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The Development of Cultural Competence: A Positivist Case Study of a Healthcare Organization

Thomas D. Hoverman
University of St. Thomas, Minnesota

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The Development of Cultural Competence:
A Positivistic Case Study of a Health Care Organization

A THESIS
SUBMITTED TO THE FACULTY OF THE GRADUATE SCHOOL
OF THE UNIVERSITY OF ST. THOMAS

By
Thomas Duane Hoverman

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE OF
DOCTOR OF EDUCATION

Dr. John Conbere, Ed.D.,
Dr. James Brown, Ph.D.,
and Dr. Alla Heorhiadi, Ph.D., Ed.D., Advisors

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Thank you to my parents, Duane and Phyllis Hoverman, who made my childhood a nurturing and loving garden. They instilled a love of learning that has shaped my life. Whatever accomplishments I might reach are a reflection of their abiding love and steadfast support throughout my life.

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Finally, I thank God for my daughter Abigail and son William whose intellect and love of learning would inspire any scholar. In their effortless example, I see what a post-racial world might look like. I love you.

Thomas Duane Hoverman

THE DEVELOPMENT OF CULTURAL COMPETENCE
A POSITIVISTIC CASE STUDY OF A HEALTH CARE ORGANIZATION

Abstract

The researcher developed a tentative theory regarding the development of cultural competence through online training. The theory was tested and revised, using a positivistic case study methodology put forth by Yin (2003) and the theory building model of Dubin (1969). This study reviewed the effects of an online cultural competence training program on the awareness, knowledge, and skill of 10 nurses and five physicians. The study also considered the impact of this training on the quality of care delivered to culturally diverse patients. The study's hypotheses were that the training would positively affect awareness, knowledge, and skill and that these changes would positively impact the quality of patient care.

The theory proposed by the researcher was supported by the findings. Additional factors relevant to the development of cultural competence but not incorporated in the proposed theory were reported.

Dr. John Conbere, Committee Chair

Date

Dr. James Brown, Advisor

Date

Dr. Alla Heorhiadi, Advisor

Date

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CHAPTER I.

GENERAL CONTEXT OF THE PROBLEM

The United States continues to become more culturally and ethnically diverse primarily due to the influx of immigrants from other countries. The 2010 U.S. Census confirmed that the country has become more diverse than ever before. In 2010, 12% of people living in the United States were foreign born, representing a 51.9% rate of increase from 1990. This shift is reflected in a more racially diverse population. By 2050, these demographics are projected to shift even more, with both the number of Asians and the number of “all other races” more than tripling (U.S. Census Bureau, 2010).

While this increase in diversity has the potential to enrich and broaden the social experiences of these immigrants and the communities they join, it also introduces a new set of demands on communities to provide services that are accessible to everyone. The need for culturally competent healthcare in the United States is great.

Patients present a broad range of perspectives regarding health and illness shaped by their social and cultural backgrounds. In this changing environment, delivering effective cross-cultural care is rapidly becoming a major quality issue for health care systems, a risk management issue for physicians and a necessary skill set for all clinicians. Racial and ethnic minorities are burdened with higher rates of disease, disability, and death. They tend to receive a lower quality of health care than non-minorities, even when access-related factors, such as insurance status and income, are taken into account (Smedley, Stith, & Nelson, 2002).

Developing cultural competence has received more attention as part of a strategy to address the factors that contribute to racial/ethnic disparities in health care (Betancourt, Carrillo, & Green, 2002). Cultural competence in health care describes the ability of systems to provide care to patients with diverse values, beliefs, and behaviors including tailoring delivery to meet patients' social, cultural, and linguistic needs. The ultimate goal is a health care system and workforce that can deliver the highest quality of care to every patient, regardless of race, ethnicity, cultural background, or English proficiency.

Statement of the Problem

The racial and ethnic diversification of the U.S. population presents a clear call for health care professionals to surmount the barriers they have encountered in reaching U.S. racial and ethnic groups with culturally appropriate health promotion and prevention messages (Luquis & Perez, 2003). Racial and ethnic disparities in health care are not entirely explained by differences in access, clinical appropriateness, or patient preferences. There is ever growing evidence that health care professionals' behavior and clinical practice patterns contribute to disparities in health care. One way to correct this is cultural competence education (Smedley, Stith, & Nelson, 2002).

Health disparities related to socioeconomic disadvantage support the need for culturally competent health care in the U.S., a crucial factor in delivering quality care. Access to appropriate care among racial and ethnic minorities may be challenged by language barriers and the health care professional's insensitivity to cultural diversity (Anderson et al., 2003).

The growing cultural diversity of the United States population is a significant trend that has generated an enormous amount of activity over the years among leaders in business, government, and academic research (Jackson & Joshi, 2001). Although many organizations have become more diverse, entrenched organizational cultures, which can be inhospitable to traditionally underrepresented groups, have been slow to change. (Kochan et al., 2002). To develop organizational cultures within which cross-cultural awareness, sensitivity and competence are strengths rather than weaknesses, companies have applied a variety of methods.

Cultural competence education is the most common method that organizations have chosen for managing diversity (Burkart, 1999; Cox & Blake, 1991). In a survey of Fortune 500 companies, 75% of these companies reported using cultural competence training (Gilbert & Ivancevich, 2000). These efforts focus on changing employees' attitudes and eliminating behaviors that reflect more subtle forms of discrimination and exclusion, which often inhibit effective interactions among people. The widespread adoption of such training programs has expanded the concept of "diversity" as organizational leaders have realized that visible, legally recognized demographic differences such as race and gender were not the only types of differences that affected work relationships among employees.

As a result, training initiatives have proliferated, encouraging people to value the full spectrum of physical, cultural, and interpersonal differences. Cultural competence training generally has three objectives: To increase knowledge and awareness about diversity issues, to reduce biases and stereotypes, and to change behaviors of individuals

(Cox, 1993; Hanover & Cellar, 1998; Roberson, Kulik, & Pepper, 2001; Sanchez & Medkirk, 2004).

Kaplan and Inguanzo (2010) suggested that important steps health care institutions can take to make their services more accessible to clients from diverse cultural backgrounds include: 1) developing a training curriculum for care providers that promotes culturally competent practices; 2) implementing policies that encourage the development of culturally appropriate services for patients and families; and 3) providing follow-up after training to help dare give apply their newly gained knowledge and skills to serve their client populations.

Research Purpose

Despite the growing reliance on cultural competence training, there is little empirical data documenting its effectiveness (Gilbert & Ivancevich, 2000; Roberson, Kulik & Pepper, 2001), and there is little published about the evaluation of cultural competence education (Center for Healthy Families and Cultural Diversity, 2005; Cohen, 2005; Cook, Omofolasade & O'Brien, 2005; United States Department of Health and Human Services Office of Minority Affairs, 1999; Doutrich & Storey, 2005; United States Department of Health and Human Services Office of Minority Health, 2001; Donini-Lenhoff & Hedrick, 2000). Among the few studies that have been done, most show that such training rarely leads to the desired long-term changes in attitudes and behavior (Bezrukova & Jehn, 2001).

In addition, the criteria needed to evaluate the effectiveness of cultural competence training programs and the mechanisms by which this training is hypothesized

to influence organizational outcomes have not been clearly delineated. Further, design features that influence the effectiveness of cultural competence training have not been empirically examined.

The purpose of this study was to create a theory regarding the design of effective cultural competence training and test that theory in the case of the organization being studied. Toward this purpose, the researcher chose a positivistic case study approach to gain insight into the process of developing a training program that develops the participants' cultural competence.

Research Question

The researcher studied the design, implementation, and impact of an online cultural competence training program in the case of one healthcare organization. The objective of this research was to provide an empirical examination of an online cultural competence training program. The primary research question to be considered was “Does cultural competence training promote individual cultural competence?” The intent of this research was to examine how the participants perceived the effectiveness of cultural competence training.

Design Rationale

The researcher applied empirical case study research methodology as described by Yin (2003) (please refer to the research design and methodology section below). The researcher deemed case study an appropriate method to pursue his interest in building

theory to be generalized. Yin's methodology begins with developing a tentative theory. This theory frames the inquiries within the research study. This model also positions the research to collect data that might not be an explicit part of researcher's initial theory, but may prove to be relevant and significant to the research effort. Collected data are analyzed and used to refine the theory as appropriate. The end product is a theory that reflects the data collected within the study.

Site for the Study

The researcher chose a health care provider in the St. Paul, Minnesota area as the site for this research. The HealthEast Care System includes hospitals, clinics and outpatient services. HealthEast has more than 7,000 employees, including 1,300 physicians on staff. The physicians and nurses who participated in this study were all employees of HealthEast.

In 2007, HealthEast cared for patients making 66,700 emergency care visits. HealthEast serves a diverse local community including significant numbers of Hispanics, Hmong, and Somalis, many of whom have immigrated to the United States. In the interest of best serving a diverse local population, HealthEast has made a commitment to develop cultural competence among its employees, beginning with emergency room staff.

The researcher approached The System Director of Organization Development at HealthEast, who introduced the researcher to emergency room physicians and nurses. These personal introductions helped the researcher in gaining the trust and cooperation of the emergency room staff.

Definition of Terms

Terms applicable to this study are defined in this section.

Case study

In this research, case study is based on a positivistic epistemology. The goal of the case study is to gain insight into a phenomenon using empirical inquiry within an explicitly defined context. This is in contrast to the historical convention that Yin (1994) described of pursuing a case study as a form of ethnographic research, to be completed as preliminary step in formulating a more empirical research strategy.

Cultural competence

“A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or amongst professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations” (Cross, Bazron, Dennis, & Isaacs, 1989, p. iv).

Cultural awareness

“The deliberate, cognitive process in which health care providers become appreciative and sensitive to the values, beliefs, lifeways, practices, and problem solving strategies of clients' cultures” (Campinha-Bacote, 1999, p. 204). Self-awareness is an important aspect of cultural awareness. Without being aware of the influence of one's own cultural values, there is a risk that health care providers may engage in cultural imposition.

Cultural knowledge

“A sound educational foundation concerning the various world views of different cultures. The goal of cultural knowledge is to understand the client's world view”

(Campinha-Bacote, 1999, p. 204). One of the most important concepts for understanding clients' behaviors is to understand their world views. In addition to seeking and obtaining a sound educational foundation concerning the various world views of different cultures, the process of cultural knowledge also involves obtaining knowledge regarding specific physical, biological, and physiological variations among ethnic groups.

Cultural diversity

“The representation, in one social system, of people with distinctly different group affiliations of cultural significance” (Cox, 1994, p. 6).

Cultural skill

“The ability to collect relevant cultural data regarding the clients' health histories and presenting problems as well as accurately performing a culturally specific physical assessment. This process involves learning how to conduct a cultural assessment and culturally based physical assessments” (Campinha-Bacote, 1999, p. 204).

Culture

A highly variable system of meanings that are learned and shared by an identifiable racial, ethnic, religious or social group. It includes components of life that are transmitted across generations (Rohner, 1984). These systems of meanings include thoughts, communication styles, customs, beliefs, ways of interacting, views on roles and relationships, values and institutions (Cross, Bazron, Dennis & Isaacs, 1989). Culture shapes how we understand and interact with the world.

Diversity

The differences between individuals on any attribute that may lead to the perception that another person is different from self (Williams & O'Reilly, 1998). Among a potentially infinite number of dimensions, diversity research has mainly focused on gender, age, race/ethnicity, tenure, educational background, and functional background (Milliken & Martins, 1996; Williams & O'Reilly, 1998).

Quality of care

In the context of cross-cultural care, Wade and Bernstein (1991) defined quality of care as health care providers' effect on improving outcomes of patient satisfaction, reducing racial or ethnic differentials in utilization and treatment, and improving objective measures of health status.

Unit of analysis

Dubin stated, "...the units of a theory are properties of things rather than the things themselves" (1969, p. 51). Properly defining the unit of analysis is crucial in order to understand how the case study relates to a broader body of knowledge – thus enabling generalization. Dubin referred to units of analysis as the theory's concepts, representing the things or variables whose interaction is the focus of the theory.

CHAPTER II.
REVIEW OF THE LITERATURE

In order to properly prepare and conduct a research study, a review of current literature must be done (Burns & Grove, 2001). It is imperative that a researcher's work begins with the accomplishments of others (Kaplan, 1964). According to Becker (1986), science and humanistic scholarship are cumulative enterprises; few would be interested in study findings if not correlated with the works of previous scholars. This chapter provides the reader a background of the relevant literature pertaining to cultural competence and its development. It also provides a framework within which a theory can be developed regarding a theory of cultural competency development.

The review encompasses the study's theoretical framework by presenting various cultural competence models of care, guidelines and standards, clinical approaches, cultural competence teaching methods, education resources, assessment tools and instrumentation, translation services and studies conducted relevant to the study. Each following section of the literature review introduction allows the researcher to explore current literature as it corresponds to components of the researcher's theoretical model: (a) cultural competence training, (b) cultural awareness, (c) cultural knowledge, (d) cultural skill, and (e) quality of care.

Theoretical Models of Cultural Competence

There are several cultural competence models utilized by health care professionals in the nation (Luquis & Perez, 2003; The Cultural Competency Work Group, 2002; Like,

Steiner, & Rubel, 1996; Porter & Villarruel, 1993). Four prominent models noted in current literature are: (a) the Papadopoulos (2003) Model for the Development of Cultural Competence in Nursing, (b) the Bennett (1998) Developmental Model of Intercultural Sensitivity, (c) the Hicks (1998) Organizational Cultural Competence Assessment Model, and (d) the Cross (1988) Model of Cultural Competence. These models provide a visual picture or recipe to guide health care professionals toward cultural competence.

Table 1

Four Prominent Models of Cultural Competence

Name of model	Model for the Development of Cultural Competence in Nursing	Developmental Model of Intercultural Sensitivity (DMIS)	Organizational Cultural Competence Assessment Model	Model of Cultural Competence
Researcher	Papadopoulos (2003)	Bennett (1998)	Hicks (1998)	Cross (1988)
Brief description	Widely used by students and academics in the United Kingdom and Europe	Explains how people or groups tend to think and feel about cultural difference	Most prominent theory that focuses on organizational development	Seminal research on cultural competence
Definition of cultural competence	Ability to provide effective health care taking into consideration an individual's cultural beliefs, behaviors and needs	Communication competencies useful in any cross-cultural situation, including cultural self-awareness, non-evaluative perception, cultural adaptation strategies, and cross-cultural empathy.	Ongoing process of organizational development that occurs in four stages	Movement along a continuum that is based on the premise of respect and appreciation of individuals and cultural differences
Focus of theory	Define stages in evolution of cultural competence in individuals	Define stages in the development of personal intercultural sensitivity	Define stages in evolution of cultural competence in individuals	Define stages in evolution of cultural competence in individuals

Papadopoulos' Model for the Development of Cultural Competence in Nursing

Developed by Rena Papadopoulos, Mary Tilki, and Gina Taylor, the Model for the Development of Cultural Competence in Nursing consists of four stages: (a) cultural

awareness, (b) cultural knowledge, (c) cultural sensitivity, and (d) cultural competence (Papadopoulos, 2003). In this model, cultural competence is defined as the ability to provide effective health care taking into consideration an individual's cultural beliefs, behaviors and needs. The first stage, cultural awareness, examines personal value bases and beliefs. Health beliefs and practices are described as essential elements of a learning platform. The second stage, cultural knowledge, is gained through meaningful contact with individuals from different ethnic groups. The third stage, cultural sensitivity, requires that nurses view patients as equals or true partners. The fourth stage, cultural competence, is the synthesis and application of previously mentioned stages. In as much as it is impossible to know everything about every cultural group, according to Gerrish and Papadopoulos (1999) the culturally competent nurse has culture-generic competencies. Culture-generic competencies include appreciation of how cultural identity mediates for health, and a deeper understanding of the underpinning societal and organizational structures that promote or hinder culturally competent care (Gerrish & Papadopoulos, 1999). The Papadopoulos, Tilki and Taylor Model for the Development of Cultural Competence in Nursing is now widely used by students and academics in the United Kingdom and Europe.

Bennett's Developmental Model of Intercultural Sensitivity

Bennett's (1998) Developmental Model of Intercultural Sensitivity describes an approach for intercultural adaptation, a developmental process whereby one's worldview is expanded to include behavior and values appropriate to the another culture. The following are short descriptions of each of six stages of development.

Denial. People at the denial stage are unable to conceive of cultural differences in complex ways. Either they do not perceive cultural differences at all, or they can conceive only of broad categories. People at this stage may use stereotypes in their description of others that are not meant to denigrate but are based on knowing only one or two things about the other people. Consequently, when actually confronted by cultural diversity, people in denial unconsciously attribute less than human status to the outsiders (Bennett, 1998).

Defense. People at the defense stage have more ability to recognize cultural difference, but they attach negative evaluations to it. They combat the threat of change to their stable worldview by denigrating others with negative stereotypes and by attaching positive stereotypes to themselves. People in defense consider themselves under siege. Members of socially dominant cultures may attempt to protect privilege and deny opportunities to outsiders, while nondominant culture members may aggressively protect their ethnic identity from suppression by the majority (Bennett, 1998).

