EVALUATION OF THE CULTURALLY COMPETENT

NURSING MODULES

A Major Paper Presented

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Abstract

The dramatic aging of the U.S. population and the growing proportion of racial and ethnic minority groups are two factors that continue to increase the urgency of addressing health disparities (State of Aging and Health in America [SAHA], 2007). With 40% of the U.S. population currently consisting of either immigrants or first-generation Americans, it is imperative that healthcare facilities provide cultural competence training for their nurses to ensure that all patients receive quality care (Hascup, 2010). Recognizing cultural diversity, integrating cultural knowledge, and acting in a culturally appropriate manner enables nurses to be more effective in initiating nursing assessments and serving as client advocates (American Nurses Association [ANA], 1991). The purpose of this project is to evaluate the *Culturally Competent Nursing Modules* commissioned by the Office of Minority Health, as an effective program for increasing cultural awareness in a long term care facility. Findings from this program evaluation indicate that the *Culturally Competent Nursing Modules* can facilitate increased cultural awareness among nurses in a long term care facility.

Table of Contents

Evaluation of the Culturally Competent Nursing Modules

Problem Statement

The dramatic aging of the United States (U.S.) population and the growing proportion of racial and ethnic minority groups are two factors that continue to increase the urgency of addressing health disparities (State of Aging and Health in America [SAHA], 2007). As aging immigrants begin to move into the cohort that is most likely to use long term care services, a situation in which multiple languages, religions, and cultural traditions are colliding can be predicted. This is occurring in a setting where intimate acts of caring for the very ill, cognitively compromised, and dying are routine events (Institute for the Future of Aging Services [IFAS], 2006). The interplay of clients, providers, and organizational culture may create barriers, cause cultural conflicts, lead to a clients lack of trust or reluctance to access services, and may ultimately result in healthcare inequalities (Andrews & Boyle, 2008). Cultural and language differences may engender misunderstanding, a lack of adherence to health care recommendations, or other factors that negatively influence clinical situations and impact patient health outcomes (U.S. Department of Health and Human Services, Office of Minority Health [USDHHS, OMH], 2007).

Increasing the cultural competence of the workforce has gained attention from health care policymakers as a strategy to improve quality and eliminate racial/ethnic disparities in healthcare (Betancourt, Green, Carrillo, & Park, 2005). With 40% of the U.S. population currently consisting of either immigrants or first-generation Americans, it is imperative that healthcare facilities provide cultural competence training for nurses

to ensure that all patients receive quality care (Hascup, 2010). Nursing facilities need to address cultural differences and cultural competence in order to anticipate and prevent potential breakdowns in communication, both within staff and between staff members and residents/families (IFAS, 2006). Ethnocentric approaches to nursing practice are ineffective in meeting the needs of diverse cultural groups of clients (American Nurses Association [ANA], 1991). Recognizing cultural diversity, integrating cultural knowledge, and acting in a culturally appropriate manner consistently enables nurses to be more effective in initiating nursing assessments and serving as client advocates (ANA).

While it is unrealistic to expect a health care professional to possess in-depth knowledge of every category and subgroup of minority older persons, it is possible to develop proficiency in levels of awareness, skills, and sensitivity that can be applied to interactions with ethnic minority older persons and their families (McBride, 2010). In 2004, The Office of Minority Health initiated the development of *Culturally Competent Nursing Modules (CCNM)* in order to help nurses develop cultural and linguistic competencies required to improve the quality of care for ethnically diverse communities (USDHHS, OMH, 2007). The goal of cultural competence is to create a health care system and workforce that is capable of delivering the highest quality care to every patient regardless of race, ethnicity, culture, or language proficiency (Betancourt et al., 2005). The purpose of this project is to evaluate the *Culturally Competent Nursing Modules* as an effective program for increasing cultural awareness in a long term care setting.

Literature Review

Epidemiology

The current growth in the number and proportion of older adults living in the U.S. is unprecedented in our nation's history. Longer lives and aging baby boomers will double the population of Americans aged 65 or older during the next 25 years (SAHA), 2007). This population is also growing more racially and ethnically diverse. In 2009, there were approximately 38,000,870 older adults in the U.S.; 85.2% of older adults were non-Hispanic White, 8.4% African American, 6.5% Hispanic, 3.2% Asian, 0.5% American Indian, and 0.1% Native Hawaiian (U.S. Census Bureau, 2009). By 2030, the changing face of older adults in the U.S. will be evident: only 72% of this population will be non-Hispanic White; 11% will be Hispanic; 10% African American; and 5% will be Asian (SAHA, 2007). Among all the states, Rhode Island (RI) ranks 11th for its 65 years and older population and 5th for its 85 years and older population (U.S. Census Bureau, 2008). By 2030, RI will face a projected population growth for adults 65 and older of 246,507 (U.S. Census Bureau, 2008). The estimated population for people in RI who are 65 and older is 148,440, comprised of: 93.2% non-Hispanic White; 2.7% African American; 3.4% Hispanic; 1.2% Asian; and 0.3% American Indian (U.S. Census Bureau, 2009). Ethnic groups in RI include: 19% Italian; 18.4% Irish; 12% English; 10.9% French; 8.7% Portuguese; 6.4% French Canadian; and 5.3% German (U.S. Census Bureau, 2008).

Vast differences are found between and within races related to health beliefs and practices, access and utilization of health care, health risks, family dynamics and care

giving, decision making process and priorities, and responses to interventions and changes in health care policies (McBride, 2010). The increasing population growth of racial and ethnic communities and linguistic groups, each with its own cultural traits and health profiles, presents a challenge to the health care delivery service industry in this country (USDHHS, 2005). The provider and the patient each bring their individual learned patterns of language and culture to the health care experience which must be transcended to achieve equal access and quality health care (USDHHS).

Health disparities

Health disparities are differences in the incidence, prevalence, mortality, burden of diseases, and other adverse health conditions or outcomes that exist among specific population groups in the U.S. (National Association of Chronic Disease Directors [NACDD], 2006). Health disparities can affect populations groups based on gender, age, ethnicity, socioeconomic status, geography, sexual orientation, disability, or special health care needs. Health disparities occur among groups who have persistently experienced historical trauma, social disadvantage, or discrimination, and these groups systematically experience worse health or greater health risks than more advantaged social groups (NACDD, 2006). In 1991, Congress requested that the Institute of Medicine (IOM) assess the extent of racial and ethnic disparities in healthcare, indentify potential sources of these disparities, and suggest intervention strategies (IOM, 2002). An IOM study committee reviewed over 100 studies; research findings demonstrated that the vast majority indicated that minorities are less likely than whites to receive needed services, including necessary procedures (IOM). These disparities exist in a number of

disease areas including cancer, cardiovascular disease, HIV/AIDS, diabetes, and mental illness, and are found across a range of procedures including routing treatment for common health problems (IOM).

The leading cause of disability and death among adults age 65 and older are: heart disease (32.4%); cancer (21.0%); stroke (7.4%); chronic lower respiratory disease (3.9%) influenza and pneumonia t (3.5%), Alzheimer's disease (2.2%); and diabetes (6.3%) (SAHA, 2007). African Americans have a significantly greater burden of disease in five of these seven leading causes of death. In 2005, death rate for African Americans was higher than whites for heart disease, stroke, cancer, asthma, influenza, pneumonia, diabetes, HIV/AIDS, and homicide (USDHHS, OMH, 2009). Hispanic populations have higher rates of obesity and higher incidence and mortality rates for stomach and liver cancer than non-Hispanic whites (USDHHS, OMH, 2009). American Indians/Alaska Natives adults are 2.3 times as likely as white adults to be diagnosed with diabetes and 60% more likely to have a stroke (USDHHS, OMH, 2010). In 2006, Asian adults 65 and older were 40% less likely to have received a pneumonia vaccine (USDHHS, OMH, 2009). The Hawaiian/Pacific Islander populations as compared to other groups have higher rates of smoking, alcohol consumption, and obesity and are 30% more likely to be diagnosed with cancer (USDHHS, OMH, 2010).

The health status of racial and ethnic minorities of all ages lags far behind that of non-minority populations, but older adults may experience the effects of health disparities more dramatically than any other population group (SAHA, 2007). A subgroup of the older adult population will experience significant aspects of physical decline or

functional disability that requires extended use of hospital, community, or home based

personal health services (Andrews & Boyle, 2008). According to the National Nursing

Home Survey, non-white residents were less likely to report or show signs of pain

compared with white residents and more likely than white residents to lack appropriate

pain management (Centers for Disease Control and Prevention, National Nursing Home

Survey [CDC, NNHS], 2004). African American residents were half as likely to have an

advanced directive when compared with white residents in nursing homes (CDC,

NNHS). Research indicates that the preference for having an advanced directive can be

influenced by individual attitudes, cultural beliefs, health conditions, and trust of health

care professionals (Centers for Disease Control and Prevention, National Center for

Health Statistics [CDC, NCHS], 2009). The survey also showed that 73% of elderly

African American nursing home residents were likely to be functionally impaired and

incontinent compared with 59% of residents of other race (CDC, NNHS, 2004).

Some of the potential reasons associated with disparities include unequal

treatment, stereotyping, language barriers, limited health literacy, and patient/provider

miscommunication (USDHHS, OMH, 2007). Even when minorities receive similar levels

of access to care, health insurance, and education, the quality and intensity of health care

that they receive are often poor (USDHHS, 2010). Access to culturally appropriate

resources and programs which address health promotion and management of acute and

chronic health problems are critical elements to improve care (McBride, 2010). Given

that stereotype, bias, and clinical uncertainty may influence diagnostic and treatment

decisions, education may be one of the most important tools as part of an overall strategy to eliminate health disparities (IOM, 2002).

Cultural competence

Culture is an extremely challenging and complex concept, requiring providers to look at themselves, their patients, their communities, their colleagues, and their employment settings from multiple perspectives (Purnell, 2005). Culturally competent healthcare, broadly defined as services that are respectful of and responsive to the cultural and linguistic need of patients, is increasingly viewed as essential in reducing racial and ethnic disparities, improving health care quality, and controlling costs (Andrews & Boyle, 2008). As the population being provided nursing care becomes more culturally diverse, it is necessary for nurses to build cultural competencies and skills to deliver effective care (Tuck, Moon, & Allocca, 2010). Many nursing professionals make reference to cultural competence because it is implied in patient-centered care and in nursing's core values of caring and service, but cultural competence is much more (Tuck et al.). Teaching cultural content to advanced practice nurses moves forward nursing's agenda to help resolve the global health crisis and promote the accomplishment of national and international health goals (Tuck et al.).

