REVIEW AND COMPARISON OF THREE CULTURAL COMPETENCY EDUCATION PROGRAMS FOR NURSES

By

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Lanette Cheryl Perkins

April 2011

DEDICATION

Plenty Coups, Chief of the Crow Tribe stated in interviews with Linderman (1930):

> In that tree is the lodge of the Chickadee. He is least in strength but strongest of mind among his kind. He is willing to work for wisdom. The chickadee-person is a good listener. Nothing escapes his ears, which he has sharpened by constant use. Whenever others are talking together of their successes or failures, there you will find the Chickadee-person listening to their words. But in all his listening he tends to his own business. He never intrudes, never speaks in strange company and yet never misses a chance to learn from others. He gains success and avoids failure by learning how others succeeded or failed, and without great trouble to himself. There is scarcely a lodge he does not know, and yet everybody likes him, because he minds his own business, or pretends to (pp. 66-67).

I dedicate and thank the philosophy and guidance of Chief Plenty Coups provided to the Crow Tribe and my family.

I am thankful for the contributions and encouragement provided by my Great Grandmother Olive for her foresight and the value of education.

I thank the wisdom and wit of my Grandmothers, Elreno and Anne, without the two, my life would not be in balance.

I thank my Father, Albert, for providing the inquisitiveness to explore the world and take on challenges.

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To everyone, thanks for your guidance along life’s journey.

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ABSTRACT

Culture and ethnicity often impact the client's perception of health and illness including culturally acceptable treatment and the type of acceptable follow-up. As a culture defines health and illness, it also defines health care and treatment practices. Cultural values determine, in part, how patients will respond to care. Health care professionals are challenged to recognize diversity in order to deliver culturally competent health care. Culturally competent care has been mandated by the federal government. However, the process to select and implement a cultural competency program can present challenges to health care institutions, nursing colleges and nurses. The purpose of this project was to identify and compare evidence-based cultural competence programs developed to enhance the delivery of nursing care to diverse populations. The research included research and review of electronic databases such as Medline, CINAHL and PubMed. The project explored terminology the of individual terms of cultural, competency, and cultural competency. English language articles were selected for review based upon content related to terminology as described the project. Systematic reviews provided a guide for hand search of references lists and relevant journals; included in the literature review were foundation and governmental publications. Personal contact was made with the three selected programs for comparison. The results of the research provided a comparison, demonstrating the strengths of the three programs. The project presented criteria for assessing cultural competency programs, examined application of the three programs for review and consideration for implementation of cultural competency education on the individual, institutional or academic level. Cultural competency programs with an organized framework and clinical cultural competent interventions will play a role in the elimination of disparities and improve health care for all Americans. In conclusion, the provision of culturally competent care will be dependent on future studies including the application of culturally focused interventions, evaluation of the effectiveness of culturally competent education and outcome data reflecting the impact of culturally competent education for nurses and the patient care.

CHAPTER 1

INTRODUCTION TO THE STUDY

> It is my contention today, as it was then, that the nursing profession, because of its inherent desire to give competent and wholistic care, must be knowledgeable about and skilled in values, beliefs and health-illness practices of diverse cultures. Without systematic study of cultures as an integral part of all nursing education, a serious gulf in providing professional services will occur (Madeline Leininger, 1981, p. 365).

Introduction

Understanding the impact of culturally competent care is critical to the future of health care delivery. Cultural factors such as ethnomedical beliefs, use of culturally traditional health beliefs, cultural values, norms, gender specific roles and status, and religion influence the outcomes of care. Factors contributing to outcomes include provider bias, prejudices, stereotypes, time pressures and the overall lack of knowledge to care for diverse populations. Health care organizations with policies that fail to ensure support for patients and advocate for culturally competent care could result in fragmented care, difficulty navigating health care systems and less favorable health outcomes. Definitions of terminology utilized in this project are listed in Appendix A.

The increase in diversity of the United States (U.S.) population characteristics are described by Pacquiao (2007). “Health disparities have been attributed to patient characteristics including values, beliefs, practices, mistrust of the care system and preferences that influence the interaction between patients and providers, and patient

adherence to treatments" (p. 28S). Systematic influences such as the lack of language support services, fragmentation of care and facility policies, impact how culturally diverse populations are able to negotiate health care systems to access services. Cultural diversity exists not only in patient populations but also among health care providers. Culturally appropriate education for health care providers affords the opportunity to not only improve health care outcomes but also advance communication among health care team members (Pacquiao, 2007). Cultural development is challenging and requires vision and commitment to advance toward cultural proficiency (Calvillo, Clark, Ballantyne, Pacquiao, Purnell & Villarruel, 2009).

Purpose

The purpose of this project is to identify and compare three evidence-based cultural competence programs developed to enhance the delivery of nursing care to diverse populations. The primary objectives include the following:

1. Review the evidence-based literature and best practice guidelines related to cultural competency programs.
2. Identify theoretical underpinnings of existing cultural comptencey programs.
3. Compare three nationally recognized and evidence-based cultural competency programs that could improve outcomes of care.

Background

Nurses are challenged to provide care for an increasingly divergent population. According to the National Center for Cultural Competence, (NCCC, 2010b),

> The makeup of the American population is changing as a result of immigration patterns and significant increases among racially, ethnically, culturally and linguistically diverse populations already residing in the United States. Health care organizations and programs, and federal, state and local governments must implement systematic change in order to meet the health needs of this diverse population (p. 1).

The U.S. population has evolved to include cultural, racial, ethnic, language, gender, socioeconomic status and regional/geographic differences. Culture and ethnicity often impact the client's perception of health and illness including culturally acceptable treatment, type of acceptable follow-up, and person making the health care decisions. As a culture defines health and illness, it also defines health care and treatment practices. Cultural values determine, in part, how patients will behave. Health care professionals are challenged to recognize diversity in order to deliver culturally competent health care.

Leininger (1967) expressed the need for cultural competence in health care, "Nursing theory and practice must take into account man's culture and social behavior so that the nurse's mode of thinking and interacting with individuals will reflect new and penetrating views about behavior in health and illness" (p. 28). Understanding the role culture has on health care begins with the health care providers understanding their own culture and experience. The interaction of the health care provider and the patient will affect the outcomes. Leininger continued, "Thus, nursing educators and practioners are remiss if they do not consider the culture of their patient community, their students, their

staff and their faculty" (p. 28). Therefore, a professional responsibility of nurses should include understanding their own culture as well as recognition of possible cultural biases. Leininger (1967) stated "To ignore such cultural differences many seriously interfere with the nurse's ability to help a patient, and can limit the patient's progress toward *his* own culturally defined health state" (p. 33).

