Improving Cultural Competency among Healthcare Providers Working with Refugee Patients

Tena Chau

Follow this and additional works at: https://scholarworks.umass.edu/nursing_dnp_capstone

Part of the Family Practice Nursing Commons


This Open Access is brought to you for free and open access by the College of Nursing at ScholarWorks@UMass Amherst. It has been accepted for inclusion in Doctor of Nursing Practice (DNP) Projects by an authorized administrator of ScholarWorks@UMass Amherst. For more information, please contact scholarworks@library.umass.edu.
Improving Cultural Competency among Healthcare Providers Working with Refugee Patients

Tena P. Chau

University of Massachusetts, Amherst

College of Nursing

Chair: Kalpana Poudel-Tandukar PhD, MPH, MPHC, CGM
Mentor: Raeann LeBlanc PhD, DNP, AGPCNP-BC, CHPN
Date of Submission: April 30th, 2020
## Table of Contents

Abstract .......................................................................................................................4

Introduction ..................................................................................................................5

  Background ..............................................................................................................5

  Problem Statement .................................................................................................7

  Organizational “Gap” Analysis of Project Site .........................................................7

Review of the Literature .............................................................................................8

  Analyzing Baseline Cultural Competency ...............................................................9

  Educational Intervention .........................................................................................9

  Dissemination of Cultural Competency .................................................................10

  Need for Cultural Competency Education ............................................................11

  Evidence Based Practice: Verification of Chosen Option ......................................11

Theoretical Framework/Evidence Based Practice Model ........................................12

Goals & Objectives .....................................................................................................13

Methods .....................................................................................................................14

  Project Site and Population ....................................................................................14

  Project Design .......................................................................................................15

  Data Collection .....................................................................................................17

  Data Analysis .......................................................................................................18

  Ethical Considerations/Protection of Human Subjects .........................................19

Results .......................................................................................................................19

  Demographic Characteristics ..............................................................................19

  Cultural Competence ............................................................................................20

  Cultural Awareness ...............................................................................................23
Abstract

**Background:** Increased diversity of the United States population has resulted in the presence of greater disparities in healthcare. One way to address factors contributing to health disparities has been to increase cultural competency in healthcare. Evidence from a review of the literature supports the idea that understanding aspects of cultural competency that are lacking among specific healthcare organizations are helpful to develop programs to address the areas of need.

**Purpose:** The purpose was to complete a quality improvement project to evaluate if an educational intervention based on a specific model would lead to increased level of cultural competence among healthcare providers. **Methods:** The Campinha-Bacote Model was used as the basis of the educational program. An electronic format of The Inventory for Assessing the Process of Cultural Competence among Healthcare Providers – Revised was used as the pre-and-post-test to evaluate the efficacy of the educational intervention. **Implementation Plan/Procedure:** For this project, cultural competency baseline levels of providers consisting of doctors, nurse practitioners, and therapists (N = 6), working with refugee patients were assessed, followed by an educational intervention via PowerPoint. A post-test and evaluation survey was administered after the intervention. **Results:** Statistically significant increases were noted in mean cultural competency scores (11.83 points). Increases were noted in the measured constructs of cultural awareness (3.00 points), knowledge (3.84 points), and skill (3.34 points).

**Implications/Conclusion:** Ongoing educational intervention may lead to increased levels of cultural competency for healthcare providers. Further practice improvement projects should be completed to evaluate the effect of increased cultural competency on patient outcomes.

**Keywords:** cultural competency, health care, Campinha-Bacote model of cultural competence, cultural competency in nursing, refugee cultural competency
Improving Cultural Competency among Healthcare Providers Working with Refugee Patients

Introduction

Since the 1970s, the United States has continued to grow more racially, ethnically, and culturally diverse (McElfish et al., 2017). It is expected that by the year 2050 there will be no one racial or ethnic group representing more than 50% of the United States population (Betancourt, Green, & Carrillo, 2018; McElfish et al., 2017). Refugees in particular face language, cultural, and socioeconomic barriers and often arrive with chronic conditions such as post-traumatic stress disorder, depression, anxiety, hypertension, and diabetes (Prescott, Dascanio, Klosko, & Shogan, 2017). As communities continue to become more racially and ethnically diverse, there have also been greater disparities in healthcare (Betancourt, Green, & Carrillo, 2018; McElfish et al., 2017). Some of the many factors that contribute to racial disparities in health care include language and literacy issues, decreased access to healthcare services, clinician biases, and lack of culturally competent care (Betancourt et al., 2018). One way to address factors contributing to health disparities has been to increase cultural competency among healthcare providers in order to prepare them to provide the best care for the changing patient population (Bauer & Bai, 2015).

Background

One in six Massachusetts residents is foreign born, according to the Massachusetts Board of Health (MABH) (2009). A refugee is a person who “owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership in a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country” (Kosoko-Lasaki, Cook, &

The level of education, health literacy, cultural beliefs, knowledge, attitudes, and behaviors vary widely among different refugee groups (Thiel de Bocanegra et al., 2018). Refugee populations in particular have unique health care needs as a result of the circumstances from which they are coming from and their journeys to the United States (MABH, 2009). Often times, health care systems and services are interrupted in areas where refugees are coming from, resulting in a lack of disease control, diagnosis, and treatment (MABH, 2009). In addition to this, the way the healthcare system in the United States is organized, accessed, and financed may be very different from systems from which refugee patients are arriving, leading to difficulties in utilization of healthcare services (MABH, 2009). Some factors that affect this include language accessibility, health beliefs, perceived appropriateness of care, and location and cultural competency of providers (MABH, 2009).

The Office of Minority Health defines cultural and linguistic competence as “a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations” (Bauer & Bai, 2015, p. 706). Cultural sensitivity has been defined as being tuned into the fact that people have different beliefs, values, and behaviors (Sekerci & Bicer, 2019). This project assesses cultural competence because in addition to being aware of cultural differences and similarities, cultural competence involves taking additional steps to enhance the skills, encounters, and the desire to further improve culturally driven patient interactions. Cultural competence goes beyond the level of an individual provider, in that all levels of a healthcare system must put into place means to allow culture to be involved in the care that is provided. Many healthcare facilities do not have the
resources to provide culturally competent care to these patients, such as access to translated materials or certified interpreters (Prescott et al., 2017). In order to eliminate health disparities it is important to not only identify the barriers stopping the patient from successfully navigating the healthcare system but also identify the varying health needs of these patient populations (Dave, 2018; Kosoko-Lasaki et al., 2009; Thiel de Bocanegra et al., 2018). Healthcare providers have a responsibility to provide holistic, culturally competent, and appropriate medical care to all patients (Dave, 2018).

**Problem Statement**

Lack of cultural competency among healthcare providers in the primary care setting serving refugee patient populations is indicated by the presence of health disparities which lead to poorer patient outcomes and lower satisfaction of care and results from the presence of clinician bias and a lack of culturally competent education, training, and services including interpreter services and racially and linguistically concordant clinicians and staff. The quality improvement project was to use the Campinha-Bacote Model “The Process of Cultural Competence in the Delivery of Healthcare Services” to create an educational program for healthcare providers to complete regarding providing culturally competent healthcare for the refugee patient population. Baseline cultural competency levels were assessed before the intervention and a post-test was used to assess if the educational intervention created any change from the baseline levels.

**Organizational “Gap” Analysis of Project Site**

Non-minorities have been found to receive higher quality healthcare compared to racial and ethnic minorities throughout the United States (Abrishami, 2018). These health disparities are often a result of the behaviors of healthcare providers including the lack of familiarity with
and discrimination toward people from different backgrounds (Abrishami, 2018). Many immigrant and refugee patients have limited access to healthcare services (Turcotte, Chaves, Ross, & Adejumo, 2016). Reasons for this include lack of health insurance and not having an understanding of insurance coverage and the healthcare system (Turcotte et al., 2016). Immigrants, non-English speakers, and refugees all face language and cultural barriers along with a lack of cultural competency among healthcare providers (Turcotte et al., 2016). In Lowell, MA about half of the population is made up of people who identify as black, Hispanic, and Asian, and also make up about 50% of the people without health insurance (TownCharts, 2018).

**Review of Literature**

Using the UMass Amherst Library website database, the keywords “cultural competency” and “health care” were searched. This provided 9787 results. Inclusion criteria were then specified to include only those articles that were scholarly peer reviewed, published after 2013, from an academic journal, and in English. Also included were articles from the database Medline. Exclusion criteria included any articles that were not from research in the United States; articles not in English; and any articles published before 2013. This resulted in 361 articles. Then a search with the keywords “cultural competency” “health care” and “Campinha-Bacote model of cultural competence” was completed. The same inclusion and exclusion criteria were used which then resulted in three results. Another search with the keywords “refugee cultural competency” was completed which yielded 285 articles. Similar inclusion and exclusion criteria were used, except to include research completed outside of the United States, which yielded 135 articles. Articles on the CINAHL database were also searched. Inclusion criteria included academia journals, articles in English, articles published after 2008, and studies from the United States. Exclusion criteria included articles published in other
languages, articles published before 2008, and articles that included studies that were completed in different countries. The key words used were “Cultural competence in nursing” “Cultural competence AND Campinha-Bacote”, “nursing AND Campinha-Bacote” and “nursing AND cultural competency”. Final articles that were included were all rated as level IB or IIB, class B (Newhouse, Dearholt, Poe, Pugh, & White, 2005).