Culturally Competent Nursing Modules (CCNM)

In 2004, USDHHS, OMH commissioned the development of the *CCNM* as a tool to assist nurses with the cultural and linguistic competencies required to improve the quality of care for minority, immigrant, and ethnically diverse communities. The development of the curriculum modules included an environmental scan that provided

both content knowledge and pedagogical strategies to support development of the *CCNM*

(USDHHS, OMH, 2007). To develop the scan, project staff conducted a review of

published literature, internet searches, and phone inquiries with experts in the field.

Other sources of information for the environmental scan included nursing schools,

federal, state, and local agencies, public and private health organizations, nursing

associations, and consumer advocacy groups (USDHHS, OMH, 2007).

Six focus groups were conducted with nurses of varying specialties in three

geographic locations during March and April 2004. The focus groups were valuable in

gaining information about the nature of cultural competency training needed, the utility

and perceived value of the *CCNM* project in meeting these needs, and the appropriate

content and format of the training modules (USDHHS, OMH, 2007). The National

Project Advisory Committee (NPAC) and consensus building meetings consisted of

experts in the field of cultural competency and health and nursing specialty groups. These

groups collaborated to develop and provide valuable guidance and subject matter

expertise throughout the development of the *CCNM*. In addition, specific

recommendations were made on the content, format, and dissemination strategies for the

modules (USDHHS, OMH). The *CCNM* were revised following field testing, submitted

for accreditation and continuing education credits, and released to the nursing community

on the World Wide Web on March 16, 2007 (USDHHS, OMH). The modules are a web-

based curriculum designed as an online educational program to help nursing

professionals provide appropriate care to ethnically diverse patients. The *CCNM*

curriculum is grounded in the National Standards for Culturally and Linguistically

Appropriate Services in Health Care and is structured around three themes: Delivering

Culturally Competent Nursing Care; Language Access Services and Supporting; and

Advocating for Culturally Competent Health Care Organizations (USDHHS, OMH).

Each theme represents a single course, which is then further divided into six distinct

modules. Each course begins with a pretest intended to measure nurses' existing

knowledge of relevant concepts, identify knowledge gaps, and focus their attention on

specific concepts discussed in the module (USDHHS, OMH). Each course is organized

around video-enabled case studies that illustrate the concepts covered in the course and

allow for participant feedback and self-assessment

Module case studies are based on interactions between nurses and a diverse group

of patients. Each of the scenarios presented reflect real life situations that nurses

encounter daily, such as language barriers and the need for appropriate interpretation

services, cultural issues, or gender concordance in patient care. After viewing each case

study, nurses answer self-exploration questions designed to stimulate in-depth reflection

of their feelings related to the learning content. All self-exploration questions were

developed by an instructional designer, reviewed by cultural competency experts,

educators, and nurses involved in the NPAC, and pilot and field tested during the

curriculum development process (USDHHS, OMH). A posttest consisting of ten

multiple choice questions is performed at the completion of each course. The items

included on the posttest were sampled from the pretest and were reviewed and validated

by the NPAC and the accrediting agency that certifies the program for continuing

education credit (USDHHS, OMH).

In the two years following the *CCNM* accreditation and launch, 11,327 nurses registered for the curriculum and 50.5% completed at least one curriculum theme (USDHHS, OMH, 2009). A two-year evaluation performed in 2009 using a four theme evaluation model developed by Kirkpatrick and Kirkpatrick (2006) concluded that the *CCNM* curriculum was successful in increasing the knowledge and awareness of cultural competency and that the curriculum has the potential for changing health care practice settings and health outcomes. This paper completed an evaluation of the *CCNM* as an effective program for increasing cultural awareness in a long term care setting. The theoretical frameworks guiding this program evaluation will be discussed next.

Theoretical Frameworks

Two frameworks were used to guide the evaluation of the *CCNM*: the Purnell

Model for Cultural Competence (2002) and the Centers for Disease Control Framework

for Program Evaluation in Public Health (1999).

The Purnell Model for Cultural Competence

The Purnell Model for Cultural Competence has been used by nurses in a variety of

countries and languages as an organizing framework to guide cultural competence among

multi-disciplinary members of the health care team (Purnell, 2002). The model has

relevance for all health care providers in diverse environmental contexts. In practice, the

model can guide the development of assessment tools, planning strategies, and

individualized interventions (Purnell). In education, the model and organizing

framework have been a valuable resource to guide the study of cultural practices and life

ways of clients during short-term immersion courses both in the U.S. and abroad. The

model (Figure 1) is depicted as a circle with an outlying rim representing global society, a

second rim representing community, a third rim representing family, and an inner rim

representing the person; these represent the model's metaparadigm concepts (Purnell).

The interior of the concentric circles is divided into twelve pie-shaped wedges

depicting cultural domains and their concepts. According to the model, domains do not

stand alone; each domain relates to and is affected by all other domains. Although the12

domains and their concepts flow from more general phenomena to more specific

phenomena, the order in which the care provider uses the domain may vary (Purnell).

The center of the model is empty, which represents unknown aspects about the cultural
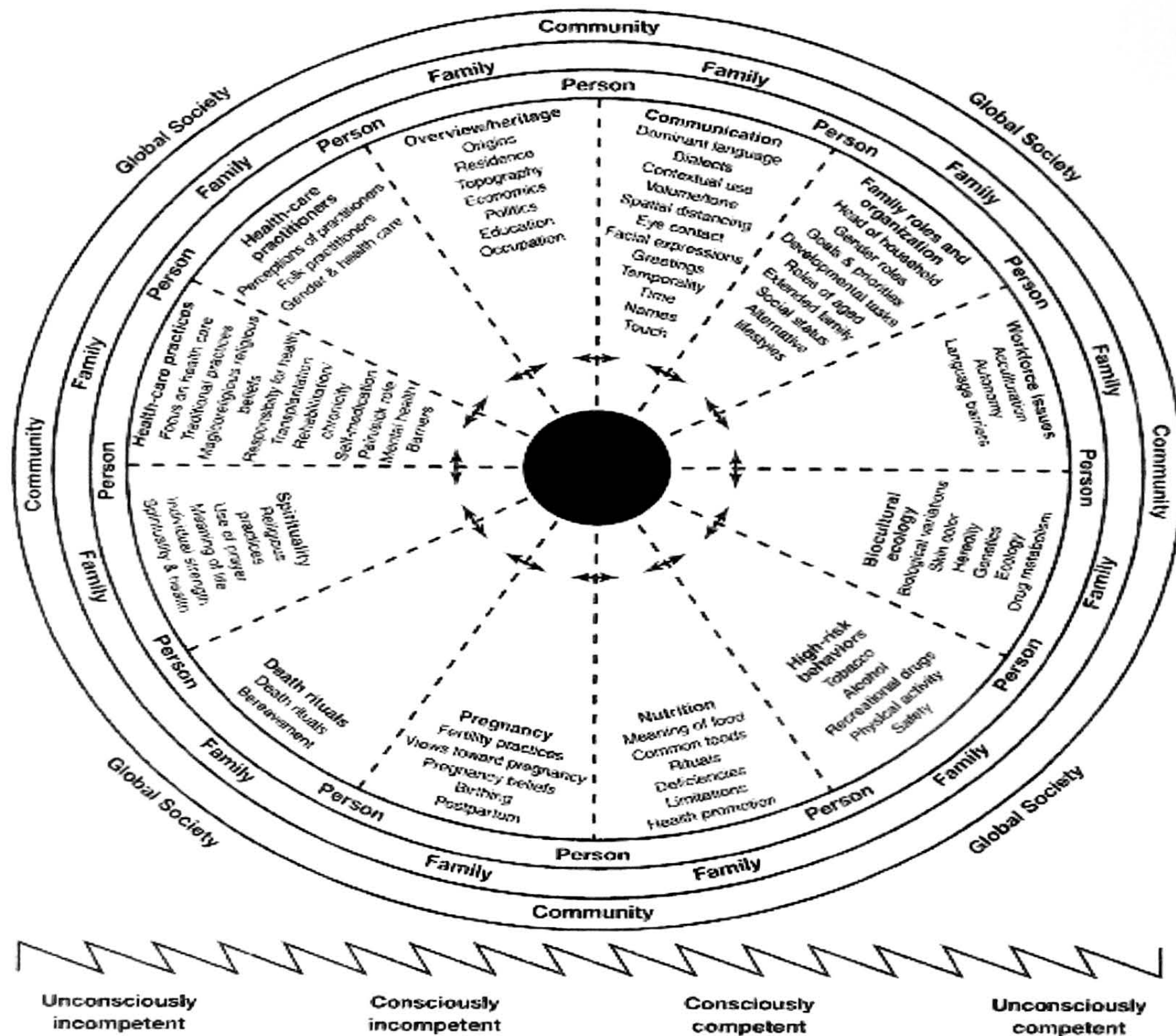
group. Along the bottom of the model is a saw-

Figure 1. The Purnell Model (Purnell, 2002).

toothed line representing the concept of cultural consciousness. This line relates

primarily to the health care provider, although organizations may also be represented on

this nonlinear line according to their stage of cultural competence as an organization

(Purnell). The Purnell Model has been used by sociologists, anthropologists, nurses,

physical therapists, and physicians to conduct ethnographic, ethnomethodological, and

constitutive ethnographical research (Purnell). The model guided data collection and

assessment of an organizational culture among nurses in the long term care setting.

Organizational cultures reflect the social structure, historical antecedents, values,

traditions, management processes, policies and procedures, and evaluation processes that

reveal the degree to which diversity in thinking, reflecting, and behaving are encouraged

or tolerated (Purnell).