Educators may also be challenged to implement creative theoretical and evidence based activities to promote learning outcomes for culturally diverse students and health care professionals. Selecting and evaluating a cultural competency program to meet the needs of each unique patient, student and community is a difficult task. The challenge includes promoting positive cultural competence learning outcomes for a diverse body of students and health care professionals to provide culturally congruent health care to diverse populations (Campinha-Bacote, 2002; Jeffreys, 2006). Smedley, Stith & Nelson (2003) discussed this challenge:

> Cross cultural education for health professionals has emerged because of three major factors. First, cross-cultural education has been deemed critical in preparing our providers to meet the health needs of our growing, diverse population (Welch, 1998). Second, it has been hypothesized that cross-cultural education could improve provider-patient communication and help eliminate the pervasive racial/ethnic disparities in medical care as seen today (Einbinder and Schulman, 2000; Williams and Rucker, 2000; Brach and Fraser, 2000). Third, in response to the Institute of Medicine Report on Primary Care which states that "there should be an understanding of cultural belief systems of patients that assist or hinder effective health care delivery" and in response to the Pew Health Professions Commission, which states that "cultural sensitivity must be a part of the educational experience of every student," accreditation bodies for medical training (i.e., Liaison Council on Medical Education, Accreditation Council on Graduate Medical Education) now have standards that require cross-cultural curricula as part of the undergraduate and graduate medical education (Liaison Committee on Medical Education, 2001; Accreditation Council for Graduate Medical Education,

> 2001; Committee on the Future of Primary Care, 1994; Pew Health Professions Commission, 1995). Although these standards are general in their language, they are being expanded in detail and remain enforceable. Similarly, leaders in nursing education recognize the importance of culture in the health of populations and patients. As early as 1977, the National League for Nursing required cultural content in nursing curricula and in 1991, the American Nursing Association published standards specifically indicating that culturally and ethically relevant care should be available to all patients (p. 203).

Significance of Cultural Competency Education for Nurses

Culturally competent care has been a focus for more than forty years, beginning in the 1960's with the work of Leininger. The condition of health care funding hinges on the delivery of culturally competent health care. American health care policy has evolved from the Civil Rights Act of 1964 to legislation allocating funds for culturally competency education programs. The National Center for Cultural Competence, (NCCC, 2010b) acknowledges, “The Federal Government has a pivotal role in insuring culturally competent health care services” (NCCC, 2010b, *p*. 3). Programs receiving Federal funding are under regulatory and accreditation mandates as defined in United States policy and the Civil Rights Act of 1964 to address cultural components:

> Prohibition against exclusion from participation in, denial of benefits of, and discrimination under federally assisted programs on ground of race, color or national origin. No person in the United States shall, on the ground of race, color or national origin, be excluded from participation in, be denied the benefits of or be subjected to discrimination under any program or activity receiving Federal financial assistance. *(Pub. L. 88-352, Title VI, Sec. 601, July 2, 1964, 78 Stat. 252.)*

Jeffreys (2006) stated, "Culturally congruent health care is a basic human right, not a privilege and therefore every human should be entitled to it” (p. xiii). U.S. health

programs receiving federal funding are under regulatory and accreditation mandates to provide culturally competent care and should work to influence the way health care is perceived and delivered (Jeffreys, 2006; NCCC, 2010b). The American Nurses Association (ANA) issued the first plan to strengthen cultural diversity programs as early as 1986. Collaborations with other organizations such as the Center for Minority Health and National Institute of Mental Health have led to grant proposals to support doctoral level preparation in mental health for ethnic and racial minority health care providers. The ANA has been instrumental in amendment ratifications, position papers, and other statements in relation to cultural diversity (Lowe and Archibald, 2009).

The Bureau of Primary Health Care; Policy Notice 98-23 (8-17-98) acknowledged that “Health centers serve culturally and linguistically diverse communities and many serve multiple cultures within one center” (NCCC, 2010b, p. 3). Maternal and Child Health Bureau and *Healthy People 2020* objectives provide a framework to improve access and outcomes to populations receiving federal funding. JCAHO and the National Committee for Quality Assurance rely on private accreditation entities to set standards and monitor compliance and support standards that require cultural and linguistic competence in health care (NCCC, 2010b, p. 4). The ICN Code for Nurses, the ANA Code of Ethics and the Nationals Standards of Culturally and Linguistically Appropriate Services in Health Care remind health care providers that they are ethically and morally obligated to provide the best cultural health care and are legally mandated to do so if they receive federal funds (NCCC, 2010b, p. 3; Maze, 2005, p. 547).

In addition to setting national standards for the inclusion of culturally competent programs, the enactment of federal and state laws compliment the process to assure the public culturally competent care. Strelitz and Watson, (2008) stated the following:

> New Jersey recently passed legislation that requires 16 hours of cultural competency education as a condition of licensure to practice medicine. Four other states have similar legislation pending. The state of Washington passed legislation requiring all state accredited programs to include cultural competency education (p. 42).

The process of becoming culturally competent is a lifelong pursuit. Development of a well-defined approach to the learning process includes cognitive, motivational and psychological factors. A comprehensive understanding of the theorists and programs provides the guidance in selecting, implementing and modifying programs to enhance the knowledge and interactions between culturally diverse populations. Health care providers are expected to know, understand and meet the needs of culturally diverse populations. However, established cultural competency programs vary in approach to health care provider education. Ideally, health care providers and nursing students should be able to explore their own belief systems and culture, learn to value the patient's perspective, develop communication skills, identify and assess issues of patients from different cultures and be proactive in order to move forward with appropriate care and service delivery (Leininger, 1981; Campinha-Bacote, 2002). Cultural theorists and cultural competency educational programs provide fundamental perspectives of theory and educational frameworks to stimulate curiosity of one's own cultural background in order to assess and incorporate respectful culturally congruent care for diverse populations.

Recognition of the importance of culturally competent care has led to the development of governmental policy-changing organizational behavior, practices and attitudes to reflect respect and responsibility to provide culturally appropriate health care to all populations. Initially, the failure to address specific needs and preferences in health care led to action such as National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care, set forth by the Office of Minority Health (OMH). Office for Minority Health's CLAS standards can be reviewed in Appendix B. CLAS provides culturally competent care standards 1-3, language access service standards 4-7, and organizational support standards 8-14. The standards respond to an increasing need for quality accessible health care service in the United States. Cultural competency is not only mandated by law for the educational institutions and health care facilities receiving federal funds, is the standards are critical to meet patient needs and work effectively with diverse populations to provide optimal patient outcomes as well as accomplish patient and staff satisfaction during the encounter.

Organization of the Remainder of the Study

An increased awareness of cultural competency education has inspired grant funding and program development to provide optimal health care outcomes. This challenges educational institutions and health care facilities to provide the cultural competency programs to nurses and health care staff. Chapter 1 discussed the background related to increasing diversity and the factors influencing cultural competency. Chapter 2 will review literature discussing the impact of cultural comptencey on health care. The

literature review will introduce insight to cultural theorist and review theory to support a comparison of three cultural competency educational programs. Chapter 3 will discuss three cultural competency programs; one program is specifically for nurses, another addressing nurses and other health care providers and a third program outlines a curriculum for health care or other service delivery systems to provide culturally competent service. Chapter 4 will compare and evaluate three cultural competency programs and discuss evidence related to cultural comptencey training and outcomes. Chapter 5 will summarize the comparison and review the results and findings.

CHAPTER 2

REVIEW OF LITERATURE

> The goal of culturally congruent care can only be achieved through the process of developing (learning and teaching) cultural competence (Jeffreys, 2006, p. 9).

Introduction to Literature Review Search

Utilization of single and combinations of keywords in the literature search provided guidance in the focus and scope of the project. A review of the literature included systematic reviews, peer-reviewed articles, and selected study articles utilizing dates from 2005 to 2010, and key word searches using the following terms: culture, diversity, transcultural, cultural competence, cultural education, cultural assessment and cultural diversity. The literature review utilized electronic databases, historic literature, and sources specific to the topic of cultural competence. Reviews included nurses and other health care professions by specialty. Expert contacts found through websites and journal publications further identified sources for review based on content and application to health care practices regarding cultural competency. The key term cultural competency was explored to find theoretical and evidence-based practice articles and documents in the research literature. A review of government programs and foundation publications from the Commonwealth Fund, Kaiser Foundation, the Kellogg Foundation, Robert Wood Johnson Foundation, California Endowment, the Office of Minority Health, the Centers for Disease Control and Prevention (CDC), the Health Resources and

Services Administration (HRSA), the National Institutes of Health (NIH), and the United States Department of Health and Human Services (US DHHS) was performed.