**Analyzing Baseline Cultural Competency**

Improving cultural competency first begins with assessing the baseline level of cultural competency, which is the first step in this proposed project. Having an understanding of which aspects of cultural competency are lacking among specific healthcare organizations and assessing what level of cultural competency providers are at, can help in developing programs to improve the areas of need (Lampley, Little, Beck-Little, & Xu, 2008; Marzilli, 2016). Using the Nurses’ Cultural Competence Scale and applying results to Purnell Model of Cultural Competence, Marzilli (2016) analyzed the level of cultural competence among nursing faculty members. Convergent parallel mixed-methods design was used in this study (Marzilli, 2016). Lampley et al. (2008) asked nurses to complete self-report surveys to assess their sense of cultural competence. Quantitative surveys and qualitative interviews were used in addition to other instruments to gather data regarding cultural competency (Lampley et al., 2008; Marzilli, 2016). While the mixed-method design and quantitative & qualitative design data support each other, a weakness is that most data is from self-reporting and interviews (Lampley et al., 2008; Marzilli, 2016). These studies were graded as Level IIB, Class B due to the quasi-experimental study design and good quality evidence.

**Educational Intervention**
Once the needs are assessed, an intervention such as a cultural competence course or immersion/training program may be used with the goal being to increase levels of cultural competency (Bauer & Bai, 2015; Brommelsiek, Peterson, & Amelung, 2018; McElfish et al., 2017). The Campinha-Bacote Model is a useful framework for studying cultural competency (Bauer & Bai, 2015; Lampley et al., 2008). Campinha-Bacote breaks down five constructs of cultural competency which are cultural awareness, cultural knowledge, cultural skill, cultural encounter, and cultural desire (Bauer & Bai, 2015; Lampley et al., 2008). Using these constructs, students completed learning modules consisting of readings, videos, interviews, presentations, and individual field trips (Bauer & Bai, 2015). Results were analyzed with ANOVA (Bauer & Bai, 2015). McElfish et al. (2017) used a similar training module approach, but training was provided to healthcare professionals rather than students. Mixed-methods evaluation based on the Kirkpatrick model of training evaluation and quantitative and qualitative data evaluation data was also collected (McElfish et al., 2017). In the study by Brommelsiek, Peterson, & Amelung (2018), graduate students participated in an immersion training program to better understand culture’s influence on patients. Pre- and post-tests were administered to assess changes in knowledge after the learning activities (Bauer & Bai, 2015; Brommelsiek, Peterson, & Amelung, 2018; McElfish et al., 2017). Again, the mixed-methods design was a strength for their research (McElfish et al., 2017). Limitations include a small sample size, long-term improvements in patient care is unknown, and there were low evaluation response rates (Bauer & Bai, 2015; Brommelsiek, Peterson, & Amelung, 2018; McElfish et al., 2017). These studies were graded as Level IIB, Class B due to the quasi-experimental study design and good quality evidence.

**Dissemination of Cultural Competency**
Successful implementation of cultural competency requires participation that goes beyond the level of individual healthcare providers (Weech-Maldonado et al., 2016). Organizational commitment is necessary to ensure that people, policies, and practices coincide to achieve this common goal (Weech-Maldonado et al., 2016). Interventions were implemented for infrastructure development, coaching and action plan training, and individual level action plans (Weech-Maldonado et al., 2016). Similar to previously mentioned studies, pre- and post-tests were completed (Weech-Maldonado et al., 2016). This study took place over two years during which time there was staff turnover as well as low response rates, which may have affected results (Weech-Maldonado et al., 2016). This study was graded as Level IB, Class B due to the randomized study design and good quality evidence.

The Need for Cultural Competency Education

With increasing patient diversity, there are differing cultures, values, and beliefs when it comes to healthcare. It is important for healthcare providers to learn about what the cultural needs are of the patient population and have access to education to address these needs (Bauer & Bai, 2015; Brommelsiek, Peterson, & Amelung, 2018; Lampley et al., 2008; Marzilli, 2016; McElfish et al., 2017). Truly effective cultural competence means having involvement at all levels of hospital infrastructure, to ensure that people, policies, and programs are in place to provide effective care to all patients (Weech-Maldonado et al., 2016). Using a framework such as the Campinha-Bacote model to assess the needs and create an education program will help to increase cultural competency among healthcare providers.

Evidence Based Practice: Verification of Chosen Option
For this project, the Campinha-Bacote Model of Cultural Competence in Healthcare Delivery (See Appendix A) is the framework and basis for the educational intervention and the pre- and post-test assessment tool, which was completed by healthcare providers.

**Theoretical Framework**

The Campinha-Bacote Model of Cultural Competence in Healthcare Delivery views cultural competence as a process in order to achieve results (Albougami, Pounds, & Alotaibi, 2016). This model defines cultural competence as “the process in which the healthcare professional continually strives to achieve the ability and availability to effectively work within the cultural context of a family” (Campinha-Bacote, 2015, para. 1). This process is achieved by developing the ability to deliver efficient and high-quality care, which incorporates five different constructs (Albougami et al., 2016; Campinha-Bacote, 2015).

The first construct is cultural awareness which is the process in which healthcare providers recognize their own cultural backgrounds, biases they may have towards other cultures, and becoming aware of the existing racism and biases that currently exist in healthcare (Albougami et al., 2016; Campinha-Bacote, 2015). The second construct is cultural knowledge, which is the process that a healthcare provider takes to acquire education about different cultural groups in relation to health-related beliefs, practices, and values as well as disease incidence and prevention (Albougami et al., 2016; Campinha-Bacote, 2015). The third construct is cultural skill which is the ability to obtain the necessary data from patients with the use of a cultural assessment and culturally-based physical assessment (Albougami et al., 2016; Campinha-Bacote, 2015). Cultural encounters is the fourth construct and is the process of engaging in direct interactions between healthcare provider and patients from culturally diverse backgrounds in order to change existing beliefs and prevent stereotyping (Albougami et al., 2016; Campinha-
Bacote, 2015). The final and fifth construct is cultural desire (Albougami et al., 2016; Campinha-Bacote, 2015). Cultural desire is the healthcare providers’ motivation and willingness to become educated, skilled, competent, and aware of culture as well as wanting to seek out cultural encounters (Albougami et al., 2016; Campinha-Bacote, 2015).

Several transcultural nursing models were compared using the criteria of comprehensiveness, logical congruence, conceptual criteria, level of abstraction, clinical utility, and perspective (Albougami et al., 2016). Campinha-Bacote’s model was the only one found to meet all six criteria (Albougami et al., 2016). This framework has often been used in nursing literature and has been found to be suitable to incorporate cultural competence into practice (Albougami et al., 2016).

**Goals, Objectives, and Expected Outcomes**

The goals of this project were to 1) conduct a quality improvement project related to cultural competency and refugee patient populations, 2) create a presentation for staff at the community health center, 3) in order to have more than half of the providers in this department complete the education, at least six providers will participate in the project 4) assess the cultural competency baseline levels of providers of this community health center, 5) increase the number of community health center healthcare providers who complete cultural competency training while working with refugee populations, 6) have providers acknowledge that culture affects patient health beliefs, medical practices, attitude toward healthcare, and establishment of trust, 7) educate community health center providers on the existence of health disparities among refugee patient populations, and 8) assess through post intervention survey results, an increase in the provider’s level of comfort in providing cultural competent care to refugee patients.

Expected outcomes included:
A) 90% of the participating staff working with the refugee population will complete the intervention and assessment within the project timeline.

B) 85% of participating providers will report an increase in their level of cultural competence following the intervention.

C) 80% of participating providers at the community health center will report that the intervention contributed positively to their ongoing process of improving cultural competency.

D) Survey results will indicate at least 90% of participating providers will indicate a desire to continue expanding their cultural worldview and encounters with those from different cultures.

Methods

This quality improvement project incorporated a review and presentation of current literature and an educational intervention via an in-person PowerPoint presentation (see Appendix B) provided for healthcare providers at an urban community health center. A quantitative pre- and post-test design was used to obtain data for this project. The pre- and post-test data was gathered with the Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals- Revised (IAPCC-R) (see Appendix E). This self-assessment tool was created by Dr. Campinha-Bacote to measure the level of cultural competence among healthcare providers. Qualitative methods were used to obtain feedback from healthcare providers regarding the effectiveness of the educational intervention. Permission was obtained from Dr. Campinha-Bacote to use the model (See Appendix D) and to use the IAPCC-R for the project’s pre-and post-tests.

