International Journal of Nursing and Midwifery Vol. 3(3), pp. 35-42, March 2011
Available online http://www.academicjournals.org/ijnm
ISSN 2141-2499 ©2011 Academic Journals

Full Length Research Papers

Cultural competence outcomes assessment: A strategy and model

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Accepted 23 December, 2010

The nursing profession has acknowledged its responsibility to prepare all practitioners to provide culturally respectful care to diverse patient populations. A culturally competent academic and clinical teaching milieu is a strategy for shaping clinical nursing expertise. It is a vital link between theory and practice. This article presents a replicable model of the process in which one U.S. University School of Nursing engaged to assess the cultural competence of the nursing curricula at both undergraduate and graduate levels, the cultural awareness of faculty and students, and the perceptions of clients about the degree of cultural sensitivity demonstrated by program graduates.

Key words: Cultural competence, cultural sensitivity, nursing workforce diversity, strategic approach.

INTRODUCTION

The demographic profile of the population of the United States (U.S.) has been changing over the last several decades, creating a greater racial and ethnic diversity. The nursing profession in the U.S. has acknowledged its responsibility and the challenges inherent in preparing a nursing workforce that reflects this diversity and to prepare all practitioners to provide culturally competent care to the clients served.

The situation in the U.S. is not unique. The challenge to provide culturally competent care is not constrained by global boundaries. All health care providers must demonstrate a sensitivity to and understanding of a variety of cultures in order to provide high quality health care. All health care providers must understand the intricate relationship between cultural and ethnic beliefs and values and the ways in which these concepts impact the context of health services both delivered (by providers) and received (by those in need of care). Further, all health care providers must appreciate the overarching influence of the social determinants of health that also influence health inequities and disparities (Egede, 2006; Navarro, 2009).

The School of Nursing (SON) at a major university (U) located in the northeastern U.S. received a grant from the U.S. Department of Health and Human Services, Health Resources and Services Administration, to implement various strategies to recruit a more diverse student population in the undergraduate and graduate programs. The strategies adopted by the SON reflected the elements that Noone (2008) summarized as the framework of a comprehensive approach to increase nursing student recruitment and retention. SON strategies included intervention into the barriers that serve as disincentives to students as they consider a decision to seek application to a program of nursing studies (example, financial need), and the challenges to sustaining enrollment through completion of the program (example, provision of mentorship to reduce feelings of isolation, and mechanisms to support adult learners) (Escallier and Fullerton, 2009).

Program faculty also engaged in a critical evaluation of the degree to which the various aspects of the USON

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educational programming were aligned with the school of nursing's mission and philosophy to prepare a nursing workforce that is prepared to deliver high quality services to a multicultural society. Attention was paid to the academic teaching milieu, the courses of study, and the context of the clinical teaching and learning environment in which students acquired practical experiences.

PURPOSE

The assessment process and its outcomes are discussed in this article in order to provide a model that other Schools of Nursing, in any global setting, might adopt as they pursue their own critical self-evaluations of the cultural competence of their academic programming.

THE CONCEPT OF CULTURAL COMPETENCE

Consciousness about the issue of cultural competence has emerged within the fields of health care education and practice over the last several decades. A similar consciousness has been raised about the need for clarification and definition of the concept and of the domains that comprise its essence. Nursing has paid particular attention to the theoretical basis (Leininger, 1988) and applications of the concept in its academic and clinical literature (Foronda, 2008; Smith, 1998).

The literature sets forth a broad variety of definitions, but most share a common view of cultural competency as an overarching concept that involves dimensions of the affective, cognitive and skills domains. These include the willingness of a health care practitioner to explore personal views about similarities and differences among cultures (cultural awareness), to appreciate and to value the cultural uniqueness and/or differences associated with a client's cultural identity (cultural sensitivity), a degree of knowledge about various cultural beliefs and practices (cultural knowledge), being open to understanding the ways in which culture shapes the views of others (cultural understanding), the ability to modify approaches to client care that resonate with that uniqueness (cultural skill), and the ability to communicate effectively within the cultural milieu (cultural interaction) (Burchum, 2002; Harper, 2006; Suh, 2004; Zander, 2007; Zion, 2009). "Cultural proficiency" emerges as the health care practitioner incorporates all of these concepts into a personal world-view and way of practice.

Cultural competence in the academic teaching environment

Sociologists, psychologists, and anthropologists have long recognized the significance of culture and its impact on knowledge acquisition. Studies examining the relationship between knowledge acquisition and academic success indicate that this relationship does not appear to be contingent upon a personal attribute of any individual, nor a collective characteristic of any ethnic group, but rather, upon whether the academic environment fostered instructional communication whereby faculty attempted to understand the student's communicative intent, and tailor the student/faculty dialogue to foster the learner's understanding (Goodenough, 2003). Lack of awareness and understanding of diverse cultural perceptions contribute to faculty/student miscommunication and conflict which can ultimately impact on student learning and knowledge acquisition (Russell et al., 2005).

