary care organizations have developed policies, education and training programs, and quality improvement practices in response to the cultural and linguistic needs of their patient populations. During these processes, cost and failure to recognize the potential benefits are specific barriers that organizations have encountered (McCalman et al., 2017).

Calo et al. (2015) addressed culturally appropriate patient registration processes. The lack of linguistically competent or diverse front office staff were themes that negatively influenced patient respect, access to care, patient satisfaction, and health outcomes. CC education and training should include all staff for organizations who want to promote a culture of patient-centered care, respect, and improved patient experiences (Calo et al., 2015).

Some of the articles in the literature review identified specific theories, models, or programs related to CC training or assessment. These are listed in Table 5.

Table 5

*Theories, models, or programs referenced in some articles*

| Authors/year | Theories/models referenced | Notes |
|---|---|---|

| | | |
|---|---|---|
| Kutob, Bormanis, Crago, Harris, Senf, & Shisslak, 2013 | Berlin & Fowkes Learn Model, cross-cultural communication tool for use in clinical practice | L: Listen with sympathy & understanding to the pt.'s perception of problem<br>E: Explain your perceptions of the problem<br>A: Acknowledge & discuss the differences & similarities<br>R: Recommend treatment<br>N: Negotiate agreement |
| Lange, Mager, & Andrews (2013) | Camphina-Bacote's CC model | ASKED guided the study:<br>A: awareness of differences<br>S: skills to assess differences<br>K: knowledge of other cultures<br>E: engaging with individuals different from oneself<br>D: desire to change one's attitudes & beliefs about others |
| Singleton, 2017 | Leininger Cultural Care | Leininger's major concepts: cultural preservation or maintenance, cultural care accommodation or negotiation, & cultural care re-patterning or restructuring (Butts & Rich, 2011). |

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| | Bandura's Social Cognitive Theory | Bandura's 4 processes within a learner: attentional phase, retention phase, reproduction phase, & motivational phase. Self-efficacy has a strong cultural component (Butts & Rich, 2011) |
| Fahlberg, Foronda, & Baptiste (2016) | Leininger Cultural Care<br>Camphina-Bacote's CC model | (see above)<br>CC model: cultural awareness, knowledge, skill, encounter, & desire (Butts & Rich, 2011). |
| Yingling, Cotler, & Hughes, 2016 | Minority Stress Framework | Environmental circumstances, minority status, general stressors, minority stress processes, community & individual support (Butts & Rich, 2011). |

Note. CC = Cultural competence; pt. = patient

## Conclusions

Based on the literature review, successful strategies for increasing CC include a combination of training and patient outcome elements at both the individual and organizational levels. CC training should include audiovisual materials, case studies, interactive workshops, self-reflection, and identification or development of accessible resources. Communication skills that prepare providers to consider the patients' views of their illness and treatment plans are also important in CC training. Kutob et al. (2013) describe the Ask, Share, Compare, and Negotiate

(ASCN) model, which has been shown to be effective. Improving communication skills is an effective strategy to reducing health disparities, improving patient satisfaction, and improving cultural awareness and self-efficacy (Fahlberg et al., 2016; Joo, 2014; Kendrick et al., 2015; Lange et al., 2013; McCalman et al., 2017; Tucker et al., 2014; Waite et al., 2013). CC training can provide examples of ways providers, staff and organizations can take steps to integrate cultural awareness into their practice and clinic environment.

The expected outcomes of the CC training include both individual and organization outcomes. First, improved CC self-efficacy amongst the participants is expected. Efficient use of translators, culturally sensitive written materials, identification of bilingual staff, and willingness to learn from others may contribute to reduced racial and ethnic disparities. Patient satisfaction may improve because of stronger, more balanced, and trustworthy provider-patient relationships. Enhanced provider cultural sensitivity and humility may improve minority patients' adherence to treatment recommendation and improve outcomes (Tucker et al., 2014). Health outcomes may improve because of closing the gaps amongst provider, staff and organizational CC practices.

## Section Three

## Conceptual Model

The conceptual model used for this project is the Donabedian model. Donabedian believed that quality in healthcare is defined by structure, process, and outcomes (Butt & Rich, 2011). The Donabedian model was used to classify the domains of CC training into the categories of "structure," "process," and "outcomes." Structure is about the setting, the material and human resources, and the organizational structure. Process denotes what is done, and outcome denotes the effects on the health status of patients and populations (Donabedian, 1988). Donabedian strongly believed that efforts to improve structure, process, and outcomes in health care require that providers genuinely care about the needs of the patient and family (Ayanian & Markel, 2016). The Donabedian model provides a step-wise approach to the development, implementation, and evaluation of strategies to improve CC in a primary care clinic. According to Ayanian and Markel (2016), Donabedian asserted that providers must recognize that the culture and social system of the clinic can enrich or diminish the quality of health care. The structure, process, and outcomes are addressed separately. Figure 2 shows how the Donabedian model is guiding this project.

### Structure

Structural measures provide a sense of the capacity, system processes, and tools that exist within the clinic. Structural measures include the attributes of where the care is delivered. The structure of the primary care clinic includes practitioner licensure and certifications, staffing patterns, clinic environment, administrative processes, and the CC training that exists, but is not used. The clinic staff report that there is no sense of CC within the clinic or episodically, even

though there is diversity among patients. The structure influences the process and outcomes in this interdependent model (Donabedian, 1988).

Figure 2. Donabedian Model Specific to CC Strategies to Improve Self-efficacy

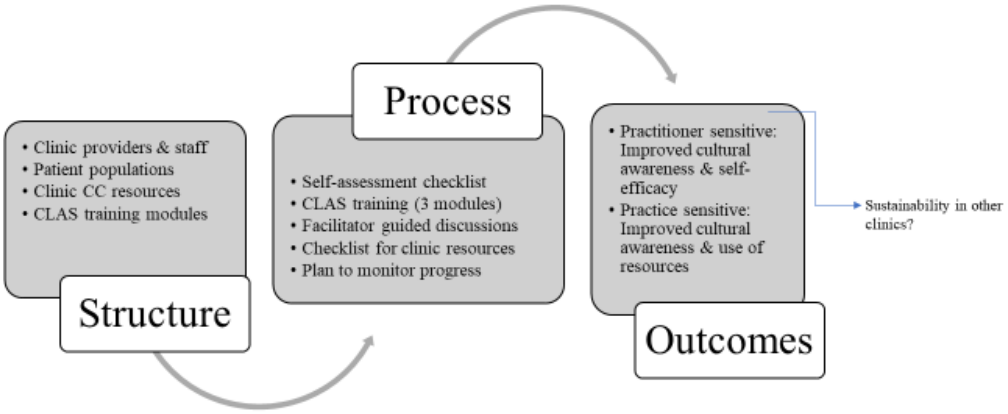


*Figure 2*. Donabedian model. CC = cultural competence. CLAS = culturally and linguistically appropriate services.

CC influences in the primary care setting regarding the success of treatments, compliance with health promotion behaviors, and the elimination of barriers that interfere with desired outcomes [American Academy of Family Physicians (AAFP), 2018]. Primary care practices are typically team-based and include physicians, APRNs, and other non-physician health professionals. Patient-centered outcome measures and experiences should be central to assessing the quality of care (AAFP, 2018). The framework of primary care includes health promotion, disease prevention, health maintenance, patient education, and the diagnosis and treatment of acute and chronic conditions (AAFP, 2018).

The CC training consists of resources and tools developed by the OMH and the Veterans Administration Learning University (VALU) Talent Management System (TMS). The project investigator (PI) will provide practitioners and clinic staff with resources and guide participants

through the CLAS training modules which include ways to incorporate CC strategies into practice. Through the training phase, participants may help identify what works and what does not work before incorporating the strategies in other primary care clinics.