Project Site and Population

This project took place at an urban federally qualified health center in Lowell, Massachusetts. The health center’s providers include physicians, nurse practitioners, physician
assistants, and certified nurse midwives. Both primary care and behavioral health services are offered. Services provided at the health center are based on a family medicine model and include chronic disease management, nutrition counseling, mental health services, traditional healing advice, acupuncture, massage therapy, social services, meditation, health education, and referrals. Additional services include addiction treatment, HIV services, dental care, eye care, and family planning.

The health center is located the fourth largest city in Massachusetts. Twenty two percent of the population of Lowell lives in poverty and 26.7% of the population is foreign born, including refugees (U.S. Census Bureau, 2018). Participants for this project included primary care and behavioral health providers who work specifically with the refugee population in order to measure cultural competency among those interacting regularly with these patients.

**Project Design**

The first step of this project was to assess the providers’ baseline level of cultural competency in regards to the five constructs of the Campinha-Bacote model and refugee patient populations with the use of the pre-test. Using the Campinha-Bacote model (Campinha-Bacote, 2015) as a framework, a review of the literature, and current data and statistics regarding the importance of cultural competency among refugee patient populations, an educational PowerPoint presentation was created and administered to the participating healthcare providers. After reviewing the educational presentation, the post-test was administered to assess if the intervention helped to increase the healthcare providers’ level of cultural competency. Finally, a post-education survey was also administered to the providers to gather descriptive data about their thoughts on the educational intervention (See Appendix F). Along with the PowerPoint presentation, providers were given a list of supplemental information and resources regarding
cultural competency. This project was done to determine if educational interventions based on Campinha-Bacote’s model could help increase the level of cultural competency among healthcare providers serving culturally diverse patient populations.

Providers were recruited to participate in the project through email and in-person notification regarding the presentation. After signing up for one of the two days when the presentation was to be provided, providers were emailed a link to complete the pre-test IAPCC-R online via a secure online survey format in order to measure their baseline level of cultural competence. They were also instructed to use an anonymous identifier that would be the same for the pre-and post-tests. Providers were given up to one week to complete the online pre-test prior to participating in the educational intervention. On the days of the presentations, lunch was brought for the participants and the PowerPoint was presented during the providers’ hour long lunch break. After the presentation, the link to the post-test was emailed to the providers. The post-test contained the same questions as the pre-test in order to evaluate if there had been a change in the providers’ level of cultural competence. Immediately after the presentation, all the participants were asked to anonymously complete a paper format survey with three multiple choice questions and two short answer questions to see how effective they felt the training program was and to measure its relevance to their daily interactions with the refugee population.

Two sessions were offered to the providers in order to maximize the amount of participants, since not every provider worked every day. Each session was one hour long and took place during providers’ lunch break hour. The education was provided via PowerPoint presentation, along with a list of supplemental information and resources to complement the education. The PowerPoint, titled “The Journey to Cultural Competency”, (Chau, 2019) started off with information about the changing demographics and statistics about the refugee population
in the United States. Additional information was provided about the health disparities and barriers refugee patient populations face. An overview about Dr. Josepha Campinha-Bacote’s theoretical model was provided. Then each construct was explored in more detail throughout the remainder of the presentation. Participants were shown links to additional websites that they could access to further explore the various components of cultural competence. In addition to this, the PowerPoint presentation consisted of an activity to examine providers’ implicit biases; charts and diagrams outlining various cultural health beliefs; pictures to show differences in cultural physical assessments; and a video case study highlighting barriers and challenges refugee patients face when trying to navigate the American healthcare system.

**Data Collection**

Both quantitative and qualitative methods were used to collect data. Quantitative data was collected with the use of the IAPCC-R. The IAPCC-R is a self-assessment tool created by Campinha-Bacote, which is designed to measure the level of cultural competence among healthcare professionals (Campinha-Bacote, 2015). The IAPCC-R has been used broadly within the United States and has been tested for reliability and validity for health care professionals. Reliability studies have established an average reliability coefficient Cronbach alpha of .81 (Campinha-Bacote, 2015). For this project, permission was obtained to use an electronic format for the IAPCC-R. The IAPCC-R contains 25 items measuring the five constructs of the Campinha-Bacote model and uses a 4-point likert scale to measure the responses in each category (Campinha-Bacote, 2015). The categories reflected by each response include strongly agree, agree, disagree, strongly disagree; very aware, aware, somewhat aware, not aware; very knowledgeable, knowledgeable, somewhat knowledgeable, not knowledgeable; very comfortable, comfortable, somewhat comfortable, not comfortable; and very involved, involved,
somewhat involved, and not involved (Campinha-Bacote, 2015). Each construct is addressed through five of the 25 questions (Campinha-Bacote, 2015). The tool takes approximately 10-15 minutes to complete and the scores may range from 25-100 indicating whether the healthcare provider is at a level of culturally proficient (91-100), culturally competent (75-90), culturally aware (51-74), or culturally incompetent (25-50) (Campinha-Bacote, 2015).

Qualitative data was collected from a 5-item paper survey with 3 questions reflecting a response of yes, no, or somewhat, and 2 open response questions. The survey evaluated participants’ level of cultural competence prior to the project, assessed the benefits of the presentation, and allowed participants to provide feedback on future recommendations.

Data Analysis

Prior to completing the educational intervention, participants completed the pre-test IAPCC-R. Immediately after the intervention, participants were asked to complete the evaluation survey in person. Then participants were asked to complete the online post-test within one week of completing the education. Both the pre-and post-test IAPCC-R was done anonymously. Each participant created an anonymous identifier which was used for the pre-and post-tests so that the scores could be compared.

The IAPCC-R Scoring Key was used to score each item of the test to come up with a total score (Campinha-Bacote, 2015). Each item is assigned a different point value, based on the scoring key, ranging from 1-4 points (Campinha-Bacote, 2015). Individual scores for overall cultural competency were calculated with each participant’s pre-and post-tests as well as mean cultural competency pre-and post-test scores. Mean scores for each construct were compared from the pre-and post-test scores. Paired sample t-tests were measured and analyzed through SPSS.
Descriptive statistics were used to present the data from the evaluation surveys. Percentages were calculated for each of the 3 multiple choice response questions and then common responses were identified for the two open response questions.

**Ethical Considerations/Protection of Human Subjects**

The University of Massachusetts, Amherst (UMass) Internal Review Board (IRB) approval was obtained prior to initiating the DNP Project (See Appendix G). This project consisted of an educational training program that was provided to healthcare providers. No patient information was collected during this project. All of the information gathered in this project was data from the participants’ evaluations and all participant information remained anonymous. The DNP student and others conducting this project followed the *Standards of Care* for practice in the community health center setting. There was no risk to any of the participants in this project. Part of the education given to the providers, though, included ethical considerations when caring for refugee patients, including accountability; moral responsibilities to provide health care regardless of patient legal status; professional responsibilities and views toward society, rights, and judiciary systems (Asgary & Smith, 2013).

**Results**

**Demographic Characteristics**

The department where the project took place has a focus on serving immigrant and refugee populations. At the time of the project, there were a total of ten providers that worked with the refugee population in this department. All ten providers were invited to participate in the project. The first day of the presentation, there were a total of three primary care providers from the department who participated. The second presentation day had a total of three providers which included one behavioral health provider and two primary care providers. All six
participants completed the intervention and assessment within the project timeline, meeting goal A of the expected outcomes. Table 1 shows the demographic breakdown of all the participants.

Table 1

*Demographic Characteristics*

<table>
<thead>
<tr>
<th>Demographic Variable</th>
<th>Intervention Group (N=6)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1</td>
</tr>
<tr>
<td>Female</td>
<td>5</td>
</tr>
<tr>
<td><strong>Department</strong></td>
<td></td>
</tr>
<tr>
<td>Primary Care</td>
<td>5</td>
</tr>
<tr>
<td>Mental Health</td>
<td>1</td>
</tr>
<tr>
<td><strong>Race/Ethnicity</strong></td>
<td></td>
</tr>
<tr>
<td>White Non-Hispanic</td>
<td>4</td>
</tr>
<tr>
<td>Asian</td>
<td>2</td>
</tr>
</tbody>
</table>

**Cultural Competence**

The pre-and post-tests were scored based on the IAPCC-R scoring key by Campinha-Bacote. A score of 91 to 100 indicated culturally proficient; 75-90 is culturally competent; 51-74 is culturally aware; and 25-50 is culturally incompetent. Scores ranged from 71 to 91 on the pre-test and 82 to 97 on the post-test, with the highest possible score being 100. The average of the pre-test scores was 78 while the average for the post-test was 90. Participant 1’s score increased after the intervention from 91 to 97 and the level of cultural competency remained the same since it was at the highest level even at baseline. Participant 2’s score remained at 82 and level of cultural competency remained at the level of competent post-intervention. Participants 3 and 4’s scores increased from 73 to 85 and 74 to 89 respectively, and cultural competency level increased from aware to competent. Participant 5’s score increased from 75 to 93 and cultural competency level increased from competent to proficient. Participant 6’s score increased from 71
to 91 and level of cultural competency increased from aware to proficient. Figure 1 depicts the pre-and post-test scores in a bar graph format, separated by each provider. All of the participants, except participant 2, had an increase in their scores from baseline to post-intervention.

