The Impact of a Cultural Competence Assessment Tool on Teaching Strategies in the DNP Curriculum at Southern Illinois University of Edwardsville

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Executive Summary

Developing culturally competent care is a dynamic process in which the goal is to provide culturally congruent care to patients from diverse backgrounds. Critical components of cultural competence in healthcare are recognition of diversity among human beings, the skill to care for individuals, being nonjudgmental and open towards all individuals, and enhancing cultural competence through lifelong learning (Repo et al., 2017). Additionally, understanding the key role culture has in all lives and how it influences behaviors, respecting cultural differences, learning to effectively use culturally modified, specific practices, and continuously developing one's own cognizance of personal cultural impacts, prejudices, or biases is crucial to developing cultural competence and subsequently providing culturally competent care to all patients (Jongen, 2018).

Due to its complexity, many definitions of cultural competence exist. The ability of healthcare professionals to integrate culture in providing healthcare services is a definition that envelopes, at the most superficial and broadest level, what culturally competent care is (NHMRC, 2006). It is the complex incorporation of knowledge, attitudes, and skills that improve cross-cultural communication and effective interactions with others (Andrews, 2003). Cultural competence as the ability of providers and organizations to successfully provide healthcare services that meet the social, cultural, and language needs of patients (Betancourt et al., 2002). Betancourt and Green (2010) also explain how the term cultural competence has grown to show the expansion of skills that enable healthcare practitioners to embrace sociocultural factors. Culturally competent care is provided through recognizing and accommodating culturally diverse patients. Through incorporating the culturally diverse patients' understanding of illness and

treatment, which may include healing methods complementary to Western medicine, culturally competent care is delivered.

Social determinants of health are circumstances in the environment where people are born, work, live, learn, work, play, worship, and age which have an impact on health, functioning and quality of life consequences and risks (Healthy People 2020, 2020). In healthcare, being knowledgeable of social determinants of health is of particular importance, affecting every individual a student will meet and provide care. These should be addressed early on, with examples and opportunities for exploring views and personal reflection. Furthermore, it is important that the student be aware of his/her own social determinants of health and culture to provide culturally competent care (Martinez et al., 2015).

Literature Review

The aims of the literature review were to investigate what culturally competent care is, how it is taught and what, if any, assessment tools exist to evaluate effectiveness of these methods. After reviewing the literature, it was evident that a various teaching strategies existed. The existing teaching strategies were being modified to better suit the changing world and incorporate e-learning along with other internet and computer-based methods. Didactic lecture, although admirable for providing a base to build on, needs to be linked to interactive activities such as discussion to be effective (Dogra et al., 2016). E-learning, consisting of short courses, blogs, discussion groups, reading materials, online lectures, webinars, and videos, provide flexible learning options for students. Attitude changes can come from active participation in seminars and workshops as deeper knowledge is gained from firsthand experiences (Dogra et al., 2016). Working in small groups allows students to explore their views and challenge each other (Robinson et al., 2016). Through participating in clinical situations in the community,

participants gain insight into the culture of the community and have a resource base for future use(Dogra et al., 2016).

Novel teaching strategies exist in the world of e-learning, including photovoice and telecollaboration. Photovoice is a method in which participants can document and discuss their impressions through an image and brief written expression of experiences and perceptions. Through photovoice, students gain insight into the context of their own culture and other cultures; this is especially useful in uncovering hidden assumptions and biases (Kelly et al., 2018). Telecollaboration as part of learning has become particularly popular in the last 10 years. Telecollaboration can lead to cultural and linguistic exchanges between participants, including students, guest speakers and e-pals from a different geographical areas or cultures (Villalobos-Buehner, 2019).

To evaluate the cultural competence assessment tools length, measurability of priority facets of cultural competence and retest and internal consistency reliability, as well as content and construct validity were reviewed. The Inventory For Assessing The Process Of Cultural Competence Among Healthcare Professionals- Revised (IAPCC-R) is a paper and pencil assessment intended for use by healthcare professionals and measures cultural desire, awareness, knowledge, skill, and encounters. The Transcultural Self-Efficacy Tool (TSET) measures cognitive, practical, and affective facets of cultural competence in nursing students. The TSET was found to be a valid, reliable instrument for measuring the impact of cultural competence education of undergraduate nursing students. The Cultural Competence Assessment (CCA) Tool is based on a cultural competence model which originally focused on the cultural competence and cultural aspects of the healthcare provider. More recent advancements in the model additionally include complex aspects of the client's culture and how these impact outcomes

(Schim et al., 2005, Schim & Doorenbos, 2010). The CCA tool assesses cultural awareness, sensitivity, and competence of the healthcare provider. For a client to be provided with culturally competent and congruent care, the healthcare provider must incorporate the client's culture and understanding of healthcare in the plan (Schim & Doorenbos, 2010).

