Implementing a Cultural Competency Protocol and Assessment Tool in an Urgent Care Setting: A Quality Improvement Project.

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Table of Contents

Abstract

This project delves into a crucial issue in the healthcare system: the lack of a patient cultural competency tool in an urgent care setting. This void obstructs the delivery of culturally sensitive care, thereby exacerbating health disparities. The concept of cultural competence is gaining traction in the healthcare sector as it adapts to tackle health disparities in healthcare organizations and other sectors.

This quality improvement project will model the National Culturally Linguistically Appropriate Services (CLAS) standard and serve as a blueprint for improving patient outcomes. To be a culturally competent establishment, healthcare providers and staff are expected to be self-aware of their cultural predispositions and able to manage them as they strive for culturally inclusive action to produce better health outcomes.

This quality improvement project used the Plan Do Study Act (PDSA)Cycle Model. The process entailed planning and testing an improvement idea (Plan), followed by implementation and data collection (Do). The presentation shed light on the relevance of the implementation protocol and how it will improve patient health outcomes. The project implementation phase occurred in weeks 2 through 4 with chart audits and data collection. The results were assessed and analyzed during the Study and Act phase.

The provider self-cultural assessment tool was given to providers to evaluate their cultural sensitivity, which they kept after completion. The providers utilized the patient-improvised tool to evaluate patient cultural preferences in the clinic. Fifteen providers actively participated in the project, demonstrating their commitment to improving cultural competency in healthcare. 276 diverse patients were seen in the clinic; 184 diverse patients agreed for the providers to administer the tool and, while 92 patients refused the tool utilization. The providers

were grouped into two groups. The first provider group that fully utilized the tool had 76.4% of diverse patients agreeing to participate in tool administration. In contrast, 22.1% of diverse patients refused to participate in tool administration. The second provider group had “partial utilization of the tool the patient improvised cultural competency tool where only 41.6% of diverse patients agreed to have the tool administered and 58.4% refused to participate. The overall provider utilization rate for patients who agreed to have the tool administered was low at 66.7%, which did not align with project objective 4 (Table 1).

The goal of the DNP project was to create a cultural competency tool that would serve as a tool to collect data or information on diverse patients’ cultural preferences in the urgent care setting. The project successfully provided training to providers and had providers utilize the patients' cultural competency tool. Though the goal of 75% was not achieved by the providers in the four weeks, the data collected provided provider insight into patients' cultural preferences.

This project highlights the significance of a cultural competency tool to help improve patient outcomes. The creation of a cultural competency protocol would help bridge the gap between management, nursing leadership, and staff while improving staff cultural awareness and providing better health outcomes for patients in the community. Further research is needed to better understand cultural competency's role in diverse populations to improve patient outcomes.

Keywords-Cultural Competency, Cultural sensitivity, National CLAS standard, Cultural Awareness.

Problem Identification

The lack of culturally competent practices in the clinic compared with the national guidelines shows that the clinic lacks a culturally inclusive environment. This contributes to failures in creating a conflict and grievance resolution process that appropriately identifies,

prevents, and resolves conflicts. Compared to national guidelines, the clinic fails to encourage and support culturally diverse governance, leadership, and an open workforce for the population served (U.S. Department of Health & Human Services, n.d.). Gaps in cultural diversity at clinics could lead to barriers to effective clinician-patient interactions, for example, non-English-speaking patients or people with unfamiliar cultural beliefs. These system barriers are noticeable when a lack of interpreter services or ethnically diverse clinicians are present and clinician biases (Betancourt et al., 2021). These are some of the gaps in practice compared to the national standard, which will be used as a model for this quality improvement project.

Although the clinic strives to attain rural health status, it has a lack of established culturally appropriate goals, policies, and accountability, and is therefore important to have a culturally appropriate policy in place to help permeate the daily running of the organization's planning and operations. This will increase engagement, productivity, and self-awareness as individuals in a diverse setting (Maryville University, 2020). This project will implement ways to improve and introduce cultural competency in the urgent care setting through policy development as it enhances cultural sensitivity and awareness within the practice.

The clinic’s lack of a culturally competent environment could lead to a workplace that does not empower its staff to develop their talents and skills and could decrease employee engagement and staff retention (Darby, 2023). The healthcare provider and staff must try to set aside any self-biases to prevent establishing a culturally competent environment to decrease negative attitudes towards optimum patient care, which could affect healthcare professionals’ perceived preparedness to take care of patients from culturally diverse cultures (Kaihlanen et al., 2019).

Cultural competence is significant nationally and globally because it inspires the

acknowledgment and acceptance of differences in appearance, behavior, and culture of oneself and others to assist in reducing disparities and improve the capabilities of organizations and systems to offer more cultural responsiveness (Rukadikar et al., 2022). It is imperative to develop and implement a culturally competent protocol under the guidance of evidenced-based national guidelines to address the multifaceted needs of migrants and ethnic minorities, as this is a challenge both in the organizational and national settings where the cultural competence of service providers is an asset for combating health disparities, inequities and encouraging well-being (Garrido et al., 2019).

Project Question

Would implementing an evidenced-based cultural competency protocol and assessment tool improve knowledge of cultural sensitivity and establish consistent utilization of patient evaluation?

P - Providers in an urgent care setting

I - To implement a cultural competency protocol and assessment tool utilizing the National CLAS standards

C -Maintain current practice at the urgent care

O - Improve knowledge of cultural sensitivity and establish consistent use of assessment tools

T- Within 4-5 weeks.

Search Methods

The Touro University Library website databases were used, and a systematic literature search was conducted using three databases (Embase, CINAHL, and ProQuest) to identify studies that have implemented and evaluated cultural competence and its interventions in

healthcare facilities. PICOT criteria were modified to convey the research question and systematically choose relevant search terms. According to Gallagher Ford & Melnyk (2019), a PICOT criterion is a search strategy that leads to an unbiased and effective search.

The keywords “cultural and competency” were modified on the Embase database to choose relevant search terms systematically. This provided 3,779 results. The inclusion criteria searched under the Embase database were then itemized to include only those articles that were peer-reviewed, included patients from age 18 and above, were published between 2019 to 2023 from an academic journal, were written in the English language, and were researched in the United States; this produced 423 articles. Exclusion criteria were non-English speaking articles, children from age 0 through age 18, and non-peer-reviewed or not evidence-based articles. The inclusion and exclusion criteria were included by adding “healthcare” and thus provided 218 articles. The Embase database was used again to search for all essential terms, such as “assessment tool,” “cultural competency,” and “healthcare,” and this provided 16 articles. When the earlier inclusion and exclusion criteria were applied, 1 article was produced. Applying the same exclusion and inclusion criteria with the “health care provider cultural competence assessment tool” on the Embase database produced 14 articles. On the Cumulative Index for Nursing and Allied Health Literature (CINHAL), applying the same exclusion and inclusion criteria, I typed cultural assessment tools for patients, and it produced seven articles.

A search was performed in the Embase database using the keywords “cultural competency,” “health care,” and “cultural assessment tools” with the same inclusion and exclusion criteria, and five articles were produced. The following database was searched using the keywords “cultural competency” and produced 6970 articles. When the keywords “cultural competency,” “healthcare,” AND “assessment tool” were used, the search produced 194 articles

without inclusion and exclusion criteria. When the inclusion and exclusion criteria were applied, six articles were produced. The last database searched was ProQuest, which was queried using the keyword “cultural competency” and the same inclusion and exclusion criteria, producing 22,254 articles. The search criteria “National CLAS standard” was added as a filter, producing 400 articles.

Review of Literature

The literature reviewed used several study designs, which included cohort studies, exploratory cross-sectional descriptive studies, online surveys, mixed methods comparison studies, qualitative analysis, focus groups, review of existing assessment measures, and peer-reviewed studies. These study designs are relevant to this DNP project as they all impact provider self-reflections regarding getting provider baseline cultural competency and factors that lead to implementing a cultural competency protocol.

Introducing a cultural competency protocol will improve provider care and patient outcomes. Sharifi et al. (2019) state that healthcare providers with improved cultural competence awareness can plan diagnosis and treatment, manage care-related activities according to patients’ cultures, and pave the way for holistic care delivery. Introducing a cultural competency protocol would allow patients to have increased trust in the healthcare systems, improve adherence to treatment regimens and quality of life, and express greater satisfaction with healthcare services (Sharifi et al., 2019).

In reviewing different diverse populations or groups, a mixed-methods comparative design in patients who identified as lesbian, gay, bisexual, transgender, and queer (LGBTQ), according to Napolitano (2022), was used to assess a cultural competency module, and the data captured by the writer was evaluated. The effect of an LGBTQ module on student knowledge

and confidence in pre- and post-assessment, descriptive statistics were calculated, and mean differences were compared using the paired sample t-test.

In a study, two cohorts participated in 12 2.5 to 3-hour multi-modal sessions. The sessions focused on numerous aspects of healthcare delivery for diverse populations and factors contributing to health disparities using a Multicultural Assessment Questionnaire. During the study, a pre-and post-assessment was conducted to assess students' self-evaluated changes in knowledge, skills, and awareness as they relate to cultural competency in healthcare (Kelly et al., 2023).

A descriptive, correlational, cross-sectional study examined nursing students' educational experiences and self-reported insights into patient safety and cultural competence related to curriculum content and learning venues (Lee et al., 2020). Lee et al. (2019) further state that one of the assessment tools used was the Cultural Competence Assessment Instrument (CCA), which resulted in participants scoring much higher for cultural awareness and sensitivity than behavior; the results also supported the need for curriculum development to include all critical aspects of cultural competencies in various teaching/learning venues.

Danielewicz et al. (2021) used a voluntary and anonymous online survey emailed to providers and staff to survey and assess self-reported knowledge and attitudes related to culturally competent care for LGBTQ+ patients. Providers were measured in terms of self-reflection, bias, and comfort level in providing medical care for LGBTQ+ patients. The results from the study showed that LGBTQ+ people and their families have unique needs, concerns, and issues when navigating severe illness. Weeden (2020) developed an online survey on current attitudes, perceptions, and knowledge of healthcare disparities affecting LGBTQ+ persons, and this online anonymous voluntary survey was performed by graduate medical trainees in various

specialties. The findings of the research supported the need for improving cultural competency in graduate medical education so that physicians can provide a standard of care to individuals who identify as sexual minorities.

The Organizational Multicultural Competence Assessment (OMCA) was developed by reviewing existing cultural competence assessment measures and item generation from researchers and policymakers. It was identified that the measure may be used continuously as a quality improvement tool. As a tool to assess agency multicultural competence, implementation, and adherence to the national CLAS standards in governance, policies, and procedures. Staff training and service delivery to address stigmatization and discrimination, accessibility of services, community relationships, quality monitoring, and evaluation (Delphin-Rittmon et al., 2021).

A project was conducted by Fish et al. (2022) that created eight focus groups that consisted of community mental and behavioral health organization (MBHO) administrators to explore factors that enabled or inhibited implementing a multicomponent LGBTQ+ cultural competency training program that required stakeholders, leaders, and employees to participate in (Fish et al., 2022). Qualitative analysis was used to develop an explanation of how existing clinic operations and provider attitudes affect equitable access to medical care for patients from diverse cultures (McCoy et al., 2022).

Ofusu et al. (2023) explored processes and challenges faced by healthcare providers in managing diabetes and obesity in relation to intercultural care. The study used qualitative research that employed nine interviews and four focus group sessions about fostering relationships and bridging cultural gaps to regularly identify and correct fundamental problems as they occur in any setting. The literature noted that two key challenges plagued healthcare

providers that impacted intercultural care for chronic diseases. These two challenges were cultural distance and the non-medical challenges of immigrants and refugees. The goal of the research was to frequently confront non-clinical obstacles that could interrupt chronic disease management and encourage cultural competency training for healthcare providers to enhance patient-provider interaction. These study methods are relevant to this DNP project because of their results of implementing a cultural competency protocol to bridge the gap in health disparities through health provider training, effective communication, and patient satisfaction.

Review Synthesis

Cultural competence is categorized as a skill that could be learned if the individuals involved are given the necessary training to deliver better health outcomes to a diverse population. Cultural competency highlights the need for healthcare systems and providers to be conscious of and respond readily to patients' cultural perspectives (Stubbe, 2020). It is important that the healthcare system considers measures to improve and implement cultural competency to improve healthcare experiences and outcomes. Cultural competency is the ability to collaborate effectively with individuals from diverse cultures, and such competence improves healthcare experiences and outcomes (Nair & Adetayo, 2019).