![Pre-test scores vs post-test scores](image)

*Figure 1.* Bar graph showing the difference in scores for each provider between the pre-tests and post-tests.

The pre- and post-test scores means were compared using a paired samples t-test, with the null hypothesis being that the pre- and post-test scores were equal (see Table 3). Mean post-test scores ($M = 89.50, SD = 5.43$) were greater than mean pre-test scores ($M = 77.67, SD = 7.53$).

<table>
<thead>
<tr>
<th>Table 3</th>
<th>Paired Samples Mean Pre-Post-Test Scores for Cultural Competency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Paired Samples Statistics</strong></td>
</tr>
<tr>
<td></td>
<td>Mean</td>
</tr>
<tr>
<td>Pair 1</td>
<td>PreTest</td>
</tr>
<tr>
<td></td>
<td>PostTest</td>
</tr>
</tbody>
</table>

Overall, the scores for cultural competency increased by 11.83 points after completion of the educational intervention. Mean post-test scores ($M = 89.50, SD = 5.43$) were greater than mean pre-test scores ($M = 77.67, SD = 7.53$). The difference in scores was found to be statistically significant, rejecting the null hypothesis, $t(5) = -3.814, p = .012$ (see Table 4).

| Table 4 | Paired Samples T-test of Pre-Post-Test Scores for Cultural Competency |
Paired Samples Test

<table>
<thead>
<tr>
<th>Pair</th>
<th>PreTest</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error</th>
<th>Lower</th>
<th>Upper</th>
<th>t</th>
<th>df</th>
<th>Sig. (2-tailed)</th>
</tr>
</thead>
</table>

Figure 2. Bar graph depicting mean overall competency score differences.

A graphical depiction of the differences in mean scores is presented in figure 2. Mean post-test scores ($M = 89.50, SD = 5.43$) were significantly greater than pre-test scores ($M = 77.67, SD = 7.53$). The Shapiro-Wilkes test of normality was not statistically significant at $p = .144$ and $p = .981$ respectively for pre-and-post test scores, indicating that the data from both tests were normally distributed.

Mean pre-and post-test scores for each individual construct (i.e. awareness, knowledge, skill, encounter, and desire) of the framework were also examined (see Figure 3). Mean scores for cultural awareness increased from pre-test ($M = 15.50, SD = 3.15$) to post-test ($M = 18.50$,
Mean scores for cultural knowledge increased from pre-test ($M = 12.83$, $SD = 1.60$) to post-test ($M = 16.67$, $SD = 1.37$). Mean scores for cultural skill increased from pre-test ($M = 14.33$, $SD = 1.51$) to post-test ($M = 17.67$, $SD = 2.16$). Mean scores for cultural encounters increased from pre-test ($M = 15.83$, $SD = 2.79$) to post-test ($M = 17.33$, $SD = 2.16$). Mean scores for cultural desire had a minor increase from pre-test scores ($M = 19.17$, $SD = 0.753$) to post-test ($M = 19.33$, $SD = 1.21$).

![Figure 3. Mean differences in scores for each construct, comparing pre-and post-test results.](image)

**Cultural Awareness**

The pre- and post-test score means for cultural awareness were compared using a paired samples t-test to test the hypothesis that these scores were equal (see Table 5). The Shapiro-Wilk tests of normality were not statistically significant at $p = .854$ and $p = .820$ respectively for pre-and-post test scores, indicating that the data from both tests were normally distributed. Overall, the scores for cultural awareness increased by 3 points after completion of the educational intervention. Mean post-test scores for cultural awareness ($M = 18.50$, $SD = 1.05$) were greater than mean pre-test scores ($M = 15.50$, $SD = 3.15$). The difference in scores was
found to be statistically significant, rejecting the null hypothesis, \( t(5) = -2.905, p = .034 \) (see Table 6).

Table 5

**Paired Samples Mean Pre-Post-Test Scores for Cultural Awareness**

<table>
<thead>
<tr>
<th>Paired Samples Statistics</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>N</td>
<td>Std. Deviation</td>
</tr>
<tr>
<td>Pair 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AwarenessPre</td>
<td>15.50</td>
<td>6</td>
<td>3.146</td>
</tr>
<tr>
<td>AwarenessPost</td>
<td>18.50</td>
<td>6</td>
<td>1.049</td>
</tr>
</tbody>
</table>

Table 6

**Paired Samples T-test of Pre-Post-Test Scores for Cultural Awareness**

<table>
<thead>
<tr>
<th>Paired Samples Test</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Paired Differences</td>
<td>Std.</td>
<td>Deviation</td>
<td>Std. Error</td>
<td>Mean</td>
<td>Deviation</td>
<td>Mean</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mean</td>
<td></td>
<td></td>
<td>Mean</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pair 1</td>
<td>AwarenessPre -</td>
<td>-3.000</td>
<td>2.530</td>
<td>1.033</td>
<td>-5.655</td>
<td>-.345</td>
<td>-2.905</td>
</tr>
<tr>
<td>AwarenessPost</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Cultural Knowledge**

The pre- and post-test score means for cultural knowledge were compared using a paired samples t-test to test the hypothesis that these scores were equal (see Table 7). The Shapiro-Wilkes tests of normality were not statistically significant at \( p = .425 \) and \( p = .093 \) respectively for pre-and-post test scores, indicating that the data from both tests were normally distributed. Overall, the scores for cultural knowledge increased by 3.84 points after completion of the educational intervention. Mean post-test scores for cultural knowledge \( (M = 16.67, SD = 1.37) \) were greater than mean pre-test scores \( (M = 12.83, SD = 1.60) \). The difference in scores was
found to be statistically significant, rejecting the null hypothesis, $t(5) = -4.053$, $p = .010$ (see Table 8).

Table 7

*Paired Samples Mean Pre-Post-Test Scores for Cultural Knowledge*

<table>
<thead>
<tr>
<th>Paired Samples Statistics</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>N</td>
<td>Std. Deviation</td>
<td>Std. Error Mean</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>Pair 1 KnowledgePre</td>
<td>12.83</td>
<td>6</td>
<td>1.602</td>
<td>.654</td>
</tr>
<tr>
<td>KnowledgePost</td>
<td>16.67</td>
<td>6</td>
<td>1.366</td>
<td>.558</td>
</tr>
</tbody>
</table>

Table 8

*Paired Samples T-test of Pre-Post-Test Scores for Cultural Knowledge*

<table>
<thead>
<tr>
<th>Paired Samples Test</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Paired Differences</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>Std. Deviation</td>
<td>Std. Error</td>
<td>Mean</td>
<td>Std. Error</td>
<td>Lower</td>
<td>Upper</td>
<td>t</td>
<td>df</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Pair 1 KnowledgePre - KnowledgePost</td>
<td>-3.833</td>
<td>2.317</td>
<td>.946</td>
<td>-6.264</td>
<td>-1.402</td>
<td>-4.053</td>
<td>5</td>
<td>.010</td>
</tr>
</tbody>
</table>

**Cultural Skill**

The pre- and post-test score means for cultural skill were compared using a paired samples t-test to test the hypothesis that these scores were equal (see Table 9). The Shapiro-Wilkes tests of normality were not statistically significant at $p = .212$ and $p = .405$ respectively for pre-and-post test scores, indicating that the data from both tests were normally distributed. Overall, the scores for cultural skill increased by 3.34 points after completion of the educational intervention. Mean post-test scores for cultural skill ($M = 17.67$, $SD = 2.16$) were greater than
mean pre-test scores \((M = 14.33, SD = 1.51)\). The difference in scores was found to be statistically significant, rejecting the null hypothesis, \(t(5) = -3.780, p = .013\) (see Table 10).

Table 9

**Paired Samples Mean Pre-Post-Test Scores for Cultural Skill**

<table>
<thead>
<tr>
<th>Paired Samples Statistics</th>
<th>Mean</th>
<th>N</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pair 1 SkillPre</td>
<td>14.33</td>
<td>6</td>
<td>1.506</td>
<td>.615</td>
</tr>
<tr>
<td>SkillPost</td>
<td>17.67</td>
<td>6</td>
<td>2.160</td>
<td>.882</td>
</tr>
</tbody>
</table>

Table 10

**Paired Samples T-test of Pre-Post-Test Scores for Cultural Skill**

<table>
<thead>
<tr>
<th>Paired Differences</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
<th>95% Confidence Interval</th>
<th>95% Confidence Interval of the Difference</th>
<th>Sig. (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pair 1 SkillPre -</td>
<td>-3.333</td>
<td>2.160</td>
<td>.882</td>
<td>-5.600 -1.066</td>
<td>-3.780</td>
</tr>
<tr>
<td>SkillPost</td>
<td></td>
<td></td>
<td></td>
<td>5</td>
<td>.013</td>
</tr>
</tbody>
</table>

**Cultural Encounters**

The pre- and post-test score means for cultural encounters were compared using a paired samples t-test to test the hypothesis that these scores were equal (see Table 11). The Shapiro-Wilkes tests of normality were not statistically significant at \(p = .941\) and \(p = .964\) respectively for pre-and-post test scores, indicating that the data from both tests were normally distributed. Overall, the scores for cultural encounters increased by 1.5 points after completion of the educational intervention. Mean post-test scores for cultural encounters \((M = 17.33, SD = 2.16)\) were greater than mean pre-test scores \((M = 15.83, SD = 2.79)\). The difference in scores was
found to not be statistically significant, accepting the null hypothesis, \( t(5) = -1.464, p = .203 \) (see Table 12).