The Center for Disease Control Framework for Program Evaluation

The Centers for Disease Control (CDC) Framework for Program Evaluation in

Public Health is a practical, non- prescriptive tool designed to summarize and organize

the essential elements of program evaluation (Figure 2). The framework is composed of

six steps that must be taken in any evaluation. They are starting points for tailoring an

evaluation to a particular public health effort at a particular time (CDC, 1999). The

evaluation cycle begins by engaging stakeholders, the persons or organizations having an

investment in what will be learned

from an evaluation and what will be done with the knowledge (CDC). Next, the cycle

continues to describing the program. Program descriptions convey the mission and

objectives of the program being evaluated. Aspects to include in a program description

are need, expected effects, activities, resources, stage of development, context, and logic

model (CDC). The third step in the cycle focuses on the evaluation design. The

evaluation must be focused to assess the issues of greatest concern to stakeholders while

using time and resources as efficiently as possible. Among the items to consider when

focusing an evaluation are purpose, users, uses, questions, methods, and agreements. The

fourth step is gathering credible evidence that will convey a well-rounded picture of the program so that the information is seen as credible. Aspects of evidence gathering that typically affect perceptions of credibility include indicators, sources, quality, quantity and logistics (CDC). In the fifth step, the evaluation conclusions are justified when they are linked to the evidence gathered and judged against agreed-upon values or standards set by the stakeholders. Justifying conclusions on the basis of evidence includes standards, analysis and synthesis, interpretation, judgment, and recommendations (CDC). In the final step, lessons learned in the course of an evaluation ensure that the evaluation processes and findings are used and disseminated appropriately. This step of the process includes five critical elements for ensuring use of an evaluation: design; preparation; feedback; follow-up; and dissemination (CDC). Although informal evaluation occurs through routine practice, standards exist to assess whether a set of evaluative activities are well designed and working to their potential. These standards are grouped into four categories that include utility, feasibility, propriety, and accuracy and include a total of 30 specific standards (CDC). Utility standards make certain that information needs of evaluation users are satisfied. Feasibility standards ensure that the evaluation is viable and pragmatic. Propriety standards guarantee that the evaluation is ethical, conducted with regard for the rights and interests of those involved. Accuracy standards make sure that the evaluation produces findings that are considered correct (CDC, 1999). The steps and standards are used together to frame the program evaluation.

Next, each step of the CDC framework and how it was used in this program evaluation will be discussed.

Engaging the stakeholder.   The evaluation cycle began by engaging the

stakeholders, identified as the nurses, residents, and the long term care facility. These

stakeholders had an investment in learning, and the *Culturally Competent Nursing*

Modules (CCNM) appeared to be an effective program for increasing the nurses' cultural

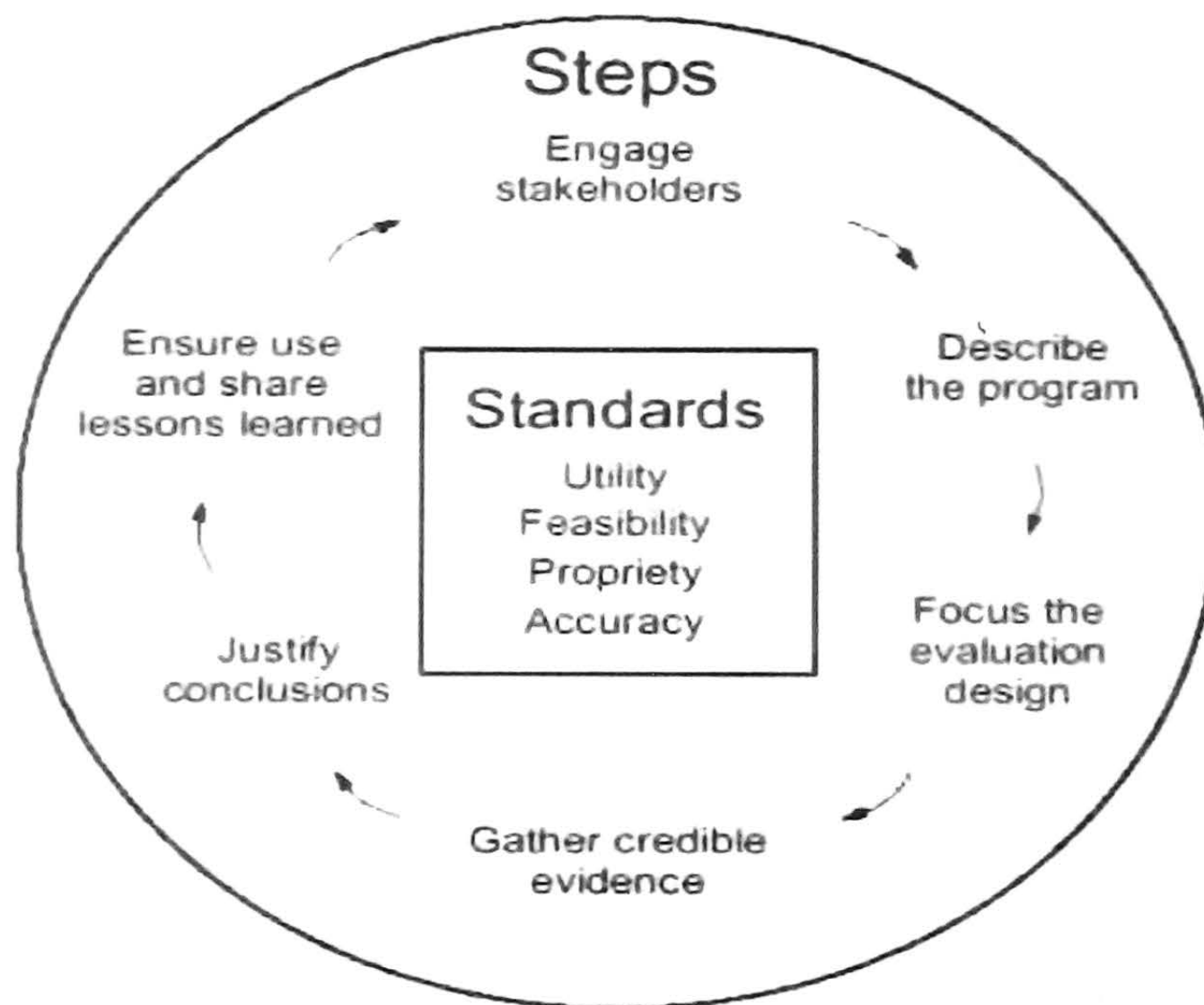awareness in providing quality care to

Figure 2. Centers for Disease Control framework for program evaluation in public

health (CDC, 1999).

diverse older adults. Residents residing in long term care were also directly affected by

the program in that they would potentially receive quality care from a culturally

competent nursing staff. The organization would be indirectly affected by benefitting

from the enhanced cultural awareness knowledge that the nurses would likely gain from

the program. With 40% of the U.S. population currently consisting of either immigrants or first-generation Americans, it is imperative that healthcare facilities provide cultural competence training for their nurses to ensure that all patients receive quality care (Hascup, 2010).

Describe the program. The second step of the model is program description, which conveys the mission and objectives of the *CCNM*. Nurses spend more time in direct patient care than any other type of health professional and, as such, are in a unique position to improve the quality of care delivered to patients at risk for health disparities (USDHHS, OMH, 2007). The *CCNM* were commissioned by the Office of Minority Health in 2004 as a tool to assist nurses with the cultural and linguistic competencies required to improve the quality of care for minority, immigrant, and ethnically diverse communities. A National Project Advisory Committee was convened to serve in an advisory capacity during the curriculum development process. During their development, the *CCNM* underwent an environmental scan that provided: both content knowledge and pedagogical strategies to support development; six focus groups with nurses in varying specialties in three geographic locations; and consensus building meetings consisting of experts in the field of cultural competency (USDHHS, OMH, 2007). It was important for the credibility and comprehensiveness of the curriculum that the perspectives, concerns, and knowledge of various stakeholders groups were reflected in how the modules were developed, presented and written.

The *CCNM* learning objectives include:

- define issues related to cultural competency in nursing practice;

- identify strategies to promote self-awareness about attitudes, beliefs, biases, and behaviors that my influence the nursing care they provide;

- devise strategies to enhance skills in the provision of culturally competent nursing care;

- demonstrate the advantage of the adoption of the *Culturally and Linguistically Appropriate Services* in healthcare (USDHHS, OMH, 2007).

The *CCNM* e-learning program was launched on the www.thinkculturalhealth.org Web site on March 16, 2007 (USDHHS, OMH, 2007). They were revised following field testing, and approved for accreditation and award of continuing education credits. As a free web-based curriculum, no geographical or institutional barriers prevent nurses from taking this course. Access to the internet is required to participate in the curriculum, and all participants must complete the online registration and pre- and post-testing sections of the curriculum to receive their accreditation certification (OMH).

The *CCNM* curriculum is organized by the three themes of the CLAS standards. Each theme represents a single course, which is then further divided into six distinct modules (USDHHS, OMH, 2007). Each course begins with a pretest intended to measure nurses' existing knowledge of relevant concepts, identify knowledge gaps, and focus their attention on specific concepts discussed in this module. Module case studies are based on interactions between nurses and a diverse group of patients, and each of the scenarios presented reflect real-life situations that nurses encounter daily, such as language barriers and the need for appropriate interpretation services, or cultural issues of gender concordance in patient care. After viewing each case study, nurses answer self-

exploration questions designed to stimulate in-depth reflection of their responses related

to the learning content. A posttest consisting of 10 multiple choice questions concludes

each course. Test questions were reviewed and validated by the NPAC and the

accrediting agency that certifies the program for continuing education credit (USDHHS,

OMH).

Included in the program description is a logic model (Figure 3) which describes

the sequence of events for bringing about change by synthesizing the main program

elements into a picture of how the program is supposed to work (CDC, 1999). One of the

virtues of a logic model is its ability to summarize the programs overall mechanism of

change by linking processes to eventual effects. The logic model (Figure 3) depicted here

was developed to illustrate the sequence of events in this program evaluation.
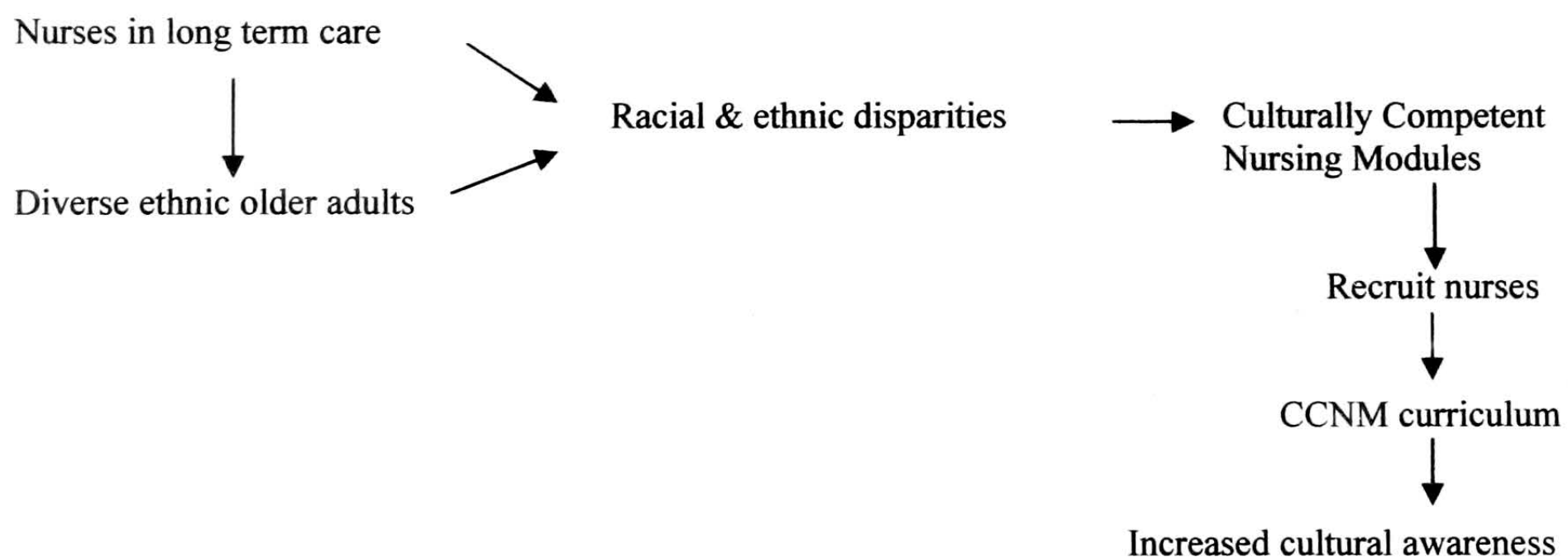
Nurses in long term care

