Cultural Competence Training Program for African Immigrants

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Abstract

Background: African immigrants have unique health care needs and most of these needs are related to their cultural practices. However, there is lack of cultural competence among health care providers regarding African immigrants and this is a major contributing factor to their poor health outcomes. Without cultural competence training, health care providers cannot effectively tackle the health care concerns of this population.

Purpose: The purpose of the project was to develop a cultural competence training program for providers regarding African immigrants to improve provider cultural competence and resource allocation and referrals for African immigrants.

Methodology: Madeleine Leininger's Cultural Care Model provided the conceptual framework for the project. The project utilized educational training sessions with pre and post survey questionnaires for 3 providers, African Immigrant Cultural Competence Toolkit, and the resources toolkit. A paired-t test and percentage calculations were used for analysis of the results.

Results: There was a statistically significant improvement in the cultural competence knowledge of providers before and after the training ($F(3, 11) = 17.23$, $p = 0.001$). All the patients (100%) who visited the clinic during the 5-week period (187 patients) were handed resource toolkits. Providers utilized the African Immigrant Cultural Competence Toolkit 50.8% of the time (95 out of 187).

Conclusion: A cultural competence training program for providers regarding African immigrants is effective in improving provider cultural competence skills and resource allocation and referrals for African immigrants.

Implications to Practice: The project will foster more consistent implementation and utilization of cultural training programs for improving providers' cultural competence skills.

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Cultural Competence Training Program for African Immigrants

Cultural competence can be described as the ability of understanding, communicating, and interacting efficiently with people across cultures (Schouler-Ocak et al., 2015). Cultural competence comprises the process of one's being aware of their own view of the world based on their cultural practices and traditions as well as developing positive attitudes toward the differences in cultures of others (Allison et al., 2016). Cultural competence is an important aspect of healthcare because cultural practices directly impact health care practices (Venters et al., 2019). African immigrants often find themselves in situations of cultural dilemmas because of the differences in culture between their original areas of residence and their new ones (Price et al., 2015).

The main problem witnessed on the project site is the lack of cultural competence among health care providers regarding African immigrants. This problem negatively affects the health care experience of African immigrants (Purnell & Fenkl, 2019). Because of the gap in cultural competence, there is a huge disparity in the quality of health services received by the African immigrant population as compared to other population groups in the United States (Clough et al., 2013). Evidence points to the fact that the African immigrant population has a lower health score and patient outcomes as compared to other groups with less than 18% of those admitted showing improved results over the course of their recovery (World Health Organization, 2020).

Knowledge gaps existing in practice causing cultural incompetence needs to be addressed because it violated the health care sector's goal of ensuring fairness and equality in the access to services regardless of ethnic or racial orientation (Allen et al., 2012). As the World Health Organization explains, the health care sector aims at ensuring that everyone can be as healthy as possible, including the African immigrants (World Health Organization, 2020). The lack of

cultural competence among health care providers that leads to African immigrants having poor health experiences violates this goal. The solution put forth by this project is the development of a cultural training program for African immigrants. This program is aimed at equipping health care providers with the right knowledge and set of skills to address the health concerns of African immigrants. The development of a cultural competence program is important because it will help in the removal of sociocultural factors that negatively impact the health experiences of African immigrants (Omenka et al., 2020).

Background

The number of African immigrants entering and settling in the United States increases almost every year (Purnell & Fenkl, 2019). This is because African immigrants prefer moving to the United States in search of better living conditions, better employment opportunities, and better health care services (Seck, 2015). However, African immigrants have been brought up in entirely different societies with completely different cultural beliefs and practices (Allen et al., 2012).

The African immigrant group has unique health care needs and most of these needs are related to their cultural practices (Purnell & Fenkl, 2019). Purnell and Fenkl (2019) reported that health care providers are not devoted to finding methods of addressing these unique health care needs of African immigrants. Omenka et al. (2020) explained that the lack of cultural competence among health care providers is a crucial contributing factor to the poor health of African immigrants. Without cultural competence training, health care providers cannot effectively tackle the health care concerns of African immigrants (Kamya, 2017).

Problem Statement

The main problem faced at the project site is the lack of cultural competence training among health care providers, specifically regarding African immigrants. The facility is a primary care clinic in Garland, Texas that attends to various groups of people and the African immigrants group is one of them. However, the African immigrant group is different in terms of their health care needs since most of their medical needs are related to their culture (Asare & Sharma, 2012). The staff has not received formal training on addressing the needs of this population; therefore, they cannot deliver health services that address the cultural, social, and linguistic needs of the African immigrant group. This results in poor health conditions for African immigrants. There are several resources available that are not being used, and this project plans to address these gaps.

The Center for Disease Control and Prevention (CDC) reported that the failure of health care providers to administer effective health care services to African immigrants puts the group at an increased risk of getting sick (CDC, 2021). The CDC reported that this has been clear, especially during the COVID-19 period, as many African immigrants have suffered from and died of COVID-19 (CDC, 2021). The proposed solution is the development of a cultural competence training program for the health care providers. This program is aimed at enabling the health care providers to gain the knowledge and techniques they can employ to provide quality health care services to African immigrants.

PICOT Question

In healthcare workers caring for African Immigrant groups (P), how can an effective cultural competence training program (I) compared to no training program (C) be developed to

improve the resource allocation and referrals for African Immigrants (O) in less than 4 weeks (T)?

Literature Review

Search Methods

The search strategy for this project included the use of databases, search terms, and keywords. The databases included MEDLINE (PubMed), Web of Science, Google Scholar, and CINAHL Complete. The keywords used were based on the PICO framework. The participants were “African immigrants”, “African incomers”, and “African in-migrants”. The intervention was “cultural competence”, “competence in cultures”, “cultural awareness”, “intercultural competence”, “culturally responsive”, “cultural literacy”, and “culturally informed”. The outcomes were “improved health care”, “better health care”, “enhanced health”, and “raised health care status”. Boolean operators were also used to combine search terms. The search terms were combined to broaden or narrow the search results. “OR” and “AND” were the Boolean operators used. The citation list was reviewed to identify any additional studies that were eligible for inclusion. This was to ensure that no relevant studies were excluded. There was focus on the breadth and specificity of the search.

Predetermined criteria for inclusion and exclusion had already been established and all the citations were reviewed against it. Various types of study designs were included, and these include systematic reviews, cross-sectional studies, and case reports and series. All included studies specifically addressed how cultural competence in the health care profession would be useful in improving the health outcomes of African immigrants or how deficiency of cultural competence among health care providers contributed to the poor health of African immigrants. The definition of cultural competency along with all its elements was based on the United States

National Library of Medicine-National Institutes of Health (National Library of Medicine, 2019). The library defines cultural competency among health care providers as the ability to collaborate effectually with individuals from different cultures to improve their health care experience and outcomes (National Library of Medicine, 2019).

The studies included also specifically compared the cultural competency of health care providers to the health outcomes and experiences of African immigrants. All potential settings, such as hospitals, clinics, community settings, and others that were related to the studies, were included. The studies included specifically had their participants as African immigrants and no other group was substituted for the participants. Studies were exempted because of the following: (a) The study population was not only African immigrants, or there was no separate reporting of the results of African immigrants. (b) The study discussed African Americans instead of African immigrants. (c) The study did not have its core focus as cultural competence among health care providers in relation to African immigrants. (d) The intervention targeted the health care system or the health care providers instead of the patients. However, no studies were excluded based on participant age or sex, or article language.

Review Synthesis

Developing the themes was founded on analysis and examination of previous studies that were related to cultural competence issues among African immigrants. The main themes that emerged include effects of cultural incompetence, how language barriers affect cultural competence, and the impact of cultural competence training on health care workers. These themes are the main points of emphasis when developing a cultural competence program for African immigrants. Focusing on these themes will guarantee the success of the cultural competence program for African immigrants.

Review of Study Methods

Most of the literature items reviewed the qualitative literature review methods to supplement the facts in their studies. The qualitative literature review research was conducted in hospital and clinical settings by assessing redacted medical records. The facts gave insight into how cultural competence affected the quality of patient outcomes among the African immigrant population. The case study aimed at identifying the percentages of hospitals and clinics that acknowledge cultural sensitivity and inclusion through cultural competence training.

Literature Themes

Effects of Cultural Incompetence

The main issue observed in the research is the lack of cultural sensitivity and competence within the health care profession regarding African immigrants. This issue has a negative impact on the healthcare received by African immigrants. Because of the disparity in cultural competence, the health care providers cannot efficiently deliver health services that cater to the cultural, social, and linguistic needs of the African immigrant patients (Purnell & Fenkl, 2019). As a result, the African immigrant group is seen to have an overall health status score that is lower compared to other groups (Seck, 2015). As the World Health Organization defines, the health care sector has a goal of guaranteeing that everyone's wellbeing is catered for as effective as possible, including African immigrants (World Health Organization, 2020). Health is determined by various social factors outside of the traditional healthcare setting (Purnell & Fenkl, 2019).

Some of these social determinants of health are housing quality, access to healthy foods, and education. Seck (2015) explained that African immigrants have unfavorable social determinants of health which contribute to their lack of quality healthcare. This leads to their

poor health experiences because of the lack of understanding by health care workers regarding these social determinants of health. Lack of representation of African immigrants both in leadership and training is also responsible for the lack of cultural competence programs for African immigrants (Clough et al., 2013). Another reason for the lack of cultural incompetence regarding African immigrants is the fact that even most health care workers are White and without cultural training, it is hard for them to understand the needs of African immigrants (Seck, 2015). Even though the medical field is showing increased diversity, most people working in healthcare are not familiar with the culture of African immigrants, so they do not know how to handle this group (Purnell & Fenkl, 2019).

Cultural incompetence has had negative outcomes for African immigrant patients, such as serious health complications and even death. Clough et al. (2013) explained that, due to cultural incompetence, African immigrants are two to three times more likely to suffer from various health-related issues compared to other groups, like White people. The cultural incompetence of health care workers makes African immigrants, who are primarily Black, suffer severely and longer from easily preventable diseases. Seck (2015) reported that some of these negative outcomes are because of subconscious prejudices and implicit bias about the African immigrant group. Addressing cultural incompetence and its effects is the first step to the development of a successful cultural training program for African immigrants (Purnell & Fenkl, 2019).

Language Barriers and Cultural Competence

Language is an aspect of culture that affects the quality of treatment in African immigrant groups (Seck, 2015). Language barriers play an important role in miscommunication between patients and medical providers, which negatively affects the quality of healthcare services and patient satisfaction regarding the African immigrant group (Allison et al., 2016). Due to language

barriers, health care professionals have an incomplete understanding of the situations of patients, poorly assess patients, prescribe treatment incompletely, or cause delayed treatment or misdiagnoses (Wamwayi & Murray, 2019). As a result of language barriers, African immigrants end up having decreased satisfaction with health care services, complications arising from medication, and a reduced level of understanding of their diagnosis even if they have access to healthcare (Venters et al., 2019).

All these elements lead to the reduction in the quality of health care experience of African immigrants. One way of overcoming the language barrier is through using technology to bridge the language gap between health care professionals and African immigrants (Venters et al., 2019). Health care professionals can make use of voice recognition technologies such as Google Assistant and Google Translate. These are technologies that allow for two-way interpretation and can help in transcribing and translating dictation such as a doctor's instructions (Wamwayi & Murray, 2019). Another effective way of overcoming the language barrier is the use of online applications, such as Duolingo, which offer new ways of learning different languages. Health care professionals can use these applications which keep things simple and make learning streamlined and easier, to understand elements of the African immigrants' language and enhance their communication (Wamwayi & Murray, 2019).

Another way of overcoming the language barrier is through the use of an interpreter. The medical facilities can have interpreters specifically for African immigrant groups to enhance communication (Venters et al., 2019). The interpreter can be available physically at the medical facility and if this is not possible, technology has made it easier for the use of an interpreter using virtual platforms such as Zoom, Google Meet, or Skype (Allison et al., 2016). All these techniques and technologies will help in breaking the language barrier and enhancing effective

communication between African immigrants and healthcare professionals. In the long run, the quality of health care services in African immigrants will improve, hence enhancing their overall health care experience and satisfaction.