Table 11

**Paired Samples Mean Pre-Post-Test Scores for Cultural Encounters**

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>N</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pair 1 EncountersPre</td>
<td>15.83</td>
<td>6</td>
<td>2.787</td>
<td>1.138</td>
</tr>
<tr>
<td>EncountersPost</td>
<td>17.33</td>
<td>6</td>
<td>2.160</td>
<td>.882</td>
</tr>
</tbody>
</table>

Table 12

**Paired Samples T-test of Pre-Post-Test Scores for Cultural Encounters**

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error</th>
<th>95% Confidence Interval of the Difference</th>
<th>Sig. (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pair 1 EncountersPre - EncountersPost</td>
<td>-1.500</td>
<td>2.510</td>
<td>1.025</td>
<td>-4.134 - 1.134 -1.464</td>
<td>.203</td>
</tr>
</tbody>
</table>

**Cultural Desire**

The pre- and post-test score means for cultural desire were compared using a paired samples t-test to test the hypothesis that these scores were equal (see Table 13). The Shapiro-Wilkes tests of normality was not statistically significant for the pre-test, \( p = .212 \), but was statistically significant for the post-test, \( p = .003 \), indicating that the data from the pre-test was normally distributed, but not for the post-test. Overall, the scores for cultural desire increased by 0.16 points after completion of the educational intervention. Mean post-test scores for cultural desire \((M = 19.33, SD = 1.21)\) were greater than mean pre-test scores \((M = 19.17, SD = 0.753)\).
The difference in scores was found to not be statistically significant, accepting the null hypothesis, $t(5) = -0.349, p = .741$ (see Table 14).

Table 13

*Paired Samples Mean Pre-Post-Test Scores for Cultural Desire*

<table>
<thead>
<tr>
<th>Paired Samples Statistics</th>
<th>Mean</th>
<th>N</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pair 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DesirePre</td>
<td>19.17</td>
<td>6</td>
<td>.753</td>
<td>.307</td>
</tr>
<tr>
<td>DesirePost</td>
<td>19.33</td>
<td>6</td>
<td>1.211</td>
<td>.494</td>
</tr>
</tbody>
</table>

Table 14

*Paired Samples T-test of Pre-Post-Test Scores for Cultural Desire*

<table>
<thead>
<tr>
<th>Paired Samples Test</th>
<th>Paired Differences</th>
<th>95% Confidence Interval of the Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>Std. Deviation</td>
</tr>
<tr>
<td>Pair 1 DesirePre</td>
<td>-.167</td>
<td>1.169</td>
</tr>
<tr>
<td>1 DesirePost</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Qualitative Data**

Table 15 shows the results from the first three questions of the anonymous survey completed by participants immediately after the presentation. Of the participants who completed the survey, 100% felt that the intervention contributed positively to their ongoing process of meeting cultural competency and 100% also had a desire to continue expanding their cultural worldview and encounters with those from different cultures, meeting goals C and D of the expected outcomes. The last two questions of the survey asked participants what they found to be the most useful/helpful piece of information presented and what they would have liked to learn.
more about (see Table 16). Participants’ responses to the most useful/helpful piece of information presented during the education included: “Being aware of own biases; resources” “Resources” “Becoming aware of internal bias”. When asked about additional information that they would have liked to know more about, participants responses included: “Cultural beliefs of different cultures” and “Learning about different cultures from the main countries our refugees are coming from so we are able to treat those patients better”.

Table 15

*Feedback from Questions 1-3 of Post Education Survey*

<table>
<thead>
<tr>
<th>Survey Questions</th>
<th>Survey Responses (N=3)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes (%)</td>
</tr>
<tr>
<td>Prior history of cultural competency training?</td>
<td>1 (33%)</td>
</tr>
<tr>
<td>Did you feel that this training contributed positively to your ongoing process of improving cultural competency?</td>
<td>3 (100%)</td>
</tr>
<tr>
<td>Do you have a desire to continue expanding your cultural worldview and encounters with those from different cultures?</td>
<td>3 (100%)</td>
</tr>
</tbody>
</table>

Table 16

*Participant Feedback from Post Education Survey*

<table>
<thead>
<tr>
<th>Survey Questions</th>
<th>Survey Comments (N=3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most useful information presented during the intervention</td>
<td>“Being aware of own biases; resources” “Resources” “Becoming aware of internal bias”</td>
</tr>
<tr>
<td>Additional information participants would like to know more about</td>
<td>“Cultural beliefs of different cultures” “Learning about different cultures from the main countries our refugees are coming from so we are able to treat those patients better”</td>
</tr>
</tbody>
</table>
Discussion

Data was gathered and analyzed from the pre-and post-tests of all participants as well as from responses of the evaluation survey. There were significant increases in mean scores for the constructs of cultural awareness, knowledge, and skill, but there were not significant changes in scores for the cultural encounters construct and cultural desire construct. The greatest improvement in scores was first in the construct of cultural knowledge, followed by skill, then awareness. Knowledge scores increased by 3.84 points from pre-test to post-test. Skill scores increased by 3.34 points from pre-test to post-test. Awareness scores increased by 3.00 points from pre-test to post-test.

The constructs of cultural desire and encounters did not have significant score changes. Providers who completed the project had high levels of cultural desire at baseline and after the intervention they continued to have a strong desire to increase their level of cultural competence. In regards to the construct of cultural encounters, while providers expressed an interest in having more cultural encounters, this construct is defined as the process of engaging in direct interactions between healthcare provider and patients from culturally diverse backgrounds in order to change existing beliefs and prevent stereotyping (Albougami et al., 2016; Campinha-Bacote, 2015). As part of an ongoing process that will occur over time, it cannot be expected that there is a significant change in this area within the time period of this project.

In the evaluation survey, providers expressed appreciation for the supplemental resources (See Appendix C) that were provided with the training. Many of the resources, links, and tools provided in this list pertained to increasing cultural knowledge and skill which could attribute to the increased scores in these categories. Some of the additional resources provided included links to various websites with additional information regarding cultural competency, health literacy,
and refugees such as the HRSA and EthnoMed; free online training courses (with CEUs) about cultural and linguistic services as well as cultural competency for behavioral health professionals; link to Dr. Campinha-Bacote’s website which has additional resources including books, journals, and articles about cultural competency; the link to the Harvard Implicit Bias Tests to further explore implicit biases; and a TED talk about cross-cultural encounters. Multiple mnemonics (e.g. ETHNIC; ADHERE) with accompanying examples and explanations were provided as well as tools (e.g. Kleinman-Explanatory Model) to utilize when performing cultural assessments during encounters with patients from diverse cultures.

Participants also reported finding the activity related to internal biases helpful, which would contribute to increased cultural awareness. During this activity, participants were presented with a scenario where a son and father were in a car accident. The father passed away at the scene and the son was brought to the hospital. At the hospital, the surgeon sees the child and claims “this is my son”. The participants were asked to explain how this could be. Some of the responses included that it was the son’s biological/foster father or that the father in the accident was a priest. The answer is that the surgeon is the child’s mother. This activity was meant to reveal the implicit bias that many individuals would immediately think of a surgeon being a man, rather than a woman.

One of the main goals for this project was to increase the level of cultural competence among providers working with refugee patient populations. Six of the ten providers working with this population completed the baseline assessment pre-test, educational intervention, and post-test. Only 50% (n = 3) of the providers completed the evaluation survey after the intervention. Overall, the level of cultural competency increased among the providers after participating in the
educational intervention. There were varying levels of score increases in all five of the constructs measured as well, although significant increases were present in only three of the five constructs.

The goal was for 85% of participants to have an increase in their level of cultural competence. This goal was not met as only 83% \((n = 5)\) had an increase in their scores. One provider’s score remained unchanged after the educational intervention, but the five other providers showed an increase in their level of cultural competence after the presentation. At baseline, 50% \((n = 3)\) of providers were at the level of culturally aware, 33.3% \((n = 2)\) were at culturally competent, and 17% \((n = 1)\) was at culturally proficient. After the intervention, 17% \((n = 1)\) remained at culturally proficient, 17% \((n = 1)\) remained at culturally competent, but the other 67% \((n = 4)\) increased to the levels of competent and proficient. Mean scores overall increased from the pre-test to the post-test by 11.83 points. Findings from this project are consistent with research from other similar studies done in 2015 by Bauer & Bai and 2008 by Lampley et al., that an educational intervention with pre-and post-tests can indicate an increase in levels of cultural competency.