Systematic Reviews

A systematic review by Pearson et al. (2007) and the Lewin Group in conjunction with HRSA, C*ultural Competence in Health Care Delivery Settings: A Review of the Literature*, provided insight for the development of this project. Research articles guided additional reviews and referenced cultural theorists for cultural competency background information and educational programs available for health care providers and organizations. Pearson et al. (2007) and the Lewin Group (2001) outlined theorists, cultural competency programs and activities to achieve culturally appropriate health care.

Pearson et al. (2007) evaluated evidence on the structures and processes supporting the development of effective culturally competent practice and a healthy work environment. The review identified 659 papers and selected 45 for full paper retrieval. However, only 19 articles met the inclusion criteria to include 20 key findings from the qualitative papers and 101 key conclusions from the 13 textual papers. Pearson et al. key findings and conclusions significant to this project include the following:

- Finding 4: Communication with ethnic minority groups has a substantial effect on the care provided (p. 63).
- Finding 7: Receiving training in cultural competence promotes confidence in engaging colleagues with different cultural values and awareness of care for ethnic minority patients (p. 63).
- Conclusion 1: Organizations need to provide a supportive environment to encourage culturally competent practices (p. 64).
- Conclusion 31: Collaboration between health care providers and communities should be facilitated to increase understanding and knowledge of culturally diverse communities (p. 66).

- Conclusion 48: The infrastructure of an organization must promote and support patient and employee diversity, and responsiveness to cross-cultural issues (p. 68).

Beach et al, (2005) developed a systematic review of educational interventions; included 34 studies reported before and after intervention evaluations; and, described control group comparisons utilizing predetermined criteria. The review of 19 studies indicated an improvement in knowledge with the training. Twenty-one of 25 studies provided evidence that attitudes and skills of health professionals demonstrated a benefit from the education. The authors reported good evidence that cultural competence training impacts patient satisfaction with three of three studies demonstrating a beneficial effect. However, there is poor evidence that cultural competence training impacts patient adherence, with one out of 34 studies demonstrating a beneficial effect. In conclusion, the authors suggested the following items for future investigations:

- (Prioritization of) avoidance of bias, general concepts of culture and patient centeredness (p. 367)
- Development of standard instruments (to measure cultural competence) (p. 367)
- (Evaluations should)compare different methods for teaching cultural competence (p. 367)
- Use objective and standardized evaluation methods and measure patient outcomes including patient adherence, health status and equity of service across racial and ethnic groups (p. 367)

Chipps, Simpson and Brysiewicz (2008) performed a systematic review of cultural competence training in community-based rehabilitation. The review included 17 articles and three systematic reviews; which included Beach, et al., 2005; Price, et al., 2005 and Anderson, Scrimshaw, Fullilove, Fielding & Task Force on Community

Preventive Services, 2003. Chipps, et al. (2008). The review addressed five studies meeting criteria for inclusion. The author findings are outlined:

- Good evidence that cultural competence training improved provider attitudes, knowledge and skills (p. 87)
- Positive outcomes were reported for most training programs. Reviewed studies had small samples and poor design (p. 85)
- Few investigators measured patient outcomes and that the heterogeniety of the curricular content, methods, and evaluation strategies made determining the effect of the training difficult (p. 87)
- Study design, which was underpowered because of high attrition rates and possibly bias feedback on practice to both intervention and control groups (p. 90)
- Instrument reliability was a threat to the studies measuring knowledge and competence (p. 92)
- Some evidence seems to indicate cultural competence training affects patient satisfaction, but little evidence that it improves patient care (p. 93)
- Added inconsistencies in patient outcomes measurement and non-significant patient outcomes findings, do not support the benefits of cultural competence training programes to improve health outcomes (p. 93)
- Lack of empirical precisions in evaluating effectiveness necessitate future study that are methodologically rigorous to allow confident recommendations for practice (p. 85)

Price, et al. (2005) provided a second review to describe the rigor involved in evaluating cultural competency training for health professionals. The review addressed 64 educational research articles, of which 34 studies met criteria. The authors reported excellent evidence that cultural competence training improved knowledge, attitudes and skills of health professionals. Furthermore, the authors reported good evidence that cultural competence training impacted patient satisfaction. The authors reported poor evidence related to cultural competence education and patient adherence. Furthermore, the authors reported poor evidence to determine the costs of cultural competence training.

The authors reported “no studies that have evaluated patient health status outcomes” (p. 356).

Beach et al. (2005) reviewed 34 studies with 13 specifically addressed nurses and observed “Overall, there is good evidence to suggest cultural competence training impacts the attitudes of healthcare providers (evidence grade B)” (p. 359). In addition, “Overall, there is excellent evidence to suggest that cultural competence training impacts the knowledge of healthcare providers (evidence grade A)” (p. 359).

The literature review presented an additional challenge in the evaluation of cultural competency programs and determining the impact the training has on nurses or health care providers. Despite the lack of evidence for effects of cultural competency education on health care outcomes, nurses still strive to provide culturally competent health care (Beach et al., 2005; Price et al., 2005; Chipps et al., 2008).

The plan for this project was to compare three culturally competent educational programs and explore the theoretical underpinning in the selection and development of a culturally competent educational program for nurses. The process and selection of a culturally competent education program was not an easy task. A search of the literature provided information regarding theorists, frameworks and models to provide cultural competency education for nurses and other health care professionals. However, the dilemma remains; how does a nurse choose a program to provide the cultural competency education and ensure the methodology is in line with the desired outcomes?

Pearson et al. (2007), recommended clarification of a healthy work environment through research to reflect the impact of culturally competent practices on the creation of

a healthy work environment with specific focus on patient, nurses and organizational outcomes. “Given that the evidence relating to culturally competent practice is predominately discursive in nature, further research embracing both the qualitative and quantitative paradigms (should) be pursued” (p. 79).

Review of Federally Funded Programs

U.S. Department of Health and Human Services, Health Resources and Services Administration in conjunction with the Lewin Group addressed cultural competence in health care settings. The Lewin Group evaluated core concepts from Campinha-Bacote, Carballeira, Cross, Isaacs, Davidhizar, Giger, Leininger and Orem’s Self Care Theory (HRSA, 2001; HRSA, 2009). The Lewin Group identified nine areas that are potentially important to the development of a measurement profile for cultural competence in health care settings. The domains include values and attitudes; cultural sensitivity; communication; policies and procedure; training and staff development; facility characteristics including capacity and infrastructure; intervention and treatment model features; family and community participation and monitoring, evaluation and research (HRSA, 2001).

Healthy People 2020 addresses a ten year agenda to improve the nation’s health. The *Healthy People 2020* objectives are “the result of a multiyear process that reflects input from a diverse group of individuals and organizations” (*Healthy People 2020,* 2011). The mission of the project establishes measurable objectives and goals. The goals include “achieve health equity, eliminate disparities and improve the health of all groups”

(*Healthy People 2020*, 2011). *Healthy People 2020* addresses educational and community based programs,

> ECBP-11 (Developmental) Increase the proportion of local health departments that have established culturally appropriate and linguistically competent community health promotion and disease prevention programs (Healthy People 2020, 2011) .