When a culturally competent protocol is implemented, it provides effective patient-provider communication by building relationships. These relationships empower providers to respect, recognize, and allow patients to help provide knowledge of their beliefs and culture to their providers, which helps maintain trust and patient satisfaction. Stubbe (2020) states that for providers to deliver individualized, patient-centered care, they should consider patients' diversity of lifestyles, experiences, and perspectives to collaborate in joint decision-making toward their care.

The themes that emerged from the review of literature and will be explored in the project are:

i) Cultural competency and the National CLAS standard

ii) Cultural challenges related to patient and provider communication and barriers to providing equitable medical care to patients.

iii) Addressing incidence and prevalence of care disparities and cultural competence

iv) Cultural competency assessment tools

Implementing a cultural competency protocol would address barriers to achieving a culturally sensitive environment that boosts awareness about the sociocultural components of diverse populations and groups. Implementing cultural competency would reflect on a healthcare professional's personal strengths and weaknesses when communicating with diverse groups as this is key to overcoming different communication difficulties. The need to increase and implement cultural competence protocol in the healthcare system is recognized with the numerous educational interventions and training programs that have been created to improve skills and cultural awareness to sustain cultural competency.

Key players (organizational leaders, stakeholders, healthcare providers, and staff) should be involved in its design, implementation, and evaluation in sustaining cultural competency. To address the needs of diverse populations and groups effectively and

To improve cultural competency, the National CLAS standard will be implemented efficiently in an urgent care setting.

Impact of the Problem

Review Themes

Cultural competency and the National CLAS standard

The National CLAS standard serves as a blueprint to improve cultural competency regarding the quality of care delivered to all individuals, and its use is based on the collaboration of the individual healthcare provider and the health organization (Kumar et al., 2019). This blueprint was set forth by the Office of Minority Health ([OMH], 2021) and created 15 Cultural and Linguistically Appropriate Service (CLAS) Standards with four themes to determine the degree to which these standards would lead to patient satisfaction, improved processes, and patient outcomes. The standards are as follows below:

(1) Principal Standard—Principal Standard relates to providing effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs, practices, preferred languages, health literacy, and other communication needs (Golden et al., 2021).

(2) Governance, Leadership, and Workforce—This entails advancing in sustaining organizational governance and leadership to promote CLAS and health equity through policy, practices, and allocated resources (U.S. Department of Health & Human Servicesn.d.). Healthcare providers and staff are unaware of their biases and cultural values, which could lead to suboptimal care of patients from diverse cultures.

(3) Communication and Language Assistance – This involves informing all individuals of the availability of language assistance services clearly and in their preferred language, verbally or in writing (U.S. Department of Health & Human Services, n.d.).

Ensure the competence of individuals providing language assistance, recognizing that the

use of untrained individuals and/or minors as interpreters should be avoided.

Ratna (2019) agrees that if communication is ineffective and impaired, it could lead to negative patient outcomes and an increase in healthcare costs.

(4) Engagement, Continuous Improvement, and Accountability

The CLAS standards are intended to advance health equity, improve quality, and help eliminate healthcare disparities.

Cultural challenges related to patient-provider communication and barriers to providing equitable medical care to patients

Variations in cultural values, patients' preferences for the doctor–patient relationships, and negative relationships with their providers due to a lack of provider competence can lead to a negative outcome in the healthcare setting. Reeves et al. (2023) found when using transgender and nonbinary (TGNB) patients, the patients experienced several barriers when seeking quality healthcare services, including unfriendly office environments directly or indirectly and perceived stigma for both the patients themselves and the provider. In another study, the absence of effective communication, as well as cultural and language barriers, were key issues related to communication between healthcare providers and immigrant patients (Alghazali, 2023).

Reeves et al. (2023) further indicated that it was important for healthcare providers to have access to more demographic data on immigrant patients because it would allow healthcare providers to be better informed on how to communicate their healthcare services most effectively to the population catered to. Refugees face diverse and extensive challenges as they migrate to the United States, and it is imperative for providers to collaborate, communicate, and offer frequent reassessment that the communication is essential and culturally appropriate to the population catered to address the needs of the minority population (Dave, 2019). Healthcare

providers must consider cultural competence in practice via training to identify the healthcare provider's baseline cultural competence to allow for guidance in the development of cultural competence education (Javier, 2023).

Evidence shows that cultural humility and cultural competence among healthcare providers have been successfully applied to boost their self-reflection on their practices, with respect to ability, disability, sexual orientation with gender identity, and numerous scopes too frequently characterized by inequitable power, privilege, and injustice that affects a patient's health and well-being (Greene-Moton & Minkler, 2019).

However, according to Miller et al. (2019), highly culturally competent providers with positive attitudes worked to resolve and understand cultural differences, educated others when they made errors, and made extra efforts to research the cultural health beliefs of fellow staff and patients. They went further to ensure patient satisfaction by confirming to patients that they understood their (patient) health information by reassuring and reassessing patients' comprehension, providing additional appointments and phone calls, and involving family members in care, whereas providers with low culturally competent attitudes expected patients to be forward-thinking with their care and did not provide additional support to their patients.

A study evaluating Tulane University's curriculum encouraged residents to examine their personal cultural backgrounds and biases (Tate & Prestidge, 2020). A systemic review by Mariman et al. (2023) revealed that attitudes and perceptions from undergraduate trainees to senior physicians tend to impact patients negatively, which diminishes the quality of the patient-healthcare provider relationship, outcomes, patient satisfaction, and therapeutic adherence. In a qualitative study according to Alhalel et al. (2022), patients reported both positive and negative experiences. However, they emphasized the importance of trust, listening, education, access to

care, support, and patient advocacy. The writers further stated that team members and patients agreed that active trust-building can help the provider/patient relationship, improve outcomes, and improve the understanding of barriers to care to help guide the development of an intervention to reduce the health disparities experienced by Black pregnant persons.

In another study, African immigrants were hesitant towards office visits because they feared they would lead to complications due to providers' lack of understanding of their health needs (Omenka et al., 2020). The writers further stated that the outcomes remained the same regardless of the study-initiated efforts to bridge the providers' knowledge gap due to the providers' unaccommodating outlooks.

Addressing Incidence and Prevalence of Care Disparities and Cultural Competence

Addressing the incidence and prevalence of care disparities related to cultural competence, gaps, and barriers to care necessitates healthcare providers, staff, stakeholders, and leaders of healthcare settings to consider the cultural, linguistic, religious, sexual, and racial/ethnic characteristics as an integral component of the healthcare delivery system. It highlights the need for culturally appropriate care. Nair and Adetayo (2019) concur that measures to improve cultural competence and cultural diversity will help enhance healthcare disparities and outcomes in patient populations. DuMont (2021) argued that health disparities and inequitable care negatively impact diverse populations and are more significant among racial and ethnic minorities, costing the US over $400 billion per year.

Incidence, prevalence, mortality, and disease burden differ from other adverse health conditions among marginalized groups (Adeniran et al., 2023). Adeniran et al. (2023) report that health disparities in the neonatal intensive care unit (NICU) have their basis in a set of factors that include systemic racism and structural disadvantages that minority families endured. The

literature further addresses disparities in care given to Black and Hispanic infants, stating that they are more likely to receive sub-standard quality of care in the NICUs. To eliminate disparities like these, it is important to identify and address the mechanisms that lead to sub-standard care in minority preterm infants.

According to Safi et al. (2022), medical care in the US can contribute to the exclusion of marginalized populations and groups, those with racial/ethnic and linguistic differences, which leads to higher rates of erroneous diagnosis in vulnerable communities, such as older adults of color with several comorbidities. Nadeem & Kaiser (2022) suggest that the disparity of mortality between white and non-white populations that exists in the spectrum of thoracic surgery diseases, including chronic obstructive pulmonary disease, lung transplantation, lung cancer, and esophageal cancer, exists due to various levels at the individual, health care, and socio-political level.

Cultural Competency Assessment Tool

Healthcare providers consider, reflect, and analyze their own cultural beliefs when they interact with patients from diverse cultures (Nair & Adetayo, 2019). This is why it is imperative for healthcare providers to understand their patients' perceptions of cultural competency to improve patient participation in their healthcare needs as health outcomes are improved. The benefit of cultural competency assessment tools is to enable healthcare providers to go beyond the pathophysiological knowledge of their patient's disease process (Balachandran et al., 2022). This can be achieved by the provider's understanding of the patient's perspective of health and illness, the provider's knowledge of the patient's cultural preferences, language barriers being kept to a minimum, and an increase in the patient's quality of care, which leads to an improved positive treatment outcome (Balachandran et al., 2022).

The IOWA cultural understanding assessment client tool is a brief assessment tool for understanding organizational culture through the lenses of client perspective and perceptions (Gaba et al., 2023). The assessment tool examines organizational culture based on staff-client relations, environmental factors, and service delivery processes. It was modified from the Assessment Tool for Cultural Competence which was developed by the Maryland Mental Hygiene Administration of Maryland Health Partners (White et al., 2009).

The Purnell Model is a framework that guides healthcare providers to evaluate the cultural competency of their patients (Purnell, 2020, p. 21). The goal of the model is to help provide effective communication with patients from diverse cultures and backgrounds as they provide improved patient-centered care. The model incorporated 12 domains where the provider provides culturally appropriate care to patients to improve patent health outcomes.

Kucherepa & O'Connell (2021) performed a study that aimed to use the Self-Assessment of Perceived Level of Cultural Competency (SAPLCC) survey to measure cultural competency as learned social determinants of health (SDOH) and health disparities within a social and administrative science class. The class was attended by first-year pharmacy students. In the study, 75 items were rated using the Linkert scale from 1-4, and the tool captured self-reported improvements in cultural competency and understood the SDOH which was witnessed among these students due to educational intervention. SDOH are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

During an exploratory factor analysis, the Health Practitioner Cultural assessment instrument (HPCCI) measured a healthcare provider's cultural competence along 5 primary dimensions, namely awareness/sensitivity, behaviors, patient-centered communication, practice

orientation, and self-assessment (Zghal et al., 2020). In a pre-and post-intervention study design, the HPCCI was used to measure five dimensions of cultural competence within a Department of Gynecology and Obstetrics in a large academic medical center (McDonald et al., 2021). The writers stated that the post-intervention survey response rate was 30% which showed that cultural competence improved statistically significantly across all five dimensions (McDonald et al., 2021). The HPCCI was a useful assessment tool because it effectively measured the cultural competence of healthcare providers by providing useful professional feedback for practitioners and organizations seeking to increase a practitioner's cultural competence.

Another tool for measuring the healthcare provider's cultural competence is the Consumer Assessment of Healthcare Providers and Systems Cultural Competency (CAHPS-CC) item set. The Agency for Healthcare Research and Quality (AHRQ) (2023) developed this tool which is made up of 34 items and is used to assess culturally competent care from the patient's perspective with respect to 5 domains including patient-provider communication; complementary and alternative medicine; experiences of discrimination due to race/ethnicity, insurance, or language; experiences leading to trust or distrust, including level of trust, caring, and truth-telling; and linguistic competency and access to language services (AHRQ, 2023).

During this project, a pre-survey using the IOWA health provider assessment tool will be conducted to evaluate the cultural competency of their patients during clinic visits. After the surveys are collected, healthcare providers will be trained regarding cultural competency, its benefits, gaps, and barriers to implementation. Then, a post-survey will be conducted after the training to evaluate whether cultural competency has improved.

Gaps in Practice Compared to the National Standard

The gaps in practice compared to the national standards include the clinic's failure to

articulate cultural competence into its agency's mission statement, principles, and key initiatives without including community members and peers in its processes (Moore, 2020). The clinic fails to develop and establish culturally and linguistically appropriate goals, policies, and management accountability that can be intertwined with the organization's planning and operations (County of Marin; Department of Health and Human Services, Behavioral Health and Record Services, n.d). The national standard identified by CLAS expects healthcare organizations to have a cultural competency protocol to improve the quality of services provided to all individuals to reduce health disparities and achieve health equity (U.S. Department of Health & Human Service; Office of Minority Services, 2023).

The overall assessment of the literature was that cultural competency assessment tools are used to retrieve data and information from the patient's standpoint to address cultural differences when culturally appropriate interventions are implemented. The goal with these tools is to reflect that the provider is culturally competent and to take it one step further to involve the patient in compromise interventions through shared, culturally congruent decision-making. Ineffective communication could lead to negative outcomes like disruption in the patient's quality of care, increased cost burden on healthcare systems, and utilization of emergency and inpatient services. When providers incorporate effective communication into their daily dealings with the patients, they bridge a gap between the negative outcomes covered earlier.