Faculty must create a learning environment that maximizes opportunities for co-participation and instructional conversation with faculty and the student's peers that:

(a) Recognizes the significance of culture in instructional settings; (b) prevents stereotyping of minority populations; (c) assists to resolve cultural conflicts in learning; (d) integrates the social cultural beliefs of varying cultures; and (e) stimulates the development of communicative and other skills that students need in order to participate meaningfully in the instructional process (Aikenhead, 2001; Junious et al., 2010).

The nursing literature is rich in depiction of models for infusion of multiculturalism into academic learning assignments and clinical learning assignments (Barnardi et al., 2009; Caffrey et al., 2005; Brennan and Cotter, 2008; Johnston and Mohide, 2009; Kardong-Edgren, 2007; Sargent et al., 2005; Xu and Davidhizar, 2005). The literature also provides several approaches for assessing the degree to which the academic teaching environment has been successful in this effort (Benkert et al., 2005; Cuellar et al., 2008).

Cultural competence in the clinical learning environment

Commitment to the preparation of a culturally competent workforce necessarily requires congruence between what is taught and what is practiced. The literature offers a number of models for assessment of the health service delivery environments (the infrastructure) (Cross et al., 2008). It also offers models for assessment of provider performance, viewed through the lens of cultural competence, on the part of providers themselves (Hagman, 2007), and of the recipients of care (Johnstone and Kanitsaki, 2007; Roberts, 2007; Vaughn, 2009). Kim-Goodwin (2001) offers a summative model that posits that culturally competent practitioners, working within a health care system that values the community and client

view can have a direct influence on the promotion of positive health outcomes. The author concludes that the intersection between culture, community and health systems is the key factor that makes the difference in health outcomes at the individual, family and community levels.

The clinical practice settings in which students acquire practical clinical and client communication skills must therefore, reflect a commitment to the provision of culturally competent and client-focused care, so that students have the opportunity to acquire appreciation of these linkages between culturally congruent health service delivery and health outcomes. The concept of service learning (Bentley and Ellison, 2007; Worrell-Carlisle, 2005; Casey and Murphy, 2008) is another example of a model developed by nurse education programs to offer culturally congruent clinical learning opportunities in the wider context of community and a broader definition of the health delivery system.

STRATEGIC APPROACH

There were five components to the USON assessment of the academic program (Table 1). The elements of our self-constructed theory-based strategic approach emerged from this body of published literature and reflect the various domains of cultural competence (previously defined). The distinct elements of the approach, rather than the specific instruments used in this approach are the essence of the matter. The field of cultural competence assessment continues to evolve; therefore other instruments may be identified that demonstrate stronger psychometric properties, and could be substituted for use in the overall model.

Faculty self-assessment

A first component of the strategic approach focused on the degree to which faulty perceived themselves to be culturally competent. A 25-item tool was adapted from the longer (30-item) Cultural Competence Self-test for Health Care Providers (Goode, 2000). The tool covers three domains: physical environment, materials and resources; communication styles; values and attitudes. This tool is one of several similar tools designed to provide a mechanism for both institutions and providers to reflect on their approaches to the delivery of culturally competent care (National Center for Cultural Competence [NCCC], 2010). Psychometric properties of this tool have not been reported. However it was thought that the tool offered sufficient evidence of content validity for its use in this application, because item domains were congruent with the published literature.

Student self-assessment

The second component of the strategic approach was the self-assessment of cultural competence among students who enrolled in various undergraduate and graduate academic pathways and at various modalities of learning, including both distance and campus-based. Registered Nurses who were enrolled in or had recently completed the undergraduate portion of a baccalaureate to masters degree program completed the 20-item Inventory for Assessing the Process of Cultural Competence Among Health Care Professionals – Student Version) (Campinha-Bacote, 2007). The inventory covers five construct domains: cultural awareness, knowledge, skill, encounters, and desire. Psychometric properties of the student version of the inventory have not been independently reported. However the properties of the professional version have been widely studied, and results have been compiled. The instrument has been determined to have construct validity, and an acceptable range of internal reliability (between 0.60 and 0.90) in various applications (NCCC, 2010)

Student view of the curriculum

The student view of the degree to which the nursing curriculum could be considered to be culturally competent (the third element of the strategic approach) was solicited through distribution of the 31-item Blueprint for Integration of Cultural Competency in the Curriculum (BICCCQ) (Tulman and Watts, 2008) to graduate students who had completed their undergraduate studies at the USON, and to a smaller sample of USON undergraduate students who were in the final few months of their program of study. BICCCQ items were derived from another instrument originally designed to measure this concept within medical school curricula. Additional items were added by Tulman and Watts to make the tools relevant to nursing education, research and practice, in order to enhance construct validity for that application. Both the original and the adapted tool were demonstrated to have five factors: attitudes and skills; knowledge of basics; cultural communication; knowledge of theory; and knowledge of key concepts. The Chronbach's alpha internal reliability coefficient ranged from 0.73 to 0.94 across factors and was 0.96 overall.