The OMH training course supports implementation of the National CLAS Standards and was used for this project. The CLAS course includes three modules, a facilitator guide, and an option for small group learning. The first module covers fundamentals of CLAS, including strategies for delivering patient-centered care, the second module covers communication & language assistance, and the third module covers organizational CLAS-related activities, including strategic planning & community assessment. The intent is to enhance the knowledge, skills, and awareness to best serve all patients, regardless of cultural or linguistic background (OMH DHHS, 2013).

**Process**

Individual and aggregate actions are the primary processes in this project. Baseline self-efficacy, cultural humility, cultural awareness, and communication skills was established using a self-assessment checklist. Clinic staff participants completed the CLAS training modules one and two on their own. A facilitator-guided group discussion, including role-play followed. A second group discussion took place after completion of the third CLAS module. Another checklist was used to describe clinic material, use and access to resources, environment, and diversity of staff and volunteers.

Integration of aspects of Bandura's self-efficacy model is common to many training programs (Kozina, Grabovari, Stefano, & Drapeau, 2010). Self-efficacy has relevance in settings where successful and positive experiences are directly related to an individual's perception about one's ability to achieve a desired outcome (Bandura, 1986). Activities such as role-play,

watching video case scenarios, and receiving constructive feedback are used in many training programs to increase self-efficacy perceptions (Bandura, 1986).

According to Bandura (1994), people's beliefs in their efficacy are developed by four main sources of influence. They include mastery experiences, vicarious experiences, social persuasion, and inferences from somatic and emotional states indicative of personal strengths and vulnerabilities. Specific actions include drawing from experiences, observation of successful role models, boosting one's confidence with positive feedback and coaching, and maintaining a positive attitude. A psychologist, James Maddux, added imaginal experiences as a fifth source of influence (Akhtar, 2008). This translates to the self-visualization of behaving successfully in a situation. These influences are incorporated into the CC training and discussions.

Process measures include the repeating the self-awareness checklist after the training and reviewing the clinic resource checklist to define a quality improvement plan for monitoring progress. The process measures will inform practice as it relates to CC.

**Outcomes**

Improvements in knowledge, changes in behavior, and degree of patient satisfaction are included in the definition of health status (Donabedian, 1988). The ultimate goals of the implementation of the DNP project include individual and organizational outcomes. The end hope is that the practitioners and staff demonstrate improved CC self-awareness and self-efficacy. Individual changes in self-efficacy were reported using a self-assessment checklist. Organizational improvement in cultural awareness and utilization of resources could be monitored with a clinic resource checklist.

Donabedian outcomes are broad and multi-leveled. CC is required at all socio-ecologic levels including policy, community, organization, relationship, and individuals (McCalman et al.,

2017). Details of outcome measures can be reflected on multiple levels such as quality improvement programs, mandated or recommended CC training, increasing diversity in communities and workforce, quality of care in the face of disparities, access to care, linguistic services, and self-efficacy.

Specifically, outcome measures include the effect the identified strategies to increase CC has on providers, clinic staff, practice, and process sensitive outcomes. Because outcomes are dependent on the structure and processes, both may be manipulated to improve outcomes. Manipulation or revisions need continued monitoring to ensure quality (Donabedian, 1988). The potential adoption of the CC strategies used for the women's clinics by other primary care clinics is another anticipated outcome.

# Section Four

# Methods

## Ethical Consideration

This DNP project was created following *The Essentials of Doctoral Education for Advanced Nursing Practice* by the AACN: scientific underpinnings, leadership for quality improvement and systems thinking, clinical scholarship and analytical methods for evidence-based practice, technology and information literacy, healthcare policy, collaboration for improving patient and population outcomes, clinical prevention and population health, and advanced nursing practice (AACN, 2006). A capstone immersion log was updated bi-weekly to document the alignment of the expected learning outcomes for a DNP student at the university during the development of the DNP project.

This project aligns with the core values of the American Nurses Association *Code of Ethic for Nurses with Interpretive Statements.* CC aligns most directly with Provisions 1 and 8. Provision 1 states that culture, value systems, beliefs, lifestyle, social support systems, sexual orientation, and primary language should be considered when planning care. Provision 8 addresses the universal right to health. This right has economic, social, political, and cultural dimensions. Collaboration with other healthcare professionals to create a moral milieu that is culturally sensitive may help to reduce healthcare disparities (ANA, 2015).

The DNP PI completed the Collaborative Institutional Training Initiative (CITI) Program's Social and Behavioral Responsible Conduct of Research course in January 2018. The course was directed to students conducting research with no more than minimal risk.
This project was conducted as a Quality Improvement Program and as such was not formally supervised by the Institutional Review Board per their policies. Permission to conduct the

quality improvement project from a university Institutional Review Board based on a Request for Determination of Non-Human Research Form submission was submitted and approved. The Chief of Education and Organizational Development at the Grand Junction Veterans Health Care System has approved the project (see Appendices A and B for letters of approval).

**Context**

The DNP project was conducted in the women's primary care clinic at a Veterans Health Care System (VHSC). The Grand Junction VHSC serves 37,000 veterans residing on the Western Slope. The VHCS consists of one facility located in the city of Grand Junction, a community-based outpatient clinic (CBOC) serving the southwestern Colorado counties, and a telehealth outreach clinic serving northwestern Colorado and southwestern Wyoming. The VHCS provides acute medical, surgical, and psychiatric inpatient services, as well as a full range of outpatient services (US Department of Veteran Affairs, 2015).

The project identified strategies to improve cultural awareness and self-efficacy among providers and staff, integrated cultural awareness into individual practices, and identified use of resources within the women's primary care clinic that may improve cultural awareness. The project may benefit practitioners, clinic staff, patients, and the organization by enhancing knowledge about cultural concepts and different cultural patterns, confidence in delivering CC care, patient engagement in their own health and patient satisfaction with care.

Clinician stakeholders including FNPs, physicians, nurses, social workers, mental health providers, and other clinic staff or volunteers were invited to participate in the training. Invitations were sent via email with information, consent forms, a demographic questionnaire, and instructions for reply.

**Methodology**

A mixed methodology was used with quantitative and descriptive analysis. Qualitative feedback was sought in addition to the self-assessment checklist because the N was insufficient to rely on quantitative measures alone. The descriptive analysis was used for the aggregate data using the office environment checklist.

Demographic information about the participants was collected upon agreement to participate. Demographic information included gender, age group, ethnicity, language spoken at home, and years of experience in primary care and in the women's clinic. The demographic information was determined based on the literature review (see Appendix C for the Demographic Information Sheet).

The Promoting Cultural and Linguistic Competency Self-Assessment Checklist for Personnel Providing Primary Health Care Services was used to establish a baseline and monitor progress toward self-efficacy (see Appendix D for the Self-Assessment Checklist). Goode (2009) as a resource for the Georgetown University National Center developed the checklist for Cultural Competence (GU NCCC). With a focus on primary care, the checklist provides examples of the kinds of beliefs, attitudes, values and practices that foster CC at individual levels (Goode, 2009). The self-assessment checklist was used to identify strengths and growth at all levels of an organization (GU NCCC, n.d.). The self-assessment provides a snapshot as to where an individual or organization is at a specific point in time. The results are used to plan strategies to enhance an individual's and organization's capacity to deliver culturally competent services at all levels. According to the GU NCCC (n.d.), benefits are derived from self-comparison over extended periods to determine the extent of growth.

The Office Environment Checklist from *A Practical Guide for Implementing the Recommended National Standards for culturally and Linguistically Appropriate Services* was

used for the aggregate checklist (OMH DHHS, n.d.). The criteria on the checklist aligns with findings in the literature review regarding resources, interactions, materials, and environmental and organizational strategies for delivering culturally competent services (see Appendix E for the Office Environment Checklist). The environmental checklist helps to identify areas needing improvement to meet the cultural competency needs of diverse populations served within the clinic (OMH DHHS, n.d.).