Minimization. People at the minimization stage try to bury cultural differences within already-familiar categories of physical and philosophical similarity. They recognize and accept superficial cultural differences such as eating customs and other social norms, but they assume that deep down all people are essentially the same. As a consequence of this assumption, certain cultural values may be mistaken for universal desires. While people at the minimization stage are considerably more knowledgeable than those in denial and a lot nicer than those in defense, they are still ethnocentric in their adherence to these culture-bound universalistic assumptions (Bennett, 1998).

Acceptance. People at the acceptance stage enjoy recognizing and exploring cultural differences. They are aware that they themselves are cultural beings. They are fairly tolerant of ambiguity and are comfortable knowing there is no one right answer. “Acceptance” does not mean that a person has to agree with or take on a cultural perspective other than his or her own. Rather, people accept the viability of different cultural ways of thinking and behaving, even though they might not like them. This is the first stage in which people begin to think about the notion of cultural relativity—that their own behavior and values are not the only good way to be in the world (Bennett, 1998).

Adaptation. People at the adaptation stage use knowledge about their own and others’ cultures to intentionally shift into a different cultural frame of reference. That is, they can empathize or take another person’s perspective in order to understand and be understood across cultural boundaries. Another way to think about this is that people in adaptation have increased their repertoire of behavior—they have maintained the skills of operating in their own cultures while adding the ability to operate effectively in one or more other cultures. Advanced forms of adaptation are “bicultural” or “multicultural,” wherein people have internalized one or more cultural frames in addition to that in which they were originally socialized. Bicultural people can completely shift their cultural frame of reference without much conscious effort (Bennett, 1998).

Integration. People at the integration stage of development are attempting to reconcile the sometimes conflicting cultural frames that they have internalized. As they move into integration, people achieve an identity that allows them to see themselves as “interculturalists” or “multiculturalists” in addition to their national and ethnic backgrounds. They recognize that worldviews are collective constructs and that identity

is itself a construction of consciousness. People in integration are inclined to interpret and evaluate behavior from a variety of cultural frames of reference, so that there is never a single right or wrong answer. But, unlike the resulting paralysis of action that may occur in earlier stages, people in integration are capable of engaging in “contextual evaluation” (Bennett, 1998).

Hicks’ Organizational Cultural Competence Assessment Model

The Organizational Cultural Competence Assessment Model, created by Hicks (1998) asserts that cultural competence is an ongoing process that occurs in four stages. The first stage, “Unaware, Not Yet Competent” is the least desired stage; the services do not meet the needs of diverse populations (Hicks, 1998, p. 14). The organization is “culturally blind” (Hicks, 1998, p. 14). The second stage, “Aware, Not Yet Competent” exists when the organization is aware of culturally diverse issues but does not know how to handle them (Hicks, 1998, p. 14). The needs of culturally diverse populations are minimally met (Betancourt, Carrillo, & Green, 2002). The third stage, “Aware, Competent” exists when the organization acknowledges culturally diversity, tolerates the differences, and has plans for meeting the needs of the culturally diverse population and for organizational improvement (Hicks, 1998, 14). The fourth stage, “Intrinsically Aware, Competent” is the most desired stage; the services provided satisfy the needs of diverse populations with little conscious effort by nurses (Hicks, 1998, p. 14). In addition to the model, Hicks (1998) lists the twelve characteristics of culturally competent organizations: (a) leadership, (b) vision/mission, (c) staff composition, (d) cultural concepts, (e) work climate, (f) collaboration, (g) policies/procedures, (h) service delivery, (i) training/staff

delivery, (j) communication/outreach, (k) outcomes management, and (l) rewards/performance evaluation.

Cross' Model of Cultural Competence

The Cross (1998) Model of Cultural Competence comprises six stages: (a) cultural destructiveness, (b) cultural incapacity, (c) cultural blindness, (d) cultural pre-competence, (e) basic cultural competence, and (f) advanced cultural competence.

Cultural Destructiveness. This is the most negative end of the continuum. Individuals in this phase view culture as a problem; believe that if culture or population can be suppressed or destroyed, people will be better off; believe that people should be more like the “mainstream”; and assume that one culture is superior and should eradicate “lesser” cultures (Cross, 1998).

Cultural Incapacity. Individuals in this phase lack cultural awareness and skills; may have been brought up in a homogeneous society, been taught to behave in certain ways, and never questioned what they were taught; believe in the racial superiority of a dominant group and assume a paternalistic posture toward others; and maintain stereotypes (Cross, 1998).

Cultural Blindness. Individuals in this phase see others in terms of their own culture and claim that all people are exactly alike; believe that culture makes no difference (“we are all the same”); and believe that all people should be treated in the same way regardless of race, etc. (Cross, 1998).

Cultural Pre-Competence. Individuals in this phase recognize that there are cultural differences and start to educate themselves and others concerning these

differences; realize their shortcomings in interacting within a diverse environment; but may become complacent in their efforts (Cross, 1998).

Basic Cultural Competence. Individuals in this phase accept, appreciate, and accommodate cultural differences; value diversity and accept and respect differences; accept the influence of their own culture in relation to other cultures; understand and manage the dynamics of difference when cultures intersect; and are willing to examine components of cross-cultural interactions (communication, problem solving, etc.) (Cross, 1998).

Advanced Cultural Competence. Individuals at this phase move beyond accepting, appreciating, and accommodating cultural difference and begin actively to educate less informed individuals about cultural differences; and seek out knowledge about diverse cultures, develop skills to interact in diverse environments, and become allies with and feel comfortable interacting with others in multicultural settings (Cross, 1998).

Cross (1998) offered both an institutional and individual framework to help gauge progress on various diversity initiatives. He described cultural competency as movement along a continuum that is based on the premise of respect and appreciation of individuals and cultural differences. It is important to note that institutions and individuals can be at different stages of development *simultaneously* on the Cross continuum. For example, an institution or an individual may be at the Basic Culturally Competent stage with reference to race, but be at the Cultural Incapacity stage with regard to sexual orientation issues.

Cultural Competence Training

Some organizations provide cultural competence education as a multicultural perspective in all of their employee education, new employee orientation, or a separate activity (Brach & Fraser, 2000). Unfortunately, many organizations are hesitant to offer cultural competence education to all of their employees because of the cost, the time lost, or the lack of desire to address potential cultural issues within the organization (Fortier, 1999). The United States Department of Health and Human Services Office of Minority Health conducted a study (2001) of eight states. It concluded that most cultural competence education was provided to minority health entities.

Goals of Cultural Competence Training

Anderson, Scrimshaw, Fullilove, et. al (2003) stated that cultural competence training for health care providers is designed to:

1. Enhance self-awareness of attitudes toward people of different racial and ethnic groups;
2. Improve care by increasing knowledge about the cultural beliefs and practices, attitudes toward health care, healthcare-seeking behaviors, and the burden of various diseases in different populations served;
3. Improve skills such as communication.

According to Campinha-Bacote's (2002) model, developing cultural competence is a process involving the examination of one's own biases as a preliminary attempt to be sensitive and appreciative of others' cultures. The attainment of cultural knowledge involves seeking and obtaining diverse cultural information and education, in order to

understand the patients' perspectives. Developing cultural assessment skills are necessary to collect relevant cultural data using a culturally sensitive approach. In cultural encounters, the health care provider engages the patient in cultural interactions. The health care provider may also engage the patient in multiple interactions in order to ensure an in-depth understanding of the patient's values and beliefs, thus, enhancing culturally competent practice.

According to Cross, Bazron, Dennis, et. al (1989), and Isaacs and Benjamin (1991), five important features contribute to a health care professional becoming more culturally competent: valuing diversity, conducting a cultural self-assessment, understanding the dynamics of difference, incorporating cultural knowledge in the service delivery, and adapting to diversity. Each of these factors is described below.

Valuing Diversity. Valuing diversity essentially means to see and appreciate the worth of diversity in culture. Respecting the significant or subtle differences that patients bring to the situation is vital for effective treatment and can affect the care giving process.

Conducting a Cultural Self-Assessment. The second feature of cultural competence includes performing a cultural self-assessment. In order to understand the role that culture plays in a patient's life, it is imperative that the professional understand how culture influences his or her life. An introspective evaluation of one's own cultural ideology, value system and cultural influence may contribute to a greater sensitivity to the issues, problems and perspectives of the patients being served. A cultural self-assessment should also include an examination of the clinician's own biases regarding culture and ethnicity. Several researchers have concluded that an introspection and

exploration of one's biases is crucial in effecting greater cultural competence (Atkinson, 1994).

Understanding the Dynamics of Difference. Each cultural group involved in a treatment system brings with it a repertoire of histories and perceptions that may influence the relationship between the groups. These include learned stereotypes, feelings, behaviors, communication strategies and values. The clinician must understand these dynamics of difference in order to empathize and prevent negative outcomes resulting from misinterpretation and ignorance.

Incorporating Cultural Knowledge. The clinician should be trained in understanding the breadth, depth and application of cultural knowledge. This should include the information, attitudes, history, customs, help-seeking behaviors, and familial issues of the respective culture being served. These factors will assist with a greater understanding of the patient's perceptions, relationships and coping mechanisms. Such an understanding may also further the collaborative relationship important for proper treatment.

Adapting to Diversity. The clinician must be able to adapt his or her treatment strategy to the patient's diverse background and needs. Assessment and treatment strategies offering an array of collaborative services are examples of adaptation to cultural diversity.

Education develops health care professionals' awareness, knowledge, and skills to provide culturally competent health care to an increasingly diverse population (Pope-Davis, Eliason, & Ottavi, 1994). There are hundreds of consultants and educators teaching cultural competence to health care professionals (Caffrey, Neander, Markle &

Stewart, 2005). According to Like et al. (1996), their credentials range from no formal education to previous experience in human resources diversity education to doctoral level research and academic experience in cross cultural issues (i.e. medical anthropology, transcultural psychology, intercultural relations). Each educator develops the content and teaching approach, and both content and approach vary widely (Like et al., 1996).

Best Practices in Cultural Competence Training

Education in cultural competence provides the health care professional with information about a variety of cultural, language services and organizational concerns utilizing a multiplicity of interactive case studies and role play with participants (Caffrey et al., 2005; Kardong-Edgern, 2004; Alpers & Zoucha, 1996; Clinton, 1996; Like et al., 1996). Outside academic settings, continuing education courses and courses designed for organizations and staff range from a few hours to a few days (Like et al., 1996).

According to the United States Department of Health and Human Services Health Resources and Services Administration (2005) cultural and linguistic competence curricula need to be intellectually stimulating, emotionally rewarding, and lively. Subject matter, such as key concepts and principles can be integrated into lectures and grand rounds, patient assessments, diagnostics, and case study examples (United States Department of Health and Human Services Health Resources and Services Administration, 2005). Attitudes that are accepting of diversity and differences are necessary to obtaining the knowledge and skills necessary for cultural and linguistic competence (United States Department of Health and Human Services Health Resources and Services Administration, 2005). Further, discussions addressing issues of racism,

homophobia, biases and prejudices must be an integral part of the curricula (United States Department of Health and Human Services Health Resources and Services Administration, 2005).

Individuals may be reluctant to speak about biases, or even be emotionally upset when confronted with them. In order to reveal biases, skillfully facilitated classroom discussions, videos and small group work in a safe non-judgmental environment are crucial (United States Department of Health and Human Services Health Resources and Services Administration, 2005). Utilization of scenarios in which cultural difference is an obstacle to the delivery of quality health care cultivates a participatory decision-making style that fosters compromise when such differences arise in provider-patient situations (Cooper-Patrick et al, 1999).

In 1986, the American Nurse Association provided guidelines for the inclusion of cultural content in nursing curricula and teaching methods for nursing educators (Grant, 2003). However, in 1998, a survey of nursing school deans and directors in Florida revealed that schools lacked cultural knowledge, cultural awareness, and sensitivity to cultural similarities and differences (Grossman et al, 1998). A program developed to improve the cultural knowledge of nursing faculty was cited as successful although there was no formal evaluation (Chrisman, 1998). The grant funded program consisted of three phases (Chrisman, 1998). In phase 1, videotapes were developed illustrating appropriate nurse-patient interactions with the patients discussing their health problems (Chrisman, 1998). In phase 2, extensive article bibliographies related to cultural competence were created. Phase 3, consisted of four seminars with each seminar lasting two hours. One requirement for inclusion in the seminars was past cultural immersion

experience that provides the feeling of being an outsider. An immersion experience may include visitation to a cultural religious ceremony.

The Federal Interagency Forum on Aging-related Statistics (2000) reported that by 2050 the population of minority elders is expected to increase 510%. The University of California's Academic Geriatric Resources Program partnered with the Ethnogeriatrics Committee of the American Geriatrics Society to develop a curricular framework for multicultural geriatric care that is compatible to several academic programs (Xakellis et al, 2004). The framework (Xakellis et al., 2004) was created with the *Core Competencies for the Care of Older Patients: Recommendations of the American Geriatrics Society* (The Education Committee Writing Group of the American Geriatric Society, 2000) in mind. The competencies in the framework were created primarily for educating physicians at the residency level, but can be revised to aid students, faculty, and practitioners from any health care discipline (Xakellis et al., 2004). However, due to the complexity of the framework it is recommended that segments be incorporated over time as experience is acquired (Xakellis et al., 2004).

The LEARN Model for Cross-Cultural Healthcare, developed by Berlin and Fowkes (1983), is commonly taught to medical students and residents. This model assumes that cultural understanding is a constant work in progress that allows for ease of recognition when dealing with culturally diverse patients (Berlin & Fowkes, 1983). The limitation of this model is the relative lack of breadth that can be obtained, but it does provide a starting point and conceptual framework for improving cultural sensitivity (Berlin & Fowkes, 1983). LEARN is an acronym for the steps necessary to implement the model (Berlin & Fowkes, 1983).

The LEARN Model for Cross-Cultural Healthcare:

L-isten to your patient from his or her cultural perspective

E-xplain your reasons for asking for personal information

A-cknowledge your patient's concerns

R-ecommend a course of action

N-egotiate a plan that takes into consideration your patient's cultural norms and personal lifestyle (Berlin & Fowkes, 1983).

Grant (2003) reviewed studies of current nursing school curricula that includes cultural diversity and objectively measures cultural competence. The methods utilized by the nursing schools to improve nurses' cultural competence were standard courses, mandatory or elective, and projects presented in class with more expansive goals other than cultural competence (Grant, 2003). Nursing schools that offered courses that included international experiences were alike in that almost all were elective (Grant, 2003).

According to Grant, in the studies reviewed, no efforts were made to determine the level of cultural competence of students prior to the course (2003). In addition, no outcome studies were documented to ascertain the level of cultural competence of graduates and practicing nurses (Grant, 2003).

Studies of Cultural Competence Training Programs

Edwards (1997) conducted a quasi-experimental comparison study that examined the most effective ways to teach culturally sensitive material, using a developmental model that considers racial identity and the relationship to social work education. The

study consisted of 48 students enrolled in the master degree social work program. All participants completed the D'Andrea, Daniels, & Heck's Multicultural Awareness, Knowledge, and Skills Survey as both pre-test and post-test. The study group participated in the educational model and the comparison group participated in the traditional teaching format emphasizing knowledge component (Edwards, 1997). During the course, the study group completed the Janet Helm's Social Identity Scales (1990). In addition, both instructor and students created journals for qualitative analysis (Edwards, 1997). Edwards' (1997) study results showed significant improvement in the competency area of awareness, racial identity stages and cultural competency scores in the participants that participated in the education model (study group).

Price (2005) examined the methodological rigor of students utilizing cultural competence training as a strategy to increase the quality of minority health. Studies published in English from 1980 to 2003 that evaluated cultural competence education were reviewed for selected study characteristics associated with better study quality as defined by five domains (Price et al., 2005). The five domains of better study quality were (a) representativeness, (b) intervention description, (c) bias, (d) confounding, (e) outcome assessment, and analytic approach. The study's authors selected 64 qualified articles. Nearly all studies (59) were published in 1990 through 2003 in education and nursing journals. Targeted learners were mainly nurses and physicians. Among the 64 studies, designs consisted of randomized or concurrent controlled trials ($n = 10$), pre-test/post-test ($n = 22$), post-test only ($n = 27$), and qualitative evaluative evaluation ($n = 5$). Curricular content, teaching strategies, and evaluation methods differed. Most health care provider outcomes were cited (Price et al., 2005).

Twenty-one articles adequately described health care provider representatives, 21 completely described curricular interventions, eight had adequate comparison groups, 27 used objective evaluations, three blinded outcome assessors, 14 reported the number or reason for omitted data, and 15 reported scale differences and variability indexes (Price et al., 2005). Studies directed at physicians more often described health care providers and interventions. Most trials completely described targeted providers, had adequate comparison groups, and reported objective evaluations. Study quality did not differ over time, by journal type, or by the presence or absence of reported results. The study authors determined that the lack of methodological rigor limits the evidence for the effect of cultural competence training on quality of minority health care (Price et al., 2005).