Expert review of the curriculum

An external review of course objectives and course content for several undergraduate and graduate level courses was undertaken to determine the degree to which the USON commitment to cultural competence was reflected in course objectives, materials and teaching strategies (the fourth element of the strategic approach). The review also assessed the degree to which clinical learning experiences were arranged within community-based settings that provided health care services to multicultural population groups. The review was conducted by a professor of nursing who is widely acknowledged to be an expert in the field of cultural competency. The content review used standards established by the SON and the relevant literature as benchmarks of quality.

Client perceptions

The fifth component of the overarching program review focused on client perception of the degree to which they received culturally competent health care services. The University's Human Subjects Committee reviewed the protocol and approved the use of a client survey to generate this information. The survey was conducted in a health care setting (outpatient pediatric clinic) that was the representative of the type of clinical learning environment to which USON students were assigned for practical experience. A large proportion of care providers in this setting were graduates of the USON. Therefore, we believed that the activity would provide information about the relationship between USON efforts to infuse cultural competency into the nursing curriculum, and how these

efforts were reflected at the community health systems level (Kim-Goodwin, 2001) and that the findings would serve as a proxy indicator of the degree to which the USON's strategies for educating a culturally competent nurse workforce have been successful.

The instrument entitled Cultural Competence Assessment – Primary Care (CCA-PC) authored by Sarah Hudson Scholle (1998) was selected. The CCA-PC was adapted from a larger inventory (Switzer et al., 1998) with four subscales: respect for cultural differences, community and family involvement, appropriateness of assessment and treatment options, and agency services and structure. The psychometric properties of the instrument are not reported by the author of the tool. However, a review of the items by content experts associated with the USON indicated that there was internal content validity, suitable to its intended application. Program administrators and faculty also agreed that the content of this instrument were closely aligned with the statements of intended outcomes for cultural competency of program graduates that had been endorsed by the SON.

RESULTS

The findings from the assessment were expected to be favorably positive, given the SON's long history of engagement in the promotion of cultural competence. In fact, there was very little variance among faculty in their very high self-assessment ratings of cultural competence. The most compelling finding from the faculty self-assessment included the acknowledgement by faculty that the lack of ability to communicate with clients in their own languages presented a potential barrier to the effective exchange of health information.

All student respondents also reported a "strongly positive" self-assessment of cultural competence. However some students acknowledged a small degree of frustration when they encountered clients whose cultural views had to be negotiated to accommodate these views with recommended health interventions.

Student respondents were largely supportive of the cultural competency of the overarching program of study, including both the academic and clinical components. However, they indicated that the curriculum could be enhanced by placing greater emphasis on discussion of the theoretical formulations related to culture and nursing and on the bio-physiological determinants of health.

The cultural competency expert consultant supported the students' perspective. She recommended that the USON expand the variety of teaching/learning methods employed by faculty to include, for example, the use and application of case studies, live case enactments, as well as reflective journaling. She also recommended that a specific objective pertaining to cultural competence be included throughout all course curricula both at the undergraduate and graduate levels. These recommendations were presented to the USON Curriculum Committee for consideration and action.

The fifth element of the program assessment strategy focused on parental perceptions of the cultural competence of the healthcare providers who provided health care services to their children. A total of 92 surveys were completed by parents who had brought their children to the health facility to receive services. Respondents indicated that the child's health provider understood how the parent perceived the child's problem, respected the family's values and customs, and helped them to get services that were needed from other agencies or health care providers. Most respondents felt that they were included in decision making and were viewed as members of the health care team. There was very little variance in the opinions expressed about any of the tool's 12 questions as a function of demographic identity, level of education, or health insurance status (Table 2). There was a statistically significant difference ($p = 0.034$) between White respondents and respondents of other ethnicities, compared to Latin American respon-dents concerning the discussion of use of alternative healing therapies. Latin American respondents indicated that they were more comfortable in raising this discussion with the health care provider.