Project Aims

The quality improvement project aims to identify gaps and barriers in the clinic setting that diminish the care given to the diverse population. It plans to educate providers on cultural competency, cultural awareness, cultural sensitivity, and cultural assessment tools for the patients. Other aims of the project are to evaluate each healthcare provider's personal cultural

awareness and increase provider knowledge of patient cultural preferences to meet the needs of a diverse patient population.

Project Objectives

The project objectives are as follows:

Objective 1: Evaluate each healthcare provider's personal cultural awareness.

Objective 2: Educate providers on cultural competency, cultural awareness, and cultural sensitivity related to the National CLAS standards.

Objective 3: Educate each healthcare provider on the cultural assessment tool for the patients via a PowerPoint presentation.

Objective 4: Participant utilization of the cultural assessment tool will be 75% or better.

Project Framework

The Plan, Do, Study, Act (PDSA) cycle, also known as the Model for Improvement, is a tool that can be deployed to put quality improvement ideas into practice immediately (Chen et al., 2020). The PDSA model involves repeating processes focused on quality and process improvement that can be implemented for all types of processes, especially in creating and implementing a cultural competency protocol in the clinic. For projects assessing quality improvement (QI), this Model for Improvement tool can be easily utilized without requiring industrial or engineering expertise (Brown et al., 2019).

The PDSA cycle's first step is to test a change, and the second step is to test a change on a small scale before implementing it on a much larger scale. Three focus questions are involved in the Model for Improvement that will help guide this QI implementation. The focus questions are as follows:

i) Setting the aims-this entails asking, "What are we trying to accomplish?"

ii) By establishing a measure-this involves asking, “How do we know that a change is an improvement”?

iii) Selecting change by asking, “What changes can we make that will result in improvement?” (Arceo, 2021).

When these focus questions are answered, the second step is to test a change in the practice setting using the PDSA cycle. This framework model is in line with this quality improvement DNP project, the requirements for implementation science research, and the aim of finally improving quality in the healthcare system and practice (Arceo, 2021).

Historical Development of the PDSA Framework

The PDSA model began as the Plan, Do, Check, Act (PDCA) cycle, which was introduced by Walter Shewhart in the 1920s (Katowa-Mukwato et al., 2021). The PDSA cycle method originated from Walter Shewhart and Edward Deming in 1986, during the Crisis MIT Center for Advanced Engineering Study (Quality et al., 2016). Taylor et al. (2014) stated that following the early teachings of Deming in Japan on PDCA, the terms PDSA and PDCA are used interchangeably.

The PDSA provides a structure for iterative testing of changes to improve the quality of systems, and this method is now widely accepted in health care improvement. The Shewhart Cycle was created by Walter Andrew Shewhart, an American physicist, engineer, and statistician whom Dr. Deming influenced. Shewhart's book “Statistical Methods from the Viewpoint of Quality Control” was published in 1939 and introduced the concept of a straight-line first, three-step scientific process of specification, production, and inspection.

Shewhart attributed the three stages of the mass production process through scientific methods drawing from parallel specifications, production, and inspections to hypothesize, as

experiments are conducted, the hypothesis is evaluated. During the formation of these stages, knowledge of the scientific approach to knowledge acquisition as he subsequently clarifies the above steps while following a circular progression rather than a linear progression, which gave rise to what is known today as the Shewhart cycle (Millard, 2022).

According to Millard (2022), Dr. W. Edwards Deming was an American engineer, statistician, and management consultant who started his career as an electrical engineer and later specialized in mathematical physics. The writer states that Dr. Deming was best known for his work in Japan's auto industry after the Second World War. He is considered among the most influential non-Japanese people in the Japanese manufacturing industry. He championed the statistical process control management principle, a precursor of Total Quality Management.

Dr. Deming built off Shewhart's cycle idea and revised it. In his new revision launched in 1950, he reiterated the importance of constant interaction among the four steps of design, production, sales, and research, which became known as the Deming Wheel or Deming's Circle (Millard, 2022). PDSA cycles were utilized to implement practice change. Deming emphasized the relevance of frequent collaborations among design, production, sales, and research and emphasized that the four steps should be rotated constantly, with product and service quality as the main objective (Millard, 2022). Deming’s Shewhart cycle was modified slightly in 1951, which led to the Japanese calling the PDSA the “Deming Wheel” (or Deming Circle) (Moen, n.d). At the age of 39, Deming edited a series of lectures Shewhart delivered to the U.S. Department of Agriculture into what eventually became the basis of Shewhart’s 1939 book. Deming got the chance to present the new version of the cycle in 1950 during an eight-day seminar in Japan, which was sponsored by the Japanese Union of Scientists and Engineers (JUSE). PDCA terminology was developed following Deming's early teaching in Japan. The

terms PDSA and PDCA are often used interchangeably about the method.

Application to DNP Project

Major Framework Tenets

Plan

"Plan" involves the test or observation and includes a plan for collecting data. This is where the objective of the test is stated, along with predictions about what will happen and why, and a plan is developed to test the change (Institute for Healthcare Improvement, 2020). During this DNP project, a PowerPoint presentation will be used to educate and discuss with healthcare providers cultural awareness, cultural sensitivity, and cultural competency as they relate to the National CLAS standards. This presentation will shed light on the relevance of the protocol implementation and how it will improve patient health outcomes in their care. During the planning phase, the team and the DNP lead will determine what will be accomplished during the implementation phase. Benchmarks for improvement with potential solutions to be tested will be discussed (Agency for Healthcare Research and Quality, 2023).This involves recruiting a team that has knowledge of the problem or an opportunity for improvement. Selection will be based on the strengths of each team member, as selection will be based on looking for engaged, forward-thinking individuals. After recruiting team members, roles and responsibilities will be identified, timelines will be set, and a meeting schedule will be established. The team will comprise the DNP lead, nurse managers, nurse educator stakeholders, and leaders. It is essential that all team members participate in creating the plan to understand the problems and to ensure that team members are aware of how important they all are in being instrumental in implementing the plan once it is analyzed and tested. Successful planning will increase the likelihood of healthcare providers becoming more culturally equipped in skills and knowledge to

meet the needs of their diverse patients. Thorough and careful design helps prevent wasted PDSA cycles and determines any QI project's final quality and success (Chen, 2021). A spreadsheet will be used to assign tasks to each individual member, set timelines, allocate resources, and track the status of PDSA execution.

Do

The Institute for Healthcare Improvement (2020) states that the "Do" in the PDSA cycle executes the test on a small scale, begins to document problems and address potential changes that will lead to measurable improvement, and documents unforeseen observations objectively and data analysis. The DNP lead will write observations during this implementation stage, evaluating healthcare provider responses. Other observations would be made with staff, leaders (owners, nurse managers, nurse educators), and stakeholder participation in this stage. Observations will be documented on how it fits into the clinic setting, and everything will be evaluated to see if everything went as planned and if there is a need for modifications. Chen et al. (2020) state that the major task in the Do stage is to measure baseline data, pilot improvement on ideas, and observe and collect follow-up data. During this DNP project, it is critical to collect baseline data before implementing any changes. Baseline data includes patient demographics, which will be evaluated if there is a cultural assessment tool. The cultural competency of the providers will be assessed by evaluating attitudes about diversity, health beliefs, attitudes toward patients' opinions, and cultural contexts.

A PowerPoint presentation will be presented to educate and discuss cultural awareness, cultural sensitivity, cultural competency, and cultural assessment tools with providers. After the PowerPoint presentation, the DNP lead will hand out cultural assessment tools to providers to self-evaluate themselves. Also, after the PowerPoint presentation, the DNP lead will disseminate

the patient cultural assessment tool, which will be used to evaluate the patients' cultural preferences.

The providers will take the completed cultural assessment tools to the project lead for review. The DNP lead will also observe and perform chart audits to evaluate changes, determine whether providers comply with completing the assessment tool, and review the responses. When completed, data collection and analysis will begin.

The data collected will confirm the need for the QI initiative and allow the DNP lead and the team to evaluate the effectiveness of project interventions by comparing pre-implementation and post-implementation results (Chen et al., 2020). As the DNP lead observes what happens during the implementation period, they will be able to document how the people involved reacted to the changes, problems raised, and/or unexpected effects. Qualitative feedback can help the project adjust existing plans and lead to new improvement ideas.

Study

The "Study" phase is the data analysis phase. The quantitative data regarding the experimental improvement are collected and compared against the expected and past results (Institute for Healthcare Improvement, 2020). The DNP lead gathers data and analyzes it to decide if a measurable improvement was achieved. Finally, the DNP lead decides if the outcome synchronizes with the expectations defined in the planning phase, as noted in Appendix B (Gorenflo & Moran, 2010).

Control charts are a popular tool for visualizing process performance over time, and they are often used during the Study phase of PDSA (Institute for Healthcare Improvement, 2020). Using the aim from Stage 1: Plan, and data gathered during Stage 2: Do, once the

implementation of pilot changes and measuring impact is complete, the Study phase in the DNP project would determine the following:

i) Did the plan result in an improvement? By how much/little?

ii) Was the action worth the investment?

iii) Were any trends noted?

iv) Were there unintended side effects?

The "Study" will occur in Project 3 and involve documenting problems and unexpected observations, analyzing the results, and interpreting them. The DNP lead will investigate any positive or negative limitations in the study.

Adjust/Act

If the study confirms that an improvement that meets expectations has been achieved, the changed process becomes the baseline for future improvement cycles. They update their documents and performance expectations and train providers on the new approach (Institute for Healthcare Improvement, 2020).

In the "Act" phase, I will write what was learned from the implementation, whether it was successful or not. If it does not work, the team will propose what to do differently in the next cycle to address concerns. If it did work, the team and the DNP lead would evaluate if the clinic is ready to implement it across the practice (Agency for Healthcare Research and Quality, 2023).

In Project 3, the DNP lead and the team will review the changes made and address what the next PDSA cycle will entail. The team will discuss this to evaluate whether the cycle can be implemented continuously after the changes are made.

Population of Interest

The DNP project population of interest is based on direct and indirect populations. The healthcare providers and nurses are the direct populations. The project site has 15 healthcare providers consisting of 11 nurse practitioners and 4 physicians. The cultural competency training will focus on the providers, while other staff members will also be trained in a condensed version but not as intensely as the providers. The inclusion criteria will focus on patients with literacy levels from 7th grade and above and adults between ages 18 and 65. The healthcare providers will be trained on cultural competency after completing a self-evaluation on cultural competency.

Any staff who are not licensed healthcare providers and have no encounters with patients from diverse backgrounds in the facility are excluded. The computer and human resource personnel are excluded. Patients who are Caucasians are excluded. Patients from diverse cultures who come to the clinic will form an indirect population of interest. Their ages would range from age 18 to 65. The inclusion criteria for the indirect population are adult patients of other ethnic groups, such as Hispanic, African American, Asian, and American Indian patients visiting the clinic. Other exclusion factors are literacy level below 7th grade level (National Assessment of Adult Literacy, n.d.). The literary level will be known when patients respond to questions on the tool's highest level of education.

Setting

The project site is a Rural Health Clinic located in Jacksonville, Texas. It is a 7-room private practice that offers urgent and primary care services for patients ranging from newborns to geriatrics. This location was selected for the DNP project because it caters to multicultural patients. Fifty percent (50%) of patients who visit the clinic are Hispanics, followed by Caucasians, African Americans, and Asians. The project site serves 75 to 100 patients monthly

for nursing and medical interventions.

The project site consists of 40 employees. The employees are made up of 4 Physicians (MDs), 11 Nurse Practitioners (NPs), and 4 Registered Nurses (RNs); 3 are nurse managers, and 1 is a nurse educator). Seven Certified Medical Assistants (CMAs) and two Certified Nurse Assistants (CNAs) work on a rotating schedule at the clinic, and 10 front office staff. The rotating schedule entails working 7 am to 7 pm daily for 7 days and personnel being off on the weekends. The staff who would work a scheduled weekend are usually off two days during the week preceding the weekend. Other personnel in the clinic are 1 human resource staff, 1 computer specialist, and 10 front office staff. Due to liability concerns from malpractice insurance, the clinic does not hire Physician Assistants (PAs) per management.