Dogra and Carter-Pokras (2005) explored the views of stakeholders in medical education about the potential outcomes of cultural diversity teaching and how they thought cultural diversity programs might be effectively evaluated in the United Kingdom. A group of 61 stakeholders (policy makers, diversity teachers, students, patients, patient representatives and advocates) were interviewed in-person or via telephone. The interview consisted of three parts. Basic demographic data, roles and experience were obtained in the first part of the interview. Four open-ended questions related to cultural diversity, undergraduate cultural diversity teaching, main topics to be taught at the undergraduate level, and teaching methods were asked of the participants during the second part, in addition to discussion pertaining to delivery methods, assessment, learning outcomes and effect on clinical practice and student perspectives. The third part required participants to state how they comprehended or used key terms such as race, ethnicity and multiculturalism. At the end of the interview participants

discussed their cultural diversity experience and/or training. A combination of quasi-statistical, template qualitative methodology and a series of systematic steps were utilized to analyze the data collected. According to the study results cultural diversity teaching needs to be reviewed in undergraduate and postgraduate medicine and better evaluation tools need to be developed (Dogra & Carter-Pokras, 2005).

The Task Force on Community Preventive Services reviewed six published studies describing five interventions to expand cultural competence in health care systems: (a) strategies to recruit and retain nurses who mirror the cultural diversity of the community, (b) use of interpreters or bilingual nurses, (c) cultural competence training for nurses, (d) use of linguistically and culturally appropriate health education materials, (e) and culturally specific health care settings (Anderson et al., 2003). The fundamental goals of the interventions were (a) to make the health care system more responsive to the needs of all patients, (b) to enhance their satisfaction with and access to healthcare, (c) decrease inappropriate variations in the characteristics and quality of care provided, and (d) decrease the disparities in health status across diverse populations within the U.S. (Anderson et al., 2003). However, the researchers were unable to ascertain the effectiveness of interventions because of the insufficient number of comparison studies or because the studies did not analyze the outcome measures evaluated in the review.

In a study of Florida nursing program deans, Grossman et al. (1998) gathered from the subjects ($n=46$) the ethnic composition of students and faculty in Florida programs noted 5% of students and 2% of faculty were Hispanic (compared with 12% of the Florida population). African-Americans and Asian-Americans were also under-represented (Grossman et al., 1998). Many subjects believed that promoting cultural

diversity within curricula was crucial and they indicated critical cultural diversity issues as being the lack of cultural knowledge, sensitivity, and awareness. Grossman and colleagues also found that 50% of Florida nursing programs integrated cultural subject matter; the others used various short-term classroom strategies or offered a transcultural nursing course (1998). For these subjects, the most frequently identified barrier to a culturally diverse faculty was identified as an insufficient number of qualified, available applicants; the most frequently identified barrier to a culturally diverse student body was insufficient educational preparation of applicants and an inability to meet admission requirements. According to the deans, help was needed help with statistics, strategies, and success stories as they implemented cultural diversity into their programs (Grossman et al., 1998).

Grant (2003) reviewed current literature exploring cultural content in nursing curricula and the educational delivery methods utilized by nurse educators. Grant noted that--although examples of programs, classes, seminars created to develop culturally competent nursing students were plentiful in current literature--few attempts to determine the effectiveness of teaching strategies had been made. (Grant, 2003). Subsequent research has developed our understanding of the effectiveness of cultural competence training.

Sargent, Sedlak and Marsolf (2005) evaluated the level of cultural competence of students and faculty at Kent State University College of Nursing and discussed the implications for nursing curricula in relation to cultural competence. Campinha-Bacote's model of culturally competent care provided the theoretical framework and Campinha-Bacote's Inventory for Assessing the Process of Cultural Competence Among Healthcare

Professionals (IAPCC) measured levels of self-reported cultural competence. A convenience sample of 88 first year, 121 fourth year baccalaureate students and 51 faculty members at the nursing college was examined. Analysis of variance exposed a statistically significant difference ($F = 43.915$, $df = 259$, $p < .0001$) among the three sets. A positive correlation was discovered between IAPCC scores and many demographic variables. The results suggested that structured cultural competence content enhances nursing curricula (Sargent et al., 2005).

Nokes, Nickitas, Keida and Neville (2005) conducted two pilot tests to: (a) create a 15-hour service-learning intervention, (b) enhance the 15-hour service-learning intervention, and (c) investigate whether participation in the intervention made a difference in the cultural competence of Hunter College's Hunter-Bellevue School of Nursing student participants. Although the sample was small ($n = 14$), results of paired t tests found that, after the intervention, cultural competence scores measured by the IAPCC were significantly lower ($t = 4.83$, $p = .000$) cites Nokes et al. (2005).

“Influence of Nurse on Characteristics on the Acquisition of Cultural Competence”, examined the effect of nurse's personal and professional characteristics on their response to an educational intervention to increase their cultural knowledge and cultural competence (Brathwaite, 2006). The effectiveness of the intervention was evaluated by one-group repeated measures, which 76 public health nurses attended. Mixed methods were used to examine the ability of the course to increase the level of cultural competence. A one-group repeated measures design was used to ascertain the pattern of change in participants over time.

The results supported the quantitative findings, which were substantial in relating to the five dimensions of Campinha-Bacote's model of cultural competence (Brathwaite, 2006). Pre-test results revealed that 81.3% of participants were culturally aware and 18.6% were culturally competent on the adapted IAPCC-R. Immediate post-test results revealed that 15.0% of participants were culturally aware, 59.8% were culturally competent, and 24.7% were culturally proficient. Third month follow-up revealed that 7.8% of participants were culturally aware, 48.1% were culturally competent, and 44.2% were culturally proficient (Brathwaite, 2006).

These results illustrated that the majority of participants had moved from culturally aware to culturally competent and proficient levels, indicating a significant change in their behavior and clinical practice following the educational intervention (Brathwaite, 2006). These results were confirmed by the qualitative findings. Overall, the participants responded positively to open-ended questions regarding the effectiveness of the program. Forty-two participants (55.3%) stated that the program was very effective, 18 (23.9%) stated that the program was excellent, and 16 (21%) stated that the educational intervention was most enjoyable and informative (Brathwaite, 2006).

Cultural Competence Training Resources

Currently, there are several types of training resources such as CD-Rom format, lectures, training kits, etc. (MacFadden & Herie, 2005). *Standard of Best Cultural Competency Practices for Medicaid Managed Care Populations*, funded by the Robert Wood Johnson Foundation, is available in either soft cover or CD-Rom format (cited in American Medical Association, 1999). With the *Cultural Competence Compendium*, a

collection of resources for physicians and the public, the American Medical Association (AMA) is responding to the dramatic changes in the nation's demographics and in health care delivery systems with a broad-based initiative to establish cultural competence as the fifth physician competence (AMA, 1999). AMA aims to motivate the medical profession and the public to create behavioral and institutional strategies that will enable physicians to provide individualized, patient-centered care that recognizes the diverse cultures of their patients (AMA, 1999).

Cultural Competence Assessment Tools and Instruments

According to the AAMC (2005), mixed-methods of evaluation that consist of both quantitative and qualitative strategies are necessary to measure the effectiveness of cross-cultural (cultural competence) curricula. Instrumentation (Burns & Grove, 2001), is the application of specific rules to develop a measurement device. Further, instrumentation obtains trustworthy evidence that evaluates the research outcomes (Burns & Grove, 2001). Often, as in the case of cultural competence, the item to be measured is an abstract idea or concept (Leininger & MacFarland, 2002). When measuring a concept, the concept is not measured it is instead the indicators or attributes of the concept which represent the abstraction that is measured, this is referred to as indirect measurement (Burns & Grove, 2001).

Cultural competence is a concept that is measured by utilizing criterion-referenced testing (Cochran, 2005). This type of testing involves the comparison of a subject's score with a criterion of achievement that includes the definition of target behavior (Burns & Grove, 2001). Prominent instruments created to measure levels of

cultural competence include the Intercultural Development Inventory (Hammer, 2003), Cultural Competence Assessment (Schim et al., 2003), Quality and Culture Quiz (Management for Sciences of Health, 2005), Clinical Cultural Competency Questionnaire (Center for Healthy Families and Cultural Diversity, 2005), Cultural Competence Self-Assessment Questionnaire (The Cultural Competence Work Group, 2002), Cultural Self-Efficiency Scale (Bernal & Froman, 1987), and the Tool for Assessing Cultural Competence Training (The Association of American Medical Colleges, 2005). These instruments are used collectively as well as independently.

Table 2

Six Established Instruments for Measuring Levels of Cultural Competence

Name of instrument	Developed by	Structure	Focus
Intercultural Development Inventory (IDI)	Hammer (2003)	60-item paper and pencil instrument based on Bennett's Developmental Model of Intercultural Sensitivity (DMIS)	Measures orientations (denial, defense, reversal, minimization, acceptance, adaptation, and integration) toward cultural differences
Cultural Competence Assessment (CCA)	Schim et al., (2003)	38-item questionnaire assessing health care providers' cultural competence	Measures cultural diversity experience, awareness and sensitivity, and competence behaviors
Clinical Cultural Competency Questionnaire (CCCQ)	Center for Healthy Families and Cultural Diversity (2005)	46-item questionnaire for assessing physicians' ability to provide culturally competent health care to culturally diverse populations	Measures physicians' knowledge, skills, and attitudes regarding cultural differences
Cultural Competence Self-Assessment Questionnaire (CCSAQ)	The Cultural Competence Work Group (2002)	59-item Likert scale questionnaire for assessing child- and family-serving agencies' strengths and weaknesses regarding cultural competence to	Based on the Child & Adolescent Service System Program Cultural Competence Model, which describes cultural competency in four dimensions: attitude, practice, policy, and structure
Cultural Self Efficacy Scale (CSES)	Bernal & Froman (1987)	26-item Likert scale tool for assessing nurses caring for culturally diverse clients	Measures the perceived sense of cultural self-efficacy of nurses in terms of knowledge, skills, and cultural confidence.
Tool for Assessing Cultural Competence Training (TACCT)	Association of American Medical Colleges (2005)	67-item Yes/No tool for assessing cultural competence training in medical school curricula	Measures individual cultural competency in terms of knowledge, skills, and attitudes

The Intercultural Development Inventory (IDI) was formulated by Dr. Mitchell Hammer (2003) in cooperation with Dr. Milton Bennett. The IDI is a 60-item, theory-based paper and pencil instrument that measures five of the six major stages of Bennett's (1998) Developmental Model of Intercultural Sensitivity (DMIS). The instrument generates a profile of an individual's or group's predominant stage of development, an interpretation of that stage, and issues associated with moving to the next stage of development. Factor analysis established that the items constituted six discrete dimensions that corresponded to five of the six DMIS stages (Denial, Defense, Minimization, Acceptance, and two forms of Adaptation; the last stage, Integration, was not measured) (Hammer, 2003).

As a theory-based test, the IDI meets the standard scientific criteria for a valid psychometric instrument (Nunnally, 1978; DeVellis, 1991). Because the IDI measures patterns of thinking rather than attitudes, the instrument is more stable, and it is more generalizable than other tests commonly in use. Reliability of the IDI is extremely high. Items on the IDI are actual statements selected from interviews of a sample of 40 culturally diverse subjects (Hammer, 2003).

The Cultural Competence Assessment (CCA) instrument was based on a model describing cultural competence components of fact, knowledge, attitude, and behavior (Schim et al., 2003). It was designed to provide proof of cultural competence among nurses and staff (Schim et al., 2003). The researchers administered the CCA to an interdisciplinary health care team in a community hospice setting (Schim et al., 2003). Preliminary findings suggested that the CCA performed well. Content and face validity

were established through expert panel review, subject feedback, and field-testing. Internal consistency reliability for the scale was .92, with construct validity by factor analysis demonstrating that 25 items had loadings above .42 (Schim et al., 2003). Construct validity was supported with a significant correlation to the widely used Campinha-Bacote's (1999) Inventory for Assessing the Process of Cultural Competence (IAPCC).

From the *Provider's Guide to Quality and Culture* (Management for Sciences of Health, 2005) the Quality and Culture Quiz is a 23 item instrument include both multiple choice and true/false items that examines an individual's own cultural competence. The goal of the quiz is to stimulate the individual's thinking about cultural competence and aid them in reflecting on their experience, knowledge, and attitudes regarding culturally diverse populations (Management for Sciences of Health, 2005).

Available online at the University of Missouri Web site, the Clinical Cultural Competency Questionnaire (CCCQ), is a questionnaire for assessing physicians' knowledge, skills, and attitudes relating to the provision of culturally competent health care to culturally diverse populations (Center for Healthy Families and Cultural Diversity, 2005). The CCCQ was developed by the Center for Healthy Families and Cultural Diversity (2005), Department of Family Medicine UMDNJ-Robert Wood Johnson Medical School.

The Cultural Competence Self-Assessment Questionnaire was created to aid agencies in evaluating cultural competence in policy-making, administrative procedures and practices (The Cultural Competence Work Group, 2002). The 119-item instrument is a self-administered questionnaire (The Cultural Competence Work Group, 2002). It provides a comprehensive review of operational and programmatic functions (The

Cultural Competence Work Group, 2002). The Cultural Competence Self-Assessment Questionnaire (CCSAQ) is an instrument that evaluates cultural competence in four dimensions: (a) attitude, (b) practice, (c) application, and (d) policy/structure (The Cultural Competence Work Group, 2002). The instrument takes about thirty minutes to complete and was created to assess cross-cultural strengths and weaknesses of agencies to create more effective education methods (The Cultural Competence Work Group, 2002).

Alpers and Zoucha performed the Cultural Self Efficiency Scale (CSES), which is based on Bandura's (1977) construct of self-efficacy, in 1996 on nursing students. The CSES created by Bernal and Froman (1987) is a 26-item Likert scale consisting of three different categories: (a) knowledge of general transcultural concepts, (b) knowledge of general patterns, and (c) skill specific transcultural nursing tasks. The study conducted by Alpers and Zoucha compared cultural competence and cultural confidence of senior nursing students in a private southern university (Campinha-Bacote, 2002).

The Tool for Assessing Cultural Competence Training created by the Association of American Medical Colleges (AAMC) project, entitled "Medical Education and Cultural Competence: A Strategy to Eliminate Racial and Ethnic Disparities in Health Care" and sponsored by The Commonwealth Fund assesses cultural competence training in medical schools (AAMC, 2005). The TACCT aids schools to meet the Liaison Committee on Medical Education (LCME) standards pertaining to cultural competence education in undergraduate curriculum (AAMC, 2005). The first standard, ED-21, requires the faculty and students to demonstrate an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, disease, and treatments (AAMC, 2005). The second standard, ED-22,

requires the medical students to recognize and appropriately address gender and cultural biases in themselves and others, and in the process of health care delivery (AAMC, 2005). The TACCT permits gaps to be identified, as well as planned and unplanned redundancies that will allow schools to make the best use of opportunities and resources (AAMC, 2005). There are two parts to the TACCT grid (AAMC, 2005). One part (Domains) allows monitoring of overall curricular offerings (AAMC, 2005). The other part (Specific Components) provides a framework for identification of education for detailed knowledge, skills and attitudes (AAMC, 2005). Once the Domains evaluation grid is completed an overall curriculum blueprint emerges, such as the absence of content material (AAMC, 2005). The TACCT is a self-administered assessment tool that can be used by medical schools to examine all components of the entire medical school curriculum, by evaluating the quality of curricular offerings as well as identify teaching and student assessment methods (AAMC, 2005).

Grant (2003) reviewed studies of current nursing school curricula that includes cultural diversity and objectively measures cultural competence. Overwhelmingly, most of the studies reviewed performed the Cultural Self-Efficacy Scale (Grant, 2003). This scale (assessment tool) examines the confidence level in delivering cultural care to patients by student nurses and nurses (Grant, 2003). Other studies reviewed utilized self-created surveys, open-ended questions, and the Transcultural and International Nursing Inventory. This inventory (assessment tool) examines the transcultural practices of nurses and student nurses throughout the U.S. (Grant, 2003).

Cultural Awareness

Cultural competence is a term that is used in reference both to individuals and organizations. In reviewing several training programs on cultural competence, Chrisman and Schultz (1997) noted there was an incomplete conceptualization regarding the nature of cultural competence. Chrisman and Schultz recommended scholars develop consensus on the conceptualization of cultural competence and to create a variety of theoretical frameworks to concretely guide nursing actions.

It is important to clarify the distinction between individual cultural competence and organizational cultural competence. Culturally competent organizations are able to integrate and transform knowledge about diverse groups of people into standards, policies, practices to increase the quality of services they provide (Davis & Donald, 1997). Campinha-Bacote, Yahle, and Langenkamp (1996) defined individual cultural competence as "a process, not an end point, in which the nurse continuously strives to achieve the ability to effectively work within the cultural context of an individual, family or community from a diverse cultural/ethnic background" (p. 6). Attaining cultural competence is viewed as a process that links cultural awareness, cultural knowledge, and cultural skill.