**Intervention**

The literature review provided ideas about CC training strategies and information about the impact of CC training on patient satisfaction and behavioral changes to improve health outcomes. Assessment of the attitudes and practices of the providers and clinic staff was useful when planning and incorporating CC within a clinic. Competency in recognizing the needs, preferences, and satisfaction of the patients and families was also essential.

The CC training modules are derived from the CLAS course entitled: *A Physician's Practical Guide to Culturally Competent Care.* The target audience for the course includes physicians, physician assistants, NPs, and any direct service provider interested in the topic. The themes for each of the three CLAS modules are listed in Table 6. A thematic analysis notes form was created using the CLAS themes and findings in the literature review. Notes were documented on the thematic analysis form during each session for qualitative analysis (see Appendix G for the thematic analysis notes form).

Table 6

*Themes of the CLAS Training Modules*

| Module | Themes |
|---|---|

| | |
|---|---|
| CLAS Module 1: Fundamentals of CLAS | Obtaining knowledge about pts' cultural beliefs; Influence of personal bias & beliefs on pt. relationship; Communication models |
| CLAS Module 2: Communication & language assistance | Pt.-centered care & effective communication; Consequences of not understanding the impact of linguistic differences; Use of interpreters |
| CLAS Module 3: Organizational CLAS-related activities | Cultural environment; Strategies for promoting a diverse staff; Seeking community input; Practice profile data |

*Note.* CLAS = culturally linguistically appropriate services. Pt. = patient

A timeline for the implementation of the DNP project is outlined in Table 7. Once participants were enrolled, they were sent a link to the CLAS modules on a separate website created for the small group training. The participants earned continuing education credits for completing the course. A pre- and post-test was included before and after each module for individual assessment. Participants were asked to complete the modules in advance of the group sessions. Two one-hour group sessions were scheduled. An agenda and participant agreements were reviewed at the beginning of each session (see Appendix F for Informed Consent to Participate in a DNP project). The PI guided the discussions using suggested prompts and allotment of time for each discussion. Short case study videos, previously viewed in the modules, were viewed again to remind participants of the details of each case. Group discussion prompts included self-exploration questions, further exploration questions to brainstorm ideas, and a role-play activity. Additional discussion explored how issues presented in the case were manifested in their own practice environment (OMH DHHS, 2013).

Table 7

*Timeline for implementation of the DNP project.*

| Week of in 2018 | What |
|---|---|
| May | Meet with the education director & clinic FNP to review the project plan |
| Week 1 | Submission to IRB for Quality Improvement Program |
| Week 2 | Recruit participants from the women's clinic upon IRB approval (email invitation to participate) |
| Week 3 | Email participant agreement forms & participant demographic forms; collect signed agreements & demographic forms; Distribute the Self-Awareness Checklist; Email links to the CLAS modules for participants |
| Week 4 | Collect the completed checklists; analyze demographic data |
| Week 5 | Remind participants to complete Modules 1 & 2; Schedule sessions 1 & 2; Complete the Clinic Environment Checklist; Complete thematic analysis form after session 1 |
| Week 6 | Complete session 1; Complete thematic analysis form after session 1; Remind participants to complete Module 3 |
| Week 9 | Complete session 2; Complete thematic analysis from after session 2; Distribute self-awareness checklist and course evaluation form |
| Week 10 | Complete analysis of the environment checklist; Collect the self-awareness checklists and the course evaluations |
| Week 12 | De-brief with the FNP & clinic staff & nurse educator; Complete analysis of the self-awareness checklists |

*Note.* CLAS = Culturally linguistically appropriate services.

A self-assessment checklist was used to establish baseline prior to and at the completion of the training to heighten awareness of CC in the primary care clinic. The results provided insight into the effectiveness of the clinic in meeting the needs and preferences of culturally and linguistically diverse groups. The results were used to plan short and long-term goals to strengthen the clinic's delivery of CC services and may be used to monitor growth over time. A CC organization assumes responsibility for reducing disparities in health outcomes by proactively addressing gaps in care related to cultural diversity. At the completion of the second session, participants were asked to complete a course evaluation (see Appendix H for the Course Evaluation form). The document was collected by the FNP and submitted to the PI for anonymous analysis.

**Expenses**

There were no direct or indirect expenses incurred by this author for implementation of the project. FNP and clinic staff hours were not calculated, as participation was voluntary and supported by the administration to be conducted during scheduled work hours.

**Conclusion**

According to the *Social Policy Statement* nursing's understanding nursing theories and theories of other disciplines are the basis for evidence-based nursing actions to protect promote and optimize health, prevent illness/injury and alleviate suffering and advocate for patients and families. Nursing has an active role in the organization, delivery, and cost of quality health care. This includes health disparities, safety, access, and services. The nurse-patient relationship occurs within the context of the values and beliefs of both and within individuals, family, groups, communities, or populations (ANA, 2010). The need for nurses and other health care providers

to be trained in CC and be prepared to effectively treat diverse populations may minimize negative outcomes associated with health care disparities (OMH DHHS, 2013).

## Section Five

## Data Analysis and Results

Five (100%) participants completed the Self-Assessment Checklist for Personnel Providing Primary Health Care Services and the Demographic Information Sheet. Table 8 describes the participants' demographic information. One (20%) participant withdrew from participation after completing the initial Self-Assessment Checklist and the Demographic Information Sheet. Over an eight-week period, four (100%) participants completed the CLAS training modules and attended two group discussion sessions. Two weeks after the last group discussion, four (100%) participants completed a second Self-Assessment Checklist. The four participants included two nurse practitioners, one registered nurse, and one administrator. The Office Environment Assessment Checklist was completed at the end of the second group discussion. Notes from each group discussion session were recorded on a thematic analysis form (Table 9). Participants completed a course evaluation at the end of the second session (Table 10).

Table 8

*Participants' demographic information*

| **Variable** | | **N=5** | **n(%)** |
|---|---|---|---|
| Gender | | | |
| | Female | 5 | 100 |
| | Male | 0 | |
| Age in years | | | |
| | 40 to < 50 | 2 | 40 |
| | 50 to < 60 | 3 | 60 |

| | | | |
|---|---|---|---|
| | 60 to < 70 | | |
| Ethnicity | | | |
| | White | 5 | 100 |
| Language spoken at home | | | |
| | English | 5 | 100 |
| Veteran Status | | | |
| | Yes | 1 | 20 |
| | No | 4 | 80 |
| Time working in clinic | | | |
| | Less than one year | 3 | 60 |
| | Over 10 years | 2 | 40 |
| Hours worked in the clinic | | | |
| | ≥ 40 hours per week | 5 | 100 |

The Self-Assessment Checklist was completed by each participant prior to the training and again after completion of the training and discussion. One participant (20%) did not complete the training or the second checklist. Of the participants who did complete the training, there were changes in responses that which suggests increased cultural awareness. The changes in the prompts on the self-assessment checklist related to communication styles suggests an increased understanding of communication and language assistance. Three participants (75%) reported a stronger understanding of the principles and practices of linguistic competency after the training. This included the appropriate use of interpreters. The training reinforced the importance of ensuring competent, trained interpreters and avoiding the use of minors as

interpreters. One (25%) participant described an encounter where a minor family member was used as an interpreter. After the training, the participant recognized this was not recommended.

There were changes in the value and attitude prompts on the self-assessment checklist. Three (75%) participants were willing to avail themselves to professional development and training to enhance knowledge and skills in the provision of services to culturally and linguistically diverse groups at a greater degree than the initial reply. After the training, two participants (50%) reported improved knowledge in treatments and interventions for the delivery of healthcare to groups served by their clinic. However, two participants (50%) were less confident in their ability to recognize and understand that beliefs and concepts of emotional well-being vary significantly from culture to culture than they initially reported. In addition, they were not confident that they consistently avoided imposing values that may conflict with patients' values. One participant (25%) reported increased confidence related to seeking information from patients and families that would assist in responding to preferences of culturally diverse groups served by the clinic.