Racial & ethnic disparities → Culturally Competent Nursing Modules

Diverse ethnic older adults

↓ Recruit nurses

↓ CCNM curriculum

↓ Increased cultural awareness

Figure 3. Logic model for evaluation of the *Culturally Competent Nursing Modules*

Focusing the evaluation design. Step three focuses the evaluation design to

assess the issues of greatest concern to stakeholders while using time and resources as

efficiently as possible (CDC, 1999). The purpose of the *CCNM* is to help nurses develop

the competencies required to improve the quality of care for ethnically diverse

communities. The purpose of this project was to evaluate the *CCNM* as an effective program for increasing cultural awareness in a long term care setting. This project represents an outcomes based evaluation of the *CCNM* curriculum that will use a pre-test, intervention, and post-test design. Data sources for this evaluation include pre and posttest scores captured by the program database and a paper/pen survey developed by the project investigator. Knowledge gained from this evaluation will provide information on the practicality of implementing the *CCNM* in long term care to bring about increased cultural awareness among nurses. This evaluation could also change practice by refining plans for introducing the *CCNM* program in order to enhance cultural awareness/competence in long term care. A final purpose involved using the process of evaluation inquiry to affect the nurses who participated in the project by raising awareness regarding health disparities and cultural competency in order to support organizational change.

Gather credible evidence. Step four strives to collect information that will convey a well-rounded picture of the program so that the information is seen as credible by the evaluations primary users (CDC, 1999). Credible evidence was collected from program participants' pretests, posttests, and surveys. There are three pretest and posttests consisting of 10 multiple choice questions reviewed and validated by the National Project Advisory Committee (USDHHS, OMH, 2009). The pretests and posttest completed by the participants were used to identify if there was a knowledge gain related to cultural awareness. Participants also completed a survey developed by the project investigator consisting of questions assessing prior cultural competency training,

profession, satisfaction with the type of training, what they disliked or would change about the CCNM, and what they had learned from the *CCNM* that would increase personal or professional growth.

Justifying conclusions. In step five, the evaluation conclusions are justified when they are linked to the evidence gathered and judged against agreed-upon values or standards set by the stakeholders (CDC, 1999). The values or standards set by the stakeholders include degree of participation, program objectives, program protocols and procedures, feasibility, fixed criteria of performance, and absence of harm. Stakeholders were made aware of the criteria for participating in the project and that participation was voluntary. The programs objective was made clear to the participants, as was that program evaluation would include pretests, posttests, and survey analysis. The program protocols and procedures were reviewed with the participants and informed consent was obtained. Pretest and posttest results were analyzed against fixed criteria of performance, specifically national test averages of nurses who have completed the program.

Ensuring use and sharing lessons learned. Step six, ensuring use and sharing lessons learned, does not automatically translate into informed decision-making and appropriate action (CDC, 1999). The goal is to ensure the stakeholders are aware of the evaluation and its findings. Both the procedures and lessons learned from the evaluation will be disseminated to stakeholders to facilitate the transfer of evaluation conclusions into appropriate actions. The results of this project evaluation will be disseminated at a presentation at the target site to provide professional development and perhaps policy formulation and implementation of cultural awareness programs in long term care.

Project dissemination also includes manuscript submission to peer-reviewed journals to communicate the findings and promote the use of evaluation findings in nursing practice.

Standards for effective evaluation.

The program evaluation standards make conducting sound and fair evaluations practical by providing guidelines to follow when having to decide among evaluation options (CDC, 1999). These standards are grouped into four categories: utility, feasibility, propriety, and accuracy, and include a total of 30 specific standards (CDC). Utility standards ensure that an evaluation will service the information needs of intended users (CDC). Under this standard, stakeholders were identified as the nurses, residents, and the long term care organization in order to address their needs. The evaluator is trustworthy and competent in performing the program evaluation. Evaluation reports clearly described the *CCNM* context, purpose, procedure, and findings. Project evaluation results will be disseminated to intended users and evaluation impact will occur by encouraging stakeholder follow-through (CDC).

Feasibility standards make certain that an evaluation will be realistic, prudent, diplomatic, and frugal (CDC). Practical procedures were undertaken to minimize disruption while obtaining information for this program evaluation. Political viability was considered and permission was obtained and granted from the RIC IRB and nursing home administration to plan and conduct this evaluation. Participants had seven weeks to complete a nine hour program including pretests, posttests, and a five question survey. In terms of cost-effectiveness, the *CCNM* are free. Participants did not get paid to participate and the long term care facility did not reimburse nurses for participating.

Participants who completed all of the courses were enrolled in a raffle sponsored by the investigator for a $30 gift certificate to an ethnic restaurant. Five nurses completed the program, and one nurse won the gift certificate.

Propriety standards guarantee that an evaluation will be conducted legally, ethnically, and with regard for the welfare of those involved in the evaluation as well as those affected by its results (CDC, 1999). The purpose of the evaluation was to evaluate the *CCNM* as an effective program for increasing cultural awareness in a long term care setting. The programs strengths and weaknesses are addressed fairly. An IRB approved consent form outlining the project purpose and procedures was distributed to potential nurse participants at a scheduled nurses meeting approved by the nursing administration at the facility. Ethical consideration was maintained to protect the privacy, dignity, and integrity of the participants during this project. There were no foreseeable risks. The benefits of participation included: increased knowledge of cultural awareness; contributed to policy change within long term care, helped decrease health disparities in diverse populations; and the utilized technology to improve health outcomes.

Accuracy standards ensure that an evaluation will convey technically adequate information regarding the determining features of merit of the program (CDC, 1999). Under this standard, the *CCNM* and its context are described, including the purpose and procedures of the evaluation. Data was gathered through the pretests, posttests, and surveys completed by the participants and analyzed systematically. Based on this summary, it is believed that the conclusions reached in this program evaluation are justified.

Methods

Purpose

The purpose of the project was to evaluate the *Culturally Competent Nursing Modules (CCNM)* as an effective program for increasing cultural awareness in a long term care setting.

Design

This project was an outcomes-based evaluation of the *CCNM* curriculum and used a pre-test, intervention, and post-test design.

Site and Sample

The project was conducted at a skilled long term care and rehabilitation facility in Bristol, Rhode Island. Long term care nurses were the target population. The sample was derived from 32 registered nurses and licensed practical nurses working in one long term care facility. A convenience sample of up to 10 nurses was selected voluntarily from the 32 potential participants. Inclusion criteria specified that participants were registered nurses or licensed practical nurses that provided care for the facility's long term care residents. Male nurses were eligible to participate; however, there were none currently working at this long term care facility.

Procedures

An IRB approved consent form (Appendix A) outlining the project purpose and procedures was distributed to potential nurse participants at a scheduled nurses' meeting approved by the nursing administration at the facility. The participants were provided an explanation of the procedures and an opportunity to ask questions. Participants were

assured that their participation was voluntary, that they could decide not to continue at any time without prejudice and that their responses were anonymous. Those participants who volunteered to participate were given a consent form to review and sign. A survey (Appendix B) developed by the investigator was also handed out to the participants to be collected and placed in a designated box upon completion of the curriculum along with pretests (Appendix C) and posttests (Appendix D). Once the recruitment process was completed, the consent forms were collected by the project investigator and stored in a secure file to which only the investigator had access. The project investigator then met with the participants to answer questions and provide a demonstration of accessing the *CCNM* website and curriculum. The *CCNM* content is an online self-study curriculum; access to the internet is required to participate. Participants were given the option to complete the *CCNM* at home or to utilize work computers during non-paid times. Nurses wishing to use the computers at work were asked to notify the project investigator so that computers would be made available

The modules were accessed on the http://www.thinkculturalhealth.hhs.gov website. Participants were shown how to log onto the website and register by choosing a username and password which they would use to access the website at anytime. Upon registering, participants completed a tutorial about the *CCNM*. Once the tutorial was completed, participants began the training by taking a ten question multiple choice course pretest (Appendix C). Then, the participants would start the course, consisting of six modules (see Intervention section).

Upon completion of each course, the participants took a multiple choice posttest (Appendix D). The program includes three courses for a total of 18 modules (Appendix E). The *CCNM* curriculum took approximately nine hours to complete, three hours per course. Participants were allowed seven weeks to complete the program. Participation was voluntary, and nurses did not receive reimbursement to participate. Upon completion of the modules, participants were asked to submit three pretests, three posttests, and a survey. A total of nine continuing education units were awarded to those participants who completed all three courses and earned a passing score of 70% or higher on each of the posttests. Participants who completed all of the courses in the *CCNM* curriculum were also enrolled in a raffle sponsored by the project investigator for a $30 gift certificate to an ethnic restaurant. Ethical consideration was maintained to protect the privacy, dignity and integrity of the participants during this project. Participants were assured of confidentiality; data was not shared with administration at the facility. Pretests, posttest and surveys completed by the participants were returned to the investigator in a designated drop box to which only the investigator had access.

Intervention

The *CCNM* content is an online self-study curriculum which is organized by the three themes of the National Standards for Culturally and Linguistically Appropriate Services in Health Care (USDHHS, OMH, 2007). The curriculum was created with support from the federal Office of Minority Health and guided by the National Project Advisory Committee comprised of nationally recognized experts on culturally competent

nursing. The curriculum consists of three courses further divided into six distinct modules, for a total of 18 modules (Appendix E).