According to Campinha-Bacote's (2002) cultural competency model, cultural awareness is a process involving the examination of one's own biases as a preliminary attempt to be sensitive and appreciative of others' cultures. A move toward improving cultural understanding among health care professionals and within health care organizations is critical (Caffrey et al., 2005; Chin, 2003; Bonder et al., 2001; United

States Department of Health and Human Services Office of Minority Affairs, 1999; Geiger, 1996; Berlin & Froman, 1987).

Anand (2000) identified two general categories of awareness that individuals need to interact in a culturally competent manner: Being aware of one's own culture, values, and biases; and being aware of and working at controlling own biases and how these may affect interactions with others.

When ethnic groups seek out medical care, the process of mutual accommodation has been initiated (Bonder et al., 2001). Mutual accommodation is defined as the process by which individuals from differing cultures reach an understanding about how they will resolve a situation (Bonder et al., 2001). The process of mutual accommodation between patients and health care organizations is likely to occur once the willingness to learn cultural competence skills by health care professionals increases (Bonder et al., 2001).

Bonder, Martin, and Miracle (2001) discussed three approaches for developing cultural competence: (a) fact-centered approach, (b) attitude-centered approach, and (c) ethnographic questioning. The fact-centered approach relies on the premise that factual information can be effective in designing population-specific methods, which may be applied during cross-cultural interactions (Bonder et al., 2001). Information regarding the health behavior and beliefs of a particular group are obtained through this approach (Bonder et al., 2001). The advantage of the fact-centered approach is that it provides a beginning reference (Bonder et al., 2001). The attitude-centered approach focuses on developing an open-minded awareness and respect for valuing different cultures (Bonder et al., 2001). Rather than concentrating on specific skills, this approach relies on a health care professional's ability to challenge personal biases.

Cultural Knowledge

The attainment of cultural knowledge involves seeking and obtaining diverse cultural information and education, in order to understand the patients' perspectives. Anand (2000) identifies two general categories of knowledge that individuals need to interact in a culturally competent manner: Having culture-specific knowledge and having knowledge of institutional barriers that prevent some populations from accessing resources.

Wilson (1982) defined standards for knowledge that he found to be critical for cultural competence: Clinicians must hold and apply knowledge of the client's culture, heritage and history. This involves having a knowledge about values, helping behaviors, class, ethnicity, role of language, impact of social policies and laws, resources and relationships. This component also involves having an understanding of the strategies necessary to also become advocates and spokespersons for patients.

Several approaches have been developed to aid health care professionals in developing culturally knowledge (Leininger & MacFarland, 2002). However, no one could ever know everything about every culture. Therefore, approaches that concentrate only on the facts are few, and are usually paired with approaches that provide skills that are more universal and transferrable (Center on an Aging Society, 2004).

Cultural Skill

Developing cultural assessment skills are necessary to collect relevant cultural data using a culturally sensitive approach. In cultural encounters, the health care provider may engage the patient in multiple interactions in order to ensure an in-depth understanding of the patient's values and beliefs, thus, enhancing culturally competent practice.

In surveying different models of cultural competency, listed below are the basic set of common skills that individuals need to interact in a culturally competent manner:

(Anand, 2000)

1. Being aware of one's own culture, values, and biases.
2. Being aware of and working at controlling own biases and how these may affect interactions with others.
3. Having culture-specific knowledge.
4. Having knowledge of institutional barriers that prevent some populations from accessing resources.
5. Being able to build strong cross-cultural relationships and to be at ease with difference.
6. Being flexible and adaptable to diverse environments.
7. Being able and willing to be an ally to individuals who are different from oneself.
8. Having effective communication skills across differences.
9. Being able to mediate cross-cultural conflicts.

Wilson (1982) defined standards for skill that he found to be critical for cultural competence: Clinicians must have the ability to learn about the cultures of patient groups, to convey accurate information about their patients' culture to the public and to agencies; to advocate and assess the meaning ethnicity has for the patients' coping and adjustment. The clinician must also be able to skillfully differentiate between problems resulting from endogenous factors and those resulting from social events, perceptions and policies. Assessment skills and service skills focusing on empowerment and recognition of racism, discrimination and stereotypes are also vital goals. Lastly, the clinician should be able to be able to identify and critically evaluate new knowledge and tools relevant to the minority group he or she is treating.

Bonder, Martin, and Miracle (2001) highlighted the importance of ethnographic questioning as a cultural competency. Ethnographic questioning, often utilized in the field of anthropology (Bonder et al., 2001; Burns & Grove, 2001), consists of interviewing techniques, participant observation, and prolonged fieldwork (Savage, 2000). Many researchers (Lambert & McKeivitt, 2002; Burns & Grove, 2001; Fahrenwald, Boysen, Fischer & Maurer, 2001; Bonder et al., 2001; Savage, 2000; DeSantis, 1994) have noted the benefits of anthropology and the applications to health care. Ethnographic interviewing techniques give health care professionals a strategy for questioning that supports learning how to ask (Briggs, 1986). Savage (2000) affirmed that “ethnography can help nurses solve problems... particularly in the understanding of patients’ and clinicians’ worlds” (p. 1400).

Quality of Care

The researcher identified one study (Wade & Bernstein, 1991) that examined the effectiveness of cultural competence training programs for health care providers on improving outcomes of patient satisfaction, racial or ethnic differentials in utilization and treatment, and health status measures. The intervention setting was a metropolitan college mental health center. The 80 subjects were lower-income African-American women, with a mean age of 38 years, who resided in the community. They were referred to the counseling clinic by area social services agencies or were self-referred. The intervention consisted of four hours of cultural sensitivity training for four counselors (two white and two African American). Four other counselors (two white and two African American) received usual training.

Clients in the intervention group reported greater satisfaction with counseling than did controls (standard effect size 1.6, $p < 0.001$), independent of the race of the counselor. Clients were asked to return for three follow-up visits; those assigned to the intervention group returned for more sessions than did those assigned to the control group (absolute difference 33%, $p < 0.001$). Clients were asked to return for three follow-up visits; those assigned to the intervention group returned for more sessions than did those assigned to the control group (absolute difference 33%, $p < 0.001$).

One study is insufficient to determine the effectiveness of cultural competence training programs for healthcare providers.

Efforts to improve patient care in hospitals and health systems have mainly focused on translation and interpretative services (Maltby, 1999; Riddick, 1997). Maltby (1999) identified several problems associated with health care professionals who

exclusively rely on interpreters. First, health care professionals may not summon the services of an interpreter as a matter of policy when a non-English-speaking patient accesses the health system; rather, they do so as the need for such service arises. Second, interpreters may not accurately translate what either party is trying to communicate.

Interpreters are also susceptible to cultural filtration and bias when translating messages (Maltby, 1999). Cultural filtration occurs when cultural beliefs or ideas are applied and/or removed as a result of the interpreter's bias. Translation of materials, such as health pamphlets, also presents potential issues of cultural filtration. Although translation and interpretation may be good reference points, health care administrators must be aware of their limitations and must seek to develop a deeper understanding of the cultural influences that affect decisions (Maltby, 1999).

The true manifestation of poor communication and quality rests with the inability of health care professionals to understand the cultural underpinnings of ethnic groups (Cole, 2002). If generally held cultural beliefs were better understood, health care professionals would be better able to win trust and influence health behavior (Cole, 2002; Beckley, 2002; Bonder et al., 2001).

Guidelines and Standards

Many models for culturally competent standards are available (Association of American Medical Colleges, 2005). The difficulty is in deciding which standards are best suited for a uniform level of culturally competent guidelines within the health care industry.

In 1999, the United States Department of Health and Human Services Office of Minority Affairs (OMA) developed a list of 14 standards for Culturally and Linguistically Appropriate Healthcare Services (CLAS) for health care organizations and practitioners to ensure cultural competence. Other models for cultural competence standards precluded CLAS (Administration on Aging, 2001), but a uniform guideline of national standards for cultural and linguistic competencies did not become available until 1999. A central challenge is in trying to determine what information should be utilized to establish cultural competence (OMA, 1999). CLAS standards were developed to replace the patchwork of various definitions, recommendations, and terms with a universal set of guidelines (OMA, 1999).

The CLAS standards outlined by the OMA provide standards applicable to laws which address the responsibilities of health care professionals in rendering appropriate care to ethnic populations (OMA, 1999). Furthermore, OMA researchers found that most cultural competence models focused mainly on linguistic and interpretative competence, as opposed to cultural competence (OMA, 1999). The literature review conducted by researchers at the OMA indicates that low interest to cultural issues fosters less than optimal health care, and that addressing these concerns or using certain CLAS interventions fosters improved outcomes (OMA, 1999). Improving communication, understanding cultural customs, and respecting diversity will create better relationships between racial and ethnically diverse populations and health care organizations (OMA, 1999). This will ultimately lead to better health outcomes (OMA, 1999). By developing policy and educational initiatives based on the standards set forth by CLAS, health care administrators may avoid potential legal ramifications but, more importantly, will ensure

that their organizations are addressing the needs of their defined populations based on a uniform set of expectations (OMA, 1999).

OMA's *Assuring Cultural Competence in Healthcare: Recommendations for Nation Standards and Outcomes-focused Research Agenda* advocates health care organizations adhere to standards of culturally competent care (1999). Those standards are as follows:

1. Promote and support the attitudes, behaviors, knowledge, and skills necessary for staff to work respectfully and effectively with patients and each other in a culturally diverse work environment.
2. Have a comprehensive management strategy to address culturally and linguistically appropriate services, including strategic goals, plans, policies, procedures and designated staff responsible for implementation.
3. Utilize formal mechanisms for community and consumer involvement in the design and execution of service delivery, including planning, policy making, operations, evaluation, training, and, as appropriate, treatment plans.
4. Develop and implement a strategy to recruit, retain, and promote qualified, diverse and culturally competent administrative, clinical, and support staff to address the needs of the racial and ethnic communities being served.
5. Require and arrange for ongoing education and training for administrative, clinical, and support staff in culturally and linguistically competent service delivery.
6. Provide all clients with limited English proficiency access to bilingual staff interpretation services.

7. Provide oral and written notices, including translated signage at key points of contact, to clients in their primary language informing them of their right to receive interpreter services free of charge.
8. Translate and make available signage and commonly used written patient educational material and other materials for members of the predominant language groups in service areas.
9. Ensure that interpreters and bilingual staff can demonstrate bilingual proficiency and receive training that includes the skills and ethnics of interpreting and knowledge in both languages of the terms and concepts relevant to clinical or no clinical encounters. Family or friends are not considered adequate substitutes because they usually lack these abilities.
10. Ensure that the client's primary spoken language and self-identified race/ethnicity is included in the healthcare organization's management information system as well as any patient records used by provider staff.
11. Use a variety of methods to collect and utilize accurate demographic, cultural, epidemiological, and clinical outcome data for racial and ethnic groups in the service area, and become informed about the ethnic/cultural needs, resources, and assets of the surrounding community.
12. Undertake ongoing organizational self-assessments of cultural and linguistic competence, and integrate measures of access, satisfaction, quality, and outcomes for CLAS into other organizational internal audits and performance improvement programs.

13. Develop structures and procedures to address cross-cultural ethical and legal conflicts in healthcare delivery and complaints or grievances by patients and staff about unfair, culturally insensitive or discriminatory treatment, or difficulty in accessing services, or denial of services.
14. Prepare an annual progress report that documents the organization's progress with implementing CLAS standards, including information on programs, staffing and resources (OMA, 1999).

Cross Cultural Health Care Program (CCHCP) was selected to perform a study, entitled "OMH Project: Reflections on the CLAS Standards" which examined the CLAS standards and reviewed ongoing CLAS and multicultural related efforts in a number of projects (CCHCP, 2005). Researchers with the Oklahoma Office of Minority Health (OMH) traveled to evaluate six sites in the states of Alaska, Texas, Rhode Island, Maryland, Massachusetts and Washington (CCHCP, 2005). The final report cites interventions that reflect the CLAS standards and discuss future strategies for the OMH project (CCHCP, 2005).

There are many guidelines and standards of cultural competence noted in current literature (Betancourt et al., 2002). Moreover, associations, organizations, and some Federal and State agencies have independently developed guidelines, programs, or coursework addressing culturally effective health care (Like et al., 1996). However, to date, there are no nationally accepted standards for cultural or linguistic proficiency in health care service delivery (Cohen, 2005).

Summary

Culture is an extremely important component of one's life. The literature review shows that cultural competence is an essential component in delivering effective health care services to culturally and ethnically diverse patients. Health care professionals must be culturally competent to respond to the specific needs of individual patients (Bonder et al., 2001).

An understanding of culture and respect for differences will allow health care administrators to make more culturally appropriate planning and intervention decisions (Riddick, 1998). Researchers have also noted that knowledge of specific cultures permits health care professionals to understand how patient's culturally based beliefs can affect the course and outcome of disease (Riddick, 1998). The basic premise of cultural competence is conceptually understood and presented by many researchers, but specific standards of competence vary widely and are difficult to rely on in developing a true level of competence (Cohen, 2005; Akin, 2004; Anderson et al., 2003; Chin, 2003; Administration on Aging, 2001; AMA, 1999).

On the individual level, developing cultural competence is a challenge that many health care professionals are not well trained and suited to accomplish (Management for Sciences of Health, 2005; Luquis & Perez, 2003; Bonder et al., 2001; Like et al., 1996). According to Bonder et al. (2001, p. 37), "it is not a simple matter to gather the information about a client's 'cultural mores' [or about] culturally and socio-politically relevant factors." Despite the apparent challenges and difficulties in developing cultural competence, efforts to do so are still essential (Like et al., 1996).

Several theoretical models (Papadopoulos, 2003; Bennett, 1998; Hicks, 1998; Cross, 1988) have been developed that explain the process by which an individual develops cultural competence. While each of these models is distinguished by unique attributes, they share a common premise that cultural competence does not arrive in a moment of insight. Rather, cultural competence appears to develop incrementally through a series of stages. This development through stages resembles the development of cognition as described by Piaget (1954) or morality as described by Kohlberg (1983). With well-defined stages of development, learner's levels of development are easier to identify. As a result, training can be more effectively designed to meet the needs of adult learners.

While these developmental stages are well-defined and supported by research, very little has been written about what learning experiences move people from one stage to the next. There are studies that describe cultural competency training programs that objectively and significantly improve learners' cultural competence. Among these, few provide a detailed analysis of the learning activities or supporting materials. In effect, an organization interested in developing cultural competence is left enticed but not enabled to duplicate the success of the programs studied.

Perhaps most importantly, the researcher identified only one study that attempted to measure the impact of cultural competence training on the quality of health care delivered to people of color. Clearly, additional research is needed to relate training efforts to the intended benefit of improved quality of care.

From the research presented in this chapter, the researcher used the lessons learned and unresolved questions to develop his theoretical model. This theory is presented in detail in Chapter III and presented as a visual model on p. 56.

CHAPTER III.

RESEARCH DESIGN AND METHODOLOGY

The “research design is a logical plan for getting from here to there, where here may be defined as the initial questions to be answered, and there is some set of conclusions about those questions” (Yin 2003, p. 20). The design of this research was based on Yin’s (1994) positivistic case study methodology. Case study research is defined as “...an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when boundaries between the phenomenon and context are not clearly evident” (Yin, 1994, p.13). The case study approach was appropriate in that the online cultural competence training program at HealthEast provided a real life context in which to study the phenomenon of cultural competence development.

The researcher’s study investigated and attempted to explain a phenomenon that occurs in a contemporary or “real-life” context, in which the researcher would not have been able to control or manipulate the behavior of the participants. These are the conditions that Yin’s (2003) case study methodology are designed to address. Given that the participants’ cultural competence development is influenced by their ongoing personal and professional experiences, discerning it from the countless variables the participants encounter in their everyday life would be difficult or impossible. In this case, the positivistic case study methodology is best suited for this research study.

Interviewing the physicians and nurses at HealthEast was a primary source of data for this study. The accuracy of data gathered by this means is prone to distortion. Their recollection of their training experiences and how they interpret their experiences is subject to change over time. In some cases, participants were interviewed within days of

their cultural competence training. In other cases, months had passed between the time of the participant's training and their subsequent interviews with the researcher. Also, in designing a structured set of interview questions, the researcher inevitably elicited a subset of the data that participants might have been able to provide if the researcher had unlimited access to the participants for the purpose of data collection. Considering the phenomenon to be studied and acknowledging these limitations, the researcher chose the positivistic case study as the most appropriate research methodology.