Stakeholders

The significance of involving stakeholders in key organizational activities is to provide ongoing and meaningful opportunities for communication and input to allow them to contribute as experts in their field and have their issues voiced and heard as they contribute to the decision-making process (Childcare Technical Assistance Network, n.d.). The stakeholder's support for the DNP project’s success is crucial for the project to emerge successfully.

One of the stakeholders for this DNP project is the nurse managers. The nurse managers, who are registered nurses, are essential in directing the clinic's daily operations. They will ensure and be held accountable for maintaining best practices in the clinic. They would work to support other team members in executing best practices to provide an efficient health system that is safe to achieve optimal patient outcomes and increase patient volume and satisfaction. They will ensure that staff see how clinic goals align with project objectives.

Accurate documentation is necessary to track and measure goals. For maximum training

attendance, the nurse educator will make announcements via email, staff text messages, posters, and weekly meetings. Nurse manager duties include ensuring front office staff are issuing and collecting questionnaires when complete. As the most important stakeholders, patients will be informed of the project and evaluated if they would participate in the questionnaire activity during the intake process. Registered nurses, CMAs, and CNAs will ensure that the questionnaires are completed before returning to the lead. They will ensure copies are made when questionnaires are finished, even though the lead will ensure copies are readily available. The staff members, who are Spanish speakers, would interpret the questionnaires, which are in English, to the patients. The interpretation services will be used to fill out questionnaires on days without Spanish-speaking staff in the clinic. Patients who meet the project inclusion criteria and are seen by the provider will be stakeholders.

Approval and permission to conduct the project at the site were obtained through an affiliation agreement granted and signed by one of the site nurse managers. An affiliation agreement was necessary for this project to facilitate and provide instruction in the project setting.

Interventions

The project lead will lead daily activities at the project site during working hours and assist and guide participants in the implementation phase.

The first intervention will be to issue providers the self-cultural assessment tool they will complete and keep for themselves to evaluate their self-cultural awareness (Appendix A). The project lead in the second intervention will give a PowerPoint presentation on cultural competency, cultural awareness, and cultural sensitivity related to the National CLAS standards and their benefits. Also, in this intervention, during the PowerPoint presentation, the project lead

will train providers on how to use the patient's cultural preference tool (Appendix B) to evaluate the patient's cultural preferences. The patient cultural preference tool will be issued to the providers during the PowerPoint presentation.

During the implementation phase, the third intervention will be for providers to complete the patients' cultural preference tool during the visit. The completed patient tools will be given to the project lead or nurse manager. The fourth intervention will be for the project lead to collect data through a chart audit.

The project lead will provide support and answer questions regarding the project and processes as they arise. The project lead will provide support and answer questions regarding the project and processes as they arise. Nurse managers and the project lead will ensure that staff know the expectations during the implementation phase. The participants will be evaluated on their compliance with the utilization of the cultural assessment tool completed on the patients via a chart audit. CMAs, CNAs, LVNs, and RNs will ensure that providers fill out the forms in their entirety before submitting them to the nurse manager or project lead.

Week 1 (Dates)	Week 1: Feb 28–March 5 Providers will be given the self-assessment tool to complete. (Appendix C) When completed, the provider self-assessment tool will remain with the provider A concise PowerPoint training on cultural competency for healthcare providers with emphasis on the National CLAS module will be presented in two sessions (Appendix C). The first session would be on Wednesday the first week; the second would be on Monday on the other clinic rotation to ensure all providers and staff are trained effectively. The provider self-assessment tool will be issued to the providers for their review and completion. A PowerPoint presentation on how to complete the cultural assessment tool will be presented. This week, the Provider self-cultural assessment and patient cultural preference tools will be disseminated to providers for their review. Progress will be evaluated via face-to-face interaction with nurse managers and staff, and if more training is needed, it will be provided by the project lead.
Week 2 (Dates)	Week 2: Mar 6–12 Staff, and healthcare providers, will receive intermittent training with guidance from the project lead. A weekly data sheet will be used to keep track of completed cultural assessment tools by the project lead (Appendix G).

	The DNP lead will also observe and perform chart audits to evaluate if any changes occur and if providers are compliant with completing the assessment tool.
Week 3 (Dates)	Week 3: Mar 13–19- The healthcare providers will continue completing patients' cultural preference tools, and the project lead will continue collecting cultural assessment tools for data collection, evaluation for compliance, and data analysis.
Week 4 (Dates)	Week 4: Mar 20–26- The DNP lead will continue to collect all data and records pertaining to the project for compliance and data analysis.
Week 5 (Dates)	Week 5: Mar 27–April 2- Data collected will be evaluated for compliance and data analysis.

Tools

1) Cultural competence self-test

The cultural competence self-test (Appendix C) is a self-evaluation form that the healthcare providers will use to evaluate their cultural awareness, sensitivity, and competency. Tawara D. Goode created the tool with the National Center for Cultural Competence at Georgetown University Center for Child & Human Development, University Center for

Excellence in Developmental Disabilities, Education, Research & Service (National Center for Cultural Competency, 2009). This is an established tool. No permission was needed, and the tool was retrieved from the internet. The DNP project focuses on cultural competence, which will benefit present and future healthcare improvements in caring for patients from diverse cultures. This tool will effectively evaluate each healthcare provider's cultural awareness. Project stakeholders are agreeable to using tools for the project to save costs by building new tools.

2) The Improvised Cultural Assessment tool

The Healthcare provider will complete the Improvised Cultural Assessment tool (Appendix D) as they interview patients about their cultural preferences. This Assessment tool is a 10-question tool developed by the project lead by combining two resources, the AHRQ and the Fraser Health Authority. This tool was created to understand patients' cultural preferences relating to their traditional health, illnesses, beliefs, and practices so that culturally appropriate interventions are followed (Fraser Health Authority, n.d). The tool will ensure that the needs of diverse populations are met to ensure holistic and quality healthcare is delivered. The tool will be validated by Touro University Nevada Faculty, who are part of this quality improvement project.

3) eClinical Work (EcW)

The DNP project site uses an electronic health record system called eClinical Work (EcW). This electronic health record system manages patient appointments and scheduling, patient history recording, electronic prescribing, and clinical workflow/management in the clinic. The system will assist in providing accurate data tracking during chart audits to ascertain that the provider has conducted a cultural preference assessment to assist future providers in being aware of the patient's cultural preferences for the future.

4) The chart audit tool

The project lead created this tool (Appendix G) to collect weekly data on the number of diverse patients who visited the clinic and were seen by a provider and the number of cultural assessment tools returned. This tool will assess if a 75% participation utilization rate or better was met.

Data collection plan

The Improvised Cultural Assessment tool is a questionnaire. It will be distributed in paper form in person to the providers. Responses will be confidential and will be scanned into patient's charts.

The collection will occur during the 5 weeks of implementation. Outcome evaluation will occur through chart reviews, which will appear daily. The DNP lead will review between 15 and 25 charts daily, depending on the clinic's diverse population, on the implementation days. Questionnaires will be scanned into the patient's chart to protect privacy and confidentiality before shredding the document with the patient's identifiers.

Data Analysis Plan

The data will be analyzed using the paired t-test and chi-square test. At first, diverse patients will be identified and compiled using a patient data collection sheet. The DNP lead will complete this during the implementation stage in the clinic and when patients are checked in. The paired t-tests will be used to compare means the assumption of approximately normal distribution for the differences. The chi-square test will be used to check for the normality of the data to ascertain whether a set of data was sampled from a normal distribution The Chi-square test will be used to compare observed vs. expected values—the analysis process employed using the IBM SPSS Statistics. The project plans to use a statistician.

During the data analysis plan, the rate at which the Providers used the patient cultural competency tool to evaluate patient cultural preferences will be analyzed. The project lead will

record the number of ethnic minority patients seen by each healthcare provider during the week, the number of diverse patients who participated in the evaluation, and the number of patients who refused to participate.

The project will measure, by chart audit, the rate at which the providers utilized the improvised cultural competency tool when interacting with diverse patients.

Ethics/Human Subjects Protection

The Touro University DNP Project Determination document was reviewed and is characterized as a quality improvement project. It is not a research study. Due to the project not being a research project, no requirement for an Institutional Review Board (IRB) committee is required. The project meets the minimum criteria for a quality improvement project. The project implementation will follow the rules of ethical standards, confidentiality, and privacy protection by the code of ethics.

The information collection followed the guidelines outlined by the Health Insurance Portability and Accountability Act (HIPAA) to ensure the safekeeping of patient healthcare information. Providers would be required to participate 100% in education on the benefits of cultural competency. This will be provided to all project participants during the PowerPoint presentation and on an ongoing basis. Loss of confidentiality and privacy could threaten the data collected. Their mitigation strategies will address the concerns for these risks and others.

Recruitment methods will be through a mandatory weekly meeting. Nurse managers are making the presentation a mandatory event for providers and other staff members. Participants will be incentivized by ordering Pizzas with other refreshments from Pizza Hut at both project PowerPoint presentations.

Results

Data collection occurred over a four-week period using eClinicalWorks software (EcW) to access patient charts for the Project Lead to review. The review included auditing provider compliance with the patient cultural assessment tool and determining whether the providers' knowledge of cultural competency had improved post-PowerPoint presentation. After data collection was completed, the data was inputted into the IBM SPSS software, and the variables were defined in the SPSS software. The chart review showed that the project site providers had seen 276 diverse patients in the 4-week period.

Week 1: The first week of the project implementation phase began with a PowerPoint presentation on cultural competency and its benefits to providers and staff. The presentation was given on two different days due to staff schedule rotation. The PowerPoint training on cultural competency for healthcare providers, emphasizing the National CLAS module, was concise and was presented in two sessions (Appendix C). Providers were issued a self-cultural competency tool (Appendix C) to complete and evaluate their self-cultural competence (which they kept after completion for their reference). Also, the providers were introduced to and issued the patients' improvised cultural assessment tool (Appendix D) so that they (providers) could evaluate patients' cultural preferences.

Week 2: The second week of project implementation used the Plan, Do, Study, Act (PDSA) model. The goal was for providers to administer the patients' improvised cultural competency tool in the clinic to their diverse patients and be compliant in administering the said tool.

Week 3: This week, implementation ran smoothly using the Plan, Do, Study, Act (PDSA) cycle. The Project Lead answered questions and supported the team. Staff and healthcare providers received intermittent training with guidance from the Project Lead. The Project Lead used the weekly data sheet to keep track of completed cultural assessment tools and then scanned them into the patient EMR chart (Appendix G). The DNP-lead observed and performed chart audits to evaluate whether any changes had occurred, assessed any disruptions in using the tool and determined whether providers were compliant with completing the assessment tool.

Week 4: The project implementation continued in Week 4 still using the PDSA model. The DNP project-lead discussed with staff and providers concerning the necessity for the implementation to be carried out by the providers and not by the nurses in Patient Intake. The Project-lead ran into a few challenges this week, but that will be discussed at a later section. The project-lead continued to collect completed tools and review charts.

Chart audits were performed while tabulating data in preparation for data analysis; the collected tools were reviewed, scanned into patient charts, and shredded to avoid violating patient privacy. When comparing the modifications to the original project timeline (Appendix F(i)) with the modified timeline (Appendix F(ii)), the following occurred: the intermittent retraining of the providers who did not want to participate initially and staff quitting, and when a few of the providers tried to make staff and nurses administer tools to the patients.

According to the providers, missing data occurred from patients who refused to participate in the tool administration due to a lack of time in the clinic or exams taking too long. This was all a deviation from the original plan but will be discussed in more detail later in the paper. The project lead received positive feedback from healthcare providers during debriefing,

stating that the improvised cultural preference tool gave them a background of patients' cultural preferences and would assist them in providing better care. The timeline is included in the Appendix.

Chart Audits

Chart audits were conducted by assessing the EcW-EHR system to evaluate and compile provider compliance in administering the patients' improvised cultural competency tool to their diverse patients (Appendix G). Appendix H shows that the fifteen providers visited with 276 diverse patients; 184 patients agreed to the tool's administration, while 92 patients refused it.

Provider demography

During the implementation stage, fifteen healthcare providers participated in the cultural competency project, including 13(86%) females and 2(13.2%) males. Their ages ranged from 18 to 65. Provider compliance with the utilization of patients' improvised Cultural Competence tool was measured using the Chi-square of independence.