The Impact of Cultural Competence Training on Health Care Workers

Training programs and cultural competence among health care workers have social, health, and business benefits for health care organizations and African immigrants (Omenka et al., 2020). Cultural competence training programs would increase mutual respect and understanding between African immigrants and health care providers (Kamya, 2017). It would also ensure the inclusion of all community members and increased participation and involvement of African immigrants in health issues (Kamya, 2017). Being culturally competent would also enable health care workers to have improved patient data collection for African immigrants and reduce the health care disparities in the African immigrant population (Asare & Sharma, 2012).

Cultural competence training programs for health care workers would help in reducing medical errors, the number of treatments, and legal costs, which increase cost savings (Asare & Sharma, 2012). When healthcare workers undergo cultural competence training programs, they will incorporate diverse ideas, perspectives, and strategies when deciding about African immigrants. Barriers that slow the progress of the health care experience of African immigrants would also be decreased and the efficiency of these care services will be improved (Omenka et al., 2020). Cultural competence training would also help health care providers to reduce the literacy gap when handling African immigrants (Omenka et al., 2020).

Most African immigrants come from backgrounds of little or no education which makes it hard for them to gain literacy skills to overcome language barriers or to read and understand instructions and conversations with health care professionals (Omenka et al., 2020). Cultural

competence training would provide health care professionals with techniques of dealing with African immigrants with low literacy and explain how to offer them the best care quality. Cultural competence training will also enable health care professionals to coordinate with traditional healers among African immigrants and incorporate culture-specific attitudes and values into health promotion activities for this group (Kamya, 2017).

National Guidelines

Various national guidelines provide standards for culturally and linguistically appropriate services in healthcare. These guidelines aim at making health care services more responsive to the individual needs of patients coming from various cultural backgrounds (U.S. Department of Health and Human Services, 2001). These guidelines include ensuring the provision of health care services in a manner that is compatible with patient cultural health beliefs, practices, and preferred language (U.S. Department of Health and Human Services, 2001). Health organizations are required to establish strategies of recruiting, keeping, and promoting organizational staff and leadership that represent demographic characteristics of the area of service (U.S. Department of Health and Human Services, 2001).

Health care organizations ensure that staff at all levels undergo education and training for culturally and linguistically appropriate delivery of service. Language help services inclusive of bilingual staff and interpreter services at no cost to the patients with limited English proficiency must be offered by health care organizations (U.S. Department of Health and Human Services, 2001). Patients should be informed of the right to receive language help services for their preferred languages. Easy-to-understand materials relating to patients should be made available by health care organizations and the development, implementation, and promotion of a written strategic plan outlining clear goals and policies for providing culturally and linguistically

appropriate services must be in place (U.S. Department of Health and Human Services, 2001). Internal audits, patient satisfaction assessments, and outcome-based evaluations should be done on integrating culturally and linguistically related measures about the organization's conduct. Health records should have slots for collecting the patient's race, ethnicity, and language, and this should be integrated into the management information system of the organization management (U.S. Department of Health and Human Services, 2002).

An updated demographic cultural profile of the community should be maintained by the organization and collaborative, participatory partnerships with communities should be developed by the health care organizations regarding the designing and implementation of cultural and linguistic related activities (U.S. Department of Health and Human Services, 2002). Conflict and grievances resolution processes should be culturally and linguistically sensitive, also cross-cultural conflicts and complaints should be resolved appropriately by health care organizations (U.S. Department of Health and Human Services, 2002). Health organizations should make available to the public information about progress and successful innovations in implementing the culturally and linguistically appropriate services standards (U.S. Department of Health and Human Services, 2001).

Aims of the Quality Improvement Project

The quality improvement project is aimed at designing a cultural competence training program that will enable health care professionals to understand African immigrants' expression of health needs. The project is aimed at breaking down barriers that get in the way of African immigrant patients receiving the care they need. It is also aimed at ensuring improved understanding between African immigrant patients and their health care providers. The project is aimed at structuring a cultural competence training program that will accommodate the growing

diversity of the United States population demands regarding the African immigrant group and expanding the ability of health care professionals to address the needs of this group. Generally, this quality improvement project is aimed at developing a cultural competence training program that will train health care providers on how to incorporate different ideas, perspectives, and strategies as they make health decisions about African immigrants which would improve the overall health care experience of this group.

Objectives

The objectives of this project are:

1. To create a cultural competence training program that will help in promoting cross-cultural awareness and competence skills needed for health care professionals to be culturally competent regarding African immigrants.
2. To create an African Immigrant Cultural Competence Toolkit that will be used by care providers to assess and enhance cultural competence in the organization.
3. To create a Resources Toolkit that will be given to African immigrant patients visiting the primary care clinic.

Conceptual Model: Madeleine Leininger's Cultural Care Theory

The theoretical underpinning or conceptual framework for this project will be provided by Madeleine Leininger's cultural care theory. Leininger's theory focuses on the definition of what pertains to transcultural nursing and how nurses comprehend the beliefs and practices of diverse cultural groups (Leininger, 1988). This theory is the most appropriate for this DNP project since it aims at explaining how nurses can provide culturally congruent care through taking actions that are mainly designed to suit the individual's, group's, or institution's cultural

values, lifeways, and beliefs (Leininger, 1988). The goal of the cultural care theory is to enable improved health outcomes for individuals of different cultural backgrounds (Leininger, 1988).

Historical Development of the Theory

In the late 1950s, Madeleine Leininger envisioned how the world was increasingly becoming integrated, and human beings were interacting on a global scale (Leininger, 1988). Leininger decided that she would go beyond anthropology and emphasize groups of people from diverse parts of the world in expressing her thoughts from a nursing perspective (Leininger, 1988). Leininger had always believed that care is the most essential component of nursing, even before establishing the field of transcultural nursing (Leininger, 1988). Her study of the Gadsup people in Papua New Guinea in the early 1960s was the first transcultural nursing research, and she proceeded to establish the initial formal doctoral programs and courses in transcultural nursing in 1965 at the University of Colorado School of Nursing (Wehbe-Alamah, 2015). The first book to be published regarding Leininger's cultural care theory was *Nursing and Anthropology: Two Worlds to Blend*, which was published in 1970 (Wehbe-Alamah, 2015). A third and an updated edition of *Transcultural Nursing: Concepts, Theories, and Research Practices* was authored by Leininger and McFarland in 2002 (Wehbe-Alamah, 2015).

Through her discussions of the theory, Leininger continued to elaborate on the significant features of culture care diversity within the context of transcultural nursing. Leininger established the Transcultural Nursing Society in 1974, aimed at serving nurses worldwide through teaching them how to reinforce the quality of culturally competent care aimed at improving the health and well-being of people worldwide (Wehbe-Alamah, 2015). Over the years, Leininger's theory has been used in training nurses how to provide culturally specific care, which is aimed at improving the health and well-being of people as well as helping them to face

unfavorable human conditions, illnesses, or death, in culturally meaningful ways (Wehbe-Alamah, 2015).

The Major Tenets

In developing the major components of the theory, several factors were taken into account by Leininger. These factors were the elements that guided the development of the major tenets of the cultural care theory (Leininger, 1988). Leininger explained that wellness and illness are molded by various factors, inclusive of perception and coping skills (Leininger, 1988). Cultural competence is an essential component of nursing, and culture affects diverse segments of human life including illness, health, and the search for relief from distress or diseases (Leininger, 1988). Cultural and religious knowledge is a significant aspect of healthcare, and the health concepts that cultural groups hold may impact how they seek modern medical care (Leininger, 1988).

Before discussing the major tenets of the theory, it is important to understand the meaning of certain terms related to the theory as defined by Leininger. *Care* is assisting others in an effort of improving their human conditions of concern or facing death (Wehbe-Alamah, 2015). *Caring* is the act of providing care (Wehbe-Alamah, 2015). *Culture* is the learned, shared, and transmitted norms, beliefs, ways of life, and values of a specific group that guide their decision or lifestyle (Wehbe-Alamah, 2015). *Cultural care* refers to various elements of culture which are responsible for influencing and enabling people to enhance their human conditions or to face illnesses or death (Wehbe-Alamah, 2015). *Cultural care diversity* describes the differences in meanings, values, or accepted modes of care between or within diverse groups of people, while *cultural care universality* describes the common and similar meanings of care in the cultures (Wehbe-Alamah, 2015).

Theory Application to the DNP Project

Generally, the major tenets of the cultural care theory were used in guiding the research and documenting how health care providers can develop an understanding, appreciation, and respect for the diversity and individuality of African immigrant patients' values, beliefs, culture, and spirituality, in the context of illnesses, causes of illnesses, treatment, and outcomes (Wehbe-Alamah, 2015). They will be used in the project to research and document how nurses can develop care that fits the values, beliefs, and lifestyles of African immigrants, which is based on the patients themselves rather than on predetermined criteria (Wehbe-Alamah, 2015). The major tenets of the theory were also used to identify how nurses can bridge the cultural gap to achieve meaningful and supportive care for African immigrant patients and their families (Wehbe-Alamah, 2015). Based on the concepts of the theory, the project found out how nurses can self-examine their backgrounds and recognize biases prejudices, and assumptions about the African immigrant group.

Cultural care preservation or maintenance was used to identify how the health care providers can develop assistive and facilitative professional actions and decisions that can aid the African immigrants to preserve or retain relevant care values that will help them in maintaining their well-being, recovering from illnesses, or facing handicaps or death (Wehbe-Alamah, 2015).

Cultural care accommodation or negotiation was used in the project to guide the identification and documentation of the assistive, supportive, enabling, or facilitative professional decisions or actions that may help the health care providers in training African immigrants to adapt culturally, for improved and satisfactory health outcomes (Leininger, 1988).

Cultural care repositioning or restructuring was used in the identification and documentation of techniques that the health care providers can use to help African immigrants in

reordering, changing, or greatly modifying their lifestyles for newer, better, and different health care patterns while respecting the African immigrants' cultural values and beliefs (Leininger, 1988).

Implementation Model: The Plan-Do-Study-Act Model

Much health care research and many reports recommend the Plan-Do-Study-Act model as an implementation model for quality improvement projects (Donnelly & Kirk, 2015). The model is made up of four repeating phrases that are cyclical in nature. These are Plan, Do, Study, and Act (Donnelly & Kirk, 2015). *Plan* is about the effort and background work of proposing change (Donnelly & Kirk, 2015). *Do* is about implementing the proposed change (Donnelly & Kirk, 2015). *Study* is about conducting analysis and evaluation of the outcomes of the proposed change (Donnelly & Kirk, 2015). *Act* is about revisiting and redesigning the previously planned change to take into account the lessons which have been obtained at the Do and Study phases (Donnelly & Kirk, 2015).

The PDSA model was selected because it will be effective in giving rise to changes in a short period and will likely facilitate continuous quality improvement (Donnelly & Kirk, 2015). This model will be used to test the proposed change during the implementation process (Donnelly & Kirk, 2015). It was used to the test the change through planning, trying, observing results, and taking action on the lessons learnt (Donnelly & Kirk, 2015). The model was used during the course of the project to assess how the project implementation could be done in a manner that would lead to the desired improvement (Donnelly & Kirk, 2015). The model was also used to evaluate how much improvement could be expected from the change and how best the proposed change could work in the real environment of interest (Donnelly & Kirk, 2015).

Setting

The setting of this project is a primary care clinic in Texas. It is an ideal place for conducting this project because it is home to a huge number of African immigrants (Chikanda & Morris, 2021). According to the American Immigration Council, African immigrants are ever-growing and constitute a diverse group in the United States (Chikanda & Morris, 2021). According to the American Immigration Council, Texas is one of the locations with the largest number of African immigrants; other areas are California, New York, Virginia, and Maryland (Chikanda & Morris, 2021). This means that because the project addresses cultural competence concerning African immigrants, it will be beneficial both currently and in the future. The practice location in Texas is made up of 10 health care providers, including a nurse, family nurse practitioner, office administrator, and medical assistants.

The system used as the solution for electronic health records is EPIC. EPIC provides the primary care clinic with a standard range of primary EHR functions, and modules can be added depending on specialty (Milinovich & Kattan, 2018). The primary care clinic uses the EPIC system for appointment management, patient history, scheduling, e-prescription, and clinical workflow. The EPIC system will act as a significant source of data during data collection for the project because it contains all the necessary information about the patients who visit the clinic.