The post-education survey was only completed and returned by 50% \((n = 3)\) of providers. The other three providers had patients to see immediately after the presentation and therefore did not have a chance to complete the survey. The goal was for 80% of participants to report that the intervention contributed positively to their ongoing process of becoming culturally competent. This goal was met with 100% \((n = 3)\). These scores were only obtained though from the three completed surveys. When looking at the survey results that were available, only one provider had cultural competency education prior to this project and any education provided by the health center. All three respondents though, felt that the education provided was helpful in contributing to their level of cultural competence and all three of these providers had an increase in their level
of cultural competence after the intervention. All of the providers who completed the survey had a desire to continue having encounters with those of other cultures and expand their knowledge of other cultures, which is an important and necessary aspect in increased cultural competency.

As mentioned in Campinha-Bacote’s theoretical framework, cultural competency is an ongoing process, and this feedback supports the idea that education must be ongoing in the goal to achieve cultural competency (Campinha-Bacote, 2015).

**Limitations and Strengths**

Limitations for this project include a small sample size, low project evaluation response rates, and the short duration of the overall time period when the project took place. First, the small sample size can limit the statistical significance of the project results. Results though were significant for increasing cultural competency for this specific group of providers working with the health center’s refugee patient population. Second, the low evaluation response limits the feedback collected about the positive aspects and suggestions for improvement regarding the educational intervention. The feedback that was collected had consistent themes though which did reflect differences in the pre-and-post test scores. Finally, long term effects of the education are unknown due to the short duration of the project.

One of the strengths of this project was that the educational intervention only takes a one-hour period of time which allows providers to be able complete it without interfering with times for patient visits. A reliable and valid tool (IAPCC-R) was used to evaluate any changes that occur as a result of the educational intervention. For there to be effective change and improvements in provider cultural competency, there needs to be participation and support that goes beyond the level of individual healthcare providers (Weech-Maldonado et al., 2016). The director of health promotion and education, the chief of the department, and the health center’s
Research Ethics Committee were facilitators for this project and advocates for making culturally competent care for this population a priority.

**Implications for Practice**

Researchers have found that educational interventions are useful in increasing cultural competency levels among various populations (Lampley et al., 2008). In this project, providers successfully completed an educational intervention based on Campinha-Bacote’s framework. Data collected from pre-and post-tests were statistically significant for increased levels of cultural competence after completing the education, particularly in areas of cultural awareness, knowledge, and skills. This project did not include an evaluation on the impact that improved cultural competency can have on patient care. Future practice improvement projects may evaluate how increasing levels of cultural competency can affect the quality and effectiveness of care provided to refugee patients.

Effective cultural competence should have involvement at all levels of hospital infrastructure, to ensure that people, policies, and programs are in place to provide effective care to all patients (Weech-Maldonado et al., 2016). Future practice improvement projects may include providing the educational intervention to providers in all different departments throughout the community health center in order to further improve provider cultural competence levels. In addition to this, there must be a desire to engage in the ongoing process of knowledge attainment and practicing of skills (Campinha-Bacote, 2015). This happens over time with greater exposure to and encounters with varying cultures. For future practice, education should take place continuously over time. This may include providing different levels of cultural competency training over various sessions. For example, the first session may start with a general overview and then subsequent trainings becoming more specific to frameworks such as
Campinha-Bacote’s model. As providers complete those trainings, additional education can be provided for specific cultural patient populations present at the health center.

**Conclusion**

The patient population in the United States continues to become more diversified. With this diversity there are differing cultures, values, and beliefs when it comes to healthcare. Refugee patient populations in particular face many health disparities in access to and receiving healthcare services. It is important for healthcare providers to learn about what the cultural needs are of this patient population and have access to resources to address these needs. Cultural competence involves being aware of one’s own cultural biases and health disparities (cultural awareness); education about cultural differences in healthcare (cultural knowledge); resources in how to incorporate cultural competence in the patient visit (cultural skill); increasing cultural encounters with patients (cultural encounters); and having the willingness and want to better understand the impact culture has on health (cultural desire).

Using the Campinha-Bacote model, the educational intervention created for this project successfully increased cultural competency among healthcare providers working with the refugee patient population at the community health center. Whether participants had previous cultural competency training or not, all expressed that this presentation was useful to them, demonstrating that ongoing education should be provided to all health center providers as a way of increasing cultural competence. Participants of this project have a desire to continue on this journey of cultural competence and with ongoing education and access to proper resources, healthcare establishments may be able to contribute to increasing providers’ levels of cultural competence and effectively provide culturally competent care to the patients they encounter every day in practice.
References


Campinha-Bacote, J. (2015). *The process of cultural competence in the delivery of healthcare*


Evidence-based Practice Rating Scale. The Johns Hopkins Hospital; Johns Hopkins University School of Nursing.


https://www.census.gov/quickfacts/lowellcitymassachusetts

Weech-Maldonado, R., Dreachslin, J., Epané, J., Gail, J., Gupta, S., & Anne Wainio, J. (2016). Hospital cultural competency as a systematic organizational intervention: Key findings from the national center for healthcare leadership diversity demonstration project. Health Care Management Review. 43(1), 30-41. DOI: 10.1097/HMR.0000000000000128
Appendix

Appendix A

Campinha-Bacote Models for Cultural Competence

Appendix B

Educational Intervention PowerPoint

**THE JOURNEY TO CULTURAL COMPETENCY**
For Healthcare Professionals
Working with Immigrant & Refugee Patient Populations

**CHANGING DEMOGRAPHICS**

**REFUGEES AND ASYLEES IN U.S.A.**

**Where America’s Refugees Come From**
Top 10 origin countries for refugees admitted to the U.S. in FY 2018

- Burundi: 2,895
- Ukraine: 2,296
- Bhutan: 2,228
- Eritrea: 2,228
- Afghanistan: 2,228
- El Salvador: 725
- Pakistan: 411
- Russia: 411
- Ethiopia: 376

**REFUGEES**
- Unique healthcare needs
- Language, cultural, socioeconomic barriers
- Merging levels of education, literacy, beliefs, and behaviors
- Come from interrupted healthcare systems
- Have to learn to navigate U.S. healthcare system

**HEALTH DISPARITIES & BARRIERS**
ACTIVITY

“A father and son were involved in a car accident in which the father was killed and the son was seriously injured. The father was pronounced dead at the scene of the accident and his body was taken to a local morgue. The son was taken by ambulance to a nearby hospital and was immediately wheeled into an emergency operating room. A surgeon was called. Upon arrival and seeing the patient, the standing surgeon exclaimed “Oh my God, it’s my son! Can you explain this?”

CULTURAL KNOWLEDGE

The process that a healthcare provider takes to acquire education about different cultural groups in relation to:

A) Health-related beliefs, practices, and values
B) Disease incidence and prevention
C) Treatment efficacy

HEALTH RELATED BELIEFS

DIAGNOSTIC CLARITY

Culture bound illness/syndrome
- 20 More Rare and Unusual Psychiatric Syndromes
  (Medicare)
- Cultural Formation Interview

DISEASE INCIDENCE AND PREVALENCE

- Basal ganglia disease
- Cerebral palsy
- Epilepsy
- Huntington's disease
- Marfan syndrome
- Tourette's syndrome
- Valproic acid
- Trigeminal neuralgia
- Wilson's disease

- Anorexia
- Bipolar disorder
- Depression
- Eating disorders
- Schizophrenia
- Substance Abuse
- Transgender
- Thyroid disease
- Tuberculosis
- Vitiligo

- African Americans
- American Indians
- Asian Americans
- Arab Americans
- Jewish Americans
- Korean Americans
- Mexican Americans
- Native Americans
- Vietnamese Americans
- White Americans

- Alzheimer's disease
- Breast cancer
- Diabetes Mellitus
- Heart disease
- HIV
- Liver disease
- Lung cancer
- Multiple sclerosis
- Rheumatoid arthritis
- Stroke
- Tuberculosis
- Type 2 diabetes mellitus

- Anorexia
- Bipolar disorder
- Depression
- Eating disorders
- Schizophrenia
- Substance Abuse
- Transgender
- Thyroid disease
- Tuberculosis
- Vitiligo

- African Americans
- American Indians
- Asian Americans
- Arab Americans
- Jewish Americans
- Korean Americans
- Mexican Americans
- Native Americans
- Vietnamese Americans
- White Americans

- Alzheimer's disease
- Breast cancer
- Diabetes Mellitus
- Heart disease
- HIV
- Liver disease
- Lung cancer
- Multiple sclerosis
- Rheumatoid arthritis
- Stroke
- Tuberculosis
- Type 2 diabetes mellitus

- Anorexia
- Bipolar disorder
- Depression
- Eating disorders
- Schizophrenia
- Substance Abuse
- Transgender
- Thyroid disease
- Tuberculosis
- Vitiligo

- African Americans
- American Indians
- Asian Americans
- Arab Americans
- Jewish Americans
- Korean Americans
- Mexican Americans
- Native Americans
- Vietnamese Americans
- White Americans
CULTURAL COMPETENCY HEALTHCARE PROVIDERS

TREATMENT EFFICACY

- Ethnopharmacology field of study investigating the impact that culture, environment, genetics, bio-tribalistic, and microbiological factors have on absorption and metabolism of, and response to, therapeutic medications.