Table 9

*Thematic analysis notes*

| **MODULE 1: Fundamentals of Culturally Competent (CC) Care** | | |
|---|---|---|
| **Themes** | **Facilitator Notes** | **Participant Perspectives/Comments** |
| Importance of CC | Health disparities are well documented and have received attention from states, professional organizations, and accrediting bodies. | Personal biases: "low tolerance for racist views" finds it "hard to re-direct;" Important to understand the "jargon" (sexual orientation, ethnic |

| | | |
|---|---|---|
| | Health care providers in the U.S. are seeing an increase in the numbers of patients from different cultural backgrounds. Factors such as economic, geographic, social and cultural barriers affect access to health care. The growing body of research on health disparities has also positioned cultural competency as a national health concern; Background and purpose of the CLAS Standards. | cultures, plethora of Native American tribes and the many differences in beliefs, practices, language, respect and trust); Discussion about what illness means to the patient: Young patient with diabetes at risk for losing limb, only concern was paying rent so did not lose his belongings.; Male veteran presents with GD at visit to act as an interpreter, and no one asks the GD to leave to examine for evaluation of herpetic lesions at the first two visits. Finally, the NP did on the third visit and was able to prescribe appropriately; Shared some of their own beliefs; many found themselves very open, non-judgmental, but also "lacked the knowledge and training to be more culturally aware and purposeful about it." |
| Impact on Practice | Negative impacts and risks of not understanding the impact of cultural | Not sure how to access resources for CC training; Lack of formal training |

| | | |
|---|---|---|
| | and language differences; Benefits of cultural competency in one's practice; Strategies to promote a diverse office staff; Approaches to support ongoing cultural competency training for practice staff. | in CC; Able to list patient compliance, satisfaction, poor outcomes, errors as problems with lack of CC; Need to understand era of wars served to know risk factors; Anger, illnesses, sexual orientation, abuse, expectations; Lack of knowledge about some vulnerable groups (rural, transgender, female veterans). |

**MODULE 2: Speaking of Culturally Competent Care**

| Themes | Facilitator Notes | Participant Perspectives/Comments |
|---|---|---|
| Language Access Services | Use of interpreters in medical practice; Written material. | No one knew where to find resources for interpreters; did not know where the language brochures were "I know we have them;" NP had identified encounters where "should have used an interpreter, but not sure where to find one." |
| Best practices for | Best practices include understand that patients may have different levels of comfort with formality, silence, | Described encounters on the Indian reservation where there was misinterpretation of the language |

| | | |
|---|---|---|
| interpersonal communication | physical distance, or eye contact; Learn the preferences of patients and their communities; Be conservative in your body language; Do not discount the effect of beliefs about the supernatural on health; Learn basic words or phrases from each patient's language; Know your patients' preferences on communicating health news. | and another where practices regarding the body after death were not respected; Two participants brought up the book, *The Spirit Catches You and You Fall Down* book, and the Hmong population.; Rural farmers identified as a vulnerable population seen in the clinic; Reviewed best practices and goals of CC; Attitude versus skill centered car discussed. |
| Frameworks for developing CC | Models for effective communication; Promoting patient-centered care; Potential communication difficulties; Illness versus disease; LEARN, BATHE, ETHNIC models. | Reviewed the BATHE, LEARN and ETHNIC models; reviewed video of BATHE example; liked language of the BATHE model and thought this would be realistic to use in their clinic; Also talked about MI and the effectiveness of this approach; All participants were trained in MI. |

**MODULE 3: Structuring Culturally Competent Care**

| **Themes** | **Facilitator Notes** | **Participant Perspectives/Comments** |
|---|---|---|

| | | |
|---|---|---|
| Office Environment & Climate | Strategies to promote more CC environment; Completion of Clinic Environment Checklist. | Culture of this clinic is fluid, intuitive, happy, and supportive. Culture of the entire primary care clinic is silo-like, negative, and cramped; Flagging patient preferences on the EHR such as preferred name, preferred time of day to call; Lack of workforce diversity; Confusion of roles of staff and providers (no clarification on nametags, uniform differentiation); Waiting room uncomfortable; Mixed reviews about greeting patients. |
| Community Partnerships | Potential partners; Minority communities; Benefits; Barriers. | Specialty providers in the community (women's health, urology); Timely service & care; Lack of awareness of military culture, transgender care; Lack of workforce diversity; Workforce does include female veterans. |

Note. CC = Cultural competence; CLAS = Culturally and linguistically appropriate services; GD = granddaughter; NP = Nurse practitioner; LEARN = Listen, explain, acknowledge, recommend, negotiate; BATHE = Background, affect, trouble, handling, empathy; ETHNIC = Explanation,

treatment, healers, negotiation, intervention, collaboration; MI = Motivational interviewing; EHR = Electronic health record.

Table 10

*Course evaluation N = 4*

| **Prompt** | **Choices** | **Response n (%)** |
|---|---|---|
| What overall rating would you give the course? | Excellent | 3 (75) |
| | Very Good | 1 (25) |
| Would you recommend this training for other primary care clinics at the VA? | Definitely | 4 (100) |
| The training modules were: | Just right | 2 (50) |
| | Too long | 1 (25) |
| | Somewhere in-between | 1 (25) |
| The group discussion sessions were: | Just right | 3 (75) |
| | Too short | 1 (25) |
| **Open-ended prompts** | **Replies** | |
| What did you like most about the group sessions? | Varied experiences about diverse backgrounds of other participants; Participants were clearly interested, topics furthered conversation about diversity/culture and need for organizational changes; Discussion about our environment, patient population and ways we can improve our service to patients; Exploring | |

| | |
|---|---|
| | examples of what we do and identify areas we can improve. |
| What did you like least about the group sessions? | Nothing. |
| Please provide any comments or suggestions that may help to improve this course: | Watch the training modules without interruptions or distractions; Increase group size. |

The Office Environment Assessment Checklist addressed resources, interactions, materials, environment, and organizational strategies. Participants agreed that language resources were not easily accessible but, patients with special needs are afforded extra time in scheduling. Participants agreed that interactions among staff and patients were not consistently open-minded and respectful. For example, the attitudes and behaviors toward transgender patients were not always welcoming. Staff members were not diverse and culturally aware of differences and effects. Some practitioners, other employees, and volunteers are veterans. Participants agreed that written materials do not consider health literacy. The administration has a rigorous approval process for materials, videos, or other media and they are free from negative cultural, racial, or ethnic stereotypes. The waiting area environment was not comfortable, or clean, and had potentially noxious odors of popcorn. There was limited art on the walls, occasional holiday decorations, and occasional themes appropriate to the diversity of the patient community. The facility has monthly cultural celebrations. The reception practices, telephone manners, secure messaging options were effective and positive. The mission plan includes the delivery of culturally competent care, is visible to patients, and is delivered by leadership to the employees

consistently during meetings and morning rounds. New employee orientation includes culturally and linguistically appropriate services. Employees have access to training via the Talent Management System (TMS) but participants report limited time to complete optional training sessions. Participants reported no rewards for CC behaviors and no sanctions for culturally incompetent behavior. Data about patient satisfaction related to culturally competent care was not available.

The course evaluations were positive and suggested a desire for further training. Participants thought the training modules would be appropriate for other clinics in the facility. Comments suggested the small group discussions were engaging and may be more valuable if the group size was larger.

## Section Six

## Discussion

The purpose of this DNP project was to develop, implement, and evaluate cultural awareness in a primary care medical clinic using the CLAS training modules. Strategies to increase cultural awareness within the clinic were identified and a plan for monitoring the progress of utilization of CC resources within the clinic was defined. Tools for CC training used for this project included video-based case studies and vignettes, self-assessment exercises, presentations, and handouts. The literature review supported the use of these tools for CC training and supported the concept of CC as a dynamic process that requires ongoing training and evaluation at both individual and organizational levels (Fox et al., 2016; Lang, Mager, & Andrews, 2013; Yingling, Cotler, & Hughes, 2016). There is limited evidence on what training method is most effective and there is no one standard of measurement to consider someone CC. When preparing CC trainings, organizers should consider the organization's strengths, weaknesses, and the needs of its patients (Lange et al., 2013; McCalman et al., 2017; Yingling et al., 2017).