Population of Interest

The population of interest for this project is in terms of direct and indirect population. The health care providers form the direct population of interest. These health care providers are the focus of this cultural competence program for African immigrants, and they include nurse, family nurse practitioner, office administrator, and medical assistants. The inclusion criteria focus on health care providers attending to the health concerns of the African immigrant patients.

Anyone else who works at the clinic (either temporarily or permanently) but who is not involved in the provision of care for African immigrant patients is excluded. This means that all other workers who are not involved in the treatment of African immigrants visiting the clinic for primary care services are excluded from the project.

The African immigrant population visiting the clinic for primary care services forms the indirect population of interest. The inclusion criteria for this population are any adults who identify as African immigrants and who visit the clinic for primary care services. The exclusion criteria are any other patients besides African immigrants visiting the clinic for primary health services. This excludes patients from other ethnicities visiting the clinic for primary care services.

Stakeholders

The significant stakeholders in this project are the clinic owner, the medical director, and the health care providers. The owner of the clinic is a significant stakeholder because she is responsible for overseeing the daily operations of the facility (Kirchner et al., 2012). The owner of the clinic also provides administrative support and oversees the hiring, firing, and training of staff members (Kirchner et al., 2012). The owner of the clinic is also responsible for liaising with patients and health care providers as well as coordinating plans for patient care (Kirchner et al., 2012). The site administrator is significant because he or she is responsible for ensuring that the running of the activities in the clinic is top notch and as expected. He or she also ensures that quality medical care is provided to the community being served by the clinic (Kirchner et al., 2012). The medical director is significant because he or she is in charge of the daily operations of the clinic and documentation of the patients seen (Kirchner et al., 2012).

Obtaining permission was vital for the sake of the project, and it was granted by the owner of the clinic, the site administrator, and the medical director. Obtaining permission helps in ensuring that the activities of the project at the site will be conducted with adherence to both ethical and legal guidelines and considerations (Milinovich & Kattan, 2018). No affiliation agreements were necessary for this project.

Interventions

The activities of the project were conducted during regular working hours. The project lead was available to assist the medical providers with any questions about the AICCT tool Communication with the staff was through physical means and phone calls or emails as needed. The following is a weekly timeline of the implementation.

Week 1

In the first week, a pretest, located in Appendix E, was administered. This was done 1 day before an educational training. The educational training was then conducted the next day using the PowerPoint presentation material in Appendix D. The educational training session was brief and to the point and touched on all issues that concern cultural competence when handling the African immigrant group. One detailed session was deemed enough although progress was monitored to identify any need for an additional training session. The session also included training participants on how to use the African Immigrant Cultural Competence Toolkit (Appendix B). It also included training the staff on how to use the African Immigrant Resources Toolkit (Appendix C). After the session, both toolkits were handed to the participants. Additionally, a posttest was administered after the educational training session. The posttest was done using the material in Appendix E, and a pass grade of 80% was required. The goal is to determine how the participants perform in the test before the training and after the training has

taken place. A remediation class was also conducted for participants with a grade less than 80% on the posttest.

Weeks 2 to 4

The resources toolkit was handed to the patients as they visited the clinic. Continued education and support were provided to the participants to ensure efficiency of the progress of the program. Participants made use of the toolkit handed to them, and data collection and assessment of compliance were done at the end of each week to ensure that any loopholes were identified and any additional support was identified as well. Participants were retrained if needed.

Week 5

In Week 5, data compilation was done and its analysis followed. The success of the project was measured by the rate at which the resources toolkit was handed out to African immigrants and the rate at which the providers utilized the African Immigrant Cultural Competence Toolkit while interacting with African immigrant patients. The approach for measuring these rates is outlined in the Chart Audit Tool (Appendix F).

Tools

The tools used during this DNP project include the AICCT, AIRT, educational presentation, pretest/posttest questionnaire, and chart audit tool. The following is an explanation of each tool.

African Immigrant Cultural Competence Toolkit (AICCT) (Appendix B)

This is a one-page guideline that acts as a reference point for the African immigrants cultural competence issues. The guideline has cultural issues, their descriptions, and the solutions. It is to be handed to the health care providers. The toolkit is developed by the project

lead and utilizes project team consultation for validation. The tool was developed based on evidence-based research about the main cultural competence issues and solutions involved when handling the African immigrant population, and the sources are listed in the references.

African Immigrant Resources Toolkit (AIRT) (Appendix C)

This is a one-page toolkit with information about food assistance; legal services; housing services; employment, financial, and health resources; and where they can be found locally. It is to be handed to the patients during their visits to the clinic. It is developed and updated by the project lead and utilizes project team consultation for validation. The tool was developed based on evidence-based literature identifying these resources as primary needs of African immigrants. These resources are important because they play a huge role in the social determinants of health of the African immigrant population. These resources impact the environment and manner in which the African immigrants live and work, which in turn impacts their health outcomes.

Educational Presentation (Appendix D)

This is PowerPoint presentation educational material that was used for the training session. It was developed by the project lead and utilized the project site and team for consultation and validation before seeking approval. The material is based on evidence-based literature regarding the cultural competence of African immigrants in healthcare. The material addresses the meaning of cultural competence for African immigrants, its importance, and expected impacts. The material also addresses the main challenges faced by African immigrants in healthcare and their solutions. It addresses the objectives of this project and the interventions for achieving these objectives.

Pre- and PostTest Questionnaire (Appendix E)

This is a tool used to assess the health care professionals' level of cultural competence regarding the African immigrant group (see Appendix E). It was developed by the project lead and required expert and project team consultation for validation. The tool was developed based on the objectives of the project and the educational material used in the educational training session. The tool contains 10 questions; each question addresses specific content while testing a specific level of knowledge. The test is in a multiple-choice question format. Three experts will rate the relevance of each item on the test using the Expert Rating Form (see Appendix F). This data will then be used to calculate the validity of the tool.

Chart Audit Tool (Appendix F)

This is a tool for auditing the rate that the handout of resources was provided to African immigrant patients and the rate at which the providers utilized the African immigrant toolkit when interacting with the patient. Guidelines on how these rates are calculated are provided with the tool (see Appendix F). The tool was developed by the project lead and required experts and project team consultation for validation.

Patient Data Collection Form (Appendix G)

This is a tool used to collect data about the patient to determine whether the patient is part of the African immigrant population and whether they need assistance with community resources. The tool was developed by the project lead and it utilized project and site team consultation for validation.

Provider Data Collection Form (Appendix H)

This is a tool that is used to collect data about the providers such as the number of African immigrants attended to in a week, the number of resources toolkits a provider had in the

beginning of the week, the number of resources toolkit the provider has at the end of the week, and the number of times the provider utilized the AICCT when interacting with the patients. The tool was used to collect data about whether the providers are utilizing the AICCT and whether they are handing out resource toolkits to African immigrant patients. The tool was developed by the project lead and required project and site team consultation for validation.

Data Collection Procedures

Two separate forms were utilized for the project to facilitate data collection. One form was used for the providers and another for the patients. The patient form has sections for a patient to fill their name, race, ethnicity, immigration status, and country of origin. This was given to all patients at the intake level. This is what the provider used to screen the patient. The provider's form contains the initials of the participant, the number of the project week, the number of African immigrant patients attended to, the number of resources toolkits at the beginning of the week and at the end, and the number of instances the provider referred to the AICCT when attending to the patient. This form was filled in at the end of the week and was collected weekly. It provided the project lead with all the information needed to calculate the outcomes.

The data collection segment involved the pre-survey about the cultural competence of the participants. This was administered on the same day as the educational presentation and was stored in digital form to prevent manipulation of data. The educational training on cultural competence via a PowerPoint presentation was then conducted by the project lead. This educational training included information regarding the purpose, goals, expected outcomes, and the flow of activities of the project. A post-survey was administered after the session, and the data were collected. The surveys have a label with the names of each participant, but they were

recorded using unidentified initials for privacy and confidentiality (Martinez et al., 2018). This helped to mark the end of the objective regarding the creation and delivery of a cultural competence training session for African immigrant patients.

At the end of the educational training session, the participants received both the resources toolkits that they handed to patients visiting the clinic and the developed cultural competence toolkit that acts as a guideline as they attend to the patients. The intervention then began, and data collection occurred at the end of each of the 5 weeks. The data collected included information regarding whether the African immigrant patients visiting the clinic were given the resource toolkit and whether the health care provider participants were using the cultural competence guideline tool handed to them. The site administrator was consulted to validate the providers' utilization of the toolkits. The procedure for collecting data about whether a patient is an African immigrant was done using the Patient Data Collection Tool. All patients filled out the form at the intake level with information about their race, ethnicity, whether they identify as immigrants, their initial country of origin, and whether they need assistance with community resources.

Assessing whether the providers are handing out resources toolkits to patients and whether they are utilizing the AIICT was done using data collected from the Provider Data Collection form. Each participant was given a specific number of copies of the resources toolkit. At the end of each week, the project lead collected information about how many African immigrant patients the participant attended to in that week, how many toolkits the participant had in the beginning of the week, and how many toolkits the participant has at the end of the week. This way, the project lead was able to calculate the difference in the number of toolkits. Additionally, every participant recorded how many African immigrant patients they attended to

during the week and the number of instances they utilized the African immigrant toolkit. For example, a health care provider may have attended to four African immigrant patients during the week and utilized the African immigrant toolkit on two of those occasions. These data were collected weekly. The researcher consulted a statistician to ensure that appropriate statistical testing was utilized to analyze collected data.

Ethics/Human Subjects Protection

After reviewing the Touro University DNP Project Determination document, it was determined that the project is a Quality Improvement project and not a research project. Therefore, this means that there is no need for an Institutional Review Board committee, as it meets the minimum requirements for a quality improvement project. However, the DNP project still upholds the highest standards of ethical practice, inclusive of issues regarding confidentiality and privacy as required by the code of ethics. The Health Insurance Portability and Accountability Act (HIPAA) rules were maintained during the extraction of information because of the sensitivity of data in healthcare. These data collection procedures also aimed to ensure that only data required for this project were collected and no unauthorized parties had access to this information. Anonymity of the data was also upheld for preserving identities, locations, and addresses as private (Martinez et al., 2018). Some techniques used included the removal and destruction of data identifiers to ensure that the information is anonymous (Kamya, 2017).

All participants were educated on the benefits and risks of taking part in the project. Benefits of their participation in the project include boosting their skills in handling this population, reducing inefficiencies when attending to this population, and improving African immigrants' overall health care experience. The risks involve loss of confidentiality and privacy

of the data that the participants provide. However, the issues are addressed in the project document and various approaches of mitigating them were implemented as described earlier.

Recruitment was mandatory for all the health care professionals attending to the health care needs of African immigrants at the target facility and was done by email. The recruitment was fair and just, and no participant was excluded from the research based on gender, age, race, religion, or socioeconomic status. All the benefits and burdens of the project were shared equally by the participants. The project lead requested information from the organization about the email contacts of the providers attending to African immigrants. The project lead then determined how many providers would be emailed. The project lead designed an email containing information about the overview of the project, the goal, the requirements of participation in the project, the willingness of the provider to participate, the reasons why the provider should participate, and all the information about the potential benefits and risks of participating. The email requested the recipient to reply confirming their interest in participation. The emails were sent a week before the start of the project to ensure enough time for replies. Once the project lead received responses confirming the provider's interest to participate, an email was sent to the participants to ask them about their preferred dates and times. After deciding on the best dates and times for all the participants, the project lead sent an email containing the information about the first scheduled meeting. The first meeting confirmed successful recruitment of the participants, and project activities began. The participants were compensated, and they were informed at the beginning of the project implementation.

Measurable Plan for Analysis

The data collected before and after the interventions used the SPSS statistics software for analyzing and running statistical tests. The statistical analysis of the data collected by the pre-and

posttests was done using the special processes for this project described below. To begin with, identification of the patients as part of the African immigrant population was done as they filled out the Patient Data Collection Form.