The first curriculum course, Delivering Culturally Competent Nursing Care, provides nurses with the principle of culturally competency, a self-assessment tool to address potential gaps in cultural competency learning, tools and strategies for increasing cultural awareness during a clinical encounter, as well as skills for delivering patient-centered care (USDHHS, OMH). The second curriculum course, Language Access Services, offers an overview of language access services, provides tools and strategies for effective communication between a nurse and patient, and demonstrates the rationale for health literacy (USDHHS, OMH). The third curriculum course, Supporting and Advocating for Culturally Competent Health Care Organizations, articulates the need for nurses to play the role of advocate for cultural competency within their organizations and provides tools and strategies for integrating this education into their environment (USDHHS, OMH).

Each course begins with a pretest intended to measure nurses' existing knowledge of relevant concepts, indentify knowledge gaps, and focus their attention on specific concepts discussed in the modules (USDHHS, OMH). The courses are organized around video-enabled case studies that illustrate the concepts covered in the course materials and allows for participant feedback and self assessment. Each of the scenarios presented reflect real-life situations that nurses encounter daily, such as language barriers and the need for appropriate interpretation services, or cultural issues of gender concordance in patient care (USDHHS, OMH, 2009).

Instruments

Each course begins with a pretest (Appendix C) consisting of 10 multiple choice

questions intended to measure nurses' existing knowledge of relevant concepts, identify

knowledge gaps, and focus their attention on specific concepts discussed in the modules

(USDHHS, OMH, 2007). The questions included on the posttest (Appendix D) were

sampled from the pretest and were developed by an instructional designer (USDHHS,

OMH, 2009). The pre and post test questions were reviewed and validated by the

National Project Advisory Committee (USDHHS, OMH).

The pretests and posttest, once printed, did not have any identification markers.

Therefore participants were asked to identify themselves on the tests by using initials in

order to match pre and posttests. Pretests and posttests were collected in a drop box

provided by the project investigator and confidentiality was maintained. Participants

were also asked to complete a survey developed by the project investigator that consisted

of questions assessing: prior cultural competency training; nursing degree; satisfaction

with the type of training; what they disliked or would change about the *CCNM;* and what

they had learned from the *CCNM* that would increase personal or professional growth.

The paper and pencil surveys were collected in the designated drop box.

Timeframe

The timeline (conceptual, design/planning, empirical, analytical, and

dissemination phase) for this project in calendar months was nine months. Upon approval

from the IRB, participants had seven weeks to complete the *CCNM.* Once the pretest,

posttests, and surveys were collected, the data were analyzed and utilized in the

evaluation of the *CCNM* program.

Data analysis

Descriptive statistics were used to summarize the quantitative data from the

pretests and

posttests in comparison with national test scores. The mean, median, standard deviation

and minimum and maximum values were calculated. The data from the surveys were

analyzed by identifying patterns and themes in the participant's responses.

Results

Five nurses voluntarily participated in completing the online *CCNM* over a seven week period. Table 1 illustrates data gathered from the investigator developed survey.

Table 1.

Survey Analysis

Nurses' Responses	Sample (n=5)	Percent (%)
Registered Nurse	5	100
Associate degree	3	60
Bachelors degree	1	20
Masters degree	1	20
Prior cultural competency training	1	20
Satisfied with CCNM's	5	100
CCNM's were informative	5	100
Did not like pulse points	3	60
Liked video vignettes	2	40
Increased self awareness	4	80
Increased respect for different cultures	3	60
CCNM's too lengthy	3	60

As can be seen, of the five registered nurses participating, only the Master's prepared nurse had prior cultural competency training. Three nurses (60%) stated they had increased respect for different cultures after completing the curriculum. Three nurses

(60%) thought the program was too lengthy and they particularly did not like the pulse point sections asking participants to address self reflecting questions.

Participants completed three pretests and three posttests for each of the three courses. Table 2 illustrates the pretest and posttest scores of the five participants.

Table 2.

Participant pretest and posttest scores, based on 100%, for CCNM Curriculum

Participants	**Course 1**		**Course 2**		**Course 3**	
	Pretest	Posttest	Pretest Posttest		Pretest Posttest	
1	40	80	40	100	90	100
2	70	70	70	100	90	100
3	70	80	50	90	90	100
4	50	80	90	70	70	80
5	30	70	20	90	90	90

All of the participants increased posttest scores compared to the pretest scores for each course. Scores for course one were lower overall at posttest than for course two and three.

The participant pretest and posttest scores were compared to the CCNM national average, as illustrated in Table 3 (pretest scores) and Table 4 (posttest scores). Participant mean pretest scores were lower in course one compared to the *CCNM* national average. In course two and three, participant pretest scores were higher compared to national

average. Participant mean posttest scores were lower in all three courses compared to the

CCNM national average.

Table 3.

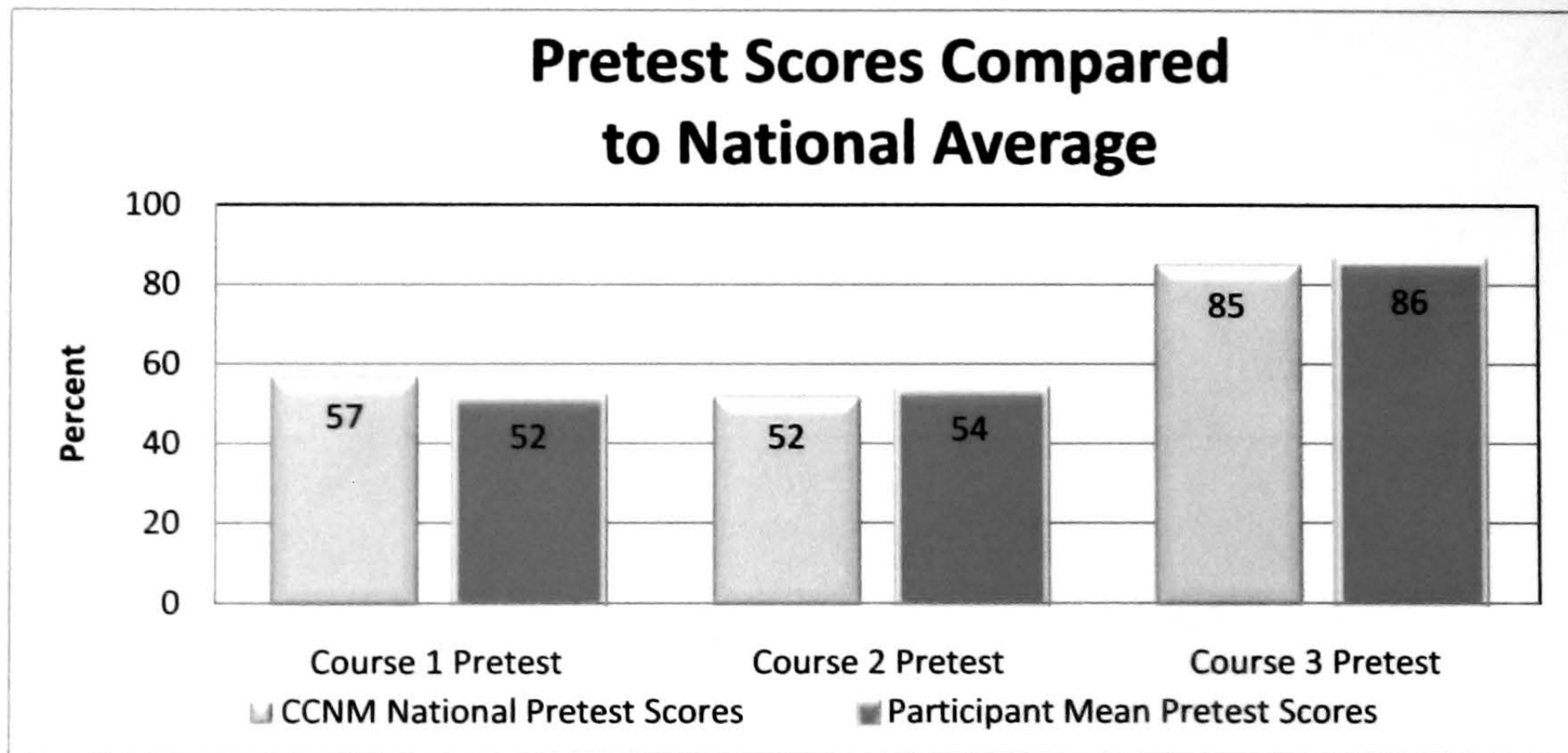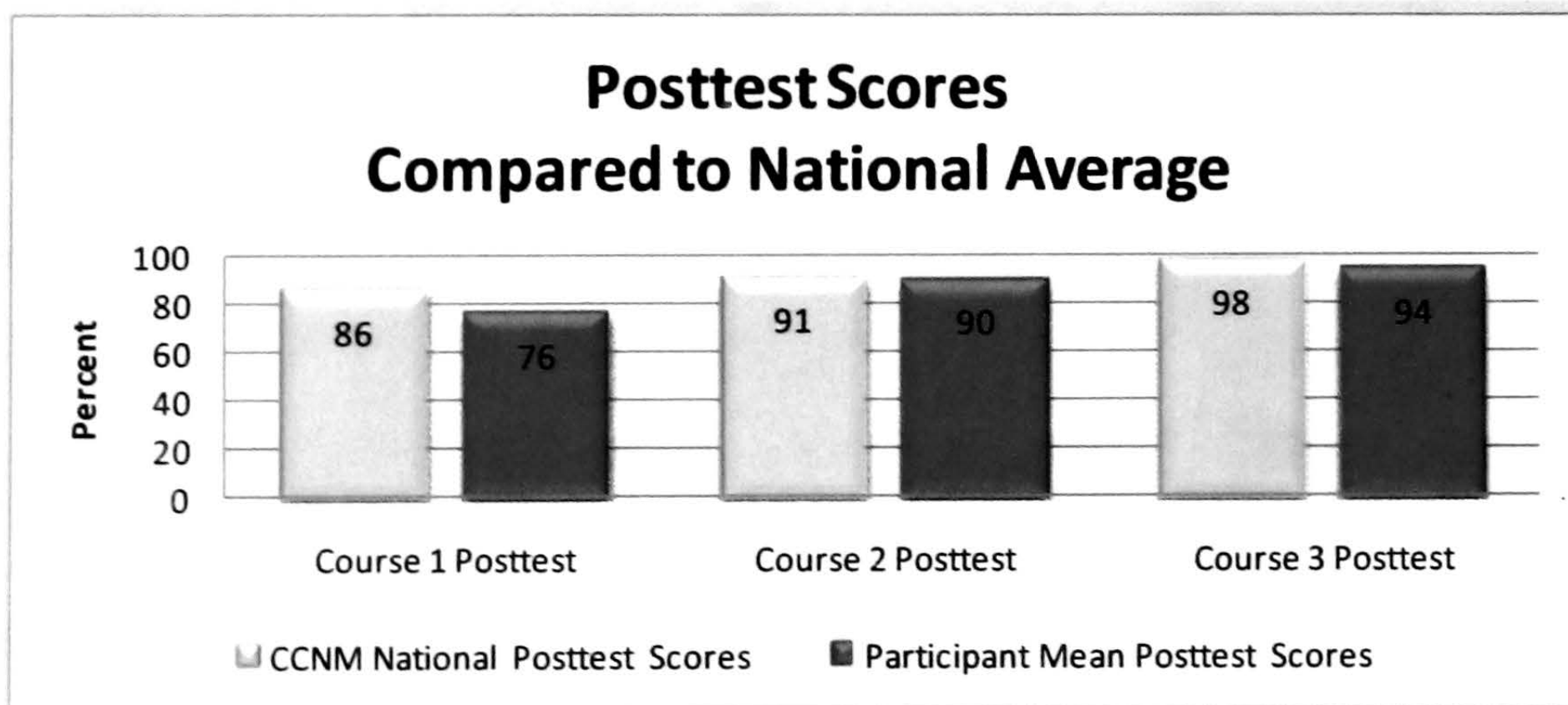*Participants mean pretest scores compared to CCNM's national average*