Interpersonal Styles
- Acculturated
- Culturally-immersed
- Traditional
- Bicultural

CULTURAL SKILL

GREET (CHONG, 2002)
- Generational status
- Reasons for immigrating to the U.S.
- Extended family or nuclear family
- Ethnic behaviors
- Time living in the U.S.

CULTURALLY BASED PHYSICAL ASSESSMENT

Guidelines for assessing skin variations (Purnell & Paulanka, 2003):
1. Establish a baseline color
2. Use direct sunlight if possible
3. Observe areas with least amount of pigmentation
4. Palpate for rashes
5. Compare skin in corresponding areas

DREYFUS MODEL OF SKILL ACQUISITION
CULTURAL ENCOUNTERS

The process of mutual respect in direct transactions between healthcare provider and patients from culturally diverse backgrounds in order to change existing beliefs and prevent misunderstandings.

- Learn from others.
- Cultural groups, healthcare professionals, and the American healthcare system.

Cultural Competency with Case Study

LINGUISTIC COMPETENCE

- Trust
- Roles
- Advocacy
- Non-judgmental attitude
- Gender
- Languages
- Acquaintance
- Time
- Moral issues

HEALTH LITERACY

Every time you talk with a healthcare provider, ask these 3 questions:

1. What is my main problem?
2. What do I need to do?
3. Why is it important for me to do this?

CULTURAL CONFLICT AND COMPASSION

People die in poverty because they fear what others may fear, and others because they do not know what others do not know what others do not know what others think others do not know what others think others do not know what others...

"The mantra of all achievement is desire... but weak desire brings weak results."

The healthcare provider’s motivation and willingness to become educated, skilled, competent, and aware of culture as well as wanting to seek out cultural encounters.

CULTURAL DESIRE

Service delivery can improve if the service provider and consumer understand each other and are willing to make adjustments for the other.

Knowledge can improve if the service provider and consumer are willing to learn about each other and understand each other's perspective.

Encourages the integration of the different aspects of care into a comprehensive approach to patient care.
Appendix C

Supplemental Resources

**Supplemental Information & Resources**


   Multiple resources created by the Health Resources and Services Administration. Topics related to culture, language, and health literacy with resources specific to different races, genders, special populations, and age. Additional resources available regarding research and education and tools for health literacy.

2. AHRQ’s Health Literacy Universal Precautions Toolkit, 2nd Edition

   The AHRQ Health Literacy Universal Precautions Toolkit, 2nd edition, can help primary care practices reduce the complexity of health care, increase patient understanding of health information, and enhance support for patients of all health literacy levels.

3. US. Dept. Health & Human Services- *Think Cultural*: *A Physician’s Practical Guide to Culturally Competent Care*
   [https://com.thinkculturalhealth.hhs.gov/](https://com.thinkculturalhealth.hhs.gov/)

   Link to a free, self-directed training course (9 CEU) designed for physicians, physician assistants, and nurse practitioners. The course goes over fundamentals of CLAS, including strategies for delivering patient-centered care, communication and language assistance, including how to work effectively with an interpreter, and organizational CLAS-related activities, including strategic planning and community assessment.

4. Improving Cultural Competency for Behavioral Health Professionals
   [https://thinkculturalhealth.hhs.gov/educations/behavioral-health](https://thinkculturalhealth.hhs.gov/educations/behavioral-health)

   Free, self-directed training course: 5 contact hours for licensed alcohol and drug counselors, nurses, psychologists, and psychiatrists; and for 4 contact hours for social workers.

5. Medline PLUS: Specific population health information
   [https://medlineplus.gov/populationsgroups.html](https://medlineplus.gov/populationsgroups.html)

   Website contains links to multiple other resources regarding health of various population groups and of health disparities.

6. Ethnomed Cross-Cultural Health
   [https://ethnomed.org/cross-cultural-health](https://ethnomed.org/cross-cultural-health)

   A collection of resources and information related to cross-cultural and refugee health topics, including refugee screening.

   [http://transculturalcare.net/](http://transculturalcare.net/)

   Dr. Campinha-Bacote’s website with a multitude of resources including books, journals, articles, audio-visual material, and websites about cultural competence, transcultural health care, cultural assessment tools, ethnic pharmacology and more.

**Supplemental Information & Resources**


9. Cultural bound illnesses/syndromes: 20 More Rare and Unusual Psychiatric Syndromes

    [https://www.youtube.com/watch?v=Uwz7OEgSLJE](https://www.youtube.com/watch?v=Uwz7OEgSLJE)
**Supplemental Information & Resources**

**Integrated Model Approach to Conducting Cultural Assessments:**

Do the following steps to effectively integrate culture into your overall assessment with the client:

1. **Review several cultural assessment tools.**
2. **Consider your discipline’s and specialty’s purpose in conducting an assessment.**
3. **Conduct your personal assets and liabilities as an interviewer.**
4. **Integrate selected questions from specific cultural assessment tools that will augment your existing assessment.**
5. **Establish your own personal style of incorporating cultural content into your patient assessment.**

### Maemonic Cultural Assessment Tools

**ETHNIC:** Levin, Like, and Gottlieb (2000)

<table>
<thead>
<tr>
<th>Explanation</th>
<th>Elicit the client’s explanation of the problem</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Treatment</strong></td>
<td>See what treatments they have tried including herbs and home remedies</td>
</tr>
<tr>
<td><strong>Healers</strong></td>
<td>Has the client sought treatment from alternative sources or folk healers?</td>
</tr>
<tr>
<td><strong>Negotiate</strong></td>
<td>Find an option that will be mutually beneficial to HCP and client</td>
</tr>
<tr>
<td><strong>Intervention</strong></td>
<td>Determine an intervention which may include alternative treatment</td>
</tr>
<tr>
<td><strong>Collaboration</strong></td>
<td>Collaborate with client, family, other HCP, healers and community resources throughout the assessment</td>
</tr>
</tbody>
</table>

**BELIEF:** Debiec, Medrano, Typinger, and Oney (2003)

<table>
<thead>
<tr>
<th>Explanation</th>
<th>Elicit the client’s explanation of the problem</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Belief</strong></td>
<td>“What caused your illness/problem?”</td>
</tr>
<tr>
<td><strong>Learn</strong></td>
<td>“Why did it happen at this time?”</td>
</tr>
<tr>
<td><strong>Impact</strong></td>
<td>“Help me understand your belief/opinion.”</td>
</tr>
<tr>
<td><strong>Empathy</strong></td>
<td>“How is this illness/problem impacting your life?”</td>
</tr>
<tr>
<td><strong>Feelings</strong></td>
<td>“This must be very difficult for you.”</td>
</tr>
<tr>
<td><strong>Belief</strong></td>
<td>“How do you feel about your illness/problem?”</td>
</tr>
</tbody>
</table>
### Supplemental Information & Resources

**RISK:** Kagawa-Singer and Kashiwagi-Lakha (2003)

| Resources                  | “What kind of assistance is available to you in your community that might be helpful?”
|                           | “Do you know others in your community who have faced similar difficulties?”
| Identity                  | Ask questions to determine acculturation-assimilation status and degree of integration within ethnic community.
| Skills                    | Assess the client and family’s skills and abilities to navigate the healthcare system and cope with disease.
| Knowledge                 | Assess knowledge about the client’s health beliefs, values, practices, and cultural communication.

**ADHERE:** Like (2004)

| Acknowledge               | Acknowledge need for treatment, inquire about prior treatments, and decide on mutual goals and desired outcomes of treatment.
| Discuss                   | Discuss possible and actual treatment strategies, consequences of non-treatment, treatment efficacy, and prognosis.
| Handle                    | Answer questions and address client fears about treatment.
| Evaluate                  | Evaluate patient’s health literacy to assess barriers and facilitators to adherence.
| Recommend                 | Recommend treatment and review treatment plan with client.
| Empower                   | Obtain client’s commitment and readiness to follow through with treatment plan.