Research Design

Case study research most commonly focuses on ethnographies or observation of participants. Yin's methodology for conducting case studies requires the researcher to be explicit about the research question, propositions, and units of analysis. In contrast with interpretive case studies in which the researcher observes and objectively reports his or her findings, in Yin's case study methodology, the researcher is more actively involved in gathering and interpreting data. Yin (2003) highlighted five elements of the research design:

1. A study's questions,
2. Its propositions, if any,
3. Its unit(s) of analysis,
4. The logic linking the data to the propositions, and
5. The criteria for interpreting the findings.

As a positivistic case study, this research is distinct from interpretive case studies in that it began with a review of literature from which the researcher built and tested a

theory by gathering data from a real world case. This approach is based on Dubin's model for quantitative research and theory building as described by Lynham (2002). This is consistent with the design described by Yin (2003).

The Research Question

In this positivistic case study, the researcher considered the question: Does cultural competence training develop cultural competence in health care workers? The researcher considered the research question based on the theory that effective cultural competence training may develop an individual's awareness and knowledge of cultural differences, and their skill in interacting with people from other cultures.

The distinction between cultural awareness and cultural knowledge is important. Campinha-Bacote (1999) defined cultural awareness as "the deliberate, cognitive process in which health care providers become appreciative and sensitive to the values, beliefs, lifeways, practices, and problem solving strategies of clients' cultures" (p. 204). Regarding cultural knowledge, Campinha-Bacote offered the following definition: "The process of seeking and obtaining a sound educational foundation concerning the various world views of different cultures. The goal of cultural knowledge is to understand the client's world view" (p. 204).

The Study's Propositions

The theory proposed by the researcher can be summarized as follows: Cultural competence training develops awareness, knowledge, and skills that enhance the

effectiveness of health care workers in delivering care to people from cultures different than their own.

This study proposed that there are three aspects of personal development promoted by effective cultural competence training:

1. Increased awareness of cultural differences,
2. Increased knowledge about cultural diversity, and
3. Increased skill in cross-cultural personal interactions.

HealthEast has recognized that effective cross-cultural communication between physicians and patients as well as between nurses and patients is a requirement for providing quality healthcare to an ethnically diverse local community that includes many individuals who have personally immigrated to the United States.

This study focused on the physicians and nurses staffing HealthEast's emergency rooms in the St Paul, Minnesota area who are participating in cultural competence training.

The Units of Analysis

Defining the unit of analysis is a fundamental problem in conducting case studies (Yin, 2003). To guide this definition, Yin explained that "...your tentative definition of the unit of analysis (and therefore of the case) is related to the way you have defined your initial research questions" (p. 23). While Dubin and Yin defined the case study process similarly, they defined unit of analysis differently. Yin described units of analysis as the frame that defines the scope of the research question, for example a hospital system or a training program. By contrast, Dubin (1969) referred to units of analysis as the theory's

concepts, representing the things or variables whose interaction is the focus of the theory. Identifying the units of analysis and making each explicit enables the researcher to understand how the case study may relate to a broader body of knowledge. With these relationships made clear, the researcher is able to generalize the data.

The researcher applied Dubin's (1969) definition of unit of analysis. Testing the individual components of the researcher's theory was deemed the most direct way to test the theory as a whole. Following Dubin's definition, there are three units of analysis in this study: Awareness, knowledge and skill in interacting with people from different cultures. The examination of individual awareness, knowledge, and skill as developed through cultural competence training is noted in the findings below.

The Logic Linking the Data to the Propositions

The researcher believes that as the population becomes more culturally diverse, training that develops awareness, knowledge, and skill in interacting with people from other cultures will become an important goal for health care organizations motivated to enhance the care of their patients. As shown in the figure 1, the researcher theorized that training leads to increased awareness, knowledge and skill. In turn, improvements in these aspects of cultural competence lead to quality of care.

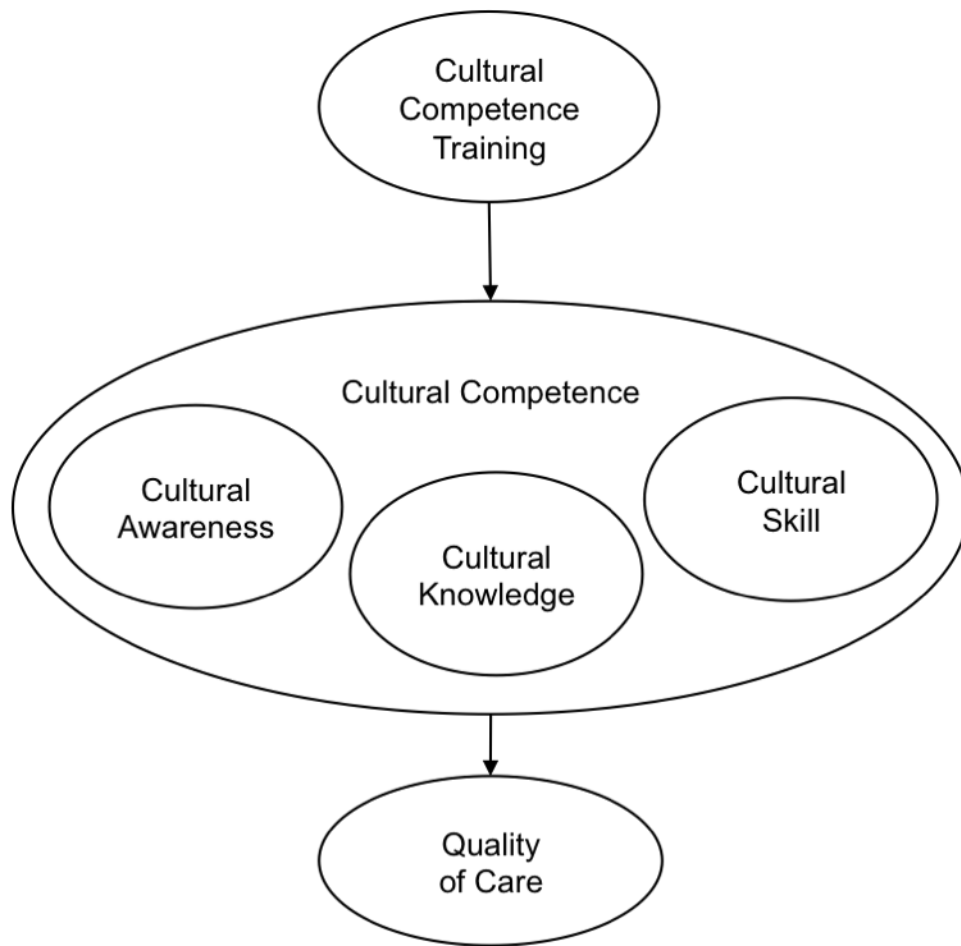


Figure 1

Relationship between Training, Cultural Competence and Quality of Care

Empirical indicators used in testing the proposition are presented in Table 3.

Table 3

Empirical Indicators Used in Testing the Proposition

Units of analysis	Empirical indicator*	Source of data	Data assessment**
1. Cultural Competence Training	Did the design of the training conform to theoretical models for the development of cultural competence	Review of curriculum design and online learning modules	Two-thirds or more of participants indicate that they “strongly agree” or “agree”
2. Cultural Awareness	Interview Question: This training increased my awareness of cultural competence as a factor in the quality of care provided to patients from different cultural backgrounds.	Participant Interviews	Two-thirds or more of participants indicate that they “strongly agree” or “agree”
3. Cultural Knowledge	Interview Question: This training increased my knowledge of how patients’ cultural backgrounds may influence their interaction with health care providers. Interview Question: As a result of this training, I am more likely to seek knowledge about the impact of culture on quality patient care in the future.	Participant Interviews	Two-thirds or more of participants indicate that they “strongly agree” or “agree”
	Twenty multiple choice questions (See Appendix C.)	Pre-/Post-Tests	Post-test scores improve by 25% or more from pre-test scores
4. Cultural Skill	Interview Question: This training increased my skill in interviewing patients about their perceptions of their health problem and treatment options. Interview Question: As a result of this training, I am more likely to integrate these skills into my practice in the future.	Participant Interviews	Two-thirds or more of participants indicate that they “strongly agree” or “agree”

	Interview Question: My experience in this training will influence how I practice.		
5. Quality of Care	Interview Question: This training will help me improve patient care.	Participant Interviews	Two-thirds or more of participants indicate that they “strongly agree” or “agree”

*In one-on-one interviews, participants were asked to respond to each of the interview questions under the heading of “Empirical Indicator” in the table above. The following five-point Likert scale was used: Strongly agree, Agree, Neither agree nor disagree, Disagree, or Strongly disagree. Participant responses of “strongly agree” and “agree” were considered to support the proposed theory.

**A minimum threshold of two-thirds of participants indicating that they “strongly agree” or “agree” was chosen (rather than 100%) in recognition of the fact some individual participants may already have achieved competence in a particular unit of analysis prior to beginning the training. For example, when asked whether the training enhanced their cultural awareness, a participant who enters the training with a high degree of cultural awareness would be unlikely to respond “strongly agree” and “agree” regardless of the quality of the training.

Data Collection Methods

The process for collecting data in this study included both interviews and review of documents. The researcher chose to employ complementary data collection techniques to corroborate data collected. This was done in the interest of developing more convincing findings according to Yin (1994). The researcher interviewed 15 emergency

room health care providers comprising five physicians and 10 nurses who participated in cultural competence training. Documents reviewed included individual and aggregate results from tests conducted both before and after the participants' training experience. The tests, designed and administered by HealthEast measured participants awareness and knowledge of cultural differences relevant to medical care.

In planning and conducting interviews, the researcher chose to apply both Likert's (1932) approach of structuring responses on a 5-point agree-disagree scale and Patton's (1987) approach of asking open-ended interview questions from a single interview guide. The researcher drafted an interview guide and reviewed the questions with both the researcher's dissertation committee chair and two managers within HealthEast's Organization Development Department. Standardized interview questions enabled the research gather data that was generally uniform in structure from each interview. Open-ended interview questions allowed the participants to provide information that was relevant to their training experience but not anticipated by the researcher. The researcher asked these standard questions in each interview and followed-up with related probing questions to gather more information from participants as they mentioned unanticipated subjects. The interview guide is included in Appendix B.

The interviews of participants and the review of related documents were focused on identifying changes in the participant's awareness, knowledge, and skill associated with their participation in cultural competence training. The researcher compared the participant's self-reporting of improvements in their knowledge with documented pre-training and post-training test results that focused on those same variables. Items in these tests focused on important aspects of culturally competent care. A correct answer to an

item demonstrated knowledge. An improved test score on a post-training test vs. the pre-training test indicated an increase in knowledge.

The areas of focus described in Table 4 were developed to structure the search for emerging themes within the collected data.

Table 4

Areas of Focus

Levels of analysis	Sources of data	Criteria
Training design	Review of curriculum design and online learning modules	The training design was reviewed for conformance to theoretical models for the development of cultural competence that emphasize a stage-based developmental process that begins with awareness, and continues on to developing knowledge, and skill in cross-cultural interactions.
Individual HealthEast nurses Individual HealthEast physicians	One-on-one interviews with individual participants. (See Appendix B for the semi-structured interview questions.)	Participants were asked to respond to each interview question using a five-point Likert scale: Strongly agree, Agree, Neither agree nor disagree, Disagree, or Strongly disagree. Units of analysis in which two-thirds or more of participants indicated that they “strongly agree” and “agree” were considered to support the proposed theory.
HealthEast nurses as a whole HealthEast physicians as a whole	Results from pre- and post-training tests of knowledge (See Appendix C for the test questions.)	Results of these tests were available only in aggregate (with one summary of nurses and a second summary of physicians). Therefore, it was not possible to compare pre- and post-training test results for any individual participant. Improvements in the mean post-training test scores in comparison with the mean pre-training test scores were considered to support the proposed theory.

The Criteria for Interpreting the Findings

Data regarding the design of the training came from the researcher's review of the curriculum and the online learning modules themselves. The researcher compared the design of the training to the established theoretical models for the development of cultural competence.

Data regarding the participants' experience in completing the training were gathered from documents and interviews. In analyzing data gathered, the researcher applied pattern matching and textual analysis to understand the validity of the study's propositions. In the interviewing process, participants were asked to categorize their answer to each question using a five-point Likert scale (Strongly agree, Agree, Neither agree nor disagree, Disagree, or Strongly disagree). This enabled the researcher to gain consistently structured responses and to produce a quantified summary of the interview results.

Yin (2003) promoted pattern matching as an effective technique for data analysis. In this study, interview results were compared and analyzed for emergent patterns. These empirically based patterns were compared with those predicted by theory. To the degree that these patterns coincide, the internal validity of the propositions are strengthened and the researcher's theory is supported.

The Case Study Database

The reliability of findings in a case study is enhanced by structuring the collected data and maintaining a traceable link between that data and subsequent findings (Yin,

1994). Such a structured database makes the data from a study more accessible and useful in subsequent research on the topic. The database for this case study consists of the following: pre- and post-training test results, notes from each interview, and correspondence with HealthEast leadership.

Sample Size and Selection Process

The head of each of HealthEast's emergency rooms granted the researcher permission to interview the participants during their regular working hours. Participants took part in the study on a voluntary basis. System Director, Organization Development at HealthEast facilitated communication between the researcher and the participants. The researcher sent her a Participant Information letter that introduced the researcher and described the purpose and scope of the study. This letter also highlighted potential benefits for participants, and described how the researcher intended to gather information from each participant. (See Appendix A for a copy of the Participant Information letter.)

The System Director, Organization Development distributed the letter to the intended participants. In the form of a cover letter, she also informed them that their participation was voluntary, that they would be allowed to participate during work hours, and that the researcher would protect both the identity of the participants and the confidentiality of the data gathered. The researcher's liaison arranged accommodations for private interviews on site at HealthEast and reserved time on each participant's schedule to be interviewed.

The researcher interviewed 15 HealthEast emergency room staff members comprising five physicians and 10 nurses who participated in cultural competence

training. No compensation for participants was provided by the researcher, but HealthEast gave permission for participants to be interviewed during their work shift. This made it possible for participants to be compensated for their time spent participating.

Participants were selected from each of the Emergency Departments in the HealthEast system. Physicians and nurses who volunteered to participate were contacted by the researcher's liaison and scheduled for individual interviews at their hospital or clinic.

The researcher carefully protected the confidentiality of the data gathered through participant interviews. However, each participant's choice to volunteer could not be kept strictly confidential because interviews were conducted on site during working hours. Due to staffing requirements, in order for a nurse or physician to take time away from their responsibilities, one of their colleagues would have to cover their post for them while they took the time to complete the interview process.

The fact that the study included 15 participants was due to the availability of volunteer participants. The final step in the selection process was conducted at the beginning of each interview session. Each volunteer was asked to read the Participant Consent Form (See Appendix D). The researcher reminded the participants verbally that they were not obligated to participate and that they had the right to change their mind about participating at any time without any repercussions from the researcher, their manager, or HealthEast. As each participant committed to follow through with the interview process, the researcher reviewed the confidentiality agreement with them and explained how their data would be used. Among the 15 volunteers, all participated throughout the course of the study.

Procedures for the Protection of Human Subjects

The researcher implemented four procedures to protect the participants and HealthEast. These procedures are in accordance with standard practices for researching human subjects and were approved by the Institutional Review Board (IRB) at the University of St. Thomas before the study began. These four procedures were followed:

1. Participant was strictly voluntary. Each participant was reminded of this verbally, and given the opportunity to withdraw from the study at any point, including after their interviews were completed.
2. Participant confidentiality was protected in several ways. Names of participants were stored independently from the research data, Each participant was identified by a random numeric code. The code list cross-referencing each numeric code with a participant's name was stored separately by the researcher. All raw data were accessible only to the researcher and were locked in a file cabinet in the researcher's home. Results of individual assessments were shared only with the participant in private. Data were reported both in this dissertation and to HealthEast in summary form only. The researcher took care that no recorded data could be attributed to a participant.
3. The researcher reviewed interview responses with each participant with two goals in mind. First, to follow through on the proposed benefit to participants that they would have the opportunity to learn about their own experiences and perspectives in the context of their peers. Second, to check the validity of the researcher's notes by confirming with the participants that the researcher accurate documented

their responses and additional comments. Quotes to be included the findings were reviewed with each participant to ensure that they were comfortable that the quotes were not attributable.

4. To maintain the separation from this study and the cultural competence training program HealthEast was conducting, the researcher reiterated that separation as part of the opening comments at the beginning of each interview session. Finally, participants were informed who would be able to view the researcher's interview notes and final report before being interviewed.

Research Design Limitations

The researcher is mindful of the potential bias introduced into the study resulting from the researcher's personal belief in the importance of developing cultural competence. Using structured interview techniques helped mitigate this limitation, as did soliciting confirmation of the accuracy of researching findings with the participants themselves. The researcher accepts some risk in reporting information in this study that may be critical of the subject organization's cultural competence training program.

Previous research evaluating the impact of cultural competence training programs on cultural competence is sparse. The results of this single case study cannot be generalized. Conclusions from this study are preliminary and serve to frame future research. This design of this research may be applied in future research to compare the findings of this study in other organizations.