Furthermore, *Healthy People 2020* suggests potential date sources with Culturally and Linguistically Appropriate Services in Health Care Standards (CLAS), Office of Minority Health; Guidance and Standards on Language Access Services and Office of the Inspector General. Cultural diversity education has expanded in recent years. *Healthy People 2020* (2011) reports the following data:

- 100% of D.O. granting medical schools provided cultural diversity content in required courses in 2009.
- 99.2% of M.D. granting medical schools provided content in cultural diversity in required courses in 2008.
- 98% of undergraduate nursing schools included content in cultural diversity in required courses in 2008.
- 96% of Nurse Practioners (required cultural diversity content in 2008).
- 99% of physician assistant schools provided content in cultural diversity in required course in 2010.

Healthy People 2020 encourages development of *Health Communication and Health Information Technology* in the 2020 objectives by projecting the following target by 2020: “Use health communication strategies and health information technology (IT) to improve population health outcomes and health care quality and to achieve health equity.” An outline of objectives and resources are provided to assist health care professionals to improve health care outcomes to Americans.

Len Epstein (personal communication November 23, 2010) provided sources and short description of the evidence from Goode, et al. (2006) and Beach et al. (2005) regarding health care outcomes related to cultural competence training. In conclusion, Epstein offered the following remarks as quoted from Brach et al. (2000),

> Unfortunately, at this point there is little by way of rigorous research evaluating the impact of particular cultural competency techniques on any outcomes, including the reduction of racial and ethnic disparities. The only exception is that subset of techniques related to overcoming language barriers. Most linkages among cultural competency techniques, the process of health care service delivery, and patient outcomes have yet to be empirically tested (p. 203).

The California Endowment, Commonwealth Fund, National Quality Forum provided reports ranging from frameworks, taking theory to practice, practices for measuring and reporting cultural competency, and health evaluation in relation to cultural competency education and programs (California Endowment, Gilbert et al., 2003; California Endowment, Nguyen et al., 2007; Commonwealth Fund, Goode, et al., 2006; Commonwealth Fund, Wu et al., 2006; Commonwealth Fund, Bettencourt, 2006; National Quality Forum, 2009).

The Office for Minority Health (2011) has been charged by the United States Congress to "support research, demonstrations, and evaluations to test new and innovative models aimed at increasing knowledge and providing a clearer understanding of health risk factors and successful prevention intervention strategies for minority populations". The Office of Minority Health has been instrumental in supporting cultural competency through resources, training tools, policies, initiatives and laws and establishing National Standards in relation to cultural competency

through the Center for Linguistic and Cultural Competence in Health Care (CLCCHC) (OMH, 2009).

Theoretical Underpinnings for Cultural Competency Programs

Cultural diversity has become more evident with increases in immigration and societal expressions of cultural differences. The need for culturally competent training was recognized by theorists as early as Leininger in the 1960s. Over the years, theorists have developed frameworks to promote and support the rationale for cultural competency education in the health care continuum.

Tortumluoglu (2006) has addressed cultural frameworks by recommending the following approach:

> Transcultural scholars underline the identification of cultural factors and their effect on an individual's behaviour in order to provide culturally appropriate care. They also stress the ethical aspects of nurse-patient encounters by stating that nurses need theoretical knowledge enabling them to understand their own cultural values, beliefs and practices in order to prevent cultural biases, cultural clashes, cultural pain and imposition of practices, major cultural conflicts and unethical care. (p. 3).

In the following section, brief overviews of four models of cultural competency theory are presented to establish foundation for the comparison of the three cultural competency programs.

Leininger's Sunrise Model

Leininger's Sunrise Model described the seven dimensions of educational programs through cultural values and life ways; religious, philosophical and spiritual

beliefs; kinship and social ties; political and legal factors; economic factors; educational factors; and technological factors. Leininger's assessment requires health care professionals to evaluate, acknowledge and respect cultural differences in worldview and social structure to provide comprehensive and culturally sensitive care. Leininger's theory decribed three modes of action (a) through cultural care preservation and/or maintenance, (b) cultural care accommodation and (c) negotiation and cultural care repatterning and/or restructuring. (HRSA, 2001; Reynolds & Leininger 1993, p. 28).

Campinha-Bacote Model of Cultural Competence in Health Care Delivery

Campinha-Bacote Model incorporated five interrelated constructs; the constructs are cultural awareness, cultural knowledge, cultural skill, cultural encounters and cultural desire. Cultural competence is process whereby providers gradually build cultural awareness, knowledge and skills that result in changing attitudes toward different cultures and eventually cultural competence. Providers progress toward cultural competence through encounters with other cultures and drawing on knowledge and skills to adapt to the situation. Furthermore, Tortumluoglu (2006) stated, "This model is useful in caring for all people, because in reality we all belong to the same race-the human race, with all the same basic needs" (p. 8). HRSA described Campinha-Bacote theory as "the intersection of these constructs represents the process of cultural competence, and as the area of intersection becomes bigger, health care providers will internalize cultural competence at a deeper level and provide higher quality care." (HRSA, 2001)

Cross, Bazron and Isaacs: Towards a Culturally Competent System of Care

Cross, Bazron and Issacs defined a set of hierarchical steps that must be progressed through to reach cultural competence. The six points include cultural destructiveness, cultural incapacity, cultural blindness, cultural pre-competence, cultural competence and cultural proficiency (Cross, Bazron & Issacs, 1989; HRSA, 2001).

Giger -Davidhizar Transcultural Model

The transcultural assessment framework described six cultural phenomena that affect health care. The six phenomena are communication, space, time orientation, social organization, environmental control and biologic variations. Giger and Davidhizer's model explores culturally sensitive encounters to assist and develop the health care provider's knowledge, awareness and assessment skills; including verbal and nonverbal cues. The model stressed training of health care professionals to provide sensitive, tailored care to meet the needs of culturally diverse individuals (Tortumluoglu, 2006; Davidhizar, Bechtel, & Giger, 1998; HRSA, 2001).

In summary, the search for evidence on cultural competency education programs was completed by searching systematic reviews and examining evidence-based practice pertinernt to cultural competency education programs available for nurses. The project will compare three programs identified through the reviews. In addition,a review of cultural theorists and theory supporting cultural competency programs was conducted. The literature provided a guide for comparison of the three cultural competency training programs described in Chapter 3.

CHAPTER 3

PROCEDURE

> Unquestionably, culture is the blueprint for thought and action and is a dominant force in determining health-illness caring patterns and behaviors (Leininger, 1993, p. 34).