Measuring If Resources Handout Was Provided to African Immigrant Patients

To measure if the handout of resources was provided to African immigrant patients, the project lead calculated the difference in the number of toolkits the provider had at the beginning and at the end of the week. The assumption here is that the toolkit was not misplaced or used for any other purpose. The project lead relied on the honesty of the participants. The rate at which the toolkit was handed out was calculated by taking the number of toolkits handed out divided by the number of African immigrant patients that the participant attended to that week. For example, if 3 toolkits were given, and the participant attended to 3 African immigrant patients, the rate will be [(3/3) *100%] which will be 100%.

Measuring the Rate at Which the Providers Utilized the African Immigrant Toolkit

To measure the rate at which the providers utilized the African immigrant toolkit when interacting with the patient, every participant recorded how many African immigrant patients they attended to during the week and the number of instances they utilized the African immigrant toolkit. For instance, if a provider attended to 4 African immigrant patients during the week and utilized the African immigrant toolkit on 2 of those occasions, the provider will have utilized the African immigrant toolkit 50% of the time. These data were calculated weekly for each of the participants and represented.

Measuring the Improvement in Cultural Competence

The improvement in cultural competence was measured using pre- and posttest scores. Participants were expected to score 80% and above on the posttest, and a paired t-test was used

to analyze results because it compares the mean of two measurements taken from the same individual, object, or related units (Yaeger, 2021). A paired t-test is used to test if the means of two paired measurements, such as pretest/posttest scores, are incomparably different. These "paired" measurements can represent things like: A measurement taken at two different times such as pretest and posttest scores with an intervention administered between the two time points (Yaeger, 2021). The assumptions of the paired t-test are that the subjects are independent and the measures for one subject do not impact the measures of other subjects (Yaeger, 2021). Another assumption is that each of the paired measurements is collected from the same subject (Yaeger, 2021). The final assumption is that the differences will be normally distributed (Yaeger, 2021). Even though no statistician was hired to help in the analysis process, a statistician was consulted to ensure that the analysis processes were effective and consistent. After the analysis, a presentation of the results and discussion of findings follow.

Analysis of Results

Recognizing the increasing number of African immigrant patients at the target health care facility and the lack of cultural competence among the health care providers, this project had three objectives. The first was to create a cultural competence training program for health care providers that would lead to measurable improvement in cultural competence. The second was to create an AICCT for measurable use by those providers, and the third was to create a Resources Toolkit for providers to give to African immigrant patients visiting the primary care clinic. The evidence of creation of these items is available in the appendixes, and the measure of the effectiveness of the implementation of the items follows.

The interventions included a cultural competence training session for the providers, pretest and post surveys before and after the training session, providing the providers with

toolkits that they would use as reference while attending to African immigrant patients, and providing providers with resource toolkits that they handed out to African immigrant patients who visited the clinic during the project implementation period. The project was implemented over 5 weeks. The training session was done in the first week, and other interventions were done from Week 2 to Week 5. The data collected during project implementation were analyzed utilizing a paired t-test to measure cultural competence by completing a pre- and posttest survey questionnaire.

The distribution of patients seen per provider per week is presented in Table 1. During the 4-week duration of the project (weeks 2–5), a total of 187 African immigrant patients were attended to by the three providers. On average, each provider saw 15.58 (*SD* = 4.71) patients per week with a range of 8 to 25 patients; however, the weekly average of patients seen varied per provider and ranged between 14.25 (*SD* = 4.19) and 16.75 (*SD* = 2.21) as presented in Table 1. Similarly, the weekly averages for patients seen by the three providers varied, where the second and third weeks registered the least (*M* = 11, *SD* = 1) and most (*M* = 19.33, *SD* = 6.03) patients seen per provider.

Measuring the Improvement in Cultural Competence

Based on the results in table 2 below, it can be observed that Provider 1 scored the lowest in the pre-test survey while Provider 3 scored the highest. After an educational training was conducted and the survey was repeated, Provider 2 showed the highest improvement from scoring 80% to 94%, even if the other providers scored more in the post-training test. All the providers scored above 94% in the post-training test; this is an indication that the educational training was effective in imparting cultural knowledge to the providers.

Table 2

Pre-and post-test scores

Providers	**Pre-Training**	**Post Training**
Provider 1	86%	98%
Provider 2	80%	94%
Provider 3	90%	100%

As shown in table 3, the paired *t*-test calculations produced a p-value of 0.01 (<0.05). This indicates that the cultural competence of the healthcare providers was statistically significantly improved after the cultural training was conducted. The assumption is the measurement of one subject did not affect the measurements of the other. The subjects were independent, and each of the paired measurements was obtained from the same subject.

Table 3

Paired-test results comparing cultural competency

Variable	Pretest		Posttest		p
	M	SD	M	SD	
Test Scores	60.00	10.00	96.67	5.77	0.01 *

N=3

**. The p-value is statistically significant at the (<0.05) level.*

The Resources Handout Rate to Patients

Each participant was required to offer a resources toolkit during the visit to measure compliance in providing the African immigrant patient with current community resources. From the results in table 1 below, it can be observed that week 4 had the highest number of patients attended at 58 patients while Provider 1 served the highest number of patients at 67 patients. Provider 3 had the most significant growth in terms of patients handled when comparing the initial two weeks and the last two weeks. Provider 3 examined 20 patients in the first two weeks, while 43 patients were served in the previous two weeks. The trends of the patients served by Provider 1 were almost consistent as the lowest number of patients was 15, and the highest was 20, which is a relatively low disparity. Provider 2 had almost the same number of patients served in the first two weeks and the last two weeks at 24 and 23 patients, respectively. However, Provider 3 had the biggest disparity observed across the weeks as it recorded the lowest number of patients at 8 patients in week 3 while the highest was 25 at week 4.

Table 1

Patients Attended

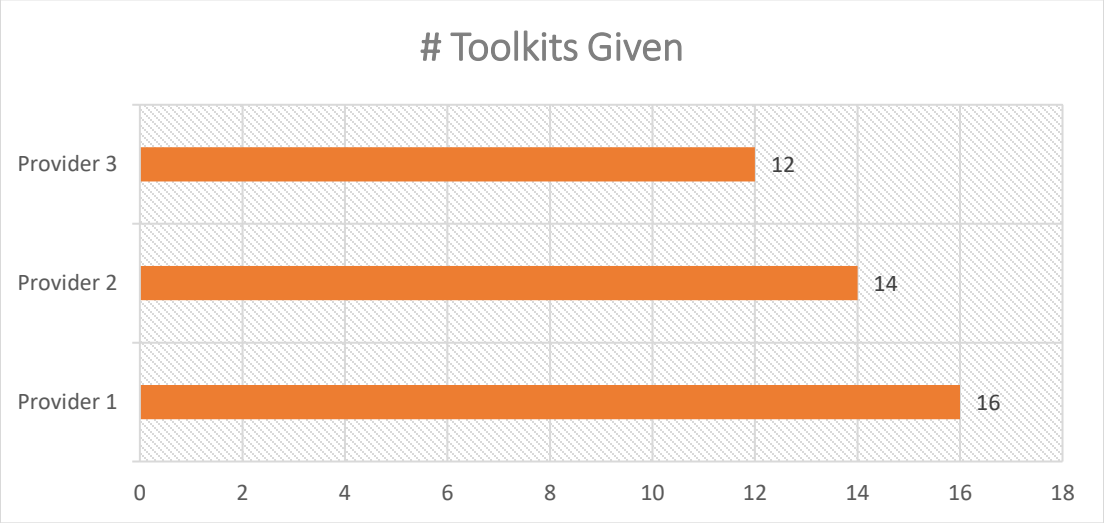
	Week 2	Week 3	Week 4	Week 5	Total
Provider 1	16	15	20	16	67
Provider 2	14	10	13	20	57
Provider 3	12	8	25	18	63
Total	42	33	58	54	187

Based on the data collected, it was observed that in week 2, Provider 1 had the highest number (16) of resources toolkits handed out while Provider 3 had the lowest number (see figure

1). It was noted that the number of patients seen was equivalent to the number of resources toolkits handed out.

Figure 1

Resources Toolkit handed out in week 2



A shown in figure 2 below, the results for week 3 also showed that the number of patients seen was similar to the number of resources toolkits handed out. It can be noted that the trend observed in week one was maintained, with Provider 1 having the highest (15) number of resources toolkits handed out while Provider 3 had the lowest (8).

Figure 2

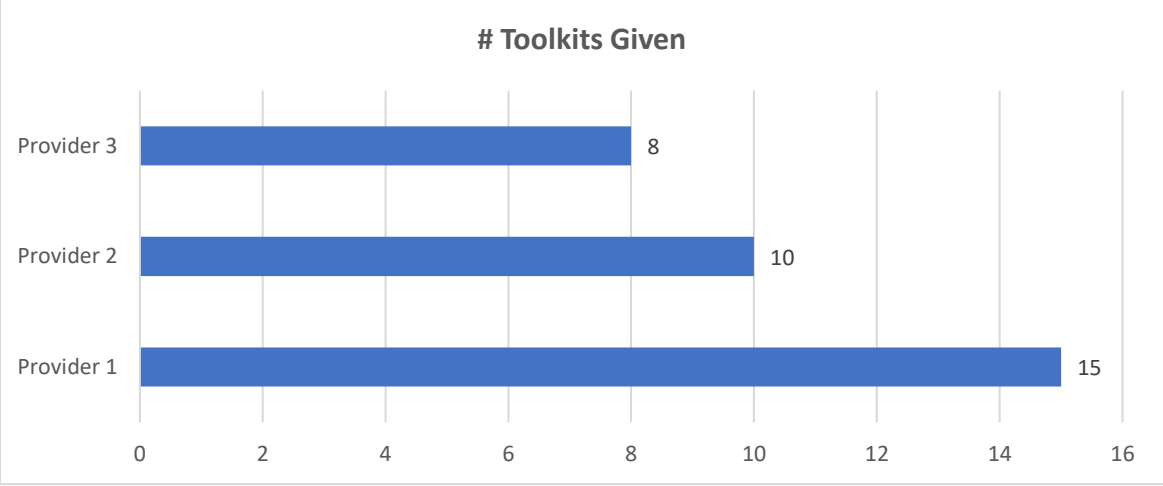
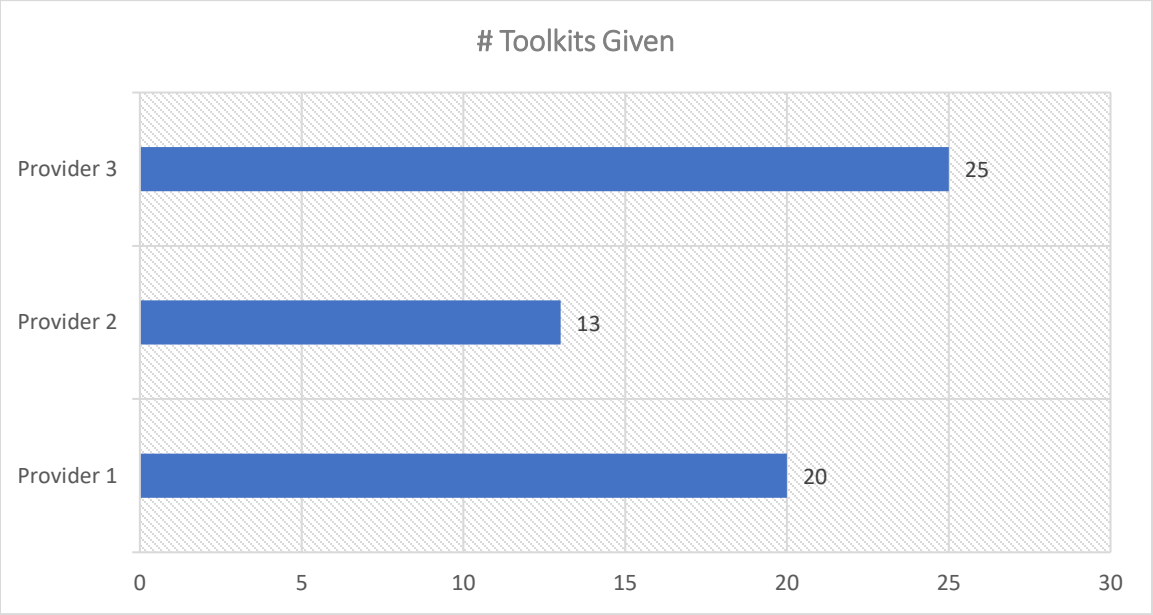


Figure 3 below shows that the trend observed was not followed in week 3 as Provider 3 had the highest (25) number of resources toolkits handed out while Provider 2 had the lowest (13). There is a need to explore what triggered the change in week 4 that helped Provider 3 to have more patients visiting them, which translated to an increased number of resources toolkits being handed out.