As with all studies, this study has limitations. An understanding of these limitations will support a more accurate interpretation of the findings. The limitations of

this study relate to the tools used to gather data and to the challenge connecting participants' attitudes to their actual behavior. Specifically, the limitations of this study are:

1. Individual perceptions and recall are inevitably prone to unintentional reinterpretation. While Gurman and Kniskern (as cited in Hovestadt, Anderson, Piercy, Cochran, & Fine, 1985) highlight the importance of self-report data, in the absence of an absolute standard of truth there is no basis to controvert an individual's perception of the "truth." This is especially true when, as in this study, the subject matter is the individual's own personal experience. Bias is inevitably present when one is asked to reflect on oneself.
2. The researcher was unable to triangulate the data gathered in this study with observations of the participants' behavior. Had observation been possible, the value of this observation would likely have been limited. The participants' awareness that they were being observed would likely have influenced them away from their natural behavior.
3. The researcher recorded all interview responses in hand writing. Subsequent review of interview data was limited to the details captured in these handwritten notes. The researcher reviewed each participant's responses with them at the end of the interview to ensure that the notes accurately reflected their thoughts and comments.
4. The questions used in post-training testing of participant awareness, knowledge and skill were identical to those used in the pre-training test. To the degree that participants may have been able to recall these questions and the correct answers

from the pre-training test, their post-training test scores may have been artificially high.

CHAPTER IV.

FINDINGS

This chapter of findings relates to the theory described in Chapter III. A summary of each unit of analysis in the theory is presented including relevant data, whether the data supports or fails to support that unit of analysis. Quotes from participants are included and presented in italics.

In following Yin's (1994) case study methodology, the researcher's theory was reviewed and revised to account for the actual findings of this study. Finally, other findings from the case that are relevant to the theoretical model presented, but not directly represented in the model are discussed.

Profiles of Participants by Role

Each participant interviewed by the researcher was either a physician or a nurse. In total, the researcher interviewed five physicians and 10 nurses. Within these two groups, participant profiles are presented in Table 5. To protect the participants' confidentiality, the researcher did not indicate their position titles.

Table 5

Profile of Study Participants

Characteristic	Criterion	Number of participants meeting criterion		
		Physicians	Nurses	Total
Gender	Female	0	8	8
	Male	5	2	7
Tenure at HealthEast	< 5 years	2	0	2
	5-10 years	2	4	6
	>10 years	1	6	7
Previous Cultural Competence Training	Yes	5	2	7
	No	0	8	8

Unit 1: Cultural Competence Training Program

The training the participants experienced was created by the Manhattan Cross Cultural Group (MCCG), a training and research organization that focuses on improving health care to diverse patient populations and eliminating health disparities. Doctors Joseph Betancourt, Alexander Green, and Emilio Carrillo, three practicing physicians and researchers in the field of cross-cultural health care founded MCCG.

The online learning program the participants experienced is known as Quality Interactions. It focuses on common clinical and cross-cultural scenarios that build a framework of knowledge and skills for delivering quality care to diverse patient populations. It is an online patient-based cross-cultural program that teaches a framework for analysis of the individual patient's social context and cultural health beliefs and behaviors (Carillo et al., 1999). The curriculum consists of five thematic units taught in four two-hour sessions. The goal is to help physicians and nurses avoid cultural

generalizations while improving their ability to understand, communicate with, and care for patients from diverse backgrounds.

This program comprises four components:

1. An introduction and cultural competence questions and answers that review the business, medical and legal reasons why cultural competence in health care is an essential professional skill set. This component also summarizes the patient-based approach to cross cultural care taught in the course.
2. Interactive cases designed to develop cross-cultural knowledge and communication skills that can be applied in any health care setting, with patients from any cultural background. These cases provide participants an opportunity to test their knowledge and skills in simulated cross-cultural interactions.
3. Personalized feedback and review that reinforces key concepts and skills and gives the participant individualized feedback.
4. Pre- and post-training tests that assess the participant's mastery of specific knowledge and skills presented in the course.

The structure and content of the training conformed to the stage-based development model that leads participants through a process of developing their awareness, knowledge, and skill in interacting with minority patients. Specifically, the learning modules are designed around five core learning objectives:

1. Identify cross-cultural issues (awareness),
2. Identify the impact of cultural issues on medical decision making (knowledge),

3. Conduct a culturally competent history and medical examination (skill),
4. Work effectively with interpreter services (skill),
5. Effectively explain a patient's diagnosis and management options (skill), and
6. Negotiate a treatment plan that improves patient cooperation (skill).

The online training program was accessible through the Internet. Participants were directed to a private website and provided login information that enabled HealthEast to track each participant's completion of the training. Participants were provided with paid time to complete the training and each had the option of completing the training either in the workplace or from any other location where they could access the Internet.

Unit 2: Cultural Awareness

This study defines cultural awareness as “the deliberate, cognitive process in which health care providers become appreciative and sensitive to the values, beliefs, lifeways, practices, and problem solving strategies of clients' cultures” (Campinha-Bacote, 1999, p. 204). Self-awareness is an important aspect of cultural awareness. Without being aware of the influence of one's own cultural values, there is a risk that health care providers may engage in cultural imposition.

The researcher posed the following interview questions to each participant regarding their perception of how the training program effected their personal cultural awareness.

Table 6

Awareness of Cultural Competence as a Factor in the Quality of Care

Unit of analysis	Interview question	Participants	Strongly agree or agree	Neither agree nor disagree	Strongly disagree or disagree
2. Cultural Awareness	1. This training increased my awareness of cultural competence as a factor in the quality of care provided to patients from different cultural backgrounds.	Physicians	3	0	2
		Nurses	9	0	1

As Table 6 summarizes, twelve of 15 study participants agreed or strongly agreed with the statement, “This training increased my awareness of cultural competence as a factor in the quality of care provided to patients from different cultural backgrounds.” This meets the criterion (of at least two-thirds either agreeing or strong agreeing) established to decide whether the data support the proposed theory. Participants who agreed or strongly agreed with this statement were asked a follow up question: “In what way?”

A common theme among several of the participants’ responses to the follow up question was that by offering the training and making it mandatory, HealthEast made a strong statement about the importance of cultural competence and the organization’s commitment to develop physicians’ and nurses’ ability to serve a diverse patient population. As one nurse stated this explicitly, “*the training focused attention on the importance of cultural competence.*”

Participants who disagreed that the training had increased their level of awareness about the importance of cultural competence each described having a keen awareness of the importance of cultural competence either from earlier training or from personal and professional experiences with people from different cultures. One such nurse highlighted the value of intercultural experiences beyond training, *“I came into training with deep inter-cultural awareness. No training can substitute for personal experiences living with people from other cultures.”* One physician (with less than two years of tenure at HealthEast indicated that cultural competence is beginning to be addressed in medical school, *“My awareness was already there due to my cultural competency training in medical school and residency core training.”*

Even among participants who claimed previous awareness of the importance of cultural competence there was an acknowledgement that developing cultural competence is an ongoing process with many dimensions. Comments from three nurses highlighted this point: *“I hadn’t been aware of some of the culture-specific details presented in case studies,”* *“The training exposed me to a new [Asian] culture that I was unfamiliar with,”* and *“It introduced information that I had no idea about.”*

One nurse described how the awareness she gained through this training has made her more sensitive to the challenges of communicating with a patient for whom English is a second language, *“I realized that the manner in which a question is asked of a patient may influence their response. Certain phrasings, word choices, and body language and speaking tones may not translate as intended into another language.”* One physician confirmed that the training had served as an important reminder that patients from Asian cultures have cultural references that may clash with western medical practices.

The fact that 80% of participants either agreed or strongly agreed that the training had increased their awareness suggests that the training was effective in fulfilling this objective. This finding is reinforced by the fact that the remaining 20% claimed prior awareness of cultural differences. In effect, they did not conclude that the training was ineffective, only that this aspect of the training was not relevant for them personally.

Unit 3: Cultural Knowledge

This study defines cultural knowledge as “the process of seeking and obtaining a sound educational foundation concerning the various world views of different cultures. The goal of cultural knowledge is to understand the client's world view” (Campinha-Bacote, 1999, p. 204). One of the most important concepts for understanding clients' behaviors is to understand their world views. In addition to seeking and obtaining a sound educational foundation concerning the various world views of different cultures, the process of cultural knowledge also involves obtaining knowledge regarding specific physical, biological, and physiological variations among ethnic groups.

The researcher posed the following interview questions to each participant regarding their perception of how the training program effected their personal cultural knowledge.

Table 7

Knowledge of Culture's Influence on Patient Interaction with Health Care Providers

Unit of analysis	Interview question	Participants	Strongly agree or agree	Neither agree nor disagree	Strongly disagree or disagree
3. Cultural Awareness	2. This training increased my knowledge of how patients' cultural backgrounds may influence their interaction with health care providers.	Physicians	1	0	4
		Nurses	9	0	1

As Table 7 summarizes, twelve of 15 study participants agreed or strongly agreed with the statement, “This training increased my knowledge of how patients’ cultural backgrounds may influence their interaction with health care providers.” This meets the criterion (of at least two-thirds either agreeing or strong agreeing) established to decide whether the data support the proposed theory. Participants who agreed or strongly agreed with this statement were asked a follow up question: “In what way?”

Several nurses who agreed that the training had increased their knowledge cited information relevant to the Hmong population they serve at HealthEast:

“In Hmong families, males speak on behalf of the patient and family. I’ve learned to address questions and information to Hmong families through the patriarch.”

“Yes, an example is the lack of eye contact with Hmong patients. I’ve learned it is a sign of respect rather than a lack of attention or lack of courtesy.”

“Yes, in the case of Hmong patients, I better understand the influence that elders have in the decisions about what diagnoses and treatments are acceptable. I also learned how

uncomfortable it can be for a patient who is asked by a nurse or doctor to step outside of their culture and make such decisions personally.”

Several nurses confirmed that the case-based patient scenarios included in the training were an effective means of increasing their knowledge. One physician agreed that these scenarios were an effective reminder that cultural context can influence a patient’s perception of their medical problems and their expectations about the treatment they might receive. He explained that recognizing and acknowledging these cultural differences can increase the probability that a patient will follow through with the treatment prescribed by a physician.

One physician was careful to point out that while knowledge of cultural generalities (as emphasized in the training) is valuable, *“even people from the same cultural background can have different opinions—end of life care, vaccinations, etcetera.”* As another physician added, *“Cultural identity is important, but it is ‘trumped’ by individual experiences and perspectives.”*

Participants who disagreed that the training had increased their knowledge of how culture influences patients’ interactions with health care providers explained that there was no new information in the training beyond what they had previously known.

Table 8

Motivation to Seek Knowledge about the Impact of Culture on Patient Care

Unit of analysis	Interview question	Participants	Strongly agree or agree	Neither agree nor disagree	Strongly disagree or disagree
3. Cultural Knowledge	3. As a result of this training, I am more likely to seek knowledge about the impact of culture on quality patient care in the future.	Physicians	1	0	4
		Nurses	6	0	4

As Table 8 summarizes, seven of 15 study participants agreed or strongly agreed with the statement, “As a result of this training, I am more likely to seek knowledge about the impact of culture on quality patient care in the future.” This fails to meet the criterion (of at least two-thirds either agreeing or strong agreeing) established to decide whether the data support the proposed theory. Participants who agreed or strongly agreed with this statement were asked a follow up question: “Why?”

Participants who agreed with this statement were emphatic about the effect of the training on their motivation to seek knowledge:

“Yes, As a result of the training, I have a more open mind. I will be more likely to ask someone if there is a cultural difference I am unfamiliar with.”

“Yes, the training is a reminder that our culture is changing and becoming more diverse.”

“Yes, particularly in the areas of religion and cultural traditions regarding medical care.”

All participants who disagreed that taking part in the training had made them more likely to seek knowledge about the impact of culture on quality patient care stated that they were already motivated to seek knowledge and the training did not increase their motivation to do so. These responses did not suggest that the training failed to motivate them. Rather, these participants stated that this question did not apply to them.

Unit 4: Cultural Skill

This study defined cultural skill as “the ability to collect relevant cultural data regarding the clients' health histories and presenting problems as well as accurately performing a culturally specific physical assessment. This process involves learning how to conduct a cultural assessment and culturally based physical assessments” (Campinha-Bacote, 1999, p. 204).

The researcher posed the following interview questions to each participant regarding their perception of how the training program effected their personal cultural skill.

Table 9

Skill in Interviewing Patients

Unit of analysis	Interview question	Participants	Strongly agree or agree	Neither agree nor disagree	Strongly disagree or disagree
4. Cultural Skill	4. This training increased my skill in interviewing patients about their perceptions of their health problem and treatment options.	Physicians	3	0	2
		Nurses	9	0	1

As Table 9 summarizes, twelve of 15 study participants agreed or strongly agreed with the statement, “This training increased my skill in interviewing patients about their perceptions of their health problem and treatment options.” This meets the criterion (of at least two-thirds either agreeing or strong agreeing) established to decide whether the data support the proposed theory. Participants who agreed or strongly agreed with this statement were asked a follow up question: “In what way?”

Participants who agreed highlighted specific interviewing skills they had developed as a result of this training. They described improvements in both in listening and understanding patients’ needs and in communicating prescribed treatments:

“One example is in interpreting eye contact (or lack of it) in interactions with Hmong patients.”

“I have learned to face the patient (rather than the interpreter) when I am asking a question or providing information.”

“I’ve learned that if a patient is continually smiling it isn’t a reflection on their intelligence, but rather a display of courtesy.”

“The training encouraged me to talk with our Hmong interpreter and discuss cultural communication barriers.”

“I now am much more careful about monitoring patients’ nonverbal feedback to my questions and I take more time explaining instructions regarding taking medications.”

“I’m more tuned into communication dynamics with interpreter and Hmong patient family members.”

“Knowing that there are some cultural biases against medication, I am especially careful to explain the purpose of prescribed medications and the importance of taking these medications.”

Table 10

Integration of Cultural Competence Skills into Practice

Unit of analysis	Interview question	Participants	Strongly agree or agree	Neither agree nor disagree	Strongly disagree or disagree
4. Cultural Skill	5. As a result of this training, I am more likely to integrate these skills into my practice in the future.	Physicians	2	0	3
		Nurses	8	0	2

As Table 10 summarizes, ten of 15 study participants agreed or strongly agreed with the statement, “As a result of this training, I am more likely to integrate these skills into my practice in the future.” This meets the criterion (of at least two-thirds either agreeing or strong agreeing) established to decide whether the data support the proposed

theory. Participants who agreed or strongly agreed with this statement were asked a follow up question: “Why?”

Participants who agreed highlighted two motivations for integrating cultural competence skills into practice. First, the potential for improved communications with patients coming from an ability to be *“more friendly to the patient of concern, and their families.”* As one nurse stated, *“the training has enhanced my understanding of how to work with interpreters to improve the quality of communication with patients.”* Second, an anticipated improvement in the quality of care resulting from increased *“options of dealing with the patient, their problems, and their families.”*

Comments from participants who disagreed that the training would make them more likely to integrate their cross cultural communication skills in their practice indicated that the issue was not the quality of the training but the lack of opportunity to apply new interviewing skills in their interactions with patients. Two physicians described the fact that in a typical two to three minute interview with an emergency room patient there is *“not much opportunity to apply different interviewing approaches.* As a result the training had *“limited impact.”*

Table 11

Influence of Cultural Competence on Practice

Unit of analysis	Interview question	Participants	Strongly agree or agree	Neither agree nor disagree	Strongly disagree or disagree
4. Cultural Skill	6. My experience in this training will influence how I practice.	Physicians	2	0	3
		Nurses	8	0	2

As Table 11 summarizes, ten of 15 study participants agreed or strongly agreed with the statement, “My experience in this training will influence how I practice.” This meets the criterion (of at least two-thirds either agreeing or strong agreeing) established to decide whether the data support the proposed theory. Participants who agreed or strongly agreed with this statement were asked a follow up question: “In what way?”

Participants who agreed indicated that the training had both improved their skills:

“Because of the training I will more effectively use interpreters.”

“I’m more accepting and less judgmental of cultural differences.”

“I will ask different triage questions as a result of the training.”

and altered their attitudes regarding patients from different cultures:

“I’m more accepting and less judgmental of cultural differences.”

Unit 5: Quality of Care

This study defined quality of care as health care providers’ effect on improving outcomes of patient satisfaction, reducing racial or ethnic differentials in utilization and treatment, and improving objective measures of health status (Wade & Bernstein, 1991).

The researcher posed the following interview question to each participant regarding their perception of how the training program effected the quality of care delivered to patients.

Table 12

Improvement of Patient Care

Unit of analysis	Interview question	Participants	Strongly agree or agree	Neither agree nor disagree	Strongly disagree or disagree
5. Quality of Care	7. This training will help me improve patient care.	Physicians	3	0	2
		Nurses	9	0	1

As Table 12 summarizes, twelve of 15 study participants agreed or strongly agreed with the statement, “This training will help me improve patient care.” This meets the criterion (of at least two-thirds either agreeing or strong agreeing) established to decide whether the data support the proposed theory. Participants who agreed or strongly agreed with this statement were asked a follow up question: “In what way?”