Comparison of Cultural Competency Programs

The three programs for comparison included the American Association of Colleges of Nursing (AACN), Culturally Competent Nursing Modules (CCNM) and National Center for Cultural Competence (NCCC) and are discussed and compared based on common criteria researched from each of the three programs. The selection of format was based upon characteristics identified in the Chipps et al. (2005) systematic review and other related literature. Chipps et al. identified five study characteristics, which established a guide to determining comparable factors among the three programs. Chipps et al. listed the following categories, first author, setting, participants, study design, intervention, outcomes and level. Additional topics were selected from data obtained from literature reviews and personal communications. Personal contact was made with each of the three program contacts to assure interpretation accuracy of the specific characteristics. Pam Malloy, RN, MN, OCN, FPCN, ELNEC Project Director gave clarification and additional insight into the AACN Toolkit's development and implementation process with colleges of nursing. Brittney Lindsey, a representative of the Think Cultural Health Technical Team for the CCNM, presented clarifications

regarding the Internet program and the rationale and process for program development and implementation. Suzanne Bronheim, PhD, Georgetown University Center for Child and Human Development provided explanation on the NCCC program and guidance and history of the NCCC program, including cultural competence training for individual and organizations. (personal communications, Bronheim [NCCC] 11-22-10, Lindsey [CCNM] 11-22-10 and Malloy [AACN] 11-23-10). Montana State University's Graduate Level Certificate in Nursing Education program guided an understanding of curriculum development, implementation and testing. Class work and course resources provided a foundation to develop the categories utilized in the comparison (Oermann et al., 2006; Billings et al., 2005; Jeffreys, 2006). The seven categories or characteristics from Chipps et al. ((2008) and considerations from Oermann et al. (2006), Billings et al. (2005) and Jeffreys, (2006) provided a method to organize characteristics of the three cultural competency programs selected for comparison. The characteristics included audience, (program) introduction date, theory, governmental influence, academic influence, funding, educational framework, mode of delivery, literacy/CLAS Standards, strategies, goals, program expansion, (pre and post testing) evaluation and testing, evaluation of the program, additional resources and contacts for chart development.

CHAPTER 4

PROGRAM COMPARISON RESULTS

> I know well that there is no end to learning, that I do not know all there is to be known about ethnic and cultural diversity, that good teachers are always learning, and that there are no guarantees or infallible formulas for perpetual success in teaching. I welcome the uncertainty and imperfections as invitations to be imaginative and innovative, to reaffirm that culturally responsive teaching is a continuous process of development, and to embrace the reality stated so eloquently by William Ayers (2004) that "teaching is never twice the same" (p. 43) (Gay 2010, p. 235).

The purpose of the project was to identify and compare evidence-based cultural competence programs developed to enhance the delivery of nursing care to diverse populations. The focus was on nurses and nursing students. *Healthy People 2020* indicated the inclusion of culture into health care curriculum ranges from 96% to 100% of the reporting programs. Furthermore, the new *Healthy People 2020* establish that 100% of undergraduate nursing students should receive cultural competency education in the curriculum by 2020.

Chipps et al, (2008) personal contacts and additional resources were used to create Table 1 and a comparison of the three cultural competency programs. The characteristics compared and described included audience, (program) introduction date, theory, governmental influence, academic influence, funding, educational framework, mode of delivery, literacy/CLAS Standards, strategies, goals, program expansion, (pre and post testing) evaluation and testing, evaluation of the program, additional resources and contacts for chart development (Billings et al., 2005; Chipps et al, 2008; Jeffreys, 2006; Oermann et al., 2006).

Audience

American Association of Colleges of Nursing (AACN), National Center for Cultural Competence (NCCC) and Culturally Competent Nursing Modules (CCNM) share the commonalities of providing cultural competency education. The AACN specifically targets baccalaureate, master and doctoral level nurses and CCNM focus on nurses and health care professional. The NCCC provides a wider scope of cultural competency education to include providers and practioners, faculty and trainers, family and consumers and organizations through a train the trainer methodology (AACN, 2009; CCNM, 2009; NCCC, 2010a)

Theory

AACN utilized theory from Campinha-Bacote, Giger, Davidhizar, Leininger, Purnell and Spector to develop the educational framework. The U.S. Department of Health and Human Services was influential in AACN program development. CCNM incorporated theory from Campinha-Bacote Culturally Competent Model of Care and Purnell Model for Cultural Competence to develop culturally competent nursing modules. CCNM worked in collaboration with the Office for Minority Health (OMH) and the National Standards for Culturally and Linguistically Appropriate Services (CLAS) to provide a culturally appropriate educational program. NCCC incorporated theory from Cross, Bazron, Dennis and Isaacs and in cooperation with Georgetown University; the Division of Research, Training and Education (DRTE); Maternal and Child Health Bureau; Health Resources and Services Administration (HRSA) and U.S.

Department of Health and Human Services to develop their curriculum (Cross, Bazron, Dennis and Isaacs, 1989; AACN, 2009; CCNM, 2009; NCCC, 2010b).

Academic Influence

AACN ‘s program received influence and input from the American Association of Critical Care Nurses, American Nurses Association, Association of Psychological Nurses, Association, Asian American/Pacific Islander Nurses Association, Hospice & Palliative Nurse Association, National Association of Hispanic Nurses, National Coalition of Ethnic Minority Nursing Associations and National Council of State Board of Nursing. CCNM included an academic influence through the American Nurses Association and the American Nurses Credentialing Center’s Commission on Accreditation for Nursing. NCCC has a partnership with Georgetown University Center for Child & Human Development, governmental and non-governmental programs.

Educational Framework and Mode of Delivery

AACN provided a case-based educational framework with five competencies, rationale and integrative learning strategies. The program is designed to integrate evidence-based practice and practice standards for faculty integration to existing nursing curriculum. CCNM and NCCC provide fully developed programs that are accessible through the internet for interactive self study. Although NCCC has a conceptual–based framework and CCNM is a case-based cultural competency curriculum with educational modules, the core components of the program are similar in providing vignettes, teaching

tools, strategies and additional resources to support the cultural learning experience. The strength of CCNM's program is based upon principles from CLAS. AACN incorporated case studies, presentations from community member and cultural healers, video and instruction to critique pamphlets for cultural content and allow for culturally appropriate pamphlet development (AACN, 2009; CCNM, 2009; NCCC, 2010a).

Educational Strategies

NCCC educational strategies include case studies, self-discovery and culturally orientated vignettes. Similarly, CCNM utilized pre and post testing for each of the three courses, vignettes and pulse points to enhance discussion and the learning process. AACN provided twenty-two classroom strategies to promote cultural immersion build cultural knowledge and develop cultural competency. AACN introduced the importance and inclusion of student to student and faculty to faculty interactions to provide an optimal learning process. Johns Hopkins University School of Nursing's baccalaureate program implemented AACN's cultural competency objectives in each course to provide proficiency across the curriculum. In addition, Johns Hopkins University nursing program has a committee on cultural competence as part of the school's governance structure. Johns Hopkins University provided an annual cultural diversity celebration; which evolved from a HRSA-funded event. The literature did not indicate an evaluation of student cultural competency (Sloand, Groves & Brager, 2004). CCNM's online case-based program incorporated Course I to develop culturally competent nursing care, Course II utilized language access services and Course III supported and advocated for

culturally competent health care organizations; which provided self assessment, course evaluation and pre and post testing. AACN, CCNM and NCCC meet the recommendations set forth by the CLAS Act. Individual reflection related to the learning exercise was identified in the NCCC program. The NCCC and AACN programs provided personalized learning plans, self assessments and a certificate of completion (AACN, 2009; CCNM, 2009; NCCC, 2010a). AACN utilized several strategies to accomplish the education process, including classroom activities, field trips, and cultural immersion. CCNM and NCCC are primarily self study, web based programs. Various activities are provided or encouraged to enhance the on-line content. All three programs utilized the CLAS standards either independently or within the content of the course.