Figure 3

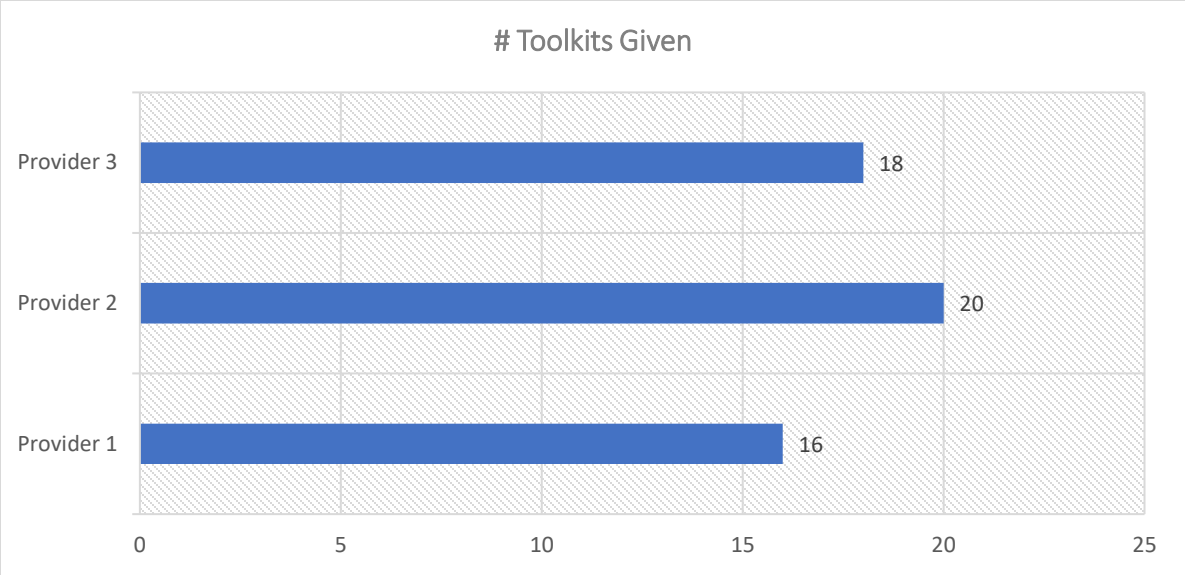
Resources toolkit handed out in week 4



The results from week 5 showed that the trend was reversed as the data indicates that Provider 2 had the highest (20) number of patients or number of resources toolkits being handed out while Provider 1 had the lowest (16). Figure 4 shows a trend of the number of patients declining for Provider 1.

Figure 4

Resources Toolkit handed out in week 5



Measuring the Utilization of the African Immigrant Toolkit

The participants attended to 187 patients during the implementation period and utilized the toolkit 95 times. The toolkit was therefore used at an average rate of 50.8% times. From table 3 below, it can be observed that week 4 had the highest number of patients attended to and had the highest number of times providers utilized the toolkits, while week 2 had the lowest. The proportion of toolkit usage over the weeks was highest in week 3 at 60%, while week 5 had the lowest at 43%.

Table 3

African Immigrant Toolkit Utilization

Week	No. of patients seen	No. of times providers utilized the toolkits	The proportion of toolkit usage
Week 2	42	21	50%
Week 3	33	16	48%
Week 4	58	35	60%
Week 5	54	23	43%

	187	95	51%

Discussion of Findings

This project implemented a cultural competence training program for health care providers in a primary care clinic in Texas that serves an increasing number of African immigrants. This population was identified because of its increasing numbers and reports from practitioners that they did not know how to work well with African immigrants, and the patients were not returning for appointments or follow-up treatment. Three process objectives were identified, completed, and implemented, and two (a and c) were measured: (a) creation of a cultural competence training program (Appendix D), (b) creation of an African Immigrant Cultural Competence Toolkit (AICCT) (Appendix B), and (c) creation of an African Immigrants Resources Toolkit (AIRT) (Appendix C).

Cultural Competence Training Program

The overall goal of the project was to improve the cultural competence knowledge and skills related specifically to African immigrants among the health care providers in the target primary clinic. Only three health care providers participated in the program. The pretest resulted in a mean score of 60%; the posttest, 96.67% ($F(3,11) = 17.23$, $p = 0.001$). The gain was statistically significant; however, the small number of participants does not allow for any form of generalization or important commentary. For this small group of health care providers, cultural competence knowledge increased significantly after a program of training.

The project findings aligned with those of previous studies regarding the impact of cultural competence training on health care workers' practices and potential patient outcomes (Asare & Sharma, 2012; Kamya, 1997; Omenka et al., 2020). For instance, Asare and Sharma (2012) explored African immigrant and African American patients' sexual attitudes regarding

HIV/AIDS in terms of gaining access to treatment and communicating with their partners. Acculturation was a significant factor as was age for African immigrants. Kamya's (1997) research was in social work, but looked at how to deal with African immigrants in the helping professions. He encouraged working with the interactive and spiritual nature of their lives in order to reduce their stress. The most recent article by Omenka et al. (2020), a scoping review, pointed out that African immigrants are also treated just like other Black people, not recognizing that they speak different languages, come from other cultures, are new to the United States, and so on. Entering the U.S. health care system, then, can often be a shock to them and requires cultural competence from providers. The important feature here is differentiation between African immigrants and African Americans—both Black in color, but very different culturally.

African Immigrant Cultural Competence Toolkit (AICCT)

The AICCT is an informational worksheet designed to offer information on how health care providers might work with African immigrants. Its use by health care providers in the target health care facility was not measured. Because its goal was for organization-wide cultural competence improvement, the scope of the distribution endeavor was not undertaken. Instead, the focus became the direct care aspect of the three participating health care providers in relation to the African immigrant patients.

The AICCT first suggests looking inward for biases and self-reflection when interacting with patients from another culture. This is where most cultural competence programs suggest starting: Look inward first to check one's own cultural competence first.

Language barriers are presented as a difficulty, and solutions of translators, alternatives of gestures and sign, or learning some basic words are offered. Learning an African language is the greatest challenge because more than 2,000 languages are spoken in Africa, more than 500 in

Nigeria alone (Statista Research Department, 2021). Encouraging patients to bring a translator with them may be the best option or using a technological resource, if one is available, may be another.

The remaining items on the AICCT relate to one another. It is important to look at each patient as a unique individual who is coming to the office with a unique set of circumstances and history. This is significant and should not be underrated or ignored. The health care provider must become aware of and respect each African immigrant's beliefs and understandings of the world no matter how different from their own. The goal of the health care provider should be to do the best job possible in diagnosing and treating the patient while being kind and culturally respectful.

African Immigrant Resources Toolkit (AIRT)

The third objective of this DNP project was to create the AIRT as a tool to be given to each African immigrant patient visiting the primary care clinic. This objective was measured. Over the 5-week program period, 187 African immigrant patients visited the primary care clinic and were seen by the three participating health care providers. All of the 187 (100%) patients received the AIRT, so the objective was met. In only 95 (50.8%) cases, however, the health care provider admitted having reviewed the AIRT with the African immigrant patient. In discussing this failure to go over the AIRT with the patient, the health care providers indicated they used it only to check for something specific during their interaction with the African immigrant patient if warranted. Consequently, because the health care providers were not directly instructed to review the AIRT with the African immigrant patients, but only distribute it to them, they chose not to go over it with them.

The health care providers made a choice not to review the AIRT with the African immigrant patients. Several possibilities come to mind. The first is time. Health insurers typically limit patient visits to 15 or 30 minutes, so that patient information is often distributed, but not reviewed. Second is cultural competence. The health care provider may not understand what the African immigrant patient needs to know or should have pointed out that is included on the AIRT. Further, the provider may not know if the patient even understands the language of the AIRT and requires a translator, who might then be located for the patient. Finally, the health care provider might not care enough to go over the AIRT with the patient because they have never had the need for such services and cannot empathize with the patient. These are the cultural competence skills this DNP project is trying to instill in health care providers.

Summary of Findings

The problem addressed in this study related to the increased number of African immigrants seen at one primary care clinic in Texas and the lack of culturally competent practices by the health care providers there observed by the project lead. This observation is consistent with the literature (Kamya, 2017; Purnell & Fenkl, 2019). Moreover, the health issues of the African immigrant population directly relate to their cultural practices (Asare & Sharma, 2012; CDC, 2021).

All three objectives of this investigation were met: (a) create a cultural competence training program (Appendix D), (b) create an African Immigrant Cultural Competence Toolkit (AICCT) (Appendix B), and (c) create an African Immigrants Resources Toolkit (AIRT) (Appendix C). The project was conducted over 5 weeks. In the first week, the cultural competence training program was conducted with three health care providers, who showed significant improved between their pre- and posttest scores. During the training program, the

three participating health care providers were given the AICCT for study and review to understand their own attitudes toward African immigrants. The goal was distribution of the AICCT agency-wide, but that goal was not measured. The third objective was to create the AIRT to be given to each African immigrant patient seen in the primary care clinic during weeks 2 through 5 of the project period by the health care provider. No instruction was provided to the health care provider regarding the AIRT.

Perhaps the most interesting finding in this project was the fact that although all the health care providers dutifully gave the AIRT to the African immigrant patients (N = 187), only half (50.8%) claimed to have reviewed the information with them. This suggests a greater need for increased sensitivity to the African immigrant population, broader cultural competence training, and further instruction in the use of the AIRT.

Significance/Implications for Nursing

This project is about cultural competence among nurses and other health care providers in the face of rising influxes of unfamiliar cultures. Cultural competence, the ability to respond to cultural diversity within health care systems, is an important aspect of healthcare because cultural practices directly impact health care practices (Cai, 2016; Venters et al., 2019). Further, nurses form the largest group of health care providers; therefore, the health care field looks to them for leadership in cultural competence to ensure safety and quality in health care environments (Cai, 2016). In addition, “Cultural competence originated from the healthcare industry because healthcare delivery without cultural competence would directly influence health outcomes, which may lead to fatal consequences” (Cai, 2016, p. 269).

Leinenger’s (1988) cultural care theory was selected as the theoretical foundation for this DNP project because it has aims similar to those of the investigation: to create a culturally

competent staff at a primary health care clinic that is experiencing an increase in African immigrant patients. Leinenger's theory explains how nurses can provide culturally congruent care through taking actions that are mainly designed to suit the individual's, group's, or institution's cultural values, lifestyles, and beliefs. In addition, the goal of the cultural care theory is to enable improved health outcomes for individuals of different cultural backgrounds (Leininger, 1988). The fundamental tenets of the cultural care theory were used in the project to research and document how nurses can develop care that fits the values, beliefs, and lifestyles of African immigrants, which is based on the patients themselves rather than on predetermined criteria (Wehbe-Alamah, 2015). Cultural competence has also been described as both an internal and external awareness of the relationship between self and other in terms of variants such as age, gender, race, ethnicity, religion, education, socioeconomic status, geographic region, and occupation, to name a few categories or criteria (Cai, 2016). This DNP project sought to develop cultural competence in one primary care practice in Garland, Texas that is experiencing an influx of African immigrants.

Limitations

This DNP project had limitations. These limitations were both modifiable and unmodifiable, which will be addressed as the stakeholders would like to discuss long term adoption of the protocol and policy development.

Project Design

One limitation of this quality improvement initiative was the small sample size of health care providers ($N = 3$). According to Leedy and Ormrod (2020), a very small sample size produces invalid results and compromises the reliability of the project's survey and the

generalizability of any findings. Furthermore, the sample was selected from a single source and was therefore, a convenience sample, again limiting generalization.