This tool was chosen due to its length, measurability of priority facets of cultural competence and exhibits retest and internal consistency reliability as well as content and construct validity.

Project Methods

The CCA tool consists of thirty questions which measure the behavioral, awareness, and sensitivity factors of cultural competence in providers. Permission for the use and modification of the tool was granted from the authors. It was modified by excluding the final questions related to personality of the survey participants, and four questions were added directly asking about teaching strategies alumni recalled from the program, and suggestions for curriculum changes. All questions were entered in a survey format in Qualtrics XM. A list of email addresses of SIUE FNP alumni from the past ten years was obtained from Dr. Valerie Griffin, Clinical Associate Professor and Director of Nurse Practitioner Specializations at SIUE. No identifiable information such as name, age, or gender was used to recruit eligible participants.

This project was submitted to the Institutional Review Board at Southern Illinois University at Edwardsville January 2021 and deemed a quality improvement project All participants received an email containing a brief overview of the project, statement of implied consent, and a link to complete the survey; completion of the survey assumed consent. The recruitment document emphasized a 14-day response timeframe, however remained open for 28

days. The data was organized in a Qualtrics survey report form and exhibited mean scores and responses of the participants. It was further divided into the facets of cultural awareness/sensitivity and cultural behaviors and measured quantitatively. Responses regarding demographics encountered, and teaching strategies were reported qualitatively.

Evaluations

Results revealed in the past 12 months participants encountered patients from diverse races and ethnicities, having the greatest contact with White/Caucasian patients. Additionally, participants encountered individuals from vulnerable populations including those who are mentally or emotionally ill, physically challenged/disabled, homeless/housing insecure, substance abusers/alcoholics, gay, lesbian, bisexual, or transgender, or from different religious/spiritual backgrounds.

About half (51.35%) of participants reported they were somewhat competent; comparatively, 18.92% reported somewhat incompetent in providing culturally competent care. Two subscales were measured, including cultural awareness and sensitivity, and cultural competence behaviors. For cultural awareness and sensitivity, the mean score was 5.8775 on a scale of one to seven, with a higher number indicating a greater level of cultural awareness and sensitivity. For the inversely scored questions the mean score was 1.4557 on a scale of one to seven, with a lower number indicating a greater level of cultural awareness. For the cultural competence behavior subscale, the mean score was 2.818, on a scale of one to seven, with a lower number indicating a greater level of cultural competence. This indicates that the survey participants possess greater self-reported levels of cultural awareness and sensitivity, and cultural competence behaviors, however as cultural competence is a dynamic concept, improvements can be made in these subscale scores for future SIUE FNP students.

There are two major limitations in this project that could be addressed in future research. First, the sample size was insufficient to produce generalizable results as 37 of 194 invited alumni participated. Secondly, due to the covid 19 pandemic, time constraints limited implementation.

Impact on Practice

Consideration should be given to changes in curriculum based on teachings strategies participants found most useful and suggestions that were provided by the surveyed alumni. Participants reported the most useful strategies were mentoring and consultation, student written reports, live immersion/study abroad, and guest lecturers. Participants made suggestions regarding curriculum content, elective classes, and events that they thought would be useful to improve cultural competence teaching. Additionally, 72.97% of the survey participants thought culturally competent care should be taught throughout the curriculum in each class.

Conclusion

Cultural competence is a dynamic concept, and although many alumni felt they were only somewhat competent in interacting with those from different cultures, the scores did show a high competence level in majority of participants. Areas for improvement did include incorporation of additional and novel teaching strategies, some of which are being incorporated in the current curriculum but were not at the time of alumni's academic experience. It is recommended that future graduates be surveyed with this tool for future curriculum planning and feedback on current teaching strategies and methods.