Nurses pointed out several results of training that they felt would improve quality of care:

“I am better able to ask questions that will elicit information for diagnosis and care.”

“I’m more sensitive to differences in communication with women and men.”

“Any relevant knowledge you gain has the potential to improve care.”

“I will be more accurate and efficient in triage.”

“Just an increased awareness will improve care.”

One senior nurse commented that she had already seen the training make a positive impact:

“The feedback I hear from patients is that care givers at HealthEast show more respect and understanding of diverse cultures, and that patients choose to come to St. John’s for this reason.”

Physicians agreed that this training will improve patient care:

“I will be able to make better diagnoses and more effective treatment plans.”

“Yes, as measured in patient satisfaction due to physicians conveying respect and sensitivity.”

“Anything that helps me and my patients stay on the same wavelength is worthwhile.”

Other Observations

Beyond the units of analysis described above, the researcher posed three additional questions in each interview. The intent of these questions was to give the participants an opportunity to express their personal conclusions about the design and value of the training program:

1. Based on your experience, would you recommend offering the e-learning training more broadly to HealthEast providers and nursing staff?

“Yes, This training would be very valuable to a lot of staff. The more you can develop empathy and sensitive, the less likely people are to be judgmental about cultural differences.”

“Yes, some people may benefit from increased awareness.”

“Yes, That would depend on their individual familiarity with cultural differences.”

“Yes, Only if people are unfamiliar with cultural differences.”

“Yes, Raising awareness is important.”

“Yes, I think that similar training should be mandatory annually for nurses, physicians, and social workers, who deal with patients most closely. I like the interactive format. TO prevent boredom from familiarity, different scenarios could be given yearly. The training could be expanding to include cultural readings (one mentioned above), lectures, etc.”

The question of whether participants would recommend the training to their colleagues was chosen on the premise that it imposes accountability on the participants to speak on behalf of their peers. Responses were generally positive. Participants volunteering suggestions for improving the training suggest that they took the question seriously and offered thoughtful responses.

2. Based on your experience in this training, do you have any suggestions for the design of future cultural competency training programs?

Responses to this question focused on the design and delivery of the training as well as the training content. Regarding design and delivery, participants had this to say:

Effectiveness of e-Learning:

“e-Learning is an effective delivery tool.”

“For e-learning, make modules shorter, therefore easier to schedule.”

“e-Learning is less effective than personal interaction with teacher.”

“Online learning is a plus.”

“Web-based training was easy to use.”

“The computer interface was challenging.”

“Nurses are hands-on learners. E-learning has reduced value”

“I appreciated being able to take training at home.”

“I particularly enjoyed the interactive format of the e-training. At first, it was a bit different, but I quickly became used to it.”

Comments on e-Learning as a delivery tool are consistent with general views of e-Learning: It offers flexibility in the timing and location of training, but at the expense of personal interaction between learner and teacher as well as “hands-on” learning that offers participants the opportunity to practice the skills being taught in the execution of their work responsibilities.

Desire for Interactive Classroom Learning:

“More interactivity would be helpful. I like learning by asking questions.”

“I would like to see interpersonal presentations and discussion with Hmong interpreters or social workers.”

“It would be ideal to have representatives of a culture (e.g. Hmong) in staff meetings to provide background and history of the culture and to answer questions.”

“Speakers representing different populations (e.g. Hmong and Somali) would allow deeper probing of issues.”

Comments regarding interactive classroom learning as an alternative to the online training that is the focus of this study highlighted the perceived value of interactive classroom learning. Many of the participants focused on their desire for interactive learning experiences with members of the Hmong community in particular. This focus reflects the high representation of Hmong clients in the population served by HealthEast.

More generally, these comments reflect a desire for interactive learning which would enable them to more deeply explore cultural differences with experts in those cultures.

Structure of Learning Modules:

“I would prefer case study structure that begins with a summary of available information and then have opportunity to ask questions.”

“The training could have been more concise.”

“Training was too long, could have been more modular.”

“Case studies could be more specific.”

“I liked the case study format.”

“Training was too long, a more modular approach would be better.”

“Case study scenarios were well-designed.”

These comments suggest that while the case study format was valuable, the opportunity exists to improve the design by making the content more modular and concise. Participants feedback to this effect perhaps reflect their experience of interacting with patients in an emergency room setting.

Other Comments Regarding Design and Delivery:

“The best learning happens at patient bedside.”

“I recommend offering recurring training over time to maintain higher levels of awareness.”

“I did the training at the hospital. Interruptions were very distracting from learning.”

These comments highlight some of the limitations of completing online training in a hospital setting. They reflect two aspects common to much medical training: First that learning and practice are integral to each other; and second, that training is administered as an ongoing program rather than a one-time event.

Regarding the content of training, participants also had several comments:

“Need to address variable of how ‘Americanized’ immigrants become over time.”

“Be more prescriptive about culturally-specific tactics for interacting with patients.”

“Include discussion about cultural perspectives on death. For example, it’s important to Hmong families that the deceased be buried in their own clothes and to have the family present at the time of death.”

“Address differences in cultural backgrounds (for example, the role of Hmong elders in decision making).”

“It’s important to remember that every family within every culture is different.”

“We need to account for number of generations a patient has been in U.S.”

“We must be careful that individual uniqueness is not missed in cultural generalizations.”

“I think the program only covered half of the cultural awareness issue! In any human communication or interaction there is a two-way street. The e-training only covered the patient side, and totally neglected the physician side of the story! My own and my staff’s side of the equation is just as important. They, too, have strong and pertinent feelings and opinions regarding cultural and ethnic variability, which must be respected. One example, I come from a religious background, which discourages

lying, I will not lie to a patient. Upon family request, I might withhold bad news, but if asked point blank by the patient I will tell the patient the truth, regardless of family wishes. I tell the families this upfront, and that is non-negotiable. Other examples abound. One's own cultural referents may also explain some cases of antipathy towards some."

These comments regarding the content of training identify a number of areas that a more comprehensive training program might cover. They suggest the value of customizing training content to reflect the local population and the unique learning needs of the people participating in the training.

3. Do you have any other comments about your experience in this training?

"Cultural competence training should be part of a continuing education, it is important."

"The most sophisticated view of cross-cultural interaction is that people are individuals and should be respected and treated with that in mind."

"It's important to remember that many patients are immigrants struggling to understand a culture and a health care system that is unfamiliar to them."

"Already familiar with information in training."

"Respecting cultural preferences for communication with patient and family may be at odds with ethical questions of being honest and open with patient."

"Resources for providing personal training include physicians, interpreters, and patients from each culture."

"Focus training on patient populations relevant to each ER location."

“Case study format is helpful, could be more focused on local population.”

“Address Native American culture.”

“Targeting training based on populations served would be more useful.”

“The online interactive case study approach is innovative and engaging. Aside from developing awareness, knowledge, or skills, recurring cultural competency training is valuable in that it gives exposure to the issue of cultural competence and keeps it ‘on the front burner.’”

“The relevance of case studies included in training depends on geographic area of practice.”

“Training was of limited value because it didn’t reflect acute care constraints in patient interaction.”

“It would have been nice to choose populations in training case studies.”

“This training has limited relevance for emergency room physicians because of our time constraints in interacting with each patient.”

This open-ended question drew divergent comments. Among these, the most direct feedback on the design of the training is that it should be ongoing, include case studies reflecting the ethnicity of the local patient population, and in prescribing dialogue with patients accommodate the unique time constraints of an emergency room environment.

Pre/Post Test Results

Pre-training and post-training tests of participants’ awareness and knowledge regarding cultural competence was integrated into the design of the online training.

Participants could access the first learning module only after completing the pre-training test. The post-training test was administered online as the final activity in the last learning module.

HealthEast’s documentation of test results did not record individually attributable test scores. The 15 study participants were among the broader population of 96 HealthEast physicians and nurses who completed training and whose scores are reflected in Table 13.

Table 13

Summary of Pre/Post Test Results

	Statistic	Physicians	Nurses	Total
Number of people completing training		29	67	96
Pre-training test results (maximum possible score = 20)	Maximum score	13	14	14
	Minimum score	3	3	3
	Mean score	7.59	7.04	7.21
Post-training test results (maximum possible score = 20)	Maximum score	19	20	20
	Minimum score	14	14	14
	Mean score	16.97	16.31	16.51
Percent Improvement (comparing individual pre- & post-training test results)	Maximum	467%	400%	467%
	Minimum	36%	14%	14%
	Mean	124%	132%	129%

Post-training test results for both nurses and physicians improved more than 100% from pre-training test scores. This improvement suggests that the training improved cultural awareness and cultural knowledge.

Improved post-training test scores may also reflect the participants' familiarity with the post-training test questions. The post-training test questions were the same as the pre-training test questions. The correct answers to the questions were not made available to participants until after they completed the post-training test. Nor did the training materials suggest that the questions on the pre-training test would appear again on the post-training test. Despite these mitigating factors, it is possible that the participants had the test questions in mind as they went through the training and that their focus may have been on discovering answers to these questions. This poses a threat to the validity of the post-training test results as a measure of participants' learning. One participant commented on this circumstance in the interviewing process: "*Both the pre-training test and post-training test seemed to include identical questions, not the best measure of learning.*"

Conclusion

The research question addressed in this study was: "*Does cultural competence training foster individual cultural competence?*" The design of the cultural competence training program was reviewed for conformance to theoretical models for the development of cultural competence that emphasize a stage-based developmental process that begins with awareness, and continues on to developing knowledge, and skill in cross-cultural interactions. The structure and content of the training conformed to the stage-

based development model that leads participants through a process of developing their awareness, knowledge, and skill in interacting with minority patients.

A comparison of pre-test and post- test results indicate that this training program did foster individual cultural competence in the participants. An increase of more than 100% from pre-test scores to post-test scores indicate strong improvements in cultural competence. This conclusion is further supported by the data gathered in interviews with training participants.

A minimum threshold of two-thirds (rather than 100%) of participants indicating that they “strongly agree” or “agree” was chosen in recognition of the fact some individual participants may already have achieved competence in a particular unit of analysis prior to beginning the training. For example, when asked whether the training enhanced their cultural awareness, a participant who enters the training with a high degree of cultural awareness would be unlikely to respond “strongly agree” and “agree” regardless of the quality of the training.

Support for this conclusion is summarized in Tables 14 and 15. Feedback from some participants that the training was redundant for them was unanticipated. These participants indicated that through their earlier experience and training they had achieved one or more of the learning objectives of the training. In response to interview questions about whether the training increased their cultural awareness, knowledge, or skill, these respondents replied that they “disagreed.” Within the structure of the Likert scale used to quantify responses, this was the most meaningful way to categorize their responses.

However, these responses may lead to the misperception that the training was ineffective when in fact, it was simply redundant for these participants. To counter this possible misperception. Table 14 includes results from all participants, while Table 15 excludes results from participants who described the training as redundant for them.

Table 14

Interview Results Including All Participants

Unit of analysis	Interview question	Participants	Strongly agree or agree	Strongly disagree or disagree
2. Cultural awareness	1. This training increased my awareness of cultural competence as a factor in the quality of care provided to patients from different cultural backgrounds.	Physicians	3	2
		Nurses	9	1
		Total	12	3
3. Cultural knowledge	2. This training increased my knowledge of how patients' cultural backgrounds may influence their interaction with health care providers.	Physicians	3	2
		Nurses	9	1
		Total	12	3
	3. As a result of this training, I am more likely to seek knowledge about the impact of culture on quality patient care in the future.	Physicians	1	4
		Nurses	6	4
		Total	7	8
4. Cultural skill	4. This training increased my skill in interviewing patients about their perceptions of their health problem and treatment options.	Physicians	3	2
		Nurses	9	1
		Total	12	3

5. As a result of this training, I am more likely to integrate these skills into my practice in the future.		Physicians	2	3
		Nurses	8	2
		Total	10	5
6. My experience in this training will influence how I practice.		Physicians	2	3
		Nurses	8	2
		Total	10	5
5. Quality of care	7. This training will help me improve patient care.	Physicians	3	2
		Nurses	9	1
		Total	12	3

Note. Participants were asked to choose among five possible responses (strongly agree, agree, neither agree nor disagree, disagree, or strongly disagree). No participant responded with “neither agree nor disagree” to any question. Therefore, that response is excluded from this table.

Table 15

Interview Results Excluding Participants for Whom Training was Redundant

Unit of analysis	Interview question	Participants	Strongly agree or agree	Strongly disagree or disagree
2. Cultural awareness	1. This training increased my awareness of cultural competence as a factor in the quality of care provided to patients from different cultural backgrounds.	Physicians	3	1
		Nurses	9	0
		Total	12	1
3. Cultural knowledge	2. This training increased my knowledge of how patients' cultural backgrounds may influence their interaction with health care providers.	Physicians	3	2
		Nurses	9	1
		Total	12	3
	3. As a result of this training, I am more likely to seek knowledge about the impact of culture on quality patient care in the future.	Physicians	1	4
		Nurses	6	4
		Total	7	8
4. Cultural skill	4. This training increased my skill in interviewing patients about their perceptions of their health problem and treatment options.	Physicians	3	2
		Nurses	9	1
		Total	12	3
	5. As a result of this training, I am more likely to integrate these skills into my practice in the future.	Physicians	2	3
		Nurses	8	2
		Total	10	5
6. My experience in this training will influence how I practice.	Physicians	2	3	
	Nurses	8	2	
	Total	10	5	

5. Quality of care	7. This training will help me improve patient care.	Physicians	3	2
		Nurses	9	1
		Total	12	3

Note. Participants were asked to choose among five possible responses (strongly agree, agree, neither agree nor disagree, disagree, or strongly disagree). No participant responded with “neither agree nor disagree” to any question. Therefore, that response is excluded from this table.

CHAPTER V.
RESEARCH SUMMARY AND RECOMMENDATIONS

Summary

While our rapidly diversifying society drives an increasing need for cultural competence, the development of cultural competence is not fully understood. The researcher sought to develop a body of knowledge to guide organizational leaders in the development of future cultural competence training programs. In this study, the researcher focused on the effects of a cultural competence training program on nurses and physicians who participated in the training. This involved creating, testing, and then revising a theory. The data from this study were collected on site at the HealthEast hospital system in St. Paul, Minnesota. The subjects of the study were emergency room physicians and nurses.

The case study started with a literature review and the development of a theory about how individuals develop awareness, knowledge and behaviors regarding cultural competence and the resulting impact on quality of patient care. In efforts to determine whether the theory proposed could be supported or disproved, the researcher interviewed 15 HealthEast employees including physicians and nurses. Participants were assessed before and after training for their awareness and knowledge of cultural issues regarding medical care. The researcher's purpose was to develop a theory about the design of effective cultural competence training and to test that theory in the case of the organization being studied.

One fact that surprised the researcher in this study was the contrast between nurses and physicians conclusions (as related to the researcher in one-on-one interviews) regarding the value of the training. The percentage of nurses who concluded that the training increased their awareness, knowledge, and skill far exceeded the percentage of doctors who drew the same conclusion. What makes this result surprising is the learning, as measured in pre- and post-training tests was comparable for both nurses and physicians. This difference may be explained by the fact that the number of nurses and physicians interviewed for this study was not large enough to reliably represent the broader population for whom pre-training and post-training test scores were summarized. It is also possible that the physician's prior training in cultural competence diminished their valuation of this training experience.

Discussion of Main Findings

The theoretical model developed and tested by the researcher was supported by the case study conducted at HealthEast. The researcher found evidence that the training reviewed in this research enhanced the awareness, knowledge, and skill of both nurses and physicians regarding cultural competence. Further, participants in this training believed that their learning influenced their interaction with patients and improved the quality of care they provided to these patients.

The findings of this study suggest that online cultural competence training can effect participants awareness and knowledge. Feedback from the participants suggests that this online training should be complemented with interactive classroom training in which participants have the opportunity to hear from and ask questions of experts in the

minority populations with which they most frequently interact. As with most adult learning, learners are more likely to be engaged and find value in the training if it is immediately relevant to their daily lives.

It is somewhat surprising that a relatively brief eight hours of online learning would enhance the participants' awareness, knowledge, and skill in the way they report it did. The researcher speculates that two factors may contribute to this finding: First, the relatively efficient use of time in online training versus classroom training. Second, the interview questions were designed to elicit answers of "yes" or "no." As a result, if a participant responded "yes" to the question of whether the training increased their knowledge, their increase in knowledge may have been slight or dramatic. A more detailed standard for qualifying the participants' responses would have provided more insight into the depth of the learning the participants experienced.

The reported increases in participants' awareness, knowledge, and skill reinforce the potential value of online learning tools for training adults in cultural competence. The self-paced and anonymous nature of individual online learning seems particularly well-suited to cross cultural topics that may be sensitive or socially awkward for individuals to discuss in a group setting.