### Other Cultural Assessment Tools

**Kleinman-Explanatory Model**

- What do you call the problem(illness)? Do you have a name for it?
- What do you think has caused your problem?
- Why do you think it started when it did?
- What do you think your sickness does to you? How does it work?
- How severe is your sickness? Will it have a short or long course?
- What kind of treatment do you think you should receive?
- What are the most important results you hope to receive from this treatment?
- What are the chief problems your sickness has caused for you?
- What do you fear most about your sickness?
Characteristics of Cultural Embeddedness

These are some questions that can be asked to see how embedded the patient is in his or her traditional culture. Cultural embeddedness refer to how aligned the patient is with their native culture. Determining the extent this can have a major influence on health care teaching.

- How recently did the patient immigrate?
- Was the immigration voluntary or involuntary?
- Did the patient live in intermediate countries before coming to the United States?
- What country did the patient immigrate from and how different is that culture from U.S. culture?
- Who does the patient associate with?
- What type of neighborhood does the patient live in?
- Does the patient follow traditional dietary habits?
- Does the patient wear native dress?
- Does the patient have any family member participate in the larger culture?
- Does the patient use folk medicine or use the practices of a native healer?
- Does the patient come from an urban or rural area in the native country?

**Pears** Clark, Hewson, and Fry (1996)

<table>
<thead>
<tr>
<th>Partners</th>
<th>&quot;Let’s tackle this together.&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Empathy</td>
<td>&quot;That sounds difficult.&quot;</td>
</tr>
<tr>
<td>Apologize</td>
<td>&quot;I apologize for the wait.&quot;</td>
</tr>
<tr>
<td>Respect</td>
<td>&quot;Help me understand.&quot;</td>
</tr>
<tr>
<td>Legitimation</td>
<td>&quot;I hear you.&quot;</td>
</tr>
<tr>
<td>Support</td>
<td>&quot;Here is my card, please call if...&quot;</td>
</tr>
</tbody>
</table>

**RESPECT:** Boston University Residency Training Program in Internal Medicine Diversity Curriculum Taskforce

<table>
<thead>
<tr>
<th>Respect</th>
<th>Enter the encounter with an attitude of respect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Explanatory Model</td>
<td>Explore the patient’s assumptions and beliefs</td>
</tr>
<tr>
<td>Socio-cultural context</td>
<td>Collect data about social and cultural factors to see how these affect care</td>
</tr>
<tr>
<td>Power differential</td>
<td>Explore the power differential in client-patient encounter</td>
</tr>
<tr>
<td>Empathy</td>
<td>Validate the significance of the client’s concerns or fears</td>
</tr>
<tr>
<td>Concern</td>
<td>Eliciting the concern or fears fosters trust and develops a therapeutic alliance</td>
</tr>
<tr>
<td>Therapeutic alliance</td>
<td>Necessary to enhance participation in and adherence to healthcare recommendations</td>
</tr>
</tbody>
</table>
Appendix D

Permission to use Cultural Competency Models

June 3, 2019

To: Ms. Tena Paul Chau
From: Dr. Josepha Campinha-Bacote
President, Transcultural C.A.R.E. Associates

RE: Contractual Agreement for Limited Use of Campinha-Bacote’s Model of Cultural Competence in a Dissertation

This letter grants one-time permission to Ms. Tena Paul Chau to copy my 1991 and 2010 models of cultural competence as they appear on my website at http://transculturalcare.net/plp/1991models.html and 2010models.html, respectively, in her academic papers (proposal and final paper) only.

TIMEFRAME: Permission to use my model is a one-time use in August 2019 and May 2020 when she submits it to her professor, these two times, in the proposal and final paper.

RESTRICTIONS OF COPYING: This permission only allows the copying/reprinting of my model in these two academic papers. Ms. Tena Paul Chau agrees that my model cannot be copied for any other reason outside of this paper. This includes, but not limited to, not being copied in another formal or informal publication, handouts, Power Point presentations, presentation to her faculty, students or colleagues, poster presentations or in any hard copy or electronic format for presentations or for any other purpose.

Ms. Tena Paul Chau will use the following citation when citing my models in her dissertation:

The Process of Cultural Competence in the Delivery of Healthcare Services
Copyrighted 1991 & 2010 by Campinha-Bacote
Reprinted with Permission from Transcultural C.A.R.E. Associates

GOVERNING LAW: All parties acknowledge that this Contractual Agreement for Limited Use of Campinha-Bacote’s Models of Cultural Competence is a valid contract. This contract shall be governed and construed under the laws of the State of Ohio, except as governed by Federal law. Jurisdiction and venue of any dispute or court action arising from or related to this contract shall be exclusively in or be transferred to Hamilton County Municipal Court, Hamilton County Court of Common Pleas, or the Federal Court situated in the County of Hamilton, Ohio.

ATTORNEYS FEES AND COSTS: In any action to enforce any provision of this Agreement, the prevailing party will be awarded reasonable attorney’s fees and costs.

[Signature]
[Date]

Ms. Tena Paul Chau
[Date]
Appendix E

Permission to use IAPCC-R

Date: August 15, 2019
To: Ms. Tena Chau
From: Dr. Josepha Campinha-Bacote
President, Transcultural C.A.R.E. Associates

RE: Contractual Agreement for Limited Use of the IAPCC-R

This letter grants permission to Ms. Tena Chau to use my tool “Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals- Revised (IAPCC-R)” to submit to her faculty adviser of her DNP project as well as to her IRB Committee. I have received payment of $50 for two tools to be used in these electronic submissions.

TIME FRAME: Permission to copy/use the IAPCC-R is granted for a one-time use only during the month of August, 2019. If Ms. Tena Chau receives approval from the IRB Committee, she will have to submit another formal letter of request and payment for additional tools when the study is implemented.

ADMINISTRATION: This permission only grants submitting the IAPCC-R to the IRB Committee and therefore does not grant any form of administration of the IAPCC-R to any individuals/participants.

RESTRICTIONS OF COPYING: Ms. Tena Chau agrees that the IAPCC-R and any of its 25 items cannot be copied or reproduced for any other reason. This includes, but not limited to, being copied in formal or informal publications, in a doctoral paper/project, DNP project, dissertation or thesis, in any academic paper, handouts for presentations, in any PowerPoint or Poster presentations or in any hard copy or electronic formats. The IAPCC-R is only to be used for the above purpose of submitting it in a proposal to be reviewed by the IRB Committee.

GOVERNING LAW: All parties acknowledge that this Contractual Agreement for Limited Use of the IAPCC-R is a valid contract. This contract shall be governed and construed under the laws of the State of Ohio, except as governed by Federal law. Jurisdiction and venue of any dispute or court action arising from or related to this contract shall lie exclusively in or be transferred to Hamilton County Municipal Court, Hamilton County Court of Common Pleas, or the Federal Court situated in the County of Hamilton, Ohio.

ATTORNEY’S FEES AND COSTS: In any action to enforce any provisions of this Agreement, the prevailing party will be awarded reasonable attorney’s fees and costs.

J. Campinha-Bacote
Transcultural Consultant

Date: 8/15/19
Ms. Tena Chau
Appendix F

Post Education Survey

CULTURAL COMPETENCY POST-EDUCATION SURVEY

1. Do you have any cultural competency training or educational experience outside of what has been provided by Lowell Community Health Center?
   A. Yes
   B. No

2. Did you feel that this training has increased your awareness of contributed positively to your ongoing process of improving cultural competency?
   A. Yes
   B. Somewhat
   C. No

3. Do you have a desire to continue expanding your cultural worldview and encounters with those from different cultures?
   A. Yes
   B. Somewhat
   C. No

4. What did you find to be the most useful/helpful piece of information presented during this education?

5. Is there any additional information that you would have liked to learn more about/thought should be included in the training?
Appendix G
IRB Approval

UMassAmherst
Human Research Protection Office

Memorandum – Not Human Subjects Research Determination

Date: September 11, 2019
To: Tenia Chau, College of Nursing

Project Title: Cultural Competency among Healthcare Providers Working with Refugee Patient Populations

IRB Determination Number: 19-141

The Human Research Protection Office (HRPO) has evaluated the above named project and has made the following determination based on the information provided to our office:

☐ The proposed project does not involve research that obtains information about living individuals [45 CFR 46.102(d)].

☐ The proposed project does not involve intervention or interaction with individuals OR does not use identifiable private information [45 CFR 46.102(b)(1), (2)].

☐ The proposed project does not meet the definition of human subject research under federal regulations [45 CFR 46.102(d)].

Submission of an Application to UMass Amherst IRB is not required.

Note: This determination applies only to the activities described in the submission. If there are changes to the activities described in this submission, please submit a new determination form to the HRPO prior to initiating any changes.

A project determined as “Not Human Subjects Research,” must still be conducted in accordance with the ethical principles outlined in the Belmont Report, respect for persons, beneficence, and justice. Researchers must also comply with all applicable federal, state and local regulations as well as UMass Amherst Policies and procedures which may include obtaining approval of your activities from other institutions or entities.

Please do not hesitate to call us at 413-545-3428 or email humansubjects@ora.umass.edu if you have any questions.

Iris L. Jenkins
Assistant Director
Human Research Protection Office