Evaluation and Testing

AACN Toolkit for Nurses was developed by American Association of Colleges of Nursing, providing educational credits within the nursing curriculum; however, no specific method for program evaluation was identified. CCNM is backed by American Nurse Credentialing Center's Commission Accreditation. CCNM provided educational credits through *A Physicians Practical Guide to Culturally Competent Care, Culturally Competent Nursing Care: A Cornerstone of Caring and Cultural Competency Curriculum for Disaster Preparedness and Crisis Response.* Each curriculum can be done in its entirety or individual unit. NCCC provided continuing education credits or credit hours for the education program. AACN provided for the integration of cultural competency education with existing nursing curriculum. CCNM and NCCC required

online access to cultural competency educational self- study modules. The NCCC program was the only program to provide online learner feedback. CCNM expanded cultural competency at the organizational level; including assessment, strategic planning, training and educational activities (AACN, 2009; CCNM, 2009; NCCC, 2010a).

Program Expansion

AACN model addressed baccalaureate, masters and doctoral level program objectives and addressed cultural competency education at the organizational level. All three cultural competency programs included resources to enhance the learning process. All three programs addressed future development and periodic updates to keep the curriculums current. The CCNM program developed and incorporated a process to prepare organizations for data collection and develop strategies to improve cultural awareness, improves access, and improve overall patient health care outcomes (AACN, 2009; CCNM, 2009; NCCC, 2010a). The NCCC placed a focus on the organization; including recommendations for organizational self assessment to assist the cultural educational process. CCNM advanced the cultural competency at the organizational level to include strategic planning and components supporting cultural education at the health care facility and the organizational levels (CCNM, 2009; NCCC, 2010a).

NCCC provided focus on leadership through training, technical assistance and consultation, networking and product development and dissemination. In addition, NCCC placed focus on culture and epidemiology of disease to promote cultural competency throughout the health care organization (AACN, 2009; CCNM, 2009; NCCC, 2010a).

Funding

AACN's cultural competency programs are funded at the academic campus level with an initial contribution from the California Endowment. The CCNM and NCCC receive governmental funding to sustain their programs. CCNM receives support from the U. S. Department of Health and Human Services and Office for Minority Health and NCCC receives funding thorough the Cooperative Agreement #U93-MC-00145-09, Maternal and Child Health Program, HRSA and DHHS (AACN, 2009; CCNM, 2009; NCCC, 2010a).

Additional Resources

AACN, CCNM and NCCC included additional resources to supplement the cultural education programs. Resources can be accessed by the Web or by contacting the program for available hard copy materials (AACN, 2009; CCNM, 2009; NCCC, 2010a).

Table 1. Comparison of Three Cultural Competency Programs.

Areas of Comparison	American Association of Colleges of Nursing (AACN) Toolkit	Culturally Competent Nursing Care (CCNM)	National Center for Cultural Competence (NCCC)
Audience	BSN, MSN, PhD	Nurses, social workers, and health care providers	Health care providers: mental, maternal & child, public health, students in health
Introduction Date	BSN program 2007 MSN and DNP developed 2008-2009, launched December 2009	Development 2004-2007. Launched e-learning on March 16, 2007	NCCC and Maternal & Child Health Bureau since 1994
Theory	Campinha-Bacote, Giger & Davidhizar, Leininger, Purnell, Spector	Campinha-Bacote	Cross, Bazron, Dennis, Issacs
Governmental Influence		Office for Minority Health, U.S. Dept Health & Human Services, CLAS	HRSA, U.S. Dept. Health & Human Services , Maternal and Child Health Bureau, Division of Research Training and Education(DRTE); Services for Children with Special Health Needs; Child, Adolescent and Family Health; Substance Abuse and Mental Health Services Administration (SAMSA); Center for Mental Health Services; Child, Adolescent and Family Branch and Special programs development Branch

Table 1: Comparison of Three Cultural Competency Programs-continued.

Areas of Comparison	American Association of Colleges of Nursing (AACN) Toolkit	Culturally Competent Nursing Care (CCNM)	National Center for Cultural Competence (NCCC)
Academic Influence	American Association of Critical Care Nurses (AACN), American Nurses Association (ANA), Association Psychological Nurses Association (APNA), Asian American/Pacific Islander Nurses Association, Hospice & Palliative Nurse Association, National Association of Hispanic Nurses, National Coalition of Ethnic Minority Nursing Associations, National Council of State Boards of Nursing	American Nurses Association, American Nurses Credentialing Center's Commission on Accreditation for Nursing (CE credits)	Georgetown University Center for Child & Human Development, university partnerships, nongovernmental programs, and foundations
Funding	California Endowment provided funding for the development of cultural competencies and toolkit for graduate nursing faculty nationwide for nursing with a 1 day seminar December 2009.	U Dept. Health & Human Services and Office for Minority Health (OMH)	Cooperative Agreement #U93-MC-00145-09, Maternal & Child Health Program (Title V of Social Security Act), HRSA and DHHS 36 years of soft money through Georgetown University Medical Center.
Educational Framework	Case-based, integrative learning strategies	Case-based, based on CLAS, utilizing modules, objectives and strategies	Conceptual-based, strategies, tools and rationale. A curriculum enhancement module, NCCC utilizes a train the trainer model/ program for faculty.
Mode of Delivery	Classroom, field trips, Class interaction/ immersion and on-line	Free Web-based, Self study	Free Web-based, Self study
Literacy/CLAS Standards	Addressed	Addressed	Addressed

Table 1: Comparison of Three Cultural Competency Programs-continued.

Areas of Comparison	American Association of Colleges of Nursing (AACN) Toolkit	Culturally Competent Nursing Care (CCNM)	National Center for Cultural Competence (NCCC)
Strategies	Competencies developed to provide a framework for developing a curriculum built on cultural competence. Integration of framework strategies into existing nursing curricula. 22 classroom strategies for cultural immersion to build cultural knowledge	Three courses, vignettes and pulse points for discussion. Online cultural video presentations. Case studies based upon interactions between nurses and diverse patients	Case studies, self-discovery, culturally oriented vignettes Teaching tools, strategies and resources. Designed for the organizational level for policy development and assessment tools to begin comncept of sustainability on day 1 of implementation.
Goals	"AACN emphasizes that graduate s from all education programs must be change agents and culturally competent" (Sloand, Groves, & Brager 2004)	Mission: "improve the health of racial and ethnic minority populations through the development of effective health policies and programs that help eliminate disparities in health" (curriculum introduction Part 2 of 10).	The mission of the NCCC is to increase the capacity of health care and mental health care programs to design, implement and evaluate culturally competent service delivery systems to address growing diversity, persistent disparities and to promote health and mental health equality.
Program Expansion	Master's and Doctoral level to continue expansion into community and organizational levels	Program expand to organizational level with assessment, planning, training and educational activities	Leadership training and Partnerships, including community partnerships
Evaluation and Testing	Per nursing program	Pre and post testing Continuing educational credit hours for nurses, physicians, social workers, other medical care providers including disaster preparedness.	Online feedback, Continuing Medical Education credits (CME)

Table 1: Comparison of Three Cultural Competency Programs-continued.