These advantages of online learning tools are countered by their limitations. The essence of cultural competence is the ability to engage with human beings as individuals, respecting and being sensitive to their cultural background but not judging them based on that background. If an individual learner's needs are primarily informational, online learning appears to be an effective tool to meet that need. However, developing cultural competence is not just a matter of expanding the pool of cultural information to which

one has access. Several participants commented that they attributed their cultural competence both to the training they had received and their personal and professional experiences interacting with people from other cultures. According to these participants, dialogue and personal interaction with people from other cultures offers a learning experience that was not duplicated by the online learning tools addressed in this study.

This feedback, coupled with the findings supporting the effectiveness of online learning, suggest that a combination of the two teaching methods may be the most effective in developing cultural competence.

Participants highlighted their belief that developing cultural competence is an ongoing effort. Cultural competence is pursued, not achieved. This insight suggests that the effectiveness of any learning experience, such as the online learning modules addressed in this study, needs to be evaluated and expressed in terms of specific learning objectives. It also suggests that an organization committed to developing cultural competence among their employees should consider an ongoing series of learning opportunities rather than a single learning event. The need for this ongoing approach is reinforced by the recognition that the representation of different cultural and ethnic groups is expanding and ever changing.

Between nurses and physicians who participated in this study, nurses tended to agree more strongly that the training improved their awareness, knowledge, and skill than did physicians. While the limited number of participants does not support statistical generalizations about the broader population, this difference would reflect the perception that nurses are more open to acknowledging areas in which their knowledge and skill are incomplete while physicians are expected to project mastery of these areas.

The findings of this study are consistent with the conclusions of current literature on cultural competence training. The design of the training is consistent with the conceptual framework of the LEARN Model for Cross-Cultural Healthcare, developed by Berlin and Fowkes (1983). The training is focused on developing the participants' competencies in listening to patients, explaining the reasons for requesting personal information from patients, acknowledging the patient's concerns, recommending a course of action and negotiating a plan that takes into consideration the patient's cultural norms.

The results of interviews with participants are consistent with Hicks' (1998) Organizational Cultural Competence Assessment Model. This model asserts that the development of cultural competence is an ongoing process that occurs in four stages: "Unaware, Not Yet Competent", "Aware, Not Yet Competent", "Aware, Competent", and "Intrinsically Aware, Competent." Participants' comments in interviews suggest that the training help them advance through these four stages, particularly from Hicks' stage 1 to stage 2 and for other participants from stage 2 to stage 3.

The development of cultural competence involves both individual learning and organization development. At HealthEast, the site of this study, initiatives in both areas were undertaken to promote cultural competence. The individual learning program was one element in a broader organization development effort focused on raising awareness of the importance of cultural competence, establishing cultural competence as an organizational strength and providing ongoing learning opportunities for employees.

Lack of individual awareness, knowledge, and skill in cultural competence can be significant barriers to health care organizations providing effective care to diverse patient populations, but they are not the only barriers. Organization development opportunities

that include making cultural competence a strategic objective of the organization, providing opportunities for employees to interact with and learn from people from other cultures, and implementing organizational performance metrics to promote cultural competence are all important complements to the development of individual awareness, knowledge, and skill.

Implications for Practice

Further research replicating these findings needs to be completed before the findings can be generalized. However, this research suggests that health care organizations serving ethnically and culturally diverse communities can improve the quality of care provided to diverse communities by developing the cultural competence of their nurses and physicians.

Using the training studied in this research as a model, the planning of cultural competence training programs may include a range of learning objectives, from awareness to advanced competency. The choice among these objectives can be supported by a pre-training assessment of individual cultural competence.

Beyond raising the awareness of cultural differences, the training examined in this research did not focus on motivating the participants to continue to develop their knowledge or skill in cultural competence beyond the training. The participants' learning and their description of the subsequent changes in their behavior suggests that they were motivated to learn and to apply this learning in their work. Such motivation may not be present in all learners. The researcher concludes that motivating learners may need to be addressed in developing cultural competence training for a broader population.

The case study structure may have aided in the transfer of the knowledge and skill developed from the participants' training to their practice in that the case studies presented in the training were designed to mirror conversations regarding diagnosis and treatment in which physicians and nurses engage with their patients in their daily work. If this is true, customizing cultural competence training to include examples of modeled behavior and opportunities to practice this behavior may enhance the translation of newly learned skills into practice.

Feedback from the participants indicated they found value in case studies within the training that related directly to the ethnic and cultural communities with whom they interact most frequently in their work. By contrast, they described finding little value in case studies within the training that focused on ethnic and cultural groups with whom they seldom interact in their work. This suggests that relevance of cultural competence training is an important factor in the design of effective learning.

Other research supports the idea that tailoring training and other interventions for specific subgroups can maximize the impact of cultural diversity training. As Anderson, Scrimshaw, Fullilove, Fielding, and Normand reported (2003), “‘one size fits all’ is contradictory to the very notion of cultural diversity” (p. 75).

Suggestions for Future Research

Basic questions remain about the potential of the training reviewed here to improve satisfaction with care, reduce ethnic differentials in utilization and treatment, and improve health care. The researcher noted an absence of studies in which interventions to improve cultural competence are compared with other care alternatives.

Evaluation studies that assess not only change in knowledge and attitudes but also use of services, receipt of treatments, and changes in health outcomes would be valuable. Much remains to be learned about the effectiveness of and potential barriers to the type of intervention reviewed here.

The differences noted between nurses' and physicians' self-reported learning need to be explored. If these differences are supported by further research, the suitability of the training for nurses and physicians should be explored. A lack of candor in responding to face-to-face interview questions might be countered by providing participants with the opportunity to provide anonymous feedback.

There is a clear need for common criteria for effective cultural competence training. These criteria should address standards for cultural knowledge, generally applicable skills, and role-specific skills for professionals (for example, health care providers, attorneys, and teachers) serving minority populations. These criteria would contribute to more effective training and provide a common basis for future research.

The recommendations for future research are suggested by questions that arose for the researcher in the course of conducting this study:

1. Does cultural competence training of healthcare providers have a lasting effect or should it be repeated periodically?
2. How does the effectiveness of online training compare with the effectiveness of face-to-face training in developing cultural competence?
3. What role should communities play in collaborating with area healthcare organizations to communicate the needs of ethnically diverse populations?

4. At what levels (e.g., management, provider, staff) in a healthcare organization does investment in cultural competencies create the greatest improvement in health or other outcomes?
5. Which cultural competencies within a healthcare system increase patient satisfaction and improve health outcomes?
6. Can the skills development described by participants in this study be confirmed and does the application of these skills improve health outcomes?
7. Would the findings of this study be supported by research focusing on a larger population of nurses and physicians?
8. Are the findings of this study unique to the geographic locale and ethnic profile of the study participants?

Conclusion

In conclusion, the results of this study indicate that there were several positive outcomes attained by participants in HealthEast's cultural competence training program. The researcher believes this study will contribute to the body of research about cultural competence training. While little or no research has been conducted to measure the impact of cultural competence training on the quality of health care, this study provides evidence that physicians and nurses who received the training believed that improved quality of care can result from a training program that develops the participants' awareness and knowledge of cultural differences and links this awareness and knowledge to developing communication skills and applying these skills in interactions with patients.

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APPENDICES

Appendix A

Participant Consent Form

Evaluating the Results of HealthEast's Cultural Competence Training Program

You are invited to participate in a research study. My name is Tom Hoverman. I am a doctoral candidate in Organization Development at the University of St. Thomas in Minneapolis, Minnesota. I am conducting research for my dissertation in the area of cultural competence and ask for your assistance with this study. I have received permission from HealthEast to conduct my study at your worksite.

BACKGROUND INFORMATION

I am studying the results of a cultural competence training program that is intended to significantly elevate the participants' cultural competence. Your input and participation in my study will help me better understand the value of your participation in HealthEast's cultural competence training program, as well as what aspects of the training proved to be most valuable.

This study is separate, but in tandem with the HealthEast cultural competence initiative.

PROCEDURES

If you agree to be in this study, I will briefly interview you, asking 10 questions. Our interview would occur during your working hours and would be conducted in a private setting. **No information will be shared with HealthEast or with your manager** The total amount of time required is approximately one hour, and would occur during your normal work hours in a private setting.

BENEFITS

Benefits for volunteers are:

- Volunteers would have the opportunity to reinforce the development of their own cultural competence by reflecting on their learning experience.
- Volunteers would receive a summary of the researcher's findings.

CONFIDENTIALITY

The records of this study will be kept strictly confidential. No comment that you make will be personally attributable to you, unless you give specific permission. No one at HealthEast will have access to your comments, to raw data, or to personally identifiable information from the data collected. In any article or report I publish, I will not include information that will make it possible to identify you in any way. Research records will be kept in a locked file, and I am the only person who will have access to the records. Your name will not be kept with the notes from the interview. Results from assessments will be shared privately with the individual only.

CONTACT

If you have any questions about the study, do not hesitate to contact me by phone, mail, or email. If you have any questions about your rights as a participant in this study, or if you feel that during the course of this project you have not been treated according to the descriptions in this letter, you may contact the University of St. Thomas Institutional Review Board at 651-962-5341, or by mail at IRB, Mail #5037, 2115 Summit Avenue, St. Paul, MN 55105-1096.

Thank you for your help with this project.

Tom Hoverman, M.B.A.
915 Hawthorne Avenue East
St. Paul, MN 55106
Office: 612.270.3816
Email: Thomas@hoverman.com

Your signature below indicates you understand what is required of you in this study, and that your participation in this study is entirely voluntary. You may terminate your participation in this study at any time without penalty. Should you decide to withdraw, data collected about you will not be used. Your decision whether or not to participate will not affect your current or future relations with the HealthEast or the University of St. Thomas.

Printed Name of the Participant:

Signed Name of the Participant:

Appendix B

Semi-Structured Interview Questions

Background Questions

1. When did you go through the e-learning?
2. How long have you been at HealthEast?
3. Have you had previous cultural competence training of any kind?

Follow-up: If yes, when? Where? What was it like?

4. What cultural groups are represented about the patients you have treated?

Main Questions

For questions 1-7 below, participants were asked to quantify their response using the following scale:

- 5 = Strongly Agree
- 4 = Agree
- 3 = Neither Agree nor Disagree
- 2 = Disagree
- 1 = Strongly Disagree

1. This training increased my awareness of cultural competence as a factor in the quality of care provided to patients from different cultural backgrounds.

Follow-up: In what way?

2. This training increased my knowledge of how patients' cultural backgrounds may influence their interaction with health care providers.

Follow-up: In what way?

3. As a result of this training, I am more likely to seek knowledge about the impact of culture on quality patient care in the future.

Follow-up: Why?

4. This training increased my skill in interviewing patients about their perceptions of their health problem and treatment options.

Follow-up: In what way?

5. As a result of this training, I am more likely to integrate these skills into my practice in the future.

Follow-up: Why?

6. My experience in this training will influence how I practice.

Follow-up: If yes, in what way? If not, why not?

7. This training will help me improve patient care.

Follow-up: If yes, in what way?

Follow-up Questions

8. Based on my experience, I would recommend offering the e-learning training more broadly to HealthEast providers and nursing staff.

Follow-up: If yes, why? If no, why not?

9. Based on your experience in this training, do you have any suggestions for the design of future cultural competence training programs?

10. Do you have any other comments about your experience in this training?

Appendix C

Pre/Post Test Questions

1. All of the following are components of health literacy except the patient's ability to:
 - A. Understand medical terms about symptoms and illness
 - B. Follow directions for diagnostic procedures and therapies
 - C. Read prescription bottles
 - D. Ask pertinent questions in the clinical encounter

2. Research has shown that low health literacy leads to:
 - A. More frequent medical visits
 - B. Higher rates of hospitalization
 - C. Lower patient satisfaction
 - D. Lower utilization of psychiatric care

3. A major nationwide survey of more than 2,000 patients (published in JAMA in 1998) found that ____% had used some complementary or alternative therapy over the past year:
 - A. 24 percent
 - B. 33 percent
 - C. 42 percent
 - D. 55 percent

4. This same survey found that of those who had used complementary and alternative therapy ____% voluntarily disclosed this information to their health care provider.
 - A. 25 percent
 - B. 38 percent
 - C. 50 percent
 - D. 62 percent

5. All the following statements are true about Hispanics' use of complementary and alternative therapies when compared to whites except:
 - A. They tend to use them as a cheaper way of getting care
 - B. Cultural beliefs are more likely to influence use
 - C. Use is more commonly related to religion
 - D. They are less likely to tell their health care provider
 - E. Lower levels of literacy contribute to use

6. "Ramadan" is an example of a tradition/custom that could dramatically affect the care of patients with:
 - A. Diabetes
 - B. Hypertension
 - C. Hypothyroidism
 - D. Coronary artery disease
 - E. None of the above

7. Studies in the field of ethnopharmacology have found that:
 - A. Hispanic diabetics tend to have a better response to sulfonylureas than whites.
 - B. Native Americans tend to have a less optimal response to some selective serotonin reuptake inhibitors (SSRIs) for depression compared to whites
 - C. African-Americans tend to have a less optimal response to angiotensin converting enzyme (ACE) inhibitors for blood pressure control compared to whites
 - D. None of the above

8. The racial/ethnic group with the highest percentage of individuals who have no health insurance is:
 - A. African-Americans
 - B. Native-Americans
 - C. Southeast Asians
 - D. Hispanic-Latinos

9. What is an "explanatory" model?
 - A. A method physicians can use to explain a diagnostic or therapeutic procedure
 - B. A technique for educating a patient about a disease process
 - C. A patient's conceptualization of their illness
 - D. A patient's interpretation of physician recommendations
 - E. None of the above

10. Research among various minority groups has shown a common belief that cancer is:
 - A. Transmitted from person to person
 - B. Always fatal
 - C. Not detectable by screening
 - D. Caused by injections

11. Research has shown that African-Americans:
- A. Have higher rates of atypical symptoms of myocardial ischemia.
 - B. Present sooner to the emergency room after symptoms of myocardial for chest pain than others.
 - C. Have longer stays in the emergency room when they present with chest pain compared to others.
 - D. Have higher pain scores than others for ischemic chest pain.
12. In a major study of over 10,000 patients with cardiovascular disease, what fraction of African-American patients who were eligible for reperfusion therapy did not receive it?
- A. Nearly 1/5
 - B. Nearly 1/4
 - C. Nearly 1/3
 - D. Nearly 1/2
13. Stereotypes:
- A. Are activated most during conditions of stress, multi-tasking, and time constraints
 - B. Are most likely centered on characteristics such as socioeconomic status and educational background
 - C. Occur as an abnormal cognitive process of categorization
 - D. None of the above
14. The Institute of Medicine Report "Unequal Treatment" found that minorities were less likely to receive appropriate diagnostic tests and treatments than whites due to their:
- A. Lower socioeconomic status
 - B. Higher rates of uninsurance
 - C. Patient preference
 - D. None of the above
15. Based on a large survey, of the following group, in rank order, who is most concerned about being treated unfairly in the health care system in the future:
- A. (1) Hispanics, (2) African-Americans, (3) Asian-Americans
 - B. (1) Asian-Americans, (2) African-Americans, (3) Hispanics
 - C. (1) African-Americans, (2) Hispanics, (3) Asian-Americans
 - D. (1) African-Americans, (2) Asian-Americans, (3) Hispanics
 - E. (1) Hispanics, (2) Asian-Americans, (3) African-Americans

16. The "Tuskegee Effect" is:
- A. Post-traumatic sociocultural stress seen in a group of African Americans studied in Tuskegee, Alabama.
 - B. The effect of increased percentages of African-Americans causing an epidemiologic shift in the prevalence of cerebrovascular disease within the "Southern Stroke Belt."
 - C. One of the key issues seen as a root cause for African-American's mistrust of the health care system
 - D. A factor in the higher prevalence of syphilis among African-Americans in the South.
17. For patients with the following communication style it is especially important that the health care provider double-check the patient's understanding:
- A. Confrontational
 - B. Deferent
 - C. Stoic
 - D. Expressive
18. Research has shown which of the following to be true regarding the care of patients with limited-English proficiency:
- A. They are more likely to follow written versus oral directions
 - B. They are less likely to have experienced problems with their care
 - C. They are more likely to return to the ER after discharge if they had a problem
 - D. They are less likely to use a trained interpreter than a family member as interpreter
 - E. All of the above
19. Of the following, the preferred situation for interpretation is:
- A. A professional interpreter of a different cultural background than the patient.
 - B. A member of the ancillary staff who is fluent in the patient's language.
 - C. A member of the patient's family who can also provide some insight into the patient's illness.
 - D. Another patient of the same cultural background as the patient being interviewed.
20. In cross-cultural interactions, withholding a terminal diagnosis from a patient:
- A. Should only be done if the patient agrees.
 - B. Is not ethically appropriate.
 - C. Is appropriate when it is the family's wishes.
 - D. Is appropriate only if the family agrees to tell the patient themselves.