Outcomes and competencies related to CC are difficult to teach and assess (Kutob et al., 2013). This is supported by both the literature review and this project's findings. Evidence supports that CC training for health care professionals improves providers' knowledge, understanding, and skills for treating patients from culturally, linguistically, and socioecological diverse backgrounds. It is clear that becoming CC is a process and there are gaps in CC training and assessment methods. For example, additional supporting evidence is needed to determine effects of CC training on patients' satisfaction with care and health outcomes. The literature review provided some evidence of improved patient satisfaction with the provider-patient

relationship because of CC training and improved cultural sensitivity to differences (Fahlberg et al., 2016; McCalman et al., 2017; & Tucker et al., 2014). This DNP project did not measure changes in patient satisfaction after CC training due to the short time-frame.

After completion of the CLAS training modules participants, were able to share ideas and questions with each other in the group discussions. Participants identified specific vulnerable populations in their clinic and were able to apply models of effective communication including motivational interviewing and the Background Affect, Trouble, Handling, and Empathy (BATHE) model as they shared examples of encounters. Some of the group discussion themes centered on two vulnerable populations served by the clinic. These included ~~military culture and~~ ethos for women in the clinic amidst military culture and healthcare needs specific to the LGTB populations. Complex health issues for women in the clinic included dealing with military sexual trauma (MIT), chronic pain, depression, anxiety, and post-traumatic stress disorder (PTSD). LGTB patients in the clinic faced health disparities related to social stigma, discrimination, higher rates of sexually transmitted diseases, substance abuse, and psychiatric disorders. The participants expressed a desire for more education specific to delivering CC care for the transgender population in particular.

The participants identified barriers to healthcare access that may be attributed to a lack CC. Some of the barriers included access to qualified interpreters and translators, written materials at the recommended level of literacy, and lack of diversity among the clinic staff. Similar systems-level CC quality improvement strategies were identified in the literature review which, in addition, noted other effective strategies such as promoting national standards and improving access to care (OMH US DHHS, n.d.).

The participants identified aspects of the clinic environment that support CC and strategies that enhance CC within the clinic environment. Principles of CC are included in new employee orientation but, ongoing training needs are not formally assessed. It was unclear who was responsible for the CC plan. There was not a process for monitoring, evaluating, and rewarding CC for staff. There was some evidence of celebrating different cultures within the clinic. One community partnership barrier identified was lack of awareness of military culture among community providers. A recommendation was made that the participants strive to integrate CLAS-related activities into future quality improvement programs, patient satisfaction assessments, and other outcomes-based evaluations. As the clinic develops collaborative partnerships with community providers, efforts to provide training specific to women in the military will be encouraged. Because of the training, the participants were more aware of CC training resources available for employees, more aware of the changing diversity in the US, and the impact on their clinic.

There are a number of frameworks and models that illustrate the development and characteristics of CC care. Campinha-Bacote's model helps healthcare professionals see CC as a process with a focus on awareness, skills, knowledge, encounters, and desire (Campinha-Bacote, 2002). The ASKED mnemonic operationalizes the constructs of Campinha-Bacote's model and was identified in the literature review and in the CLAS training modules. The models' constructs supports the use of self-assessments to monitor the development of CC and is widely used to guide empirical research and develop educational programs (Abdulrhman, Pounds, & Jazi, 2016). Topics that aligned with the constructs during the discussions included health literacy considerations during encounters, the expressed desire to become CC, and identification of specific strategies to increase knowledge about populations served. The LEARN and BATHE

models were also identified in the literature review, CLAS training modules, and acknowledged as useful options in the group sessions.

Two articles in the literature review identified Leininger's cultural care theory. Leininger's theory of culture care was one relevant theoretical framework for this project. The major premise of Leininger's theory is that there are differences and similarities in healthcare that await discovery to establish a body of knowledge relevant to transcultural nursing that will then guide nursing practice (McFarland & Wehbe-Alamah, 2015). According to McFarland and Wehbe-Alamah (2015), the purpose of the culture care theory is to discover useful knowledge in order to provide culturally congruent care that is meaningful, safe, and beneficial to people of similar or diverse cultures worldwide. The literature review provided evidence that the cultural differences between patients and health care providers were contributing factors to the lower health status of certain cultural groups. This project demonstrated that CC training was one way to deliver essential cultural knowledge to providers and impact providers' perceived cultural competency from that knowledge obtained. Improved understanding of the needs of populations served such as educational needs, access to resources, diagnoses that are more accurate and improved compliance with treatment are benefits of CC. Another benefit of CC that was clear in the self-assessments was a stronger sense of understanding the negative consequences of not recognizing the impact of cultural and linguistic differences.

Cultural competence training activities should include development of culturally-sensitive clinical skills and practices, use of a self-assessment tool for practitioners and organizations, and the implementation of policies that are responsive to the culture and diversity of the population served. A DNP prepared APRN has the skills, knowledge, and attitude needed to lead the delivery of CC care in a primary care setting. Skills that a DNP can model include

recognizing the value of diversity in the work place, importance of interacting with co-workers and patients in a more positive manner, and relating how one's own culture affects one's perceptions, assessments, and ability to communicate. In addition, the DNP has the knowledge to assertively identify, discuss, and challenge issues of diversity and the impact they may have on the clinic, patients, families, and community. The attitude of the DNP should be to appreciate working with individuals of different cultures and prioritize efforts to understand cultural differences and similarities. The CLAS training emphasized an attitude-skill centered approach also addressed in the literature review. This approach contrasts with a fact-centered approach and emphasizes the sociocultural context of individuals, enhances communication skills, and starts with an understanding of the populations served. The DNP can assume a leadership role with the organization to facilitate CC in the delivery of healthcare.

Competency in elements in each of the DNP Essentials was evident upon completion of the DNP project. Table 11 provides a summary of growth in each Essential. DNP Essentials II and V specifically address CC for this DNP project. Essential II states that leadership for quality improvement and systems are critical to improving health outcomes and eliminating health disparities. Improvements in practice are not sustainable without corresponding changes in organizational and professional culture, and the financial structures to support practice. DNP Essential II addresses the need for sensitivity to diverse organizational cultures and populations including patients or other providers. Essential V states that health policy influences health disparities, cultural sensitivity, ethics, access to care, quality of care, and issues of equity and social justice in the delivery of health care. Essential V requires the DNP to participate in all levels of health policy and to understand that health policy either facilitates or impedes

successful delivery of healthcare (AACN, 2006). The AACN (2006) points out that cultural sensitivity, access to care, and social justice influence healthcare policy.

Table 11 *DNP Essentials Summary*

| DNP Essential | Summary of Growth through the DNP Project |
|---|---|
| I. Scientific underpinnings | Formal training for the APRN increases knowledge attainment and improves perceived CC; completed the CLAS training modules; use of nursing theory and other theories to guide and evaluate CC practice approaches |
| II. Organizational and systems leadership for quality improvement and systems thinking | Leadership for quality improvement is critical to improving health outcomes and eliminating health disparities; need for sensitivity to workplace and patient population diversity; PI for this project |
| III. Clinical scholarship and analytical methods for evidence-based practice | Critically appraise literature; identify gaps in practice; disseminate evidence-based findings for improvement of health outcomes |
| IV. Information Systems/Technology and Patient Care Technology for the Improvement and Transformation of Health Care | Proficient use of technological resources for project; evaluate patient education material for appropriateness |
| V. Healthcare policy for Advocacy in healthcare | Understand and participate in all levels of health policy; advocate for social justice and equity |

| | |
|---|---|
| VI. Interprofessional collaboration for improving patient and population outcomes | Coalition building by the DNP can motivate people to stay on target and through advanced knowledge and skills the DNP may serve as a content expert |
| VII. Clinical prevention and population health | Incorporating culture-specific attitudes and values into health promotion tools |
| VIII. Advanced nursing practice | Training to increase cultural awareness, knowledge, and skills; Analyze connections between practice, organization, and healthcare policy issues |

*Note.* DNP = Doctor of nursing practice; APRN = Advanced practice registered nurse; CC = Cultural competence; CLAS=Culturally linguistically appropriate services; PI= Primary investigator.