DISCUSSION

The linkage between the self-constructed theoretical framework that guided this study and the methods and strategies used in the assessment is depicted in Table 1. The table demonstrates the unique contribution that each of the five elements of the strategic approach was able to offer in crafting an overarching view of the totality of the SON's educational and clinical programming. However, as an essential element of self-awareness, the SON also acknowledged that its responsibilities for education of a culturally competent nursing workforce extended beyond the terms and limits of the academic environment. A very recent focus in the field of academic program evaluation has been placed on assessment of the degree to which programs seek to know if the practitioners that they educate have all of the competencies that they need to make a difference to the health of the community, and that the graduates actually use these skills in their practices (Boelen, 2009). Therefore, the fifth element that was incorporated into the assessment design provided added value to the exploration of the dimensions of cultural competence within USON academic and clinical programming, specifically the component of cultural proficiency.

Conclusion

Nursing is the appropriate professional discipline to take a lead role in ensuring that culturally competent health care is provided to all patients and families. Schools of Nursing demonstrate their commitment to this philosophy

Table 1. Relationship between assessment theory and methods.

Concepts inherent in various assessment tools	Theoretical construct						
	Cultural awareness	**Cultural sensitivity**	**Cultural knowledge**	**Cultural understanding**	**Cultural skill**	**Cultural interaction**	**Cultural proficiency**
Cultural competence self-test for health care providers							
Physical environment	X						
Materials and resources	X			X			
Communication styles		X				X	
Values and attitudes	X			X			X
Inventory for assessing the process of cultural competence among health care professionals – Student version)							
Cultural awareness	X						
Knowledge			X				
Skill					X		
Encounters						X	
Desire							X
Blueprint for integration of cultural competency in the curriculum (BICCCQ)							
Attitudes and skills		X			X		
Knowledge of basics							
Cultural communication						X	
Knowledge of theory			X				
Knowledge of key concepts			X	X			
Curriculum review by content expert							
Linkage between academic and clinical educational components	X	X	X		X	X	X
Cultural competence assessment – Primary Care							
Respect for cultural differences	X	X		X			X
Community and family involvement						X	
Appropriateness of assessment and treatment	X	X	X	X	X	X	X
Agency services and structure		X				X	

through academic processes that span the continuum from student recruitment through assessment of educational outcomes. A framework and approach for assessment of cultural competence has been designed and tested. It is offered as a model for adoption by other SONs who are committed to a similar purpose.

LIMITATIONS

The number of self-assessments contributed by students and faculty was less than anticipated or desired, leading to the potential for bias, tending toward over-valuation of the degree of both individual and academic cultural competence. Nevertheless, we note again that the SON has placed a very important emphasis on this concept, and that this positive influence may be, in fact, being accurately reflected. The use of a pediatric setting for the assessment of the client view of the cultural competence of providers necessarily involved solicitation of a proxy opinion (the parent, rather than the child). However, we believe that parents would expect no less (and perhaps

Table 2. Demographic characteristics of the respondents.

Variable	N	%
Gender		
Male	34	37.0
Female	57	2.0
Missing	1	1.1
Age		
<20	1	1.1
21 – 25	10	10.9
26-29	10	10.9
30-35	10	10.9
36 – 39	7	7.7
40 – 45	24	26.1
46 +	9	9.8
Missing	21	22.8
Education		
Grade 12 or less (including technical school)	34	37.0
Some college or higher	35	38.0
Missing	23	25.0
Ethnicity		
Asian	1	1.1
African American	5	5.4
White	55	59.8
Latin American	23	25.0
Other (included Puerto Rican)	4	4.3
Missing	4	4.3
English spoken		
Yes	72	78.3
No	20	21.7
Spanish spoken		
Yes	22	23.9
No	70	76.1
English read		
Yes	63	68.5
No	16	17.4
Missing	13	14.1
Marital status		
Married	49	53.3
Single, not living with partner	14	15.2
Single, living with partner	14	15.2
Separated	4	4.3
Missing	11	12.0

Table 2. Contd

Medical insurance		
Public assistance	27	29.3
Private or other	42	45.7
None (self-pay)	4	4.3
Missing	19	20.7

more) in the way of culturally competent care for their children as they would for themselves.

ACKNOWLEDGEMENTS

We acknowledge the contributions of Ventryce Thomas, RN, MS, who serves as the Cultural Competency Coordinator for the project. We thank Jeannie Gaspard, RN, MSN and the Clinical staff in the Pediatric Oncology Cancer Center for their assistance with distribution of the surveys.

This project was supported in part by funds from the Division of Nursing, Bureau of Health Professions (BHPr), Health Resources and Service Administration, Department of Health and Human Services (DHHS), under Advanced Education Nursing Grant D09HT05303. The information or content and conclusions are those of the authors and should not be construed as the official position or policy of, nor should any endorsements be inferred by the Division of Nursing, BHPr, DHHS or the U.S. Government.

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