In addition, the timeframe was restricted to five weeks; one week was devoted to cultural competence training, and the other four weeks were comprised of handout distribution and African immigrant patient interaction. This was a challenge because four weeks was not sufficient for some of the providers (Provider 2) to learn and effectively adopt cultural competence skills for African immigrants. Kamya (2017) suggests that in practical healthcare settings attending to a large number of African immigrants, the cultural program should take at least 8 weeks to allow for effective and utilization of the skills. Generally, the length of the training is usually determined by budgets, time, the geographical spread of teams and practicality (Kamya, 2017). . To further add to the time limitation, consideration must be given to the participants as they were also attending to other patients in addition to African immigrant patients. Competing priorities may have prevented the providers from fully embracing and implementing the project.

Another fundamental project design component that was problematic was the project lead limited the focus of the three objectives to instrument design and did not include process measures. Therefore, process measures, such as improvement in provider knowledge, were not evaluated. Generally speaking, the main limitation was a faulty design.

Data Recruitment

The setting of the project is a single healthcare facility and only three providers participated in the project, the facility has a total of ten healthcare providers.

Data Collection Methods

There were no limitations noted with the data collection methods of the project.

Data Analysis

There were no limitations noted with the data analysis activities of the project.

Dissemination/Sustainability

Dissemination of this project's findings is critical to optimizing health care delivery. The project lead plans to present results to the facility's stakeholders, including management, providers, and nurses, in order to redesign the project to continue with cultural competence training for all stakeholders. The dissemination aims to increase awareness of the need to become culturally competent when examining patients from diverse cultural backgrounds. The project lead will share the project's outcomes with the stakeholders using a PowerPoint presentation and executive summary. This evidence-based project will be disseminated through publication in nursing journals (Journal of Research in Nursing, Advanced Practices in Nursing Journals, and Diversity and Equality in Healthcare Journal) and presentation of findings during local nursing conferences (Texas Healthcare Summer Conference and Texas Nursing Practitioners Conference). The project will also be disseminated to TUN facility and student peers, DNP project repository, and through posters or oral presentations.

Sustaining and optimizing the effectiveness of this project's cultural competence intervention are critical, and planning is necessary to achieve this. First, an adherence committee will be appointed to maintain the support, oversight of progress, and guidance. The committee is made up of top executives, employee representatives, human resources professionals, and members of the ethics committee. Second, the project lead and the adherence committee will help develop the facility's cultural competency policy. Third, providers will be invited regularly to discuss the program's components in which they feel competent and those in which they might be experiencing challenges. Consequently, the project lead aims to achieve sustainability through

formal discussions/feedback and real-time support. The project will be adjusted based on the results and will be implemented again at the site with similar objectives but improved approaches.

Conclusion

The purpose of the project was to develop a cultural competence training program for providers regarding African immigrants that would improve provider cultural competence and resource allocation and referrals for African immigrants. The project was implemented at a primary care clinic in Garland, Texas. The program was developed, and the project results indicated it was effective at improving provider cultural competence skills and resource referrals for African immigrants. The results of the project are consistent with previous literature, such as the one by Adekeye et al. (2018).

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Appendix A

Permission to Complete the Project at the Site

Appendix B

African Immigrant Cultural Competence Toolkit (AICCT)

AFRICAN IMMIGRANT CULTURAL COMPETENCE TOOLKIT (AICCT)

(This toolkit provides information about the most prevalent cultural issues regarding African immigrants and the short-term and long-term remedies for healthcare providers)

Cultural Issue	Description	Solution/Remedy	Long-Term Approach
Lack of cultural self-assessment for nurses regarding cultural competence for African immigrants	The situation where health care providers do not understand their strengths and weaknesses when attending to African immigrants as a group.	Selection and use of self-assessment tools for nurses to determine their strengths and weaknesses when handling African immigrants.	Continued frequent self-assessment for strengths and weaknesses for treating African immigrants.
Language Barrier	Barrier to communication between healthcare providers and African immigrants due to their inability to speak the same language.	1. Use of translators and interpreters. 2. Use of pictures, gestures, and written summaries.	1. Teaching the healthcare providers how to be bilingual and bicultural regarding African immigrants. 2. Long term solutions such as specific translators and interpreters for the African immigrant group.
Lack of cross cultural interactions with patients	Healthcare providers do not understand each African immigrant as a unique person.	Engaging healthcare providers in interactions with patients to understand that each African immigrant is a unique person and to learn how to build effective relationships with them.	Continued training for healthcare providers regarding the uniqueness of each African immigrant patient and how to respond to their individual healthcare needs.
Cultural discrimination	Any distinction, restriction, or exclusion of African immigrants in matters of healthcare based on their	Teaching healthcare providers how to accept the African immigrant culture and how to	1. Exposing healthcare providers to multicultural experiences and encouraging diverse

Conflicts in cultural beliefs and practices.	The cultural beliefs and practices of African immigrants regarding healthcare differs from the cultural beliefs and practices of healthcare providers.	Healthcare providers searching for information regarding the cultural beliefs and practices of African immigrants and how to address them appropriately while attending to the group.	Enhancing training for cultural awareness, cultural knowledge, and cultural skills for healthcare providers concerning African immigrant patients.
Faith and Religious Issues	Difference in faith and religious practices of African immigrants such as refusal of prescription medication, blood transfusions, and belief of source of illness hinder the effective treatment of this group by healthcare providers.	Asking questions to try and understand the faith and religious beliefs of the patient when attending to them.	Gathering information for making accommodations for this group and finding ways of working around their treatment plans.

Appendix C

African Immigrants Resources Toolkit (AIRT)

AFRICAN IMMIGRANT RESOURCES TOOLKIT (AIRT)

(This toolkit contains the various resources available for African immigrants in Texas)

Resource	**Information**
Food Assistance	North Dallas Shared Ministries 2875 Merrell Road, Texas 75229 (214) 358-8703 https://www.ndsm.org/ North Texas Food Bank 3677 Mapleshade Ln, Plano Texas 75075 (214) 330-13960 https://nftb.org/ Good Samaritans of Garland 214 N. 12th Street, Garland Texas 75040 (972) 276-2263 http://goodsamofgarland.org/
Legal Services	Legal Aid of Northwest Texas 1515 Main St, Dallas, Texas 75201 (214) 748-1234

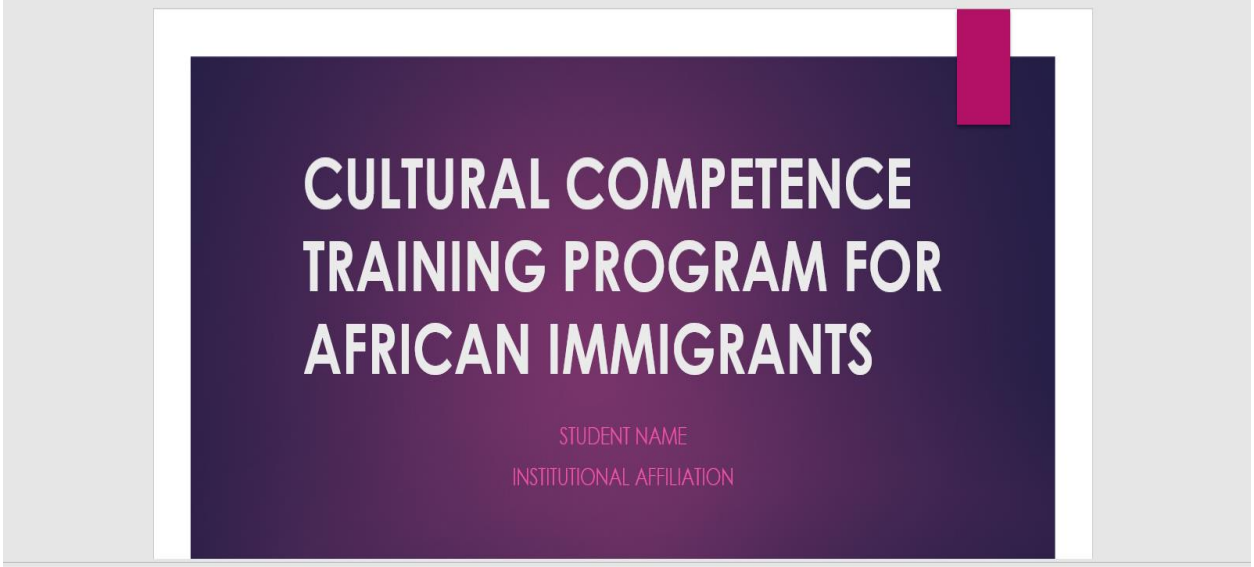
	https://internet.lanwt.orgp RAICES (Refugee and Immigrant Center for Education and Legal Services) 1910 Pacific Ave, Dallas, Texas 75201 (214) 295-9554 http://www.immigrationadvocates.org/
Housing Services	Interfaith Housing 5600 Ross Ave, Dallas, Texas 75206 (214) 827-7220 https://interfaithdallas. Org / DHA Housing Solutions for North Texas 2575 Lonestar Drive, Dallas, Texas 75212 (214) 427-6686 http://dhantx.com/s
Employment Services	Dallas Employment Services 3626 N Hall St Suite 610, Dallas, TX 75219 (713) 239-2656 https://des-inc. com/ Immigration Services Catholic Charities 249 Thornhill Dr, Fort Worth, Texas 76115

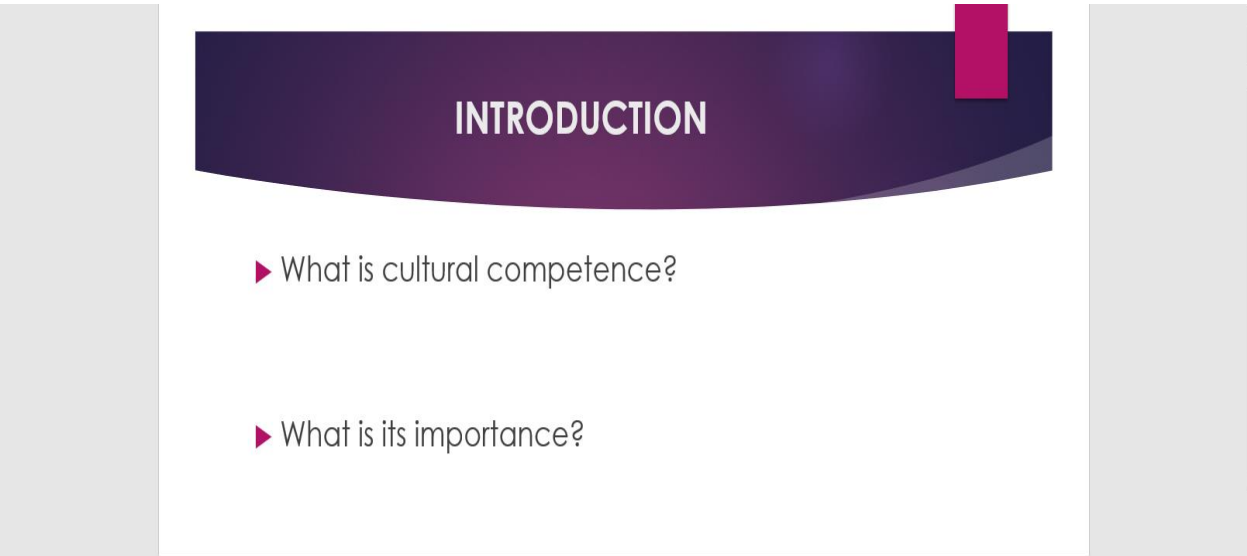
	(817) 289-4399 https://ccfwimmigration. com Immigration & Refugee Resources Dallas County 411 Elm Street, Dallas, Texas 75202 (214) 653-7949 www.dallascounty.org
Financial Assistance	North Dallas Shared Ministries 7211 Regency Square Drive. Houston, Texas 75229 (214) 358-8700 https://www.ndsm.org/about-us/ Dallas TANF Office 1010 Cadiz Bldg B, Suite 110, Dallas, Texas 75215 (214) 421-7722 http://financialhealresources.com/
Health Services	Hope Clinic of Garland 800 S 6th St Suite 100, Garland, Texas 75040 (469) 800-2500 https://hopeclinic-garland.org/ Dallas County Health and Human Services 2377 N. Stemmons Freeway, Dallas, Texas 75207

	(214) 819-2000 https://www.dallascounty.org/

Appendix D

Educational Presentation





Cultural competence can be described as the ability of understanding, communicating, and interacting efficiently with people across cultures. It comprises the process of one being aware of their own view of the world based on their cultural practices and traditions, as well as developing positive attitudes towards the difference in cultures of others. It is an important aspect of healthcare because cultural practices directly impact health care practices.
African immigrants often find themselves in situations of cultural dilemmas because of the differences in culture between their original areas of residence and their new ones .