Studies suggest that formal training for the APRN increases knowledge attainment and improves APRNs' perceived CC. The goal of CC health care services is to provide the highest quality of care to every patient, regardless of race, ethnicity, cultural background, English proficiency or literacy. The DNP-prepared practitioner can lead some of the common strategies for improving the patient-practitioner interaction and integrate changes in the health care system to increase cultural awareness, knowledge, and skills. Examples may include providing training and incorporating culture-specific attitudes and values into health promotion tools. Through partnerships and policy involvement, a DNP-prepared practitioner can assume a leadership role and motivate people to stay on target. The DNP may serve as a content expert because of advanced knowledge and skills. According to Zaccagnini and White (2017), health policy is not just a legislative process but also a comprehensive method of identifying healthcare issues and then bringing those issues to the legislature and to the American public. The DNP should

understand the levels of power and know who controls the resources of health services in their organizations.

**Conclusion**

Strategies to improve CC within the clinic include the use of the self-assessment checklist to monitor growth over an extended period and the use the office environment checklist to identify areas needing improvement to meet the cultural competency needs of diverse populations served within the clinic. The self-assessment checklist identified strengths and areas for potential growth at all levels of an organization. Because the self-assessment provides a snapshot as to where an individual or organization is at a specific point in time, results can be used to plan strategies to deliver culturally competent services (GU NCCC, n.d.). Patients from diverse groups feel more respected and more trusting when practitioners demonstrate behaviors and attitudes that suggest sensitivity to differences (Tucker et al., 2014). Increasing provider awareness of racial/ethnic and socioecological disparities within their own health setting and improving provider communication skills was an emerging theme in the literature review and supported by the results of this project.

The mainstays of CC are cultural awareness, cultural experiences, cultural knowledge and skills. Cultural humility is another construct important to the process of becoming CC. It is a hope that the APRN participants gained not only increased CC, but also an increased sense of cultural humility because of this project. Cultural humility is demonstrated by an appreciation of the need for ongoing self-evaluation, reflection about gaps in knowledge, and an awareness of treating the whole patient and not the disease. Cultural humility is the desire and passion to engage in the life-long learning in the process of becoming CC (Tervalon & Murray-Garcia, 1998; Campinha-Bacote, 2002). The literature review provided evidence that enhanced

practitioner cultural sensitivity and humility improves vulnerable patients' adherence to treatment recommendations and improve outcomes (Tucker et al., 2014). Health outcomes ~~may~~ improve because of closing the gaps amongst provider, staff and organizational CC practices. By engaging patients in their own care using respectful approaches and effective communication models, opportunities for improved health outcomes among vulnerable populations are more likely possible. The DNP is in a position to collaborate with patients and share knowledge while respecting the patients' preferences. The DNP can develop partnerships and advocate at both the individual and organizational levels. It is the responsibility of the DNP-prepared APRNs to model CC in their own patient interactions with the hope of decreasing health disparities among vulnerable populations.

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Appendix A

TO: Karen Urban

FROM: Chris Belcher
Grant & Compliance Specialist

SUBJECT: IRB Request for Determination of Non-Human Subjects Approval

DATE: August 23, 2018

STUDY: **Protocol 19-04: Strategies to improve cultural awareness and self-efficacy in a primary care practice**

The Colorado Mesa University Institutional Review Board (IRB) also known as the Human Subjects Committee has approved your request for a determination of non-human subjects research.

If there is a possibility of publishing your work, the methods section of your work MUST contain the following statement:

> "This project was conducted as a Quality Improvement / Assurance or
>
> Program Evaluation, and as such was not formally supervised by the Institutional Review Board per their policies."

No further IRB review is necessary unless future modifications to the protocol related to human research subjects are proposed.

If you have any questions, please feel free to contact me at 248-1485.

Appendix B

Project Approval

Roten, Elizabeth H. <Elizabeth.Roten@va.gov>

Tue 7/3/2018 12:55 PM

Karen,

Thank you for your submission for project approval through the Education Department at the Grand Junction VHCS. I have reviewed your project request as written below and I am happy to report this project is approved. Please provide a list of employees who participate in your project to Kari Weirath upon completion. I understand Veterans PHI will not be involved in this project. I look forward to hearing feedback from you and VHA staff on this project.

**Project Submission From Karen Urban on June 26, 2018.**

My project is titled Strategies to Improve Cultural Awareness and Self-Efficacy in a Primary Care Practice.

Elizabeth Roten RN, MSN

Chief of Education and Organizational Development

Grand Junction VHCS

970242-0731 x6054

Elizabeth.Roten@VA.GOV

Appendix C

**Participant Demographic Information Sheet:**

For DNP Project: Strategies to Improve Cultural Awareness and Self-Efficacy in a Primary Care Practice.

*For this project, the investigator is requesting demographic information. Due to the make-up of certain populations, the combined answers to these questions may make an individual person identifiable. The investigator will make every effort to protect your confidentiality. However, if you are uncomfortable answering any of these questions, you may leave them blank.*

Last 4 numbers of cell phone: _____

1. Gender: Male ☐ Female ☐

2. Age (in years):

□ 18 to less than 20 years
□ 20 to less than 30 years
□ 30 to less than 40 years
□ 40 to less than 50 years
□ 50 to less than 60 years
□ 60 to less than 70 years

3. Ethnicity:

□ White
□ Hispanic or Latino
□ Black or African American
□ Native American or American Indian
□ Asian / Pacific Islander
□ More than one
□ Other

4. What language do you speak at home?

□ English
□ Spanish
□ Other, describe: _____

4. Are you a veteran? Yes ☐ No ☐

5. How long have you worked in the GJ VA Medical Center Women's Clinic? ___years ___months

6. How many hours per week do you work in the GJ VA Medical Center Women's Clinic?

☐ 40 or more ☐ 20 to less than 40 ☐ less than 20

Appendix D

## PROMOTING CULTURAL and LINGUISTIC COMPETENCY
## Self-Assessment Checklist
## for Personnel Providing Primary Health Care Services

**Directions:** Please select A, B, or C for each item listed below.

A = Things I do frequently, or statement applies to me to a great degree
B = Things I do occasionally, or statement applies to me to a moderate degree
C = Things I do rarely or never, or statement applies to me to minimal degree or not at all

### PHYSICAL ENVIRONMENT, MATERIALS & RESOURCES

_____ 1. I display pictures, posters, artwork and other decor that reflect the cultures and ethnic backgrounds of clients served by my program or agency.

_____ 2. I ensure that magazines, brochures, and other printed materials in reception areas are of interest to and reflect the different cultures and languages of individuals and families served by my program or agency.

_____ 3. When using videos, films or other media resources for health education, treatment or other interventions, I ensure that they reflect the culture and ethnic backgrounds of individuals and families served by my program or agency.

_____ 4. I ensure that printed information disseminated by my agency or program takes into account the average literacy levels of individuals and families receiving services.

### COMMUNICATION STYLES

5. When interacting with individuals and families who have limited English proficiency I always keep in mind that:

_____ * limitations in English proficiency are in no way a reflection of their level of intellectual functioning.

_____ * their limited ability to speak the language of the dominant culture has no bearing on their ability to communicate effectively in their language of origin.

_____ * they may neither be literate in their language of origin nor in English.

_____ 6. I use bilingual/bicultural or multilingual/multicultural staff, and/or personnel and volunteers who are skilled or certified in the provision of medical interpretation services during treatment, interventions, meetings or other events for individuals and families who need or prefer this level of assistance.