Pretest Scores Compared to National Average

	Course 1 Pretest	Course 2 Pretest	Course 3 Pretest
CCNM National Pretest Scores	57	52	85
Participant Mean Pretest Scores	52	54	86

Table 4.

Participants mean posttest scores compared to CCNM's national average

Posttest Scores Compared to National Average

	Course 1 Posttest	Course 2 Posttest	Course 3 Posttest
CCNM National Posttest Scores	86	91	98
Participant Mean Posttest Scores	76	90	94

Next, summary and conclusions will be addressed.

Summary and Conclusions

The OMH commissioned the development of the *Culturally Competent Nursing Modules (CCNM)* as a tool to assist nurses with the cultural and linguistic competencies required to improve the quality of care for minority, immigrant, and ethnically diverse communities (USDHHS, OMH, 2004). With 40% of the U.S. population currently consisting of either immigrants or first-generation Americans, it is imperative that healthcare facilities provide cultural competence training for nurses to ensure that all patients receive quality care (Hascup, 2010). Nursing facilities need to address cultural differences and cultural competence in order to anticipate and prevent potential breakdowns in communication, both within staff and between staff members and residents/families (IFAS, 2006). While it is unrealistic to expect a health care professional to possess in-depth knowledge of every category and subgroup of minority older persons, it is possible to develop proficiency in levels of awareness, skills, and sensitivity that can be applied to interactions with ethnic minority older persons and their families (McBride, 2010). The purpose of this project is to evaluate the *CCNM* as an effective program for increasing cultural awareness in a long term care setting.

Five nurses working in long term care were recruited to complete the *CCNM* created by the Office of Minority Health. Upon completion, participants submitted pretests and posttests for each course completed, along with a survey developed by the project investigator. The survey revealed that 100% of the participants found the *CCNM* an effective cultural competency/cultural awareness program. Eighty percent (n=4) stated they had increased self-awareness as a result of the CCNM. However, only 60%

of the participants (n=3) stated they had increased respect for different cultures as a result of the *CCNM*. This may indicate that some of the participants did not equate increased respect as an expected outcome of the program; it is also possible that the respect already existed. Sixty percent (n=3) of the participants did not like pulse point sections where participants were asked to answer self reflective questions required to proceed through the curriculum. Only 40% (n =2) of the participants liked the video vignettes, suggesting that although informative, they added to the already lengthy curriculum described by 60% of the participants.

Participant test scores increased throughout the *CCNM* curriculum, suggesting increased knowledge. In course one, *Delivering Culturally Competent Nursing Care,* participants' mean pretest and posttest scores were slightly lower than the national average. In course two, *Using Language Access Services,* mean pretest scores were higher than the national average and mean posttest scores were slightly lower than the national average. In course three, *Supporting and Advocating for Culturally Competent Health Care Organizations,* participants mean pretest scores were higher than the national average and mean posttest scores were slightly lower than the national average. So it can be concluded that the *CCNM* resulted in increased knowledge, though it is unclear if that resulted in increased respect.

Limitations included that this evaluation was conducted with a single group of five registered nurses working in one long term care facility. All of the participants were white women. The evaluation also relied on participant's self reported data. Most

participants indicated behavioral and attitudinal changes, but it is unclear of the level of change.

In conclusion, findings from this program evaluation indicate that the *CCNM* are informative and that participants overall were satisfied with the program though some suggestions for improvement could be identified, including that only 60% acknowledged increase respect suggesting respect already existed or that knowledge alone is not enough to change attitudes. Perhaps linking this program with some role playing or hands on experience in a focus group setting would also be beneficial in changing attitudes. The *CCNM* is a cost effective program for increasing cultural awareness in a long term care organization. Participant cultural awareness knowledge increased as evidenced by increased test scores throughout the *CCNM* program.

Nurses spend the most time with patients and are in a position to make a change that can have a ripple effect throughout the healthcare system. Long term care organizations need to look more closely at implementing programs such as the *CCNM* that address cultural awareness and cultural competency among staff. The results of this project should further stimulate interest in increasing cultural awareness/competency among nurses so that they may have the knowledge and skills to care for a diverse older population.

Recommendations and Implications for Advanced Practice Nursing

Health disparities are a pervasive part of America's health care system, having been documented across the spectrum, from access to insurance to disease rates. Such disparities do not fade with age, which is why cultural competencies will be key in preparing for an older diverse population (Krisberg, 2005). To meet the needs of diverse populations, nursing is challenged to adequately prepare nurses beginning at the baccalaureate level and continuing to the graduate levels (American Association of Colleges of Nursing [AACN], (2009). The rationale for proposing the integration of cultural competence in graduate nursing education is to support the development of patient-centered care which identifies, respects, and addresses differences in patients' values, preferences, and expressed needs (AACN, 2009).

A hallmark of the educational transformation experienced by graduate-prepared nurses is their increased leadership capacity in education, research, practice, and policy (AACN, 2009). This leadership role encompasses: socially and empirically derived understanding of complex causes of disparities; implementing culturally competent nursing care; addressing social justice; advocating for patients and policies that advance health care; developing competency in collaboration with patients; key persons, agencies, and various stakeholders; attitude modification and personal transformation, and contributing to culturally competent scholarship (AACN). Cultural competencies highlight the leadership and scholarly potential of the nurse prepared at the graduate level (AACN). Teaching cultural content to advanced practice nurses moves forward nursing

agenda to help resolve the global health care crisis and promote the accomplishment of national and international health goals (Tuck et al., 2010).

Early research shows that culturally competent health care can change how older and younger minorities interact with the health care system by building on community traditions and respecting cultural beliefs (Krisberg, 2005). Advanced practice nurses in public health continue to move forward and develop successful evidence-based strategies and approaches in their practice settings. Their incremental steps taken may not seem to make dramatic change in the present but could be the foundation for the achievement of health equity in the future (Association of State and Territorial Directors of Nursing [ASTDN], 2006). Further nursing research related to cultural competence is needed to develop universal evidence based practice.

Policy is the most underdeveloped area of the many cultural competence efforts within healthcare systems (National Center for Cultural Competence [NCCC], 2010). Organizational policy is key to supporting culturally and linguistically competent practice because it: sets the mission and vision of organizations; supports the practitioners with resources to implement culturally and linguistically competent practice; measures the success of practitioners and the organization in terms of how it serves diverse families; and institutionalizes cultural and linguistic competence in the organization (NCCC). Nurses have a voice in advocating and initiating organizational and health policy changes. One area in which nurses could advocate is accreditation which could create cultural competence training as a norm in long term care.

The nursing profession was one of the early innovators in the recognition of the importance of culture in health with its recognition of transcultural nursing (ASTDN, 2006). Nursing's' values of health equity and social justice evolved out of direct experience, witnessing the visible and sometimes deadly hardships experienced by resident and undocumented populations at the turn of the 20th century (ASTDN, 2006). Advanced practice nurses have frequently been the primary providers of care to the medically underserved and ethnically diverse populations (Nidwine et al., 2004). The future of quality healthcare is dependent on the ability of nurses to serve diverse populations and develop approaches with other disciplines to eradicate health disparities (Tuck et al., 2010). The goal of cultural competence is to create a health care system and workforce that is capable of delivering the highest quality care to every patient regardless of race, ethnicity, culture, or language proficiency (Betancourt et al., 2005).

References

American Association of Colleges of Nursing. (2009). *Establishing a culturally competent master's and doctorally prepared nursing workforce.* Retrieved from http://www.aacn.nche.edu

American Nurses Association. (1991, October). *Position statement: Cultural diversity in nursing practice.* Retrieved from http://www.nursingworld.org

Andrews, M.M, & Boyle, J.S. (2008). Transcultural concepts in nursing. Philadelphia: Lipincott Williams & Williams.

Association of State and Territorial Directors of Nursing. (2006, May). *The public health nurse role in achieving health equity: Eliminating inequalities in health.* Retrieved from www.astdn.org

Betancourt, J., Green, A., Carillo, E., & Park, E.R. (2005). Cultural competence and healthcare disparities: Key perspectives and trends. *Health Affairs.* 24(2). Retrieved from http://www.healthaffairs.org

Centers for Disease Control and Prevention. (1999). Framework for program evaluation in public health. *Morbidity and mortality weekly report*, 48, RR-11.

Centers for Disease Control and Prevention, National Center for Health Statistics. (2009). *Racial differences in functioning among elderly nursing home residents.* (NCHS Publication No. 25). Retrieved from http://www.cdc.gov-nchs-data-databriefs

Centers for Disease Control and Prevention, National Nursing Home Survey. (2004). *Current resident tables.* Retrieved from http://www.cdc.gov/nchs

Hascup, V. (2010). Providing cultural competency training for your nursing staff.