Areas of Comparison	American Association of Colleges of Nursing (AACN) Toolkit	Culturally Competent Nursing Care (CCNM)	National Center for Cultural Competence (NCCC)
Evaluation of Program	"There are not really any outcomes associated with the toolkit. It is simply a compilation of resources (i.e. references, websites, case studies, etc) that faculty and students can use to enhance their knowledge and skills associated with cultural competency." Malloy, 2010.	Two-year evaluation report from March 2007 to March 2009. Data collected from control group. 14,205 participants with 11.327 were nurses with 50.5% completed at least one curriculum theme. Quantitative: pre and post test questions Qualitative; focus groups	
Additional Resources	Cultural resources, hardcopy and online	Cultural Resources throughout program	Cultural Resources throughout program
Contacts for chart development	Pam Malloy, RN, MN, OCN, FPCN, ELNEC Project Director, pmalloy@aacn.nche.edu Robert Rosseter, chief communications Officer,	Brittany Lindsey, Think Cultural Health Technical Team,	Suzanne Bronheim, PhD. Georgetown University Center for Child and Human Development.

(AACN, 2009; CCNM, 2009; NCCC, 2010a; NCCC, 2010b).

Personal communication was incorporated for appropriate interpretation and citations for programs comparison to ensure the accuracy.

CHAPTER 5

DISCUSSION

> Curriculum does not occur in a vacuum but is instead a contextual representation of global trends, national circumstances, professional priories and faculty values. Curriculum must be congruent with this social context, the interrelated conditions and factors in the setting. Without a fit between the curriculum and the broad practice environment, nurses would not have the relevant skills and attitudes necessary to effectively intervene in contemporary health care challenges or have adequate knowledge of the populations needing care (Warner as cited in Billings & Halstead, 2005, p. 109).

Summary of Findings

The comparisons of the three programs, AACN, CCNM and NCCC summarized the following project objectives:

1. Review the evidence-based literature and best practice guidelines related to cultural competency programs.
2. Identify theoretical underpinnings of existing cultural competency programs.
3. Compare three nationally recognized and evidence-based cultural competency programs that could improve outcomes of care.

Objective 1: Review of Evidence –based Literature

The review of literature related to cultural competency education was quickly expanded. Systematic reviews provided evidence for research and determination of the focus of the comparison programs based upon evidence from cultural theorists, program

curricula and implementation into actual practice in the United States. The project was narrowed from the broad topic to a focus on the comparison of three programs with specific focus on nursing and health care.

Objective 2: Theoretical Underpinnings of Cultural Competency Programs

The reviews provided good evidence for cultural competency training. Since the 1960's, various cultural theorists provided theory, frameworks and models to develop and implement a culturally competent training program for health care providers.

Cultural programs were established, studies and reports were generated reporting on patient and nurse satisfaction, health care outcomes and patient adherence to medical treatment plan of care with specific focus on culturally diverse populations (Beach et al., 2005; Chipps et al., 2008; Price et al., 2005).

Independent and governmental funded programs had been established and few continued after the funding period, presenting a challenge to determine the effectiveness of the program independent of the funding source (Calvillo, 2009; Jeffreys, 2006; Scisney-Matlock, 2000).

Objective 3: Comparison of Three Nationally Recognized Cultural Competency Programs

Evaluation of cultural competency programs produced evidence supporting the need for cultural competency education in health care providers and nurses. Increased cultural knowledge and experience of beliefs and practices has shown improved of health care outcomes. An accurate evaluation of data is difficult based on biases and methods of

self-reporting. Furthermore, efficacies of cultural competency programs have not been fully established. Currently, there are few reliable tools specific to cultural competency (Beach et al., 2005; Chipps et al., 2008; Pearson et al., 2007; Price et al., 2005; HRSA, 2001).

The *Healthy People 2020* program promoted cultural competency education at the level of doctors, nurses, physician assistants and nurse practitioners, with a promise to provide culturally competency education at 100% by 2020. NCCC's conceptual framework and CCNM's case-based and AACN's case-based frameworks address the scope of cultural competency programs for the individual, nursing program and health care institution with a focus on human interaction and active learning to create meaning and potentially positive impact on the lives of the students, health care staff and communities served (Young & Patterson, 2007, pp 91-92).

Smedley, Stith and Nelson (2003) outlined several challenges from cross cultural education, including cultural curricula. Governmental and health care organizations have provided financial support and incentives (CCNM, 2009; NCCC, 2010). However, the dilemma of choosing a cultural competency education program is not an easy task. Community partnerships with schools of nursing and culturally diverse populations may provide the opportunity to facilitate an appropriate teaching-learning strategy that produces the best outcomes for students, patients and communities (Smedley, et al., 2003; AACN, 2009: CCNM, 2009; NCCC, 2010a). Partnerships between schools and communities provide a solution to the financial challenges associated with implementing a cultural competency program in a nursing program or institutional setting (CCNM,

2009; NCCC, 2010a). Through health care institutions, Jeffreys (2006) stated, "Expectations must be patterned with structure, high quality educational opportunities and incentives for enhancing cultural comptencey development that are motivated by true commitment for cultural competence rather than by accrediting agency mandates" (p. 116). AACN incorporated cultural competency programs at the baccalaureate, master and doctoral levels of nursing. CCNM motivated cultural competency education at the organizational level; indicating an investment not only in the organization but extending into the community (AACN, 2009; CCNM, 2009). In addition, the NCCC program encouraged leadership, networking and culturally appropriate health education materials to support culturally appropriate care from the nurse, organization and community (AACN, 2009; NCCC, 2010a). Kardong-Edgren and Campinha-Bacote (2008) compared cultural competency in nursing students. The authors findings included no difference in free standing courses, age and ethnic diversity did not impact the outcome of the education, implementation of the IAPCC-R © did not provide conclusive data. Furthermore, the authors stated "we found that there was no statistically significant difference of the level of cultural competence (all received a level of cultural awareness) of the students regardless of the type of cultural content and educational strategies employed at their respective school" (p. 43). The concept of what would a cultural competency program or model consists of, continues to elude nurse educators and researchers (Kardong-Edgren et al., 2008; London, 2008).

CHAPTER 6

CONCLUSION

The project addressed a comparison of three cultural competency programs. Research demonstrated evidence supporting the project's objectives and a need for cultural competency education. The future of health care includes recognizing diverse populations and providing culturally appropriate care. The education of health care providers is an important step to providing culturally competent care. The comparisons indicated the need for future research to recognize and determine the level of impact cultural competency on health care outcomes. Limitations in data collected and the strategies used for data collection demonstrated little or no evidence supporting a particular method of cultural competency education for nurses or other health care professionals. Furthermore, there is little evidence on how to implement cultural competency programs and the content to be presented. AACN, CCNM and NCCC provided objectives and tools to provide cultural competency education. Governmental and non governmental agencies, such as the California Endowment, Commonwealth Fund, *Healthy People 2020*, OMH and HRSA provided rational and funding to support research supporting cultural competency training education. However, implications for research and education will be necessary to determine the effectiveness of the three programs and other cultural competency programs. The comparison demonstrated strengths of each program, however the actual impact of each of the programs could not be determined. Research to provide evidence supporting specific interventions and the

impact on health care outcomes, patient satisfaction are critical to reduce the health care disparities in the Untied States (Anderson, et al., 2003; Brach & Fraserirector, 2000; California Endowment, Gilbert et al., 2003; California Endowment, Nguyen et al., 2007; Commonwealth Fund, Goode, et al., 2006; Commonwealth Fund, Wu et al., 2006; Commonwealth Fund, Bettencourt, 2006; National Quality Forum; 2009 *Healthy People 2020*; HRSA, 2001; OMH, 2011).