_____ 7. For individuals and families who speak languages or dialects other than English, I attempt to learn and use key words so that I am better able to communicate with them during assessment, treatment or other interventions.

_____ 8. I attempt to determine any familial colloquialisms used by individuals or families that may impact on assessment, treatment, health promotion and education or other interventions.

_____ 9. For those who request or need this service, I ensure that all notices and communiqués to individuals and families are written in their language of origin.

_____ 10. I understand that it may be necessary to use alternatives to written communications for some individuals and families, as word of mouth may be a preferred method of receiving information.

11. I understand the principles and practices of linguistic competency and:

_____ * apply them within my program or agency.

_____ * advocate for them within my program or agency.

_____ 12. I understand the implications of health literacy within the context of my roles and responsibilities.

_____ 13. I use alternative formats and varied approaches to communicate and share information with individuals and/or their family members who experience disability.

## VALUES & ATTITUDES

_____ 14. I avoid imposing values that may conflict or be inconsistent with those of cultures or ethnic groups other than my own.

_____ 15. I screen books, movies, and other media resources for negative cultural, ethnic, or racial stereotypes before sharing them with individuals and families served by my program or agency.

_____ 16. I intervene in an appropriate manner when I observe other staff or clients within my program or agency engaging in behaviors that show cultural insensitivity, racial biases, and prejudice.

_____ 17. I recognize and accept that individuals from culturally diverse backgrounds may desire varying degrees of acculturation into the dominant culture.

_____ 18. I understand and accept that family is defined differently by different cultures (e.g. extended family members, fictive kin, godparents).

_____ 19. I accept and respect that male-female roles may vary significantly among different cultures (e.g. who makes major decisions for the family).

_____ 20. I understand that age and life cycle factors must be considered in interactions with individuals and families (e.g. high value placed on the decision of elders, the role of eldest male or female in families, or roles and expectation of children within the family).

_____ 21. Even though my professional or moral viewpoints may differ, I accept individuals and families as the ultimate decision makers for services and supports impacting their lives.

_____ 22. I recognize that the meaning or value of medical treatment and health education may vary greatly among cultures.

_____ 23. I accept that religion and other beliefs may influence how individuals and families respond to illnesses, disease, and death.

_____ 24. I understand that the perception of health, wellness, and preventive health services have different meanings to different cultural groups.

_____ 25. I recognize and understand that beliefs and concepts of emotional well-being vary significantly from culture to culture.

_____ 26. I understand that beliefs about mental illness and emotional disability are culturally based. I accept that responses to these conditions and related treatment/interventions are heavily influenced by culture.

## VALUES & ATTITUDES (CON'T)

_____ 27. I recognize and accept that folk and religious beliefs may influence an individual's or family's reaction and approach to a child born with a disability, or later diagnosed with a disability, genetic disorder, or special health care needs.

_____ 28. I understand that grief and bereavement are influenced by culture.

_____ 29. I accept and respect that customs and beliefs about food, its value, preparation, and use are different from culture to culture.

_____ 30. I seek information from individuals, families or other key community informants that will assist in service adaptation to respond to the needs and preferences of culturally and ethnically diverse groups served by my program or agency.

_____ 31. Before visiting or providing services in the home setting, I seek information on acceptable behaviors, courtesies, customs, and expectations that are unique to the culturally diverse groups served by my program or agency.

_____ 32. I keep abreast of the major health and mental health concerns and issues for ethnically and racially diverse client populations residing in the geographic locale served by my program or agency.

_____ 33. I am aware of specific health and mental health disparities and their prevalence within the communities served by my program or agency.

_____ 34. I am aware of the socio-economic and environmental risk factors that contribute to health and mental health disparities or other major health problems of culturally and linguistically diverse populations served by my program or agency.

_____ 35. I am well versed in the most current and proven practices, treatments, and interventions for the delivery of health and mental health care to specific racial, ethnic, cultural and linguistic groups within the geographic locale served by my agency or program.

_____ 36. I avail myself to professional development and training to enhance my knowledge and skills in the provision of services and supports to culturally, and linguistically diverse groups.

_____ 37. I advocate for the review of my program's or agency's mission statement, goals, policies, and procedures to ensure that they incorporate principles and practices that promote cultural and linguistic competence.

**How to use this checklist**

This checklist is intended to heighten the awareness and sensitivity of personnel to the importance of cultural and linguistic cultural competence in health, mental health and human service settings. It

provides concrete examples of the kinds of beliefs, attitudes, values and practices which foster cultural and linguistic competence at the individual or practitioner level. There is no answer key with correct responses. However, if you frequently responded "C", you may not necessarily demonstrate beliefs, attitudes, values and practices that promote cultural and linguistic competence within health and mental health care delivery programs.

# Appendix E

## Office Environment Assessment Checklist

from A Practical Guide for Implementing the Recommended National Standards for Culturally and Linguistically Appropriate Services (http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=15)

**Resources**

1. Are appropriate resources available to patients (e.g., language resources, health care information)? Does the health care center (e.g., office) offer appropriate hours based on community employment/illness needs?
2. Are patients with special needs, including language needs, afforded extra time in scheduling?

**Interactions**

1. Are interactions among staff and patients open-minded and respectful?
2. Are staff members diverse and aware of cultural differences and effects?
3. Are staff members aware of confidentiality requirements, and is confidentiality respected?
4. Do staff attitudes and behaviors welcome diversity?

**Materials**

1. Does signage appear in languages appropriate to the practice and the community profiles?
2. Are written materials of all types (including magazines) available in languages appropriate to the practice and community profiles?
3. Do written materials take into account the literacy levels of patients receiving services?
4. Do videos or other media for education, treatment, and so on, reflect the culture and ethnic background of the patients?
5. Are materials free of negative cultural, racial, or ethnic stereotypes?

**Environment**

1. Is the waiting area comfortable, with pictures, decorations, refreshments, and so on, appropriate to the diversity of the patient community?
2. Do the office's reception practices welcome patients of all backgrounds and make it equally easy for them to register, have questions answered, and obtain treatment?
3. Do telephone manners acknowledge and account for differences in patients' needs?
4. Is a mission plan visible to patients, and does it include a statement about a commitment to delivering culturally competent services?

**Organizational Strategies**

1. Are staff (including physicians) aware of policies about behavior and attitudes toward all patients, including minority patients?
2. Are there rewards for appropriate behavior and sanctions for inappropriate behavior?
3. Do all staff members receive training in areas that will contribute to cultural competence?
4. Is someone responsible for oversight about culturally competent care-related issues?
5. Does the organization have a strategic plan for delivering culturally and linguistically appropriate services?

6. Is the community involved in decisions about the care and services that are offered? Does the practice know which patients need language access services and have a method to supply the services when needed?
7. Are staff members aware of social practices, beliefs, history, traditional practices, medical approaches, and other culturally based factors that may have an impact on health care decisions for the minority/ethnic groups represented in the practice?
8. Do patients/consumers believe that they are receiving culturally competent care?

Appendix F

**COLORADO MESA UNIVERSITY**
**INFORMED CONSENT TO PARTICIPATE IN A Doctor of Nursing Practice (DNP) PROJECT**

TITLE OF PROJECT: Strategies to Improve Cultural Awareness and Self-Efficacy in a Primary Care Practice.

You are asked to participate in a quality improvement project conducted by Karen Urban RN, MSN from the Department of Health Sciences at Colorado Mesa University.

PURPOSE OF THE PROJECT
The purpose of the DNP project is to develop, implement, and evaluate cultural awareness in a primary care medical clinic using the Culturally and Linguistically Appropriate Services (CLAS) training modules. The project will be facilitated by a DNP student within a Veteran's women's primary care clinic on the western slope of Colorado.