BACKGROUND

- Why African immigrants?

- The number of African immigrants entering and settling in the United States increases almost every year. This is because African immigrants prefer moving to the United States in search of better living conditions, better employment opportunities, and better health care services.
- However, African immigrants have been brought up in entirely different societies with different cultural beliefs and practices which affect their healthcare experience.
- The group has unique health care needs and most of these needs are related to their cultural practices.
- The lack of cultural competence among health care providers is a crucial contributing factor to the poor health of African immigrants.
- Without cultural competence training, health care providers cannot effectively tackle the health care concerns of African immigrants.

OBJECTIVES OF THE QUALITY IMPROVEMENT PROJECT

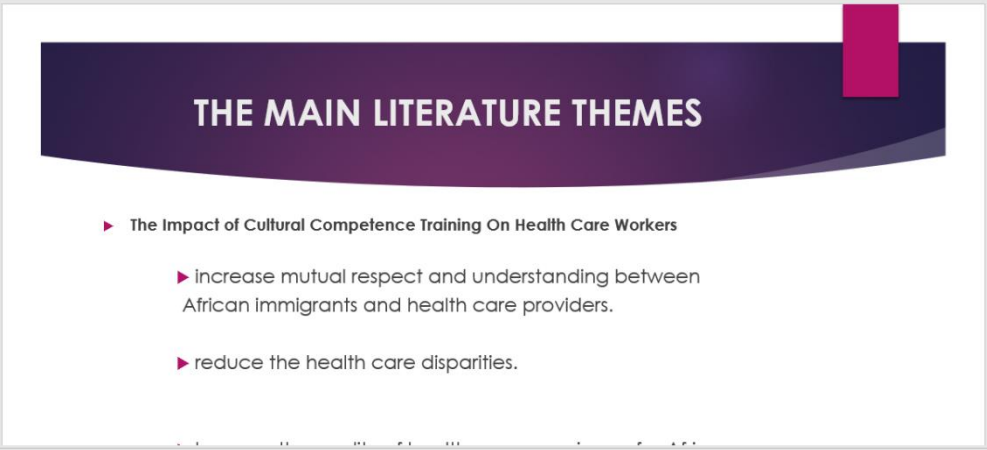
- To create a cultural competence training program that will help in promoting cross-cultural awareness and competence skills needed for health care professionals to be culturally competent regarding African immigrants.
- To create an African Immigrant Cultural Competence Toolkit that will be used by care providers to assess and enhance cultural competence in the organization.
- To create a Resources Toolkit that will be given to African immigrant patients visiting the primary

THE MAIN LITERATURE THEMES

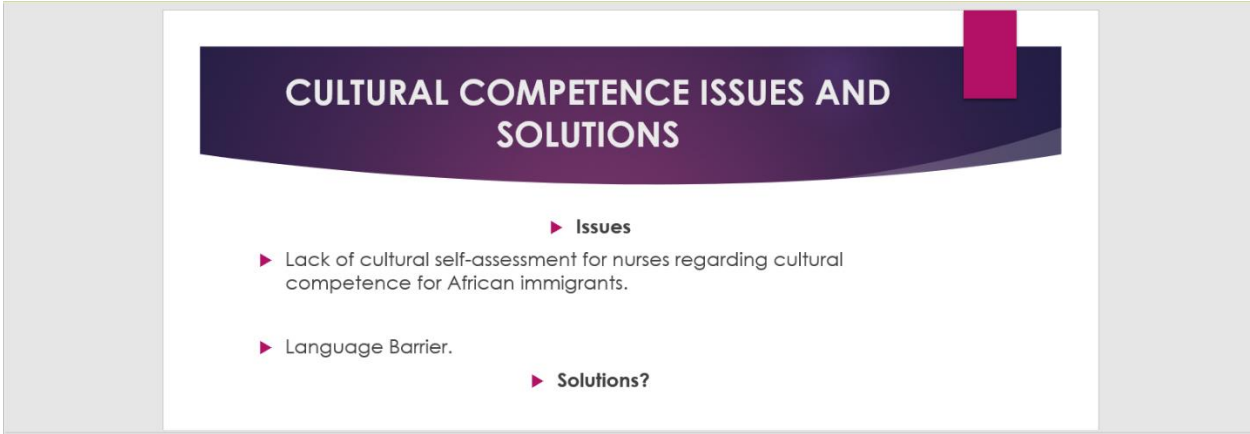
- **Effects of Cultural Incompetence among the African immigrants**
  - Inefficient delivery of healthcare services
  - Inability to understand the social determinants of health for this group.

- Because of the disparity in cultural competence, the health care providers cannot efficiently deliver health services that cater to the cultural, social, and linguistic needs of the African immigrant patients.
- African immigrants have unfavorable social determinants of health which contribute to their lack of quality healthcare. This leads to their poor health experiences because of the lack of understanding by health care workers regarding these social determinants of health.
- Due to cultural incompetence, African immigrants are two to three times more likely to suffer from various health-related issues compared to other groups, like white people.
- The cultural incompetence of health care workers makes African immigrants suffer severely and longer from easily preventable diseases.

- Language is an aspect of culture that affects the quality of treatment in African immigrant groups.
- Language barriers play an important role in miscommunication between patients and medical providers, which negatively affects the quality of healthcare services and patient satisfaction regarding the African immigrant group.
- Due to language barriers, health care professionals have an incomplete understanding of the situations of patients, poorly assess patients, prescribe treatment incompletely, or cause delayed treatment or misdiagnoses.
- As a result of language barrier, African immigrants end up having decreased satisfaction with healthcare services, complications arising from medication, and a reduced level of understanding of their diagnosis even if they have access to health care



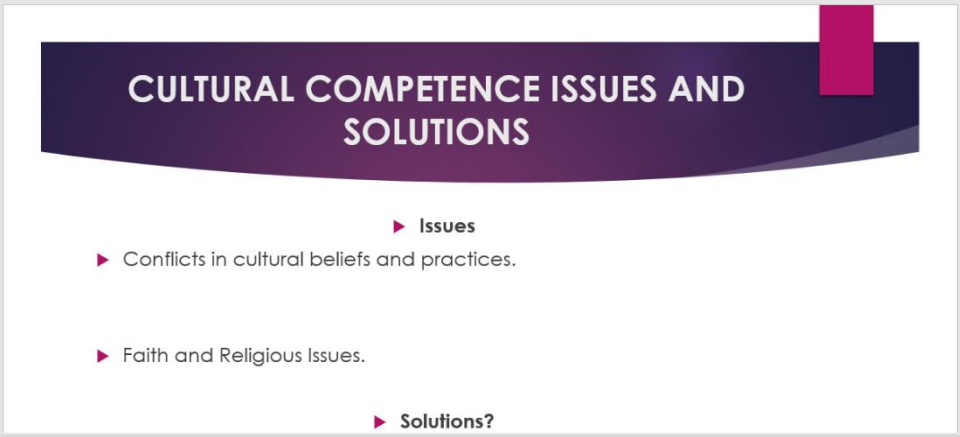
- Training programs and cultural competence among health care workers have social, health, and business benefits for healthcare organizations and African immigrants.
- Cultural competence training programs would increase mutual respect and understanding between African immigrants and health care providers.
- It would also enable health care workers to have improved patient data collection for African immigrants and reduce the health care disparities in the African immigrant population.
- It would help in reducing medical errors, the number of treatments, and legal costs, which increase cost savings.
- It would provide health care professionals with techniques of dealing with African immigrants with low literacy and explain how to offer them the best care quality.



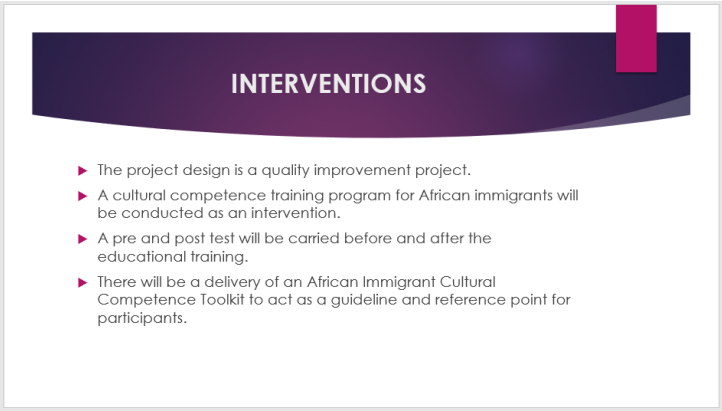
- Lack of cultural self-assessment for nurses regarding cultural competence for African immigrants is the situation where health care providers do not understand their strengths and weaknesses when attending to African immigrants as a group.
- Language barrier is the barrier to communication between healthcare providers and African immigrants due to their inability to speak the same language.
- Can be solved by
  - selection and use of self-assessment tools for nurses to determine their strengths and weaknesses when handling African immigrants.
  - Use of translators and interpreters.
  - Use of pictures, gestures, and written summaries.

- Healthcare providers do not understand each African immigrant as a unique person.
- Cultural discrimination is any distinction, restriction, or exclusion of African immigrants in matters of healthcare based on their culture.

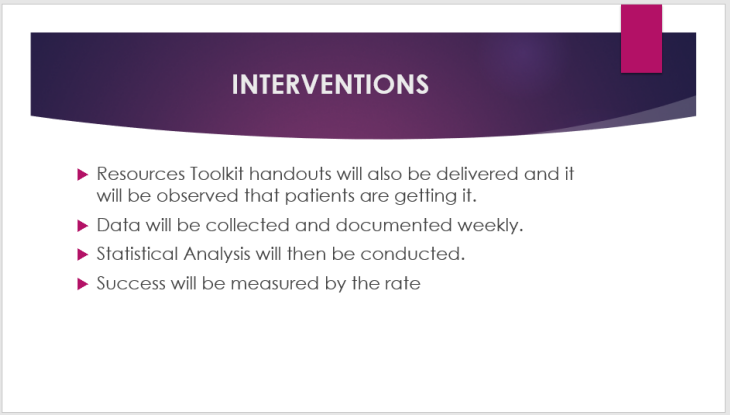
- Can be solved by
  - Engaging healthcare providers in interactions with patients to understand that each African immigrant is a unique person and to learn how to build effective relationships with them.
  - Teaching healthcare providers how to accept the African immigrant culture and how to avoid stereotypes.



- The cultural beliefs and practices of African immigrants regarding healthcare differs from the cultural beliefs and practices of healthcare providers.
- There is difference in faith and religious practices of African immigrants such as refusal of prescription medication, blood transfusions, and belief of source of illness hinder the effective treatment of this group by healthcare providers.

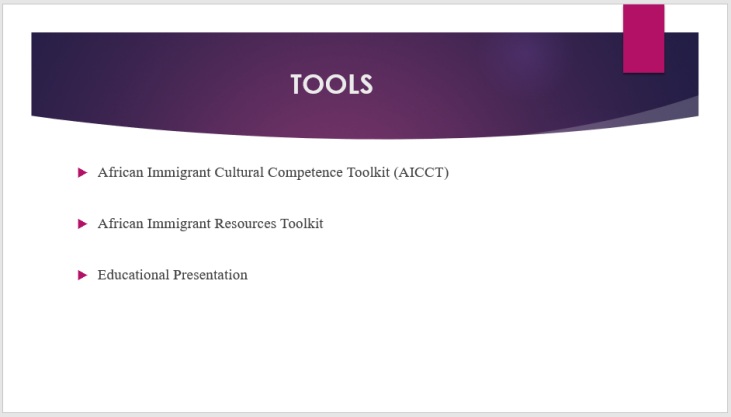


In the first week, a pretest located in Appendix E will be administered. This will be done a day before an educational training. The educational training will then be conducted the next day using the PowerPoint presentation material in Appendix D. The educational training session will be brief and to the point and will touch on all issues that concern cultural competence when handling the African immigrant group. One detailed session will be enough although the progress will be monitored to identify any need for an additional training session. The session will also include training the participants on how to use the African Immigrant Cultural Competence Toolkit (Appendix B). It will also include training the staff on how to use the African Immigrant Resources Toolkit (Appendix C). After the session, both toolkits will be handed to the participants. Additionally, a post-test will be administered after the educational training session. The post test will be done using the material in Appendix E. The goal is to determine how the participants perform in the test before the training and after the training has taken place.