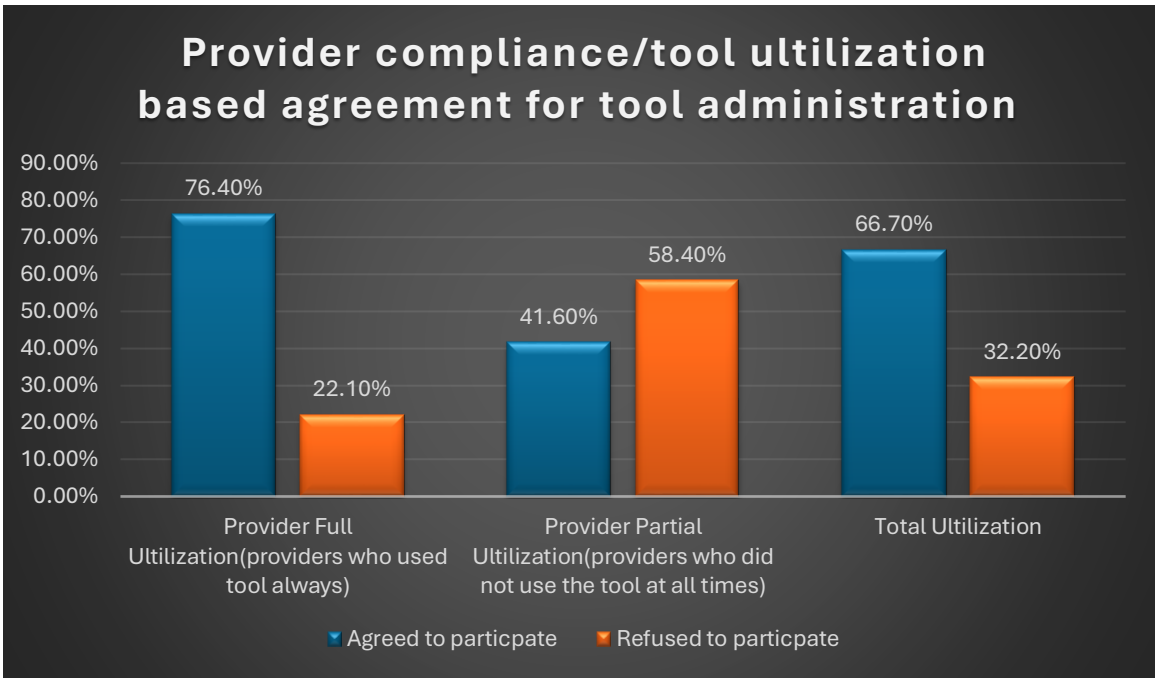
This section reveals the level of provider compliance in administering the patients' improvised cultural competency tool to their diverse patients. The Chi-square of independence was used, and its statistical results showed that 76.4% of the patient-improvised cultural assessment tool was fully utilized by the providers, and 41.6% of the tool was partially utilized by some providers. Table 1 shows the level of provider tool utilization as indicated in the number of patients who agreed to tool administration as opposed to patients who refused tool administration. Provider compliance was monitored via utilization of the patient improvised patient cultural competency tool. The objective was to show a 75% rate of tool utilization.

Table 1: Chi-square of independence of provider participation in administering patient improvised cultural competency tool.

Chi-square of independence for Provider Participation

			Participation		
			Agreed	Refused	Total
Utilization of tool	Full Utilization	Count	152	44	199
		% within the utilization of the tool	76.4%	22.1%	100.0%
	Partial utilization	Count	32	45	77
		% within the utilization of the tool	41.6%	58.4%	100.0%
Total		Count	184	89	276
		% within the utilization of the tool	66.7%	32.2%	100.0%

Figure 1: Provider compliance on utilization of the improvised cultural competency tool in the administration of the patient.



Summary

The goal was to achieve a 75% or more compliance rating from providers utilizing the patient-improvised cultural assessment tool. This was measured by the number of patients who agreed and patients who refused to have the tool administered to them. This was divided into two provider groups; "*full utilization*" represented providers who always used or fully utilized the tool, while "partial utilization" represented providers who did not always or partially utilize the tool.

The first provider group fully utilized the tool, accounting for 76.4% of the patient-improvised cultural competency tool utilized by providers who fully utilized it. This accounted for patients who agreed to have the tool administered. In contrast, with providers who fully utilized the tool, 22.1% of the patients refused to participate in tool administration.

For the second provider group, "*partial utilization*," with the patient improvised cultural competency tool, 41.6% of the patients agreed to have the tool administered, while 58.4% refused to participate; see Table 1 and Figure 1.

The chi-square level of independence showed that provider compliance was achieved by those providers who fully utilized the patient improvised cultural competency tool and was significantly more than providers who partially utilized tool $\chi 2 = (2, (N=276) = 33.9, p = <0.01)$. Objective 4's goal was to have a 75% or better participation rate, which, unfortunately, was not achieved by providers. The overall provider utilization rate for patients who agreed to have the tool administered was low at a rate of 66.7%, which did not align with project objective 4. This occurred due to some reasons such as several patients not wanting to participate, the providers

who initially did not want to participate and the project lead having to retrain them on the benefits of participating, clinic closure due to building issues, a provider quitting on one of the implementation phases, and other adverse factors. Overall, 32.2% accounts for the rate of patients who refused the tool to be administered. Providers who partially participated did so for some reason, such as still being on-the-job training, reluctance to participate, calling in sick, or due to clinic closure for exigent reasons.

Concerning the project's strengths, Spanish-speaking providers had the most input when administering patient cultural competency. Female healthcare providers were the most likely to administer the patient-improvised tools to their diverse patient populations. Healthcare providers were willing to be retrained and were enthusiastic about the tool.

Concerning weaknesses, some providers tried to have a nurse and other staff members implement the tool, but several diverse patients refused to participate in the project implementation phase. The singular reason stated by most patients was lack of time. A few providers gave because they (providers) felt unprepared and not confident enough to administer patient improvised tools to their diverse patients. For instance, stepping out of the patient's exam room to question the DNP project lead caused some patients to be insecure or impatient. This resulted in patients leaving before tool administration, and some patients stated that they took time off from their lunch breaks from their jobs to be seen at the clinic.

Some providers saw fewer patients overall compared to others due to the shortened project timeline, which did not allow every provider to visit with more patients. This occurred in the last week of the implementation phase when training was offered, and corrections were

made. Due to system issues in the clinic on some days, the clinic was closed for staff training days or repairs.

Interpretation

In comparing our findings with the literature, it was noted that 100% of the clinic's providers agreed to retrieve information on patients' cultural preferences via a tool to achieve better health outcomes for their diverse patients. The providers were compliant in retrieving the patients' cultural preferences. We hope to achieve better health outcomes as the clinic utilizes the tool.

The literature stated that we do not understand our patient's cultural preferences, which causes poor patient outcomes. The providers in the clinic all used the patients' improvised cultural competency tool to retrieve information on patients' cultural preferences to improve patient health outcomes. The providers complied with retrieving the information, but only 66.7% of patients allowed providers to administer the tool. We did not get a good outcome because the project was only for 3 weeks, and there was not enough data and a good enough time frame to conclude.

The literature discusses a lack of knowledge about Islamic culture as it could be a barrier to Muslim women's healthcare (Bagasra, 2021). The writer pointed out that healthcare professionals should be aware of cultural and religious factors that help provide culturally competent and appropriate promotion and education of health services to the Islamic population (Bagasra, 2021). In aligning with this literature, this project agrees with objective four, where

providers participated in utilizing the patients' improvised cultural competency tool to gain knowledge of the patient's cultural preferences.

Silver et al. (2023) agree that cultural competency training is essential. This qualitative study stated that healthcare professionals were often unprepared to address mental health issues in asylum seekers. The project is hopeful that the cultural competency training administered during the implementation phase will continue to improve the providers' self-cultural awareness and make providers more aware of their diverse patients 'cultural preferences.

A focused group was used to explore participant experiences in mental health with cultural competency in mind. Anton-Solanas et al. (2022) agree that a lack of cultural competency training makes nurses unprepared for the challenges ahead with patients from different cultures. In comparing the results of the paper with the literature, Alkhamees and Alasqah (2023) revealed a difference in physicians' communicative behavior when facing patients from diverse cultures compared to encounters with patients from the same cultural background. The Agency for Healthcare Research and Quality (2023) agrees that the best way to know how the patient's culture may impact their care is by asking the patient. The results of this paper agree with this position by the number of patients who agreed to participate in the tool administration.

According to the Agency for Healthcare Research and Quality (2023) and this project, knowledge of cultural customs can help avoid misunderstandings, thereby enabling practitioners to provide better care, and positively impacting the clinic. The project results and its impact on the clinic, are in alignment with the literature, and acknowledge that knowledge of patients' cultural beliefs and customs help healthcare providers to facilitate improved care and helps to

avoid misunderstandings among care providers' staff, patients, and their families (Bhattacharya et al., 2019).

Other positive impacts to the clinic are an improvement in patient cultural preference data collection, an increase in preventive care by patients, and a reduction in care disparities in the diverse patient population (SCP Health,2021). To evaluate providers' improvement in their self-evaluation of themselves and their collection of data on their patients' cultural preferences, a Likert scale pre and post-test was performed, and the providers verbalized that the training improved their cultural competency as it relates to patients from diverse cultures. The project lead is hopeful that the results from the project will have a positive impact on the clinic.

Limitations

A conflict between management and a few providers unrelated to the project occurred. For instance, two providers had verbalized that they were promised by one of the nurse managers (who quit the clinic in 11/2023) that when they completed their 6-month probationary period in 02/2024, they would get a raise; another verbalized that they had been at the clinic since the inception in 2020 and are yet to be given raises. Another few (four) verbalized not getting paid time and a half after working on a holiday; all these, as earlier mentioned, did not apply to the project.

Bias

Bias data occurred due to using specific technology systems for chart audits. The EcW was used for chart audits and had connectivity issues, which caused difficulty getting or inputting patient info into the program. Managers' negative behavior towards quality improvement significantly influenced the outcome. For instance, one manager had verbalized

that the questionnaires were taking time from the patient as it cut into the provider's clinic flow.

Design Limitations

There were design limitations. A significant limitation of the project was the implementation period, which lasted only 4 weeks. Training on cultural competency is complex and cumbersome to be performed in 4 weeks. This was insufficient time to implement and evaluate the effectiveness of the training and the tool administration. The project would have done extremely well if the time frame was longer, which would have allowed for thorough evaluation and would have revealed the project's long-term benefits overall. Another limitation was that the project was being performed at one location, which limited the reliability of the findings. Working in different settings might have provided a variety of patient populations, staff compositions, and cultural dynamics. With implementation performed at one clinic setting, it poses a disadvantage as the finding is only for the clinic where the project occurred and may not be conducive to other clinic settings. Performing the project at different locations would have impacted the project positively.

Data Collection

Data collection occurred at the clinic for 3 weeks. The short time frame impacted the project's results, as there was insufficient time to gather more patient information. The project lead was able to conduct implementation based on clinic hours and the days the clinic was operable. For instance, implementation could not occur on days the clinic closed for repairs.

Data Analysis

Data analysis was not limited. Efforts to minimize and adjust for limitations included retraining providers on the relevance of tool utilization and compliance. To achieve compliance, managers and providers were given intermittent training to address the negative behaviors, and

providers delegated staff to administer tools. Providers were re-educated on the relevance of retrieving the information from the patient and not the clinic staff.

Conclusion

Implementing a cultural competency protocol in the urgent care setting created a positive change in the clinic's present circumstances and the clinic's organization. This justified the need for an outlined protocol to improve patient cultural competency in the clinic.

The usefulness of the Project

The project was useful as it informed stakeholders, staff, and providers about the gaps in practice in relation to patients from diverse cultures. The project's usefulness will impact the clinic positively by creating a positive, welcoming environment. This will foster the appreciation of similarities and differences among cultures as the clinic staff, and providers develop their levels of cultural competence to improve patient outcomes.

The project’s importance and the information collected by the providers would help future providers who cater to diverse patients have access to patients' cultural preferences before visiting them, especially during follow-up visits. Incorporating all stakeholders' opinions, questions, and support would be an early screening of the cultural competency tool with diverse patients. As a screen, patient feedback will help to continue improving the tool. This could possibly help improve the patient's quality of life when they know their providers are aware of their cultural preferences.

Sustainability

The DNP lead discussed this with clinic management, and it was agreed that a committee would be created to maintain support, oversee progress, and assist in tool utilization. The committee would comprise top clinic stakeholders, nurse managers, office managers, and human

resources managers.

The DNP project lead and the new committee will create the facility's cultural competency policy. The healthcare providers will meet quarterly with stakeholders and nurse managers on the policy's components to evaluate if any updates to the policy will be required.