Specifically, the project will identify strategies to improve self-efficacy among providers and staff, integrate cultural awareness into individual practices, and identify use of resources with the clinic that may improve cultural awareness. A system-wide plan for monitoring the use of cultural competence resources within the clinic will be defined.

PROCEDURES
If you volunteer to participate in this project, we would ask you to do the following things:
I. Complete the following forms and return hard copies to Karen Urban

A. Participant Demographic Information Sheet by week three of start of project. For this project, the investigator is requesting demographic information. Due to the make-up of certain populations, the combined answers to these questions may make an individu al person identifiable. The investigator will make every effort to protect your confidentiality. However, if you are uncomfortable answering any of these questions, you may leave them blank.
B. Sign this Informed Consent by week three of start of project.
C. Promoting Culture and Linguistic Competence Self-Assessment Checklist for Personnel Providing Primary Care Health Services by week five of start of project and again at the end of the training, by week ten of start of project.
D. Participant evaluation of the course by week 12 of start of project using the Course Evaluation for: Cultural Competence Training Modules and Group Sessions form.

II. Complete three Culturally and Linguistically Appropriate Services (CLAS) training modules titled *A Physician's Practical Guide to Culturally Competent Care* using the link provided in the invitation to participate email. Each module will take two to three hours to complete.

A. Create a user name and login
B. Complete Modules 1 & 2 by week five of start of project.
C. Complete Module 3 by week nine of start of project.

III. Attend two one-hour group sessions, after viewing the training modules.

A. Session 1 will discuss Modules 1 & 2 content: scheduled at 5:30 pm on a day before week eight of start of project.
B. Session 2 will discuss Module 3 content: scheduled at 5:30pm on a day before week ten of start of project.
C. Be prepared to discuss issues presented in the short case videos previously viewed in the training module. Discussion prompts will include self-exploration questions and role play activities. Additional discussion may explore how issues presented in the case videos are manifested in your own clinic environment.

POTENTIAL RISKS AND DISCOMFORTS

The potential risks associated with this project include:

- Participant may become uninterested in the topic.
- Participant may be stressed by the time commitment of participation.
- Participants feel stress related to realization that they might have not met the standards of cultural awareness/competency.
- Participants may have conflicts with other group members or may feel stress at comments made by other group members.
- There is no economic risk as participants will not be penalized at work for participation or nonparticipation and will not be charged for the training.

POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY

Participants may increase cultural competence awareness and self-efficacy; this may strengthen the clinic's delivery of culturally competent services; this may reduce disparities in health outcomes by proactively addressing gaps in care related to cultural diversity.
Family Practice Physicians, Nurse Practitioners, and Physician Assistants may earn continuing education credits for completion of the CLAS training modules.

CONFIDENTIALITY

Any information that is obtained in connection with this project and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. The only people who will know that you are a participant and may have access to the records of this project are: members of the project team and representatives of Colorado Mesa University's Internal Review Board (IRB).

This project is conducted as a Quality Improvement Program and as such was not formally supervised by the IRB per their policies.

These authorized representatives may see your name, but they are bound by rules of confidentiality not to reveal your identity to others.

When the results of the project are published or discussed in conferences, no information will be included that would reveal your identity. Audiotape recordings of group sessions will be used for

educational purposes, your identity will be protected or disguised. All audiotape recordings will be deleted three years after completion of the project, December 15, 2021.

All forms submitted to the investigator will be kept in a locked file cabinet in the investigator's CMU office during the project period. All forms will be shredded three years after the completion of the project, December 15, 2021.

PAYMENT FOR PARTICIPATION

There are no payments to participants in the project.

PARTICIPATION AND WITHDRAWAL

You can choose whether to participate in this project or not. If you volunteer participate in this project, you may withdraw at any time without consequences of any kind. Participation or non-participation will not affect your employment status, or any other personal consideration or right you usually expect. You may also refuse to answer any questions you don't want to answer and remain in the project. The investigator may withdraw you from this project if circumstances arise which warrant doing so. For example, failure to complete the training modules will result in a withdrawal from the project.

STUDY CONTACTS

If you have any questions or concerns about the project, please feel free to contact

Karen Urban, DNP student
970-248-1535 or 970-216-6836
kurban@coloradomesa.edu
Kathleen Hall, Assistant Professor of Nursing
970-248-1773
khall@coloradomesa.edu
Bridget Marshall, Assistant Professor of Nursing
970-248-1840
brmarshall@coloradomesa.edu

RIGHTS OF RESEARCH SUBJECTS

Your participation in this project is voluntary. If you decide to participate, you may withdraw your consent at any time and discontinue participation without penalty or loss of benefits to which you are otherwise entitled. If you have questions regarding your rights as a participant, contact the Office of Sponsored Programs, Colorado Mesa University, 1100 North Ave., Grand Junction, CO 81501-3122; Telephone: (970) 248-1424.

SIGNATURE OF PROJECT PARTICIPANT OR LEGAL REPRESENTATIVE

I understand my participation is voluntary. I understand the procedures and conditions of my participation described above. My questions have been answered to my satisfaction, and I agree to participate in this project. I have been given a copy of this form.

_____
Printed Name of Subject

_____ _____
Signature of Subject Date

_____
Printed Name of Witness

_____ _____
Signature of Witness Date

# Appendix G

**Thematic Analysis for Group Sessions**

| **MODULE 1: Fundamentals of Culturally Competent (CC) Care** | | |
|---|---|---|
| **Themes** | **Facilitator Notes** | **Participant Perspectives/Comments** |
| Importance of CC | Health disparities are well documented and have received attention from states, professional organizations, and accrediting bodies. Health care providers in the U.S. are seeing an increase in the numbers of patients from different cultural backgrounds. Factors such as economic, geographic, social and cultural barriers affect access to health care. The growing body of research on health disparities has also positioned cultural competency as a national health concern; Background and purpose of the CLAS Standards. | |
| Impact on Practice | Negative impacts and risks of not understanding the impact of cultural and language differences; Benefits of cultural competency in one's practice; Strategies to promote a diverse office staff; Approaches to support ongoing cultural competency training for practice staff. | |
| **MODULE 2: Speaking of Culturally Competent Care** | | |
| **Themes** | **Facilitator Notes** | **Participant Perspectives/Comments** |
| Language Access Services | Use of interpreters in medical practice; Written material | |
| Best practices for interpersonal communication | Best practices include understand that patients may have different levels of comfort with formality, silence, physical distance, or eye contact; Learn the preferences of patients and their communities; Be conservative in your body language; Do not discount the effect of beliefs about the supernatural on health; Learn basic words or phrases from each patient's language; Know your patients' preferences on communicating health news. | |
| Frameworks for developing CC | Models for effective communication; Promoting patient-centered care; Potential communication difficulties; | |

| | | |
|---|---|---|
| | Illness versus disease; LEARN, BATHE, ETHNIC models | |
| **MODULE 3: Structuring Culturally Competent Care** | | |
| **Themes** | **Facilitator Notes** | **Participant Perspectives/Comments** |
| Office Environment & Climate | Strategies to promote more CC environment | |
| Community Partnerships | Potential partners; Minority communities; Benefits; Barriers | |

Notes added are based on the group session discussions

# Appendix H

**Course Evaluation for: Cultural Competence Training Modules and Group Sessions**

1. What overall rating would you give the course?
   - □ Excellent
   - □ Very Good
   - □ Good
   - □ Fair
   - □ Poor

2. Would you recommend this training for other primary care clinics at the VA?
   - □ Definitely
   - □ Probably
   - □ Not sure
   - □ Probably not
   - □ Definitely not

3. The training modules were:
   - □ Just right
   - □ Too short
   - □ Too long
   - □ Somewhere in-between

4. The group discussion sessions were
   - □ Just right
   - □ Too short
   - □ Too long
   - □ Somewhere in-between

5. What did you like most about the group sessions?

6. What did you like least about the group sessions?

7. Please provide any comments or suggestions that may help to improve this course: