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Cultural Competency Training for U.S. Army Security Force Assistance Brigade (SFAB) Brigade Medical Teams

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Executive Summary

Introduction of the Problem

The U.S. Army stood up the 1st Security Force Assistance Brigade (SFAB) in February 2018. Since then, six more brigades have been created and manned. The Army National Guard contains one of these brigades, the 54th SFAB. This unit includes an interdisciplinary Brigade Medical Team (BMT) staffed with the following specialties: Senior Physician Assistant, Medical Operations Officer, Emergency Physician, Medical-Surgical Nurse, Environmental Science Officer, Medical Logistics Officer, Medical Logistics Sergeant, Team Sergeant, Behavioral Health Officer, Physical Therapist, and Physical Therapy Sergeant.

The BMT is tasked with training, advising, assisting, enabling, and accompanying allied and partner nation forces on operations globally. To satisfy this mandate, cultural competency was selected as a key skill that every member of an SFAB unit should possess. As a new addition to the Army, these teams were ordered to implement appropriate training to develop and maintain cultural competency amongst all BMT service members.

Literature Review

Why is cultural training so important for SFAB brigade medical teams? These small teams are tasked to work with foreign security forces (FSF) all around the world. Different cultures have different social and professional taboos and mores. The SFAB specialty is all about building rapport. Being aware of the cultural norms of the FSF partners is essential to increase the efficacy of medical training and reduce any potential roadblocks. Culture clash can potentially be avoided by additional training to help them integrate into the area in which they operate.

Physicians, PAs, RNs, APNs, PTs, and PTAs all attend educational programs that require cultural awareness/competency instruction by their accrediting bodies. However, the quality and methodology of the implementation of culture training vary widely by profession and institution. Cultural training in the military is sporadic and is mostly implemented by commercially contracted entities, again leading to variation in quality and methodology. According to research by Kripalani (2016), more than 30% of patients are derived from ethnic minority groups, and some models estimate that this number will increase to over 50% by 2050. Cultural awareness training is of the utmost importance.

Many PA programs delayed the implementation of cultural awareness training, some until as late as 2010-2011. As stated by Beck et al. (2014), for example, the PA program at Carroll University created its PA program in 2010. Each semester PA students completed a survey on the quality of cultural competency training they received; each semester the program scores increased.

These results were repeated with a second cohort. However, both the student participants and the researchers suggested that cultural awareness training should be interwoven throughout all parts of the curriculum. Cohort 1 completed their cultural self-awareness training via lecture, while cohort 2 had their training implemented by completing interactive exercises. Cohort 1 showed a greater increase in their ability to discuss how their culture affects their thinking; a 52% increase over four (4) semesters. Cohort 2 also showed an increase, but it was only 23%.

Another study by Govere & Govere (2016) found that minority patients were 3.5 times more likely to rate their provider encounters positively in their provider had received cultural competence training. Families also reported they felt their loved one was “receiving individualized care,” and family satisfaction increased by 43% when the provider was trained in

cultural awareness. Cultural awareness training was also found to increase healthcare provider satisfaction and reduced burnout.

Research by a joint military team of King, Todd, & Kelley (2017) revealed that military medical providers have specific gaps in culturally relevant knowledge. The participants were 141 physicians, nurses, and corpsmen (similar to a medic or tech) assigned to a recently deployed U.S. Naval hospital ship, such as the USNS Comfort or Mercy that recently deployed to NYC and San Diego during the SARS-CoV-2 pandemic. It was discovered that a statistically significant portion of these participants was lacking in one (1) or more of three (3) categories: cultural beliefs or practices that impact delivery of care, patient cultural customs that lead to non-compliance, and/or provider awareness of social cross-cultural norms.

Project Methods

One online course from the Joint Knowledge Online (JKO) portal was chosen to develop BMT members' cultural competency – *Cross-Cultural Competence Trainer (3CT) V2*[A]. Participants completed a pre-test and then a post-test for comparison. To evaluate their retention of this information, the participants took a longitudinal test one month after the post-test. All testing was conducted online due to SARS-CoV-2 restrictions from civil and military authorities in Illinois. This quality improvement project was granted IRB-exempt status on September 17, 2020.