The DNP project lead will push for project sustainability in the future by discussing and getting quarterly feedback from providers and staff. Providers with improved awareness of their diverse patients' cultural preferences who support their leadership team are more likely to utilize the patients' improvised cultural preference tool. Thus, increasing the use of the tool in a primary care clinic would lead to an overall improvement in patient care and the quality of life in patients from diverse cultures. Feedback will be used to update the policy while reviewing project results and literature to help improve approaches to improve patient outcomes.

Sustainability of cultural competency will help build bridges while embracing, respecting, protecting, and maintaining cultural diversity. This will entail recognizing the intrinsic value of each diverse patient's culture, values, and cultural heritage and safeguarding cultural expressions.

Implications for practice in the field

Nursing Practice

More education will help promote cultural diversity by adopting intercultural communication, tolerance, and mutual understanding. Integrating diverse perspectives and experiences into educational curricula in Nursing schools can nurture a generation that appreciates and celebrates cultural diversity in patients for better health outcomes. This is achieved by incorporating all stakeholders' opinions, questions, and support. According to Michelle (2024), in an attempt to focus on reducing gaps in health disparities, healthcare providers must prioritize culturally competent care by investing in cultural competency training

of staff. The writer further states that this can be accomplished by developing culturally appropriate resources and materials and partnering with community organizations to understand different populations' unique needs better.

Policy

It is crucial to underscore the immediate need for healthcare systems and providers to be aware of and receptive to patients' cultural views and experiences. This project's results can serve as a timely and vital resource for stakeholders and policymakers, guiding decisions on implementing requirements and supporting quality process features, such as cultural competence. Policies on cultural competency are needed to invest in the capacity of healthcare providers to implement culturally competent practices (Porterfield & Scott-Little., 2019).

In the realm of policy creation, they hold the power to shape the content of professional development, thereby enhancing the capacity of their workforce. By implementing a consistent approach at the systems level, they can regulate and promote culturally competent practices, ultimately ensuring equitable healthcare access for all. This empowerment should inspire them to act.

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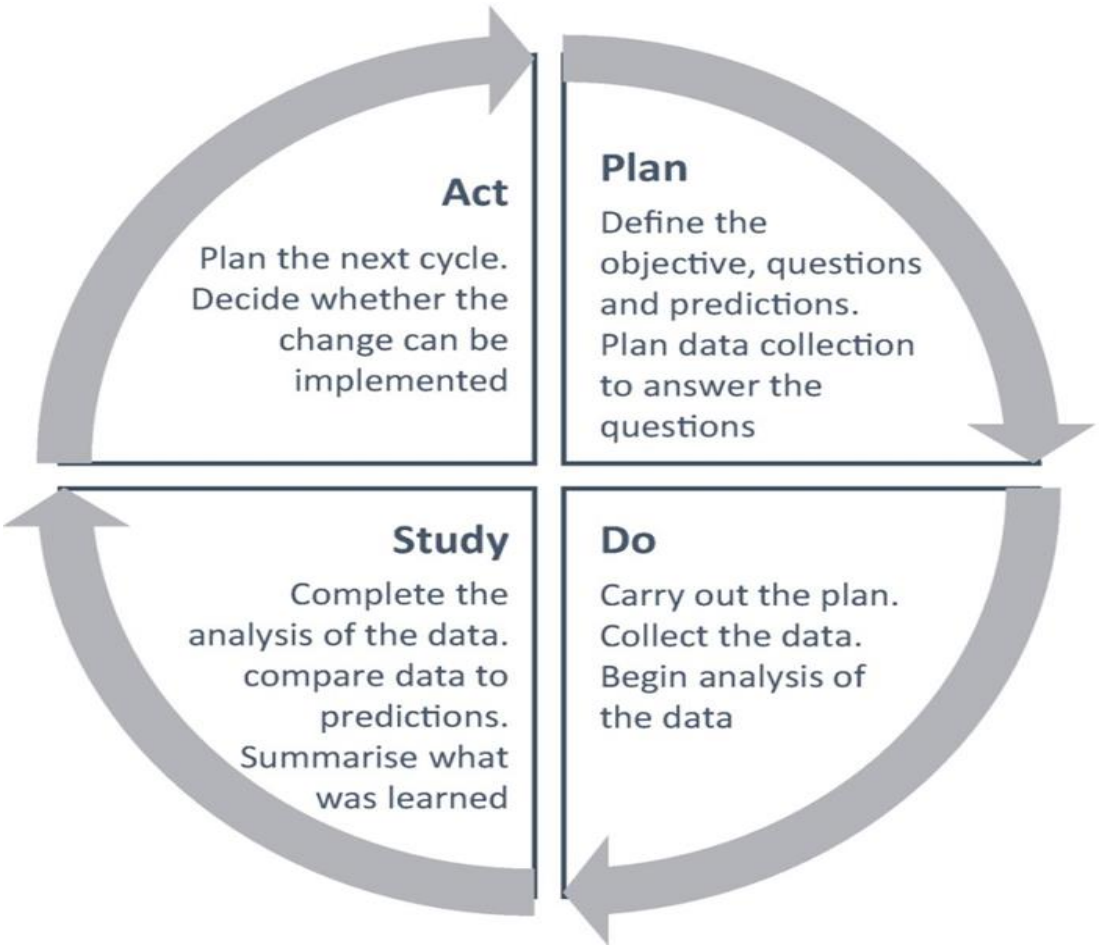
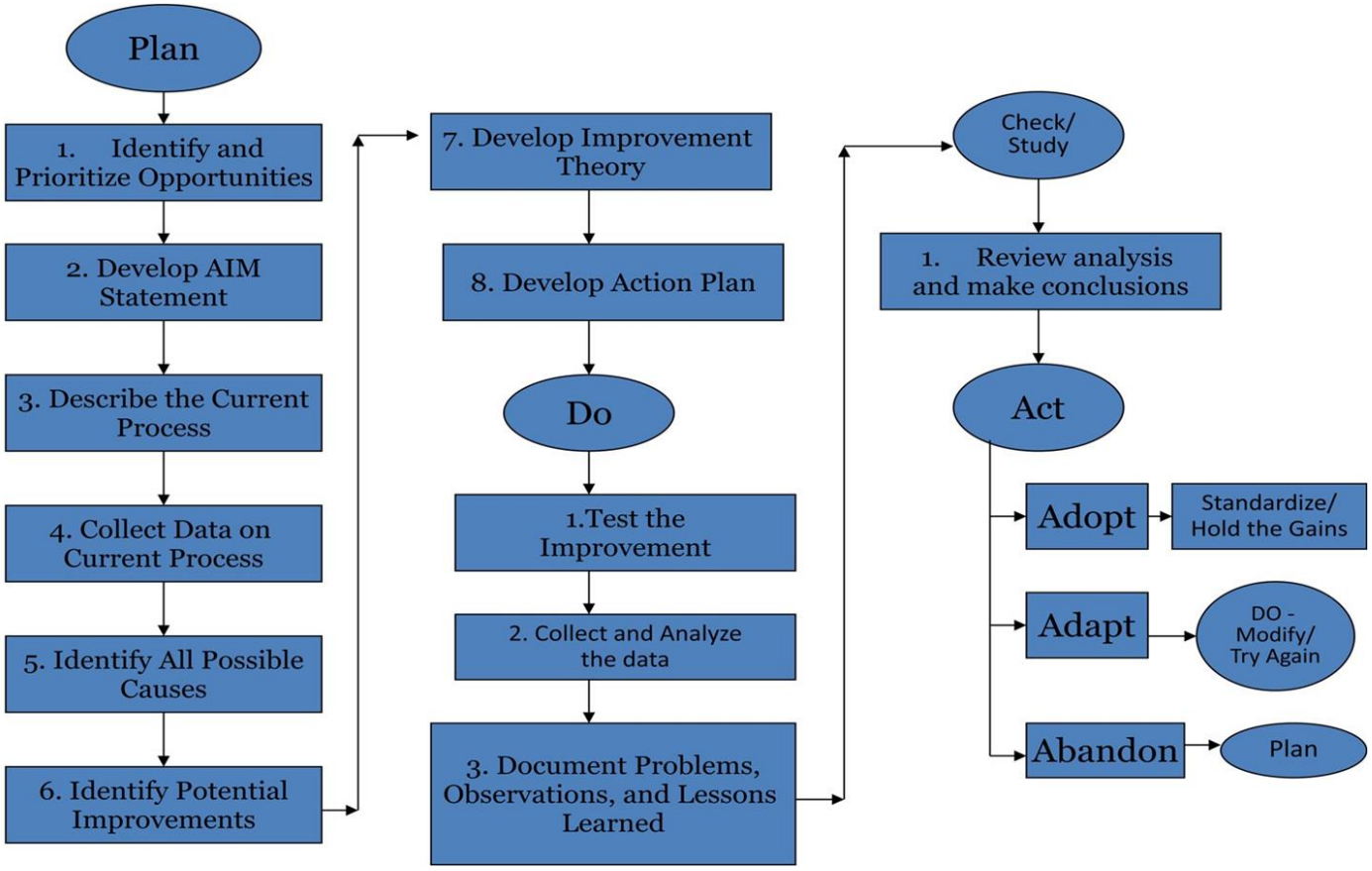
Appendix A: PDSA cycle



(Falaschi & Marsh D, 2022, p. 536)

APPENDIX B-The ABC's of PDCA



Appendix B (Gorenflo & Moran, 2010).

Appendix C — Cultural competence self-test

The following self-assessment can assist physicians in identifying areas in which they might improve the quality of their services to culturally diverse populations.

Promoting Cultural and Linguistic Competency

Self-Assessment Checklist for Personnel Providing Primary Health Care Services

Directions: Please enter A, B or C for each item listed below.
A = Things I do frequently
B = Things I do occasionally
C = Things I do rarely or never

Physical Environment, Materials & Resources

1. ____ I display pictures, posters, artwork and other decor that reflect the cultures and ethnic backgrounds of clients served by my program or agency.

2. ____ I ensure that magazines, brochures and other printed materials in reception areas are of interest to and reflect the different cultures of individuals and families served by my program or agency.

3. ____ When using videos, films or other media resources for health education, treatment or other interventions, I ensure that they reflect the cultures and ethnic background of individuals and families served by my program or agency.

4. ____ I ensure that printed information disseminated by my agency or program takes into account the average literacy levels of individuals and families receiving services.

Communication Styles

1. When interacting with individuals and families who have limited English proficiency, I always keep in mind that:

   ____ Limitations in English proficiency are in no way a reflection of their level of intellectual functioning.

   ____ Their limited ability to speak the language of the dominant culture has no bearing on their ability to communicate effectively in their language of origin.

   ____ They may or may not be literate in their language of origin or English.

2. ____ I use bilingual-bicultural staff and/or personnel and volunteers skilled or certified in the provision of medical interpretation during treatment, interventions, meetings or other events for individuals and families who need or prefer this level of assistance.

3. ____ For individuals and families who speak languages or dialects other than English, I attempt to learn and use key words in their language so that I am better able to communicate with them during assessment, treatment or other interventions.

4. ____ I attempt to determine any familial colloquialisms used by individuals or families that may impact on assessment, treatment or other interventions.

5. ____ When possible, I ensure that all notices and communiqués to individuals and families are written in their language of origin.

6. ____ I understand that it may be necessary to use alternatives to written communications for some individuals and families, as word of mouth may be a preferred method of receiving information.

Values & Attitudes

1. ____ I avoid imposing values that may conflict or be inconsistent with those of cultures or ethnic groups other than my own.

2. ____ I screen books, movies and other media resources for negative cultural, ethnic or racial stereotypes before sharing them with individuals and families served by my program or agency.

3. ____ I intervene in an appropriate manner when I observe other staff or clients within my program or agency engaging in behaviors that show cultural insensitivity, racial biases and prejudice.

4. ____ I recognize and accept that individuals from culturally diverse backgrounds may desire varying degrees of acculturation into the dominant culture.

5. ____ I understand and accept that family is defined differently by different cultures (e.g., extended family members, fictive kin, godparents).

6. ____ I accept and respect that male-female roles may vary significantly among different cultures and ethnic groups (e.g., who makes major decisions for the family).

7. ____ I understand that age and life-cycle factors must be considered in interactions with individuals and families (e.g., high value placed on the decision of elders, the role of eldest male or female in families, or roles and expectation of children within the family).

8. ____ Even though my professional or moral viewpoints may differ, I accept individuals and families as the ultimate decision makers for services and supports impacting their lives.

9. ____ I recognize that the meaning or value of medical treatment and health education may vary greatly among cultures.

10. ____ I accept that religion and other beliefs may influence how individuals and families respond to illnesses, disease and death.

11. ____ I understand that the perception of health, wellness and preventive health services have different meanings to different cultural or ethnic groups.

12. ____ I recognize and accept that folk and religious beliefs may influence an individual's or family's reaction and approach to a child born with a disability, or later diagnosed with a disability, genetic disorder or special health care needs.

13. ____ I understand that grief and bereavement are influenced by culture.

14. ____ I seek information from individuals, families or other key community informants that will assist in service adaptation to respond to the needs and preferences of culturally and ethnically diverse groups served by my program or agency.

15. ____ Before visiting or providing services in the home setting, I seek information on acceptable behaviors, courtesies, customs and expectations that are unique to the culturally and ethnically diverse groups served by my program or agency.

16. ____ I keep abreast of the major health concerns and issues for ethnically and racially diverse client populations residing in the geographic locale served by my program or agency.

17. ____ I am aware of the socioeconomic and environmental risk factors that contribute to the major health problems of culturally, ethnically and racially diverse populations served by my program or agency.

18. ____ I am well versed in the most current and proven practices, treatments and interventions for major health problems among ethnically and racially diverse groups within the geographic locale served by my agency or program.

19. ____ I avail myself to professional development and training to enhance my knowledge and skills in the provision of services and supports to culturally, ethnically, racially and linguistically diverse groups.

20. ____ I advocate for the review of my program or agency's mission statement, goals, policies and procedures to ensure that they incorporate principles and practices that promote cultural and linguistic competence.

How to use this checklist

This checklist is intended to heighten the awareness and sensitivity of personnel to the importance of cultural and linguistic competence in health and human service settings. It provides concrete examples of the kinds of beliefs, attitudes, values and practices that foster cultural and linguistic competence at the individual or practitioner level. There is no answer key with correct responses. However, if you frequently responded “C,” you may not necessarily

demonstrate beliefs, attitudes, values and practices that promote cultural and linguistic competence within health care delivery programs.
Self-assessment developed by Tawara D. Goode, Georgetown University Child Development Center-UAP. Adapted with permission from *Promoting Cultural Competence and Cultural Diversity in Early Intervention and Early Childhood Settings* and *Promoting Cultural Competence and Cultural Diversity for Personnel Providing Services and Supports to Children With Special Health Care Needs and Their Families* (June 1989; latest revision July 2000).

Appendix D —Improvised Cultural Assessment Tool for patients.

1) Do you have any dietary preferences related to your religious or cultural beliefs?

2)Are there any special foods in your culture for different illnesses or for your health and wellbeing?

3) Do you use home remedies that might be useful when someone is ill?

4) What do you think a provider should know about your culture if a family member is hospitalized?

5) Who makes the health decisions in your family?

6) Are there any special beliefs regarding organ donation or blood transfusions that are held in your culture?

7) Is there anything I should know about your culture, beliefs, or religious practices that would help me take better care of you?

8) Do you have any dietary restrictions that we should consider as we develop a food plan to help you lose weight? Or help improve your diabetes or blood pressure or high cholesterol, kidney disease or gout etc.

9) How would you like your family members to be involved in your care?

(Agency for Healthcare Research and Quality, 2020) ;(Fraser Health Authority, n.d).

APENDIX E - POWERPOINT SLIDES ON CULTURAL COMPETENCY

What is culture?

- Culture can be defined as the "personal identification, language, thoughts, communications, actions, customs, beliefs, values, and institutions that are often specific to ethnic, racial, religious, geographic, or social groups"(Patient Safety Network, 2019).

Cultural competency defined

- By definition, diversity can include differences in race, ethnicity, age, gender, size, religion, sexual orientation, and physical and mental ability (Trefil et al. 2005).

- Cultural competence has been defined in many ways; however, it generally refers to the knowledge of social and cultural factors that influence illnesses and related behavior, with actions taken to provide the best quality care considering each patient's background (Constantinou et al., 2022).

Cultural competency policy relevance

- It will emphasize the need for the clinic and providers to be aware of, and responsive to, patients' cultural perspectives and backgrounds.
- The need for providers to understand patient and family preferences, values, cultural traditions, language, and socioeconomic conditions and ensure all these are respected.
- To establish a collaborative mutual partnership with diverse patients in an open, self-reflective, other-centered approach to better understand and formulate the patients' strengths, difficulties to build a treatment plan.

(Stubbe,2020)

Cultural awareness and cultural sensitivity defined…….

- Cultural awareness means being sensitive to the differences and similarities between two cultures when communicating or interacting with members of other cultural groups.
- Cultural sensitivity involves inculcating values, attitudes, and knowledge that display openness and respect for different cultures, religions, languages, manner of dress, and communication styles.

(Evolve communities, n.d.).

Cultural awareness and cultural sensitivity contd.

- In understanding your own culture and how it affects you, you can take the first step in developing a sense of cultural awareness when it comes to interacting with people from diverse cultures who have different background than yourself.
- Cultural awareness helps one to understand their self weaknesses, self psychology, and how to become a better person.
- It also helps with cognitive flexibility, problem-solving, decision–making, and improved communication skills.

Cultural awareness and cultural sensitivity contd.

- Understanding how people acquire their cultures and how culture plays an important role in personal identities, life ways, and mental and physical health of individuals and communities.
- Being conscious of one's own culturally shaped values, beliefs, perceptions, and biases.(Evolve communities., n.d.)

The effects of cultural incompetence

- Lack of cultural competence can create an environment of mistrust which leads to communication breakdown, misunderstanding, and decreased productivity.).
- When there is a lack of cultural understanding, it increases negative attitudes towards cross-cultural care.
- It affects healthcare professionals' perceived preparedness to take care of culturally diverse patients.

(Evolve communities., n.d.)


Tips to improve Cultural competency
Learn from patients.
Healthcare providers should respectfully ask patients about their health beliefs and customs.and document their responses in their medical records.
Address patients' cultural values specifically in the context of their health care. For example:
"Is there anything I should know about your culture, beliefs, or religious practices that would help me take better care of you?"
"Do you have any dietary restrictions that we should consider as we develop a food plan to help you lose weight?"
"Your condition is very serious. Some people like to know everything that is going on with their illness, whereas others may want to know what is most important but not necessarily all the details. How much do you want to know? Is there anyone else you would like me to talk to about your condition?"
"What do you call your illness and what do you think caused it?"
"Do any traditional healers advise you about your health?"
Avoid stereotyping based on religious or cultural background. Understand that each person is an individual and may or may not adhere to certain cultural beliefs or practices common in his or her culture. Asking patients about their beliefs and way of life is the best way to be sure you know how their values may impact their care.
(Agency for Healthcare Research and Quality, 2020)


Tips to improve cultural competency contd.
Evaluate how religion, culture, and ethnic customs can influence how your patients interact with you.
Health beliefs: In some cultures, people believe that talking about a possible poor health outcome will cause that outcome to occur.
Health customs: In some cultures, family members play a large role in health care decisions.
Ethnic customs: Who makes healthcare decisions in the home? Differing roles of women and men in society may determine who makes decisions about accepting and following through with medical treatments.
Religious beliefs: Religious faith and spiritual beliefs may affect health care-seeking behavior and people's willingness to accept specific treatments or behavior changes.
Dietary customs: Disease-related dietary advice will be difficult to follow if it does not conform to the foods or cooking methods used by the patient.
Interpersonal customs: Eye contact or physical touch will be expected in some cultures and inappropriate or offensive in others. (Agency for Healthcare Research and Quality, 2020).

Cultural awareness and cultural sensitivity contd.

- Understanding how people acquire their cultures and how culture plays an important role in personal identities, life ways, and mental and physical health of individuals and communities.
- Being conscious of one's own culturally shaped values, beliefs, perceptions, and biases.(Evolve communities., n.d.)

Cultural competence self- assessment tool(Appendix C)

The cultural competence self -assessment tool was developed by Tawara D. Goode, Georgetown University Child Development Center -UAP. Adapted with permission from Promoting Cultural Competence and Cultural Diversity in Early Intervention and Early Childhood Settings and Promoting Cultural Competence and Cultural Diversity for Personnel Providing Services and Supports to Children With Special Health Care Needs and Their Families (June 1989; latest revision July 2000).

This tool will be completed by the healthcare providers to self evaluate their cultural sensitivity, awareness and cultural competence.

This tool will be kept by the provider. It will not be returned.

The Improvised Cultural Assessment Tool for patients(Appendix D)

- The Healthcare provider will complete the Improvised Cultural Assessment tool (Appendix D).
- This presentation will show providers how to utilize the abovementioned tool for the patients.
- Tool will be completed as the providers interview patients during patient visits and questioning them about their cultural preferences.
- The tool is a 10-question tool developed by the project lead.
- Developed involved combining two different resources from the Agency for Healthcare Research and Quality(AHRQ) and the Fraser Health Authority.
- This tool was created to understand patients' cultural preference as it relates to their traditional heath, illnesses, beliefs and practices so that culturally appropriate interventions are followed (Fraser Health Authority, n.d). The tool will ensure that the needs of diverse populations are met to ensure holistic and quality healthcare is delivered.
- The tool will be validated by the university Faculty who are part of this quality improvement project.

(Agency for Healthcare Research and Quality)(2020, September) (Fraser Health Authority, n.d).

APPENDIX C- Cultural competence self- assessment tool

APPENDIX A-CULTURAL COMPETENCE SELF TEST TOOL

Cultural competence self-test

The following self-assessment can assist physicians in identifying areas in which they might improve the quality of their services to culturally diverse populations.

Promoting Cultural and Linguistic Competency

Self-Assessment Checklist for Personnel Providing Primary Health Care Services

Directions: Please enter A, B or C for each item listed below.
A = Things I do frequently
B = Things I do occasionally
C = Things I do rarely or never

Physical Environment, Materials & Resources

____ I display pictures, posters, artwork and other decor that reflect the cultures and ethnic backgrounds of clients served by my program or agency.

____ I ensure that magazines, brochures and other printed materials in reception areas are of interest to and reflect the different cultures of individuals and families served by my program or agency.

____ When using videos, films or other media resources for health education, treatment or other interventions, I ensure that they reflect the cultures and ethnic background of individuals and families served by my program or agency.

____ I ensure that printed information disseminated by my agency or program takes into account the average literacy levels of individuals and families receiving services.

Communication Styles

When interacting with individuals and families who have limited English proficiency, I always keep in mind that:

____ Limitations in English proficiency are in no way a reflection of their level of intellectual functioning.

____ Their limited ability to speak the language of the dominant culture has no bearing on their ability to communicate effectively in their language of origin.

Appendix C contd.

____ Their limited ability to speak the language of the dominant culture has no bearing on their ability to communicate effectively in their language of origin.

____ They may or may not be literate in their language of origin or English.

____ I use bilingual-bicultural staff and/or personnel and volunteers skilled or certified in the provision of medical interpretation during treatment, interventions, meetings or other events for individuals and families who need or prefer this level of assistance.

____ For individuals and families who speak languages or dialects other than English, I attempt to learn and use key words in their language so that I am better able to communicate with them during assessment, treatment or other interventions.

____ I attempt to determine any familial colloquialisms used by individuals or families that may impact on assessment, treatment or other interventions.

____ When possible, I ensure that all notices and communiqués to individuals and families are written in their language of origin.

____ I understand that it may be necessary to use alternatives to written communications for some individuals and families, as word of mouth may be a preferred method of receiving information.

Values & Attitudes

____ I avoid imposing values that may conflict or be inconsistent with those of cultures or ethnic groups other than my own.

____ I screen books, movies and other media resources for negative cultural, ethnic or racial stereotypes before sharing them with individuals and families served by my program or agency.

____ I intervene in an appropriate manner when I observe other staff or clients within my program or agency engaging in behaviors that show cultural insensitivity, racial biases and prejudice.

____ I recognize and accept that individuals from culturally diverse backgrounds may desire varying degrees of acculturation into the dominant culture.

____ I understand and accept that family is defined differently by different cultures (e.g., extended family members, fictive kin, godparents).

Appendix C contd.

____ I accept and respect that male-female roles may vary significantly among different cultures and ethnic groups (e.g., who makes major decisions for the family).