Minority Nurse. Retrieved from http://www.minoritynurse.com

Institute for the Future of Aging Services. (2006). Organizational cultural competency

assessment: An intervention and evaluation. *Better Jobs Better Care.* Retrieved

from http://www.aahsa.org

Institute of Medicine. (2002). *Unequal treatment: Shaping the future of health.* Retrieved

from http://www.iom.edu

Krisberg, K. (2005). Cultural competencies needed to serve all older Americans: Culture

skills will help bridge health gaps. *Nations Health,* 35(5). Retrieved from

http://www.medscape.com

McBride, M. (2010). Ethnogeriatrics and cultural competence for nursing practice.

Hartford Institute for Geriatric Nursing. Retrieved from http://consultgerirn.org

National Association of Chronic Disease Directors. (2006). Definition of

health disparities. Retrieved from http://www.diseasechronic.org

National Center for Cultural Competence. (2010). *Policy.* Retrieved

from http://nccc.georgetown.edu

Nidwine, A., Miller, K.H., Banner, A., Imperio, K., Matzo, M., Mcneal, G., Amertil, N.,

& Feldman, Z. (2004). Enhancing cultural competencies in the twenty-first

century. *Journal of Cultural Diversity.* Retrieved from http://findarticle.com

Purnell, L. (2002). The Purnell model for cultural competence. *Journal of*

Transcultural Nursing, 13(3), 193-196.

Purnell, L. (2005). Purnell model for cultural competence. *Journal of Multicultural Nursing & Health.* Retrieved from http://findarticles.com/bnet_dev.php/

State of Aging and Health in America. (2007). *Spotlight: Reducing falls among older adults.* Retrieved from www.cdc.gov/aging

Tuck, I., Moon, M., & Allocca, P. (2010). An integrative approach to cultural competence education for advanced practice nurses. *Journal of Transcultural Nursing.* Retrieved from http://tcn.sagepub.com

U.S. Census Bureau. (2009). *American Factfinder.* Retrieved from http://factfinder.census.gov

U.S. Department of Health and Human Services, National Partnership for Action. (2010). *Health disparities.* Retrieved from http://minorityhealth.hhs.gov/npa

U.S. Department of Health and Human Services, Office of Minority Health. (2007). *Culturally competent nursing modules.* Retrieved from https://ccnm.thinkculturalhealth.org

U.S. Department of Health and Human Services, Office of Minority Health. (2009). *CCNM Two-Year Evaluation Report.* Retrieved from https://ccnm.thinkculturalhealth.org

U.S. Department of Health and Human Services, Office of Minority Health. (2010). *Data statistics.* Retrieved from http://minorityhealth.hhs.gov

Appendix A. Consent form

Rhode Island College
Evaluation of the Culturally Competent Nursing Modules

You are being asked to participate in a project evaluating the *Culturally Competent Nursing Modules*. You were selected as a possible participant because you are a registered nurse or licensed practical nurse working in long term care. Please read this form and ask any questions that you may have before agreeing to be in the research. This study is being conducted by Ana Silva, a student at Rhode Island College.

Background Information
The Office of Minority Health initiated the development of the Culturally Competent Nursing Modules in order to help nurses develop cultural and linguistic competencies required to improve the quality of care for ethnically diverse communities (OMH, 2007). With the aging population growing more racially and ethnically diverse, the purpose of this project is to evaluate the Culturally Competent Nursing Modules as an effective program for increasing cultural awareness in a long term care setting.

Procedures
If you agree to be a participant we would ask you to do the following things: Participants will be asked to complete the *Culturally Competent Nursing Modules*, a web-based curriculum of three courses each containing six distinct modules. Participants' will have seven weeks to complete the CCNM"S at home or on work computers on off times. The total estimated time required to complete each course is approximately three hours, for a total of nine hours. The project investigator will provide a demonstration of accessing and navigating the website. Participants will access the CCNM's at http://www.thinkculturalhealth.hhs.gov website and register an account which can be accessed multiple times by the participant. The website is user friendly, guiding participants through the program. A curriculum tutorial will provide information and direction before participants begin the self study curriculum. Prior to beginning each course participants will be asked to take a pretest intended to measure nurses' existing knowledge of relevant concepts. The courses are organized around video-enabled case studies that illustrate the concepts covered in the course materials and allows for participant feedback and self assessment (OMH, 2007). Posttests sampled from the pretests will conclude each course. The pretests and posttests will be collected by the project investigator. Participants will initial the pretests and posttests and place them in a designated drop box. Participants will also complete a five item demographic survey which will be collected upon completion of the program. Participants will not be paid, however nine continuing education units accredited by the American Nurses Credentialing Center will be provided to those participants who earn at least a 70% score on each posttest. A certificate will be available to print upon completion of each course evaluation. Participants completing all three courses will be enrolled in a raffle for a $30 gift certificate to an ethnic restaurant.

Risks and Benefits to Being in the Study
The risks associated with this study are minimal, meaning they are about the same as what you would encounter in your everyday life.
There are no direct benefits to you for participating.

_____ Initial here to indicate that you have read and understood this page

Confidentiality

The records of this project will be kept private. In any sort of report that might be published, we will not include any information that will make it possible to identify a participant. Records will be kept in a locked file, and access will be limited to the researchers, original data will be destroyed three years after the project has been completed.

Voluntary Nature of the Study

Your participation is voluntary. If you choose not to participate, it will not affect your current or future relations with Rhode Island College or Silver Creek Manor. There is no penalty or loss of benefits for not participating or for discontinuing your participation. You will be provided with any significant new findings that develop during the course of the research that may make you decide that you want to stop participating.

Contacts and Questions

The researchers conducting this study are Joanne Costello, PhD, RN and Ana Silva, RN, BSN. You may ask any questions you have now. If you have any questions later, you may contact Joanne Costello at jcostello@ric.edu, or Ana Silva at aoliveira_5601@ric.edu.

If you would like to talk to someone other than the researcher(s) about (1) concerns regarding this study, (2) research participant rights, (3) research-related injuries, or (4) other human subjects issues, please contact Christine Marco, Ph.D. at IRB@ric.edu, or by phoning (401) 456-8598 by writing to Christine Marco, Ph.D., c/o Department of Psychology, Rhode Island College, 600 Mount Pleasant Avenue, Providence, RI 02908.

You will be given a copy of this form for your records.

Statement of Consent

I have read the above information. I have received answers to the questions I have asked. I consent to participate in this research. I am at least 18 years of age.

Print Name of Participant: _____

Signature of Participant: _____ Date: _____

RIC Institutional Review Board
Approval # __1011-09_
Expiration Date: ___9/29/2011__

Appendix B

Participant Survey

Evaluation of the Culturally Competent Nursing Modules

Please complete the survey and place in the designated drop box along with your completed pretest and posttests.

1. Have you had prior cultural competency training?   Yes   No

2. Registered nurse_____   Licensed Practical nurse_____

3. Are you satisfied with the CCNM's as an effective tool for cultural awareness/competency training?

_____

_____

_____

4. Is there anything that you disliked or would change about the Culturally Competent Nursing Modules?

_____

_____

_____

_____

5. What have you learned from the CCNM's that will increase personal or professional growth?

_____

_____

Appendix C. Culturally Competent Nursing Module Pretest Questions

Course I: Pretest- Delivering Culturally Competent Nursing Care.

1. Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system in an agency or among professionals.

    a. True

    b. False

2. When a person believes that other groups have "natural" cultural characteristics and there are no variations within a specific culture, this person displays which of the following?

    a. Ethnocentrism

    b. Essentialism

    c. Power differentials

    d. None of the above

3. Campinha-Bacote's model of culturally competent care encourages health care providers to:

    a. Seek cultural encounters, obtain cultural knowledge, develop skills to conduct culturally-sensitive assessment, and develop self-awareness.

    b. Define circumstances that affect a person's cultural worldview.

    c. Uses a culturally holistic perspective to provide culturally congruent care.

    d. None of the above

4. Which of the following, if any, is the definition of "illness"?

    a. Physiological and psychological processes that affect a persons' health.

    b. Diseases of the human body

    c. The psychosocial meaning and experience of the perceived disease for the individual, the family and those associated with the individual.

    d. None of the above

5. CLAS Standards 1-3 provide recommendations on implementing language access services.

  a. True

  b. False

6. Which of the following is not a transcultural communication technique?

  a. Explaining to patients that they can and need to speak freely about their symptoms and fears.

  b. Providing the patient with a quiet setting

  c. Examining your stereotypes and biases

  d. Listening to what your patients are trying to tell you about their symptoms

7. Developing cultural competence is a specific achievement.

  a. True

  b. False

8. Which of the following four statements best describes the relationship between the knowledge centered and skill-centered approaches to delivering culturally competent care?

  a. The knowledge-centered approach should be given preference, because specific knowledge about culture or ethnic groups helps nurses define their patients who come from these groups.

  b. The skill-centered approach should be given preference, because no nurse can remember all of the facts relating to multiple cultures.

  c. Knowledge-centered and skill-centered approaches should be balanced.

9. Which of the following, if any, encompasses the definition of patient-centered care?

  a. The nurse provides as many services as possible directly to the patient, without relying on other health care providers.

b. The health care team meets with the patient and his or her family to develop a treatment plan for the patient.

c. The nurse is aware of the role of cultural health beliefs and practices in the person's health-seeking behavior and is able to negotiate treatment options appropriately and in a culturally sensitive way.

d. None of the above

10. Only nursing encounters with minority patients are considered "cross-cultural" encounters.

a. True

b. False

Course II: Pretest- Using Language Access Services

1. It is important for nurses and patients to communicate in the same language because a common language ensures cultural understanding.

a. True

b. False

2. Children and family members should be encouraged to serve as interpreters.

a. True

b. False

3. The explanatory model is the belief system that reveals the patients perspective on the interaction with health care providers.

a. True

b. False

4. Which of the following is the most effective way to identify patients with low literacy skills?

a. Assess their physical appearance

b. Determine their educational level

    c. Ask if they can read

    d. None of the above

5. The SMOG formula determines

    a. The patients literacy level

    b. The readability level of written material s

    c. The patients language needs

    d. The nature of language access services

6. The BATHE model helps nurses to

    a. Determine the patients level of literacy

    b. Define circumstances that affect the patients cultural worldview

    c. Elicit the psychosocial context of the patients experience with illness

    d. Experiment with communication tools

7. Which of the following is the preferred role of medical interpreters?

    a. Advocate

    b. Clarifier

    c. Conduit

    d. Culture broker

8. "Triadic" refers to which of the following relationships in a nursing interview setting?

    a. Nurse, patient, family member

    b. Nurse, doctor, patient

    c. Nurse, interpreter, patient

    d. Patient, interpreter, family member

9. Which of the following is not a requirement for a qualified translator?

    a. Previous education, experience and training in translation.

    b. Membership in the minority group for which the translation is being done

    c. Command of both English and the language into which the material will be translated

    d. Familiarity with medical terminology

10. Community members should not be involved in reviewing translated materials because the y does not have the requisite medical knowledge to appropriately judge the translations.

    a. True

    b. False

Course III: Pretest- Supporting and Advocating for Culturally Competent Health Care Organizations.