To evaluate the cultural knowledge of the participants, the researcher utilized a pre-/post-/longitudinal test consisting of 10 multiple choice, five (5) true/false questions, and five (5) "select all that apply" questions. These questions were on the knowledge and comprehension levels of the cognitive domain of Bloom's Taxonomy. Questions on this test were retrieved from a list of authorized military questions for evaluation of this specific training. The

pre-/post-/longitudinal test results were evaluated using the difference method to assess for efficacy of the course and cultural competency maintenance over time. By request of SFAB officers, participants also answered a demographic questionnaire including the following items: age, gender, education level, occupation, military rank, time-in-service (TIS), and overseas experience.

Evaluation

The BMT has 11 lines on the modification table of organization and equipment (MTOE) for healthcare positions including physicians, physician assistants, nurses, physical therapy, and administrative/logistics. Four participants began this quality improvement project; however, only three participants completed the entire protocol: two nurses and a physical therapy assistant.

The researcher initially hypothesized that there would be a significant increase in test scores from pre- to post-intervention. This played out as expected with participant #1, #2, and #3 increasing 12.5%, 19.36%, 12.19%, respectively. The mean score increased from 76.34% correct answers on the pre-test to 91.40% on the post-test.

A surprising result was revealed upon completing the longitudinal test conducted one-month (28-31 days) following *Cross-Cultural Competence Trainer (3CT) V2*^{A} training. The SFAB command team and the researcher theorized that cultural competency would degrade without continued input over this period. Indeed, in the case of participant #1 that is what occurred. Participant #1 had a decrease of 9.68% from post-test to longitudinal testing 30 days later. However, participant #2 and participant #3 both answered more correctly on their longitudinal test than the test taken immediately following the training modules! Participant #2 had an increase of 3.22%; participant #3's score improved by 6.45%.

The researcher spoke with participant #2 and #3 about these results to gain further anecdotal insight into the mechanism that allowed them both to score higher on the longitudinal test. Both Soldiers agreed that the instruction in *Cross-Cultural Competence Trainer (3CT) V2*^{A} was excellent. They became interested in cross-cultural techniques and did some self-study in the two to three days following the course; participant #1 did not. The researcher noted one other piece of data common to #2 and #3; both started with a lower pre-test score than #1. Age, occupation, TIS, and overseas experience did not appear to correlate to test outcomes.

This quality improvement project was hindered in several ways. First, SARS-CoV-2 restrictions were enacted by civil and military leadership in Illinois. This testing and training would have been included during normal paid training days for the BMT. Instead, participants were asked to conduct all aspects virtually and on their own time. Next, participant turnout was low. Voluntary participation was likely low due to the length of time of the examinations and training (~3 hours). Lastly, with so few participants, it was difficult to ascertain if these results represent the larger SFAB healthcare population.

Impact on Practice

The BMT implemented the *Cross-Cultural Competence Trainer (3CT) V2*^{A} course to develop and maintain cultural competency until further evaluation can be conducted. Between promotions, retirements, transferring assignments, and training events, the military as a whole has a high turnover rate. This training package is a tool that will continue to be used to build a baseline competency in new team members. Because this training is readily available, easy to use, and requires few resources, the researcher anticipates that it will remain the standard procedure for cultural competency training until ATP 3-24.3 *Cultural and Situational*

Understanding (the U.S. Army's "culture Bible") is re-published and training methodology is updated.

Conclusion

SFAB leadership has determined that cultural competency is a primary skill necessary for BMT personnel to achieve mission success throughout the world. The implementation of *Cross-Cultural Competence Trainer (3CT) V2*^{A} demonstrates promise as a primary method of developing and maintaining cultural competency in SFAB BMT personnel. Further evaluation with larger sample size and routine reassessment will provide the SFAB command team with the information necessary to schedule cultural competency training appropriately. As noted in the literature review, it is recommended that cultural competency/awareness education should be embedded in all training whenever feasible.

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