London (2008) stated, “Becoming a culturally competent nursing professional is, indeed, not a simple task. It is a process” (p. 283). Furthermore, London summarized, “The nurse does not have to be an expert at determining the best intervention but must know how to collaborate with the patient to find them. That is culturally competent patient education” (p. 285). Cultural competency is really nursing competence; embracing diversity and integrating cultural components into our lives and health care practices will enhance nursing satisfaction and improve health care outcomes for all populations.

The project has identified the following recommendations. Future research will need to be done to connect nursing practice to skills taken into nursing practice and the process to change patient outcomes through culturally competent care. The literature review verified cultural competency education for nurses and other health care staff has been linked to improved care. As nurses, we will continue researching and improving health care outcomes is a continuing process; incorporating cultural competency in the individualized plan of care.

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APPENDICES

APPENDIX A

DEFINITIONS

Cultural awareness: the nurse becomes sensitive to the values, beliefs, lifestyles, and practices of the patient/client, and explores her/his own values, biases, and prejudices (Campinha-Bacote, 2008 as cited in AACN, 2009).

Cultural competence: Competence is an ongoing process that involves accepting and respecting differences and not letting one's personal beliefs have an undue influence on those whose worldview is different from one's own. Cultural competence includes having general cultural as well as cultural-specific information so the health care provider knows what questions to ask." (Giger et al, 2007 as cited in AACN, 2009).

Cultural proficiency: the ability to positively resolve conflicts that results from cross-cultural encounters; the capacity to coach the resolution of interpersonal conflict; and the organizational facility to teach practical skill for cross-cultural relationships, communication and conflict resolution. It also requires willingness to continually explore and assesses one's own level of cultural proficiency. Strelitz et al. (2008) (p. 43).

Culture: the learned pattern behavioral response acquired over time that includes implicit beliefs, attitudes, values, customs, norms, taboos, arts and life ways accepted by community of individuals (Giger, Davidhizar, Purnell, Harden, Phillips & Strickland as cited in AACN, 2009).

Diversity: the all-inclusive concept of differences in race, color, ethnicity, national origin, immigration status,(refugee, sojourners, immigrant, or undocumented), religion, age, gender, sexual orientation, ability/disability, political beliefs, social and economic status, education, occupation, spirituality, marital/parental status, urban vs. rural residence, enclave identity, and other attributes of groups of people in society (Giger et al., 2007; Purnell & Paulanka, 2008 as cited in AACN, 2009).

APPENDIX B

CLAS BROCHURE

OFFICE OF MINORITY HEALTH

Affirming LEP Access and Compliance in Federal and Federally-Assisted Programs

CLAS

National Standards for Culturally & Linguistically Appropriate Services (CLAS) in Health Care

Issued by the U.S. Department of Health and Human Services' (DHHS)
Office of Minority Health (OMH)

Did You Know.....

That all federal programs and those receiving assistance from the federal government must take reasonable steps to ensure that persons who are limited English proficient have meaningful access to the programs, services, and information that those entities provide.

Who is a Limited English Proficient Person?

Limited English proficient persons are those who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English.

Why Must Organizations Comply?

Title VI of the Civil Rights Act of 1964 states, "No person in the United States shall, on the ground of race, color or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance." 42 U.S.C. § 2000d. U.S. Department of Health and Human Services, Office for Civil Rights, 2000.

The United States Supreme Court in Lau vs. Nichols (1974) stated that one type of national origin discrimination is discrimination based on a person's inability to speak, read, write, or understand English. U.S. Department of Health and Human Services, Office for Civil Rights, 2000.

Who Must Comply & Who Can be Found in Violation?

All programs and operations of entities that receive federal funds either directly or indirectly, such as subgrantees, must comply. These include but are not limited to the following:

- Hospitals
- State agencies
- Public assistance programs
- Universities
- Nursing homes
- Family health centers and clinics
- Mental health centers and programs
- Alcohol and treatment centers
- Others that receive federal financial assistance.

U.S. Department of Health and Human Services, Office for Civil Rights, 2000.

How are the CLAS Standards Related to Title VI?

The lack of comprehensive standards on culturally and linguistically appropriate services (CLAS) in health care has left organizations and providers with no clear guidance on how to provide CLAS in health care settings. Some of the CLAS standards are **mandates**, others are guidelines, and still others are recommendations. All are issued by the U.S. DHHS Office of Minority Health. They are intended to inform, guide, and facilitate requisite and recommended practices related to cultural and linguistically appropriate health services. They were designed to contribute to the elimination of health disparities by addressing the linguistic and cultural needs of individuals in an appropriate manner.

U.S. Department of Health and Human Services

These proposed standards are presented as guidelines for accreditation and credentialing agencies and others that assess and compare providers who say they provide culturally competent services, and to assure quality for diverse populations.

How are the CLAS Standards Applied?

These 14 standards are organized by themes and stringency levels:

- **Culturally Competent Care** (Standards 1-3)
- **Language Access Services** (Standards 4-7)
- **Organizational Supports for Cultural Competence** (Standards 8-14)

Mandates, Guidelines, & Recommendations?

The standards are intended to be inclusive of all cultures and not limited to any particular population group or sets of groups; however, they are especially designed to address the needs of racial, ethnic, and linguistic population groups that experience unequal access to health services.

- **Mandates (Standards 4, 5, 6, & 7)** are current Federal requirements for all recipients of Federal funds
- **Guidelines (Standards 1, 2, 3, 8, 9, 10, 11, 12, and 13)** are activities recommended by the OMH for adoption as mandates by Federal, State, and national accrediting agencies.
- **Recommendations (Standard 14)** are suggested by the OMH for voluntary adoption by health care organizations.

Mandates that Address Language Access Services

4. Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

5. Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

6. Health care organizations must assure the competence of language assistance provided to limited English proficient patients or consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/ consumer).

7. Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

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Guidelines that Address Culturally Competent Care

1. Health care organizations should ensure that patients/consumers received from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

2. Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

3. Health care organizations should ensure that staff at all levels, and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

Standards that Address Organizational Supports for Cultural Competence

8. Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, and operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

9. Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.

10. Health care organizations should ensure that data on the individual patients/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.

11. Health care organizations should maintain a current demographic, cultural and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

12. Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.

13. Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.

14. Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

Rationale for Cultural Competence in Health Care

With the increase of racially, ethnically, culturally, and linguistically diverse individuals and families coming to Nebraska, it is important that health care providers and organizations incorporate culturally competent approaches into their work. The National Center for Cultural Competence (2003) found the following reasons justify the need cultural competence at the patient-provider level:

- The perception of illness and disease and their causes vary by culture;
- Diverse belief systems exist related to physical health, mental health, healing and well being;
- Culture influences help-seeking behaviors and attitudes toward primary care providers;
- Individual preferences affect traditional and other approaches to primary care;
- Patients must overcome personal experiences of biases within primary care systems;
- Primary care providers from culturally and linguistically diverse groups are under-represented in current service delivery systems;
- Numerous others

Other Compelling Reasons for Cultural Competence

- Respond to current and projected demographic changes in the United States.
- To eliminate long-standing disparities in the health status of people of diverse racial, ethnic and cultural backgrounds.
- To eliminate disparities in the mental health of people of diverse racial, ethnic, and cultural groups.
- To improve the quality of services and primary care outcomes.
- To meet legislative, regulatory, and accreditation mandates.
- To gain a competitive edge in the market place.
- To decrease the likelihood of liability/malpractice claims.

National Center for Cultural Competence

https://www.thinkculturalhealth.hhs.gov/Documents/CLAS_Standards.pdf