____ I understand that age and life-cycle factors must be considered in interactions with individuals and families (e.g., high value placed on the decision of elders, the role of eldest male or female in families, or roles and expectation of children within the family).

____ Even though my professional or moral viewpoints may differ, I accept individuals and families as the ultimate decision makers for services and supports impacting their lives.

____ I recognize that the meaning or value of medical treatment and health education may vary greatly among cultures.

____ I accept that religion and other beliefs may influence how individuals and families respond to illnesses, disease and death.

____ I understand that the perception of health, wellness and preventive health services have different meanings to different cultural or ethnic groups.

____ I recognize and accept that folk and religious beliefs may influence an individual's or family's reaction and approach to a child born with a disability, or later diagnosed with a disability, genetic disorder or special health care needs.

____ I understand that grief and bereavement are influenced by culture.

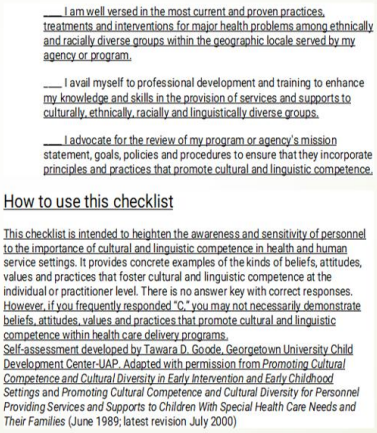
____ I seek information from individuals, families or other key community informants that will assist in service adaptation to respond to the needs and preferences of culturally and ethnically diverse groups served by my program or agency.

____ Before visiting or providing services in the home setting, I seek information on acceptable behaviors, courtesies, customs and expectations that are unique to the culturally and ethnically diverse groups served by my program or agency.

____ I keep abreast of the major health concerns and issues for ethnically and racially diverse client populations residing in the geographic locale served by my program or agency.

____ I am aware of the socioeconomic and environmental risk factors that contribute to the major health problems of culturally, ethnically and racially diverse populations served by my program or agency.

Appendix C contd.



___ I am well versed in the most current and proven practices, treatments and interventions for major health problems among ethnically and racially diverse groups within the geographic locale served by my agency or program.

___ I avail myself to professional development and training to enhance my knowledge and skills in the provision of services and supports to culturally, ethnically, racially and linguistically diverse groups.

___ I advocate for the review of my program or agency's mission statement, goals, policies and procedures to ensure that they incorporate principles and practices that promote cultural and linguistic competence.

How to use this checklist

This checklist is intended to heighten the awareness and sensitivity of personnel to the importance of cultural and linguistic competence in health and human service settings. It provides concrete examples of the kinds of beliefs, attitudes, values and practices that foster cultural and linguistic competence at the individual or practitioner level. There is no answer key with correct responses. However, if you frequently responded "C," you may not necessarily demonstrate beliefs, attitudes, values and practices that promote cultural and linguistic competence within health care delivery programs.
Self-assessment developed by Tawara D. Goode, Georgetown University Child Development Center-UAP. Adapted with permission from *Promoting Cultural Competence and Cultural Diversity in Early Intervention and Early Childhood Settings* and *Promoting Cultural Competence and Cultural Diversity for Personnel Providing Services and Supports to Children With Special Health Care Needs and Their Families* (June 1989; latest revision July 2000)

APPENDIX D- The Improvised Cultural Assessment Tool for patients

1) Do you have any dietary preferences related to your religious or cultural beliefs?

2)Are there any special foods in your culture for different illnesses or for your health and wellbeing?

3) Do you use home remedies that might be useful when someone is ill?

4) What do you think a provider should know about your culture if a family member is hospitalized?

5) Who makes the health decisions in your family?

6) Are there any special beliefs regarding organ donation or blood transfusions that are held in your culture?

7) Is there anything I should know about your culture, beliefs, or religious practices that would help me take better care of you?

8) Do you have any dietary restrictions that we should consider as we develop a food plan to help you lose weight? Or help improve your diabetes or blood pressure or high cholesterol, kidney disease or gout etc.

9) How would you like your family members to be involved in your care?

(Agency for Healthcare Research and Quality, 2020) ;(Fraser Health Authority, n.d)

conclusion

- Establishing a collaborative mutual partnership with diverse patients requires an open, self-reflective, other-centered care approach to understand and formulate the patients' strengths and difficulties to help co-constructing their treatment plan(Stubbe,2020).

Appendix F(i)-Project Timeline

Week 1 **(Dates)**	Week 1: Feb 28–March 5 Providers will be given the self-assessment tool to complete. (Appendix C) When completed, the provider self-assessment tool will remain with the provider A concise PowerPoint training on cultural competency for healthcare providers with emphasis on the National CLAS module will be presented in two sessions (Appendix C). The first session would be on Wednesday the first week; the second would be on Monday on the other clinic rotation to ensure all providers and staff are trained effectively. The provider self-assessment tool will be issued to the providers for their review and completion. A PowerPoint presentation on how to complete the cultural assessment tool will be presented.

	This week, the Provider self-cultural assessment and patient cultural preference tools will be disseminated to providers for their review. Progress will be evaluated via face-to-face interaction with nurse managers and staff, and if more training is needed, it will be provided by the project lead.
Week 2 **(Dates)**	Week 2: Mar 6–12 Staff, and healthcare providers, will receive intermittent training with guidance from the project lead. A weekly data sheet will be used to keep track of completed cultural assessment tools by the project lead (Appendix G). The DNP lead will also observe and perform chart audits to evaluate if any changes occur and if providers are compliant with completing the assessment tool.

Week 3 **(Dates)**	Week 3: Mar 13–19- The healthcare providers will continue completing patients' cultural preference tools, and the project lead will continue collecting cultural assessment tools for data collection, evaluation for compliance, and data analysis.
Week 4 **(Dates)**	Week 4: Mar 20–26- The DNP lead will continue to collect all data and records pertaining to the project for compliance and data analysis.
Week 5 **(Dates)**	Week 5: Mar 27–April 2- Data collected will be evaluated for compliance and data analysis.

Appendix F(ii)-Project Timeline

Week 1	• 02/28/24 -3/5/2024-; -Began to show PowerPoint presentation on cultural competency and its benefits to providers and staff. • Began training last Wednesday instead of Monday since the semester began on 2/28/24. • Clinic rotation resumes on new rotation on Mondays and Wednesdays at the clinic. • The presentation was done on 2/28/24 and 3/4/2024 due to staff rotation. The PowerPoint training on cultural competency for healthcare providers emphasizing the National CLAS module was concise and presented in two sessions (Appendix C).

	• Providers were issued a self-cultural competency tool (Appendix C) to complete and evaluate their self-cultural competence; they would keep this tool after completion. • Also, providers are issued with patients improvised cultural assessment tool (Appendix D) so that providers can evaluate patients' cultural preferences. • 2/29/2024,03/01/24,03/04/24, and 03/5/24 - used to answer questions and concerns from providers and staff regarding tools
Week 2	• 3/6/2024-3/12/2024-A provider called in, and the clinic closed early on 3/6/24 due to an emergency. • On the other date, implementation ran smoothly; the project lead catered to answering questions and supporting the team. On the other dates, implementation ran smoothly using the Plan, Do, Study, Act (PDSA) cycle; the project lead catered to answering questions and supporting the team. • Staff and healthcare providers received intermittent training with guidance from the project lead. A weekly data sheet was used to keep track of completed cultural assessment tools for the project lead and scanned into the patient EMR chart (Appendix G). • The DNP lead observed and performed chart audits to evaluate whether any changes occurred, assessed whether there was disruption in using the tool, and determined whether providers were compliant with completing the assessment tool.

	• After debriefing each day, it was gathered that most of the patients who refused wanted to rush back to work because they came to the clinic on their lunch break or took some portion of leave request from their jobs.
Week 3	• During week 3, the team continued to implement the project using the Plan, Do, Study, Act (PDSA) cycle. • Intermittent refresher face-to-face questions and answer sessions were performed by the project lead as needed. • Objective 4: Participant utilization of the cultural assessment tool will be 75% or better. • The participant rate was 72.3% due to issues that arose in the clinic on 3/14/24 due to the staff training day; this affected objective 4, which did not meet the 75% goal. • Project lead provided refreshments. • Some patients were noted to be impatient to have the provider complete the patient cultural preference tool; when the benefits of why the provider completed the tool, they participated, hence the refusal rate

	• Project lead continued to use the chart audit tool to gather data and scan tool into patient charts; copies were shredded to protect patient information.
Week 4	The project implementation continued in week four using the PDSA model. The DNP project lead discussed with staff and providers the necessity for the implementation to be carried out by the providers and not the nurses on intake. The Project lead ran into a few challenges like Challenge 1- An incident occurred in which three of the providers wanted nurses to administer the questionnaire to the patients during check-in or have staff in the front office have the patients complete the tool before getting them to the exam room. This was caught in time, and reinforcement was provided to the provider on the importance of why the healthcare provider should perform and administer the tool to the diverse patient population. This week afforded healthcare providers the opportunity to have their concerns continually addressed by the project lead. Nurse managers also were helpful in reinforcing to staff and providers the tool's relevance. Challenge 2 - One other provider gave a patient the tool to complete and return to the clinic, but this was caught in time. He was re-educated face-to-face and administered the questionnaire to the patient before the patient was discharged.

	Challenge 3- On 3/22/24, a healthcare provider quit abruptly due to some misunderstanding with management unrelated to the project; some other provider came in 3 hours into the day on 3/22/24 to cover the remaining of the provider's patient scheduled load. The project lead kept collecting the completed tool and chart audit while tabulating data in preparation for data analysis; the collected tools were reviewed, scanned into patient charts, and shredded to avoid violating patient privacy. The project spent at least 6 hours daily to ensure protocol was not broken or abused. Provider received positive feedback from healthcare providers during debriefing that the improvised cultural preference tool was giving them a background into patients' cultural preferences and assisting them to provide better care to their patients.
Week 5	Click or tap here to enter text. **N/A**

APPENDIX G -Chart audit tool to monitor provider compliance in administering patient improvised cultural competency tool

Week	#diverse population patients	% patient cultural assessment tool returned
2	57	(46)-80% OF THE TOOL WAS RETURNED AND SCANNED
3	74	(54)72.9% OF THE TOOL WAS RETURNED AND SCANNED
4	123	(84)68.2% OF THE TOOL WAS RETURNED AND SCANNED

APPENDIX H-Chart audit tool for documentation of cultural competency tool by providers in EcW EMR

PROVIDERS	Number of patients seen by the provider	Number of diverse patients in clinic seen by provider	Number of diverse patients seen- who agreed for tool usage	Number of diverse patients refusing to do the cultural assessment
1	56	35	22	13
2	52	22	14	8
3	49	23	12	11
4	24	5	5	0
5	13	10	9	1
6	30	18	11	7
7	47	23	15	8
8	47	30	17	13
9	38	23	14	9
10	48	43	33	10
11	54	18	14	4
12	19	4	3	1
13	28	17	9	8
14	14	2	1	1
15	21	5	5	0

APPENDIX I - Clinical Preceptorship

Agreement Signature page

10. EXECUTION

The signatories below warrant they have authority to bind their entity in contract. This contract applies to core and non-core clinical experiences.

Quick Visit Urgentcare, Jacksonville, Texas

Date: 08/18/2023

By: [signature]
Print Name: Kimberley A. Richardson
Title: East TX Regional Manager

TOURO UNIVERSITY NEVADA

Date: 09/19/2023

By: [signature]
Robert Askey, Ed.D.,
Dean, College of Health and Human Services

Date: 09/03/2023

By: [signature]
Andrew Priest, Ed.D., PT
Campus President and Provost

APPENDIX J- AFFILIATE AGREEMENT STATEMENT

Affiliation Agreement Statement:

Touro University Nevada does not require affiliation agreements for DNP Practicum Experiences. However, the project/practicum site may require an affiliation agreement with Touro. Please delegate this form to an appropriate project/practice site representative for completion.
Please fill in the blanks below and check the appropriate box:

The TUN DNP student: Ezenwanyi Onwuchekwa is authorized to complete practicum hours at the above listed project site.

✓ An affiliation agreement is required for completion of this practicum experience.

_____ An affiliation agreement is not required for completion of this practicum experience.

If an affiliation agreement is required, please insert the name and contact information of the person who will coordinate the agreement:

Name of representative: Kimberley A. Richardson

Contact Information and preferred contact method: Cell Phone - (936) 332.9194

Authorized Project Site Representative Signature: [signature]

Student Signature: [signature]