1. Culturally competent organization should ensure that patients receive which of the following care?

    a. Effective, understandable, and respectful care

    b. Low-cost primary care for patients with limited English proficiency

    c. Wellness interventions for condition under which health disparities exist

    d. Care from nurses who share the patients language and culture

2. Unless he or she is a supervisor, a nurse's only role in supporting organizational cultural competence is advocacy.

    a. True

    b. False

3. To advocate effectively for cultural competence, nurses need the following skills:

    a. Willingness to serve as a change agent

    b. Commitment to diversity and provision of quality of care to all, regardless of personal characteristics

c. Ability to work collaboratively to promote change

d. All of the above

4. Developing cultural competence and providing culturally and linguistically appropriate services should be included as an integral objective in health care organizations; strategic plans.

a. True

b. False

5. Collecting data helps a health care organization do which of the following?

a. Monitor quality of care and outcome patterns

b. Assess needs for language services and health literacy assistance

c. Build an epidemiological profile of the community

d. All of the above

6. The continuous improvement cycle includes which of the following steps?

a. Assessment

b. Planning

c. Evaluation

d. All of the above

7. Which of the following is not a critical domain for measuring organizational cultural competence?

a. Values and attitudes

b. Community involvement

c. Training and staff development

d. Number of bilingual staff

8. Cultural competence within an organization results from linear process of systemically working through checklists.

a. True

b. False

9. Which of the following is a factor that contributes to successful **partnerships**?

    a. Mutual trust, respect, and commitment

    b. Identified strengths and assets

    c. Clear and accessible communication

    d. All of the above

10. Partnerships with minority communities should mainly involve soliciting input.

    a. True

    b. False

Appendix D. Culturally Competent Nursing Module Posttest Questions

Course I: Posttest- Delivering Culturally Competent Nursing Care.

11. Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system in an agency or among professionals.

    a. True

    b. False

12. When a person believes that other groups have "natural" cultural characteristics and there are no variations within a specific culture, this person displays which of the following?

    e. Ethnocentrism

    f. Essentialism

    g. Power differentials

    h. None of the above

13. Campinha-Bacote's model of culturally competent care encourages health care providers to:

    a. Seek cultural encounters, obtain cultural knowledge, develop skills to conduct culturally-sensitive assessment, and develop self-awareness.

    b. Define circumstances that affect a person's cultural worldview.

    c. Uses a culturally holistic perspective to provide culturally congruent care.

    d. None of the above

14. Which of the following, if any, is the definition of "illness"?

    a. Physiological and psychological processes that affect a persons' health.

    b. Diseases of the human body

    c. The psychosocial meaning and experience of the perceived disease for the individual, the family and those associated with the individual.

    d. None of the above

15. CLAS Standards 1-3 provide recommendations on implementing language access services.

    a. True

    b. False

16. Which of the following is not a transcultural communication technique?

    a. Explaining to patients that they can and need to speak freely about their symptoms and fears.

    b. Providing the patient with a quiet setting

    c. Examining your stereotypes and biases

    d. Listening to what your patients are trying to tell you about their symptoms

17. Developing cultural competence is a specific achievement.

    a. True

    b. False

18. Which of the following four statements best describes the relationship between the knowledge centered and skill-centered approaches to delivering culturally competent care?

    a. The knowledge-centered approach should be given preference, because specific knowledge about culture or ethnic groups helps nurses define their patients who come from these groups.

    b. The skill-centered approach should be given preference, because no nurse can remember all of the facts relating to multiple cultures.

    c. Knowledge-centered and skill-centered approaches should be balanced.

19. Which of the following, if any, encompasses the definition of patient-centered care?

    a. The nurse provides as many services as possible directly to the patient, without relying on other health care providers.

b. The health care team meets with the patient and his or her family to develop a treatment plan for the patient.

c. The nurse is aware of the role of cultural health beliefs and practices in the person's health-seeking behavior and is able to negotiate treatment options appropriately and in a culturally sensitive way.

d. None of the above

20. Only nursing encounters with minority patients are considered "cross-cultural" encounters.

a. True

b. False

Course II: Posttest- Using Language Access Services

11. It is important for nurses and patients to communicate in the same language because a common language ensures cultural understanding.

a. True

b. False

12. Children and family members should be encouraged to serve as interpreters.

a. True

b. False

13. The explanatory model is the belief system that reveals the patients perspective on the interaction with health care providers.

a. True

b. False

14. Which of the following is the most effective way to identify patients with low literacy skills?

a. Assess their physical appearance

b. Determine their educational level

c. Ask if they can read

d. None of the above

15. The SMOG formula determines

    a. The patients literacy level

    b. The readability level of written material s

    c. The patients language needs

    d. The nature of language access services

16. The BATHE model helps nurses to

    a. Determine the patients level of literacy

    b. Define circumstances that affect the patients cultural worldview

    c. Elicit the psychosocial context of the patients experience with illness

    d. Experiment with communication tools

17. Which of the following is the preferred role of medical interpreters?

    a. Advocate

    b. Clarifier

    c. Conduit

    d. Culture broker

18. "Triadic" refers to which of the following relationships in a nursing interview setting?

    a. Nurse, patient, family member

    b. Nurse, doctor, patient

    c. Nurse, interpreter, patient

    d. Patient, interpreter, family member

19. Which of the following is not a requirement for a qualified translator?

a. Previous education, experience and training in translation.

b. Membership in the minority group for which the translation is being done

c. Command of both English and the language into which the material will be translated

d. Familiarity with medical terminology

20. Community members should not be involved in reviewing translated materials because the y does not have the requisite medical knowledge to appropriately judge the translations.

a. True

b. False

Course III: Posttest- Supporting and Advocating for Culturally Comptetent Health Care Organizations.

11. Culturally competent organization should ensure that patients receive which of the following care?

a. Effective, understandable, and respectful care

b. Low-cost primary care for patients with limited English proficiency

c. Wellness interventions for condition under which health disparities exist

d. Care from nurses who share the patients language and culture

12. Unless he or she is a supervisor, a nurse's only role in supporting organizational cultural competence is advocacy.

a. True

b. False

13. To advocate effectively for cultural competence, nurses need the following skills:

a. Willingness to serve as a change agent

b. Commitment to diversity and provision of quality of care to all, regardless of personal characteristics

c. Ability to work collaboratively to promote change

d. All of the above

14. Developing cultural competence and providing culturally and linguistically appropriate services should be included as an integral objective in health care organizations; strategic plans.

   a. True

   b. False

15. Collecting data helps a health care organization do which of the following?

   a. Monitor quality of care and outcome patterns

   b. Assess needs for language services and health literacy assistance

   c. Build an epidemiological profile of the community

   d. All of the above

16. The continuous improvement cycle includes which of the following steps?

   a. Assessment

   b. Planning

   c. Evaluation

   d. All of the above

17. Which of the following is not a critical domain for measuring organizational cultural competence?

   a. Values and attitudes

   b. Community involvement

   c. Training and staff development

   d. Number of bilingual staff

18. Cultural competence within an organization results from linear process of systemically working through checklists.

a. True

b. False

19. Which of the following is a factor that contributes to successful partnerships?

a. Mutual trust, respect, and commitment

b. Identified strengths and assets

c. Clear and accessible communication

d. All of the above

20. Partnerships with minority communities should mainly involve soliciting input.

a. True

b. False

Appendix E. Culturally Competent Nursing Modules

Course I: Delivering Culturally Competent Nursing Care

Module 1.1: Principles of Cultural Competence, defines cultural competence and presents factors that may affect a nurse's ability to provide culturally competent care.

Module1.2: The Importance of Self-Awareness, addresses the need for self-awareness in culturally competent nursing, discusses how to develop self-awareness, and presents a self-awareness tool.

Module1.3: Models for Becoming Culturally Aware, presents cultural competence development models and explains how to use the models with patients of diverse cultures.

Module 1.4: Understanding Health-Related Experience discusses the difference between disease and illness and provides information on factors that may influence a patient's experience of illness.

Module 1.5: Delivering Patient-Centered Care focuses on patient-centered care and four patient-centered principles.

Module 1.6: Balancing Knowledge-Centered and Skill-Centered Approaches, defines knowledge-centered and skill-centered approaches and explains the importance of balancing the two.

Course II: Using Language Access Services

Module 2.1: Overview of Effective Communication between Patient and Nurse discusses the importance of effective nurse-patient communication, identifies barriers that can impact this communication and provides a patient explanatory model.

Module 2.2: Tools for Effective Communication, defines patient-centered care and provides effective nurse-patient communication models.

Module 2.3: Overview of Language Access Services, defines health literacy and the factors that contribute to it. The module also provides tools and strategies for nurses in caring for patients with low health literacy.

Module 2.4: When Interpreter Services are needed, discusses the interpretation process including the triadic interview and provides guidance on how nurses can work effectively with interpreters.

Module 2.5: Role of Health Literacy in Effective Communication focuses on health literacy and strategies for working with patients with low literacy.

Module 2.6: Role of Health Literacy in Effective Communication focuses on health literacy and strategies for working with patients with low literacy.

Course III: Supporting and Advocating for Culturally Competent Health Care Organizations

Module 3.1: Culturally Competent Organizations, describes the characteristics of a culturally competent organization and also discusses ways that nurses can support cultural competence within their organizations.

Module 3.2: Nurses' Roles as Advocates for Cultural Competence in Organizations identify skills that nurses need to advocate effectively for cultural competent care in their organizations.

Module 3.3: Organizational Assessment describes the domains of organizational assessment and provides an organizational assessment checklist.

Module 3.4: Strategic Planning, discusses the ways nurses can contribute to strategic planning within their organizations, and specifically focuses on continuous quality improvement and data collection.

Module 3.5: Training and Education, discusses the importance of training and education in supporting organizational cultural competence as well as identifies attitudes, knowledge, and skills that nurses need in developing cultural competence.

Module 3.6: Developing Effective Partnerships emphasizes the importance of developing partnerships to support organizational cultural competence and describes the role of nurses in developing and maintaining partnerships.