From week 1 to week 4, the resources toolkit will be handed to the patients as they visit the clinic. There will be continued education and support to the participants to ensure efficiency of the progress. Participants will make use of the toolkit handed to them and data collection will be done at the end of each week to ensure that any loopholes are identified and any additional support is identified as well.

In week 5, data compilation will be done and its analysis will follow. The success of the project will be measured by the rate at which the resources toolkit were handed out to African immigrants and the rate at which the providers utilized the African Immigrant Cultural Competence Toolkit while interacting with African immigrant patients. The approach for measuring these rates is outlined in the Chart Audit Tool (Appendix F).



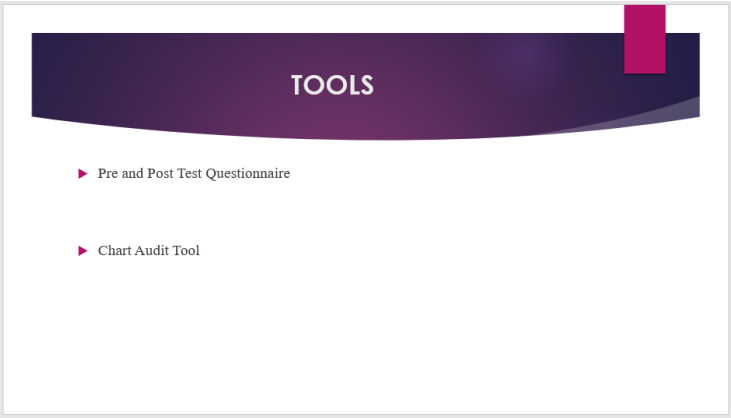
African Immigrant Cultural Competence Toolkit (AICCT) (Appendix B)

This is a one-page guideline that acts as a reference point for the African immigrants cultural competence issues. The guideline has cultural issues, their descriptions, and the solutions. It is to be handed to the healthcare providers. The toolkit is developed by the project lead and will utilize project team consultation for validation. The tool was developed based on evidence-based research about the main cultural competence issues and solutions involved when handling the African immigrant population and the sources are listed in the references.

African Immigrant Resources Toolkit (Appendix C)

This is a one-page toolkit with information about the food assistance, legal services, housing services, employment, financial, and health resources and where they can be found. It is to be handed to the patients during their visits to the clinic. It is developed by the project lead and will utilize project team consultation for validation. The tool was developed based on evidence-based literature identifying these resources as primary needs of African immigrants. These resources are important because they play a huge role in the social determinants of health of the African immigrant population. These resources impact the environment and manner in which the African immigrants live and work, which in turn impacts their health outcomes.

Educational Presentation (Appendix D)

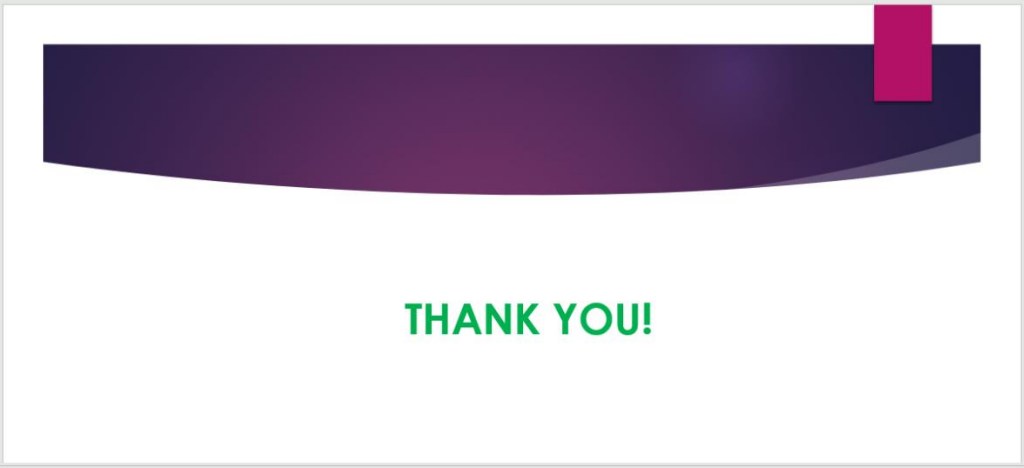


Pre and Post Test Questionnaire (Appendix E)

This is a tool used to assess the healthcare professionals' level of cultural competence regarding the African immigrant group. It is developed by the project lead and will require expert and project team consultation for validation. The tool is developed based on the objectives of the project and the educational material used in the educational training session. The tool contains 10 questions and each of the question addresses specific content while testing a specific level of cognitive skill. The test is in a multiple choice question format. Three experts will rate the relevance of each item on the test using the Expert Rating Form (see Appendix E). This data will then be used to calculate the validity of the tool.

Chart Audit Tool (Appendix F)

This is a tool for auditing the rate that the handout of resources were provided to African immigrant patients and the rate at which the providers utilized the African immigrant toolkit when interacting with the patient. Guidelines on how these rates will be calculated are provided in the tool (see Appendix F). The tool is developed by the project lead and will require experts and project team consultation for validation.



Appendix E

Pre/Post Survey Questions

Please answer all the questions to the best of your ability. Please circle the most appropriate answer. Kindly note that your responses are strictly confidential and will only be seen by the appropriate leader(s) of the project. Your participation is highly valued. Thank you!

1. What is cultural competence in healthcare?

A. The ability to be appropriately responsive to the attitudes, feelings, or circumstances of groups of people that share a common and distinctive racial, national, religious, linguistic, or cultural heritage.
B. The inevitable variety in customs, attitudes, practices, and behavior that exists among groups of people from different ethnic, racial, or national backgrounds who come into contact.
C. The ability of providers and organizations to effectively deliver health care services that meet the social, cultural, and linguistic needs of patients.
D. A long process of self-reflection and self-critique, which allows nurses to examine differences and similarities between their own beliefs, values, and health care goals with those of their patients.

2. A healthcare professional will know that he/she is culturally competent when

A. He/she has successfully completed a cultural competence program.
B. He/she is able to obtain knowledge of a patient's individualized culturally-influenced worldview and how their culture affects their physical and mental health.
C. He/she is able to answer key cultural competence questions regarding a particular cultural group.

D. He/she is able to treat a patient belonging to a different culture.

3. Which of the following would **not** be an immediate result of a failed effective communication between a healthcare provider and an African immigrant patient?

A. Difficulty understanding medical instructions.

B. Problem with the reliability of information.

C. Possible medical errors.

D. Increased readmission for the patient.

4. Which of the following is **not** a **basic** resource needed by African immigrants as they seek healthcare services?

A. Legal Resources

B. Housing Resources

C. Food Assistance Resources

D. Finance Aid Resources

5. The main reason for cultural competence in healthcare is_____

A. Delivering quality care.

B. Improving cultural awareness.

C. Demographic change

D. Changing policies.

6. What is the relationship between poverty and quality care among African immigrants?

A. African immigrants are barred from accessing healthcare when needed.

B. African immigrants are not able to purchase those things that are needed for good health.

C. B only.

D. A and B.

7. What evidence may point to cultural incompetence when a healthcare provider is attending to an African immigrant ?

A. Failing to understand the social determinants of the health of the patient.

B. Failing to communicate in the patient's language.

C. Involving a third party (e.g. translator) to help in the communication process.

D. All of the above.

8. African immigrants may fear seeking health care services due to the following reasons **except**:

A. Fear of racial discrimination.

B. Difference in culture and beliefs.

C. Fear of new environments.

D. Inability to pay for the services.

9. You are the triage nurse in the emergency department and perform the initial intake assessment on a patient who does not speak English. Based on your understanding of linguistic competence, which of the following would **not** provide solutions to the communication barrier you are experiencing?

A. Finding an effective translating software.

B. Asking a (present) member of the family to provide interpretation in the communication process.

C. Seeking the services of a professional interpreter.

D. All of the above.

10. Which of the following is an example of an **immediate** remedy for a cultural challenge when attending to African immigrants?

A. Learning about different cultures.

B. Employing diversity training.

C. Ensuring effective communication.

D. Working towards cultural humility.

Content Validity Index Table

Item	Expert 1	Expert 2	Expert 3	Mean	CVR
1	4	4	4	4.0	1
2	4	4	4	4.0	1
3	4	3	3	3.33	1
4	4	4	4	4.0	1
5	3	3	3	3.0	1
6	4	4	4	4.0	1
7	3	4	3	3.33	1
8	4	4	4	4.0	1
9	3	3	4	3.33	1
10	4	4	4	4.0	1
Mean Total				3.7	1

The procedure consists of having experts rate items on a four-point scale of relevance. Then, for each item, the item (CVI) (I-CVI) is computed as the number of experts giving a rating of 3 or 4, divided by the number of experts—the proportion in agreement about relevance.

The mean total of all the means is 3.7. This means that the questions/items in the questionnaire are **moderately/highly relevant.**

Content Validity is then calculated as:

CVR= [(X-(N/2))/(N/2)] where X is the number of experts who rated the item as **moderately/highly relevant** and N is the total number of experts.

For example:

Item 1:

CVR = [(3 - (3/2))/(3/2)]

CVR = [(3 - (1.5))/(1.5)]

CVR = 1.5/1.5

CVR = 1

Reliable

Based on Research Guidelines, the following is the reliability score of the item depending on the result of the calculation (Allison et al., 2016). **The maximum score is 1.**

> 0.79 the item is highly reliable

0.70 <X> 0.79 the item needs revision

< 0.70 the item should be eliminated

Conclusion

Based on the CVR calculation, all the items of the survey are **Highly Reliable** because they all scored a maximum score of 1. This confirms the overall reliability of the survey items.

Appendix F

Chart Audit Tool

Chart Review Tool	Rate in Percent (%)
The rate that the handout of resources was provided to African immigrant patients.	
The rate at which the providers utilized the African immigrant toolkit when interacting with the patient.	

Guidelines for the Chart Audit Toolkit

How to measure if the handout of resources was provided to African immigrant patients.

- The rate at which the toolkit was handed out will be calculated by taking the number of toolkits handed out divided by the number of African immigrant patients that the participant attended to that week. For example, if 3 toolkits were given and the participant attended to 3 African immigrant patients, the rate will be [(3/3)*100%] which will be 100%.

How to measure the rate at which the providers utilized the African immigrant toolkit when interacting with the patient.

- Every participant will record how many African immigrant patients they attended to during the week and the number of instances they utilized the African immigrant toolkit. For example, a health care provider may have attended to 4 African immigrant patients during the week and utilized the African immigrant toolkit on 2 of those occasions.

- These data will be collected weekly and a percentage will be calculated. For instance, in the example above, the provider will have utilized the African immigrant toolkit 50% of the time.
- Calculation = (X/N)* 100% where N = total number of African immigrant patients attended to
    - X = number of times the African immigrant toolkit was utilized.
- The cumulative percentage results will be added together and then divided by the total number of health care providers.

Example: Let's say health care provider A has used the African immigrant toolkit 50% of the time, provider B 100% of the time, and provider C 30% of the time.

$$\text{Rate} = \frac{(A+B+C)}{3}$$

In this case, $\frac{(50+100+30)}{3} = 60\%$

Therefore, the rate at which the providers utilized the African immigrant toolkit when interacting with the patient in this case is 60%.

Project Patient Data Collection Form (Appendix G)

Name	**Race**	**Ethnicity**	**Immigration status (Do you identify as an immigrant?) Please answer with Yes or No.**	**If Yes, what is your initial country of origin?**	**Do you need assistance with community resources? (Yes/No)**

Appendix H

Provider Data Collection Form

Kindly fill out the following form as honestly as possible. Thank you.

Week Number	**Participant Initials**	**No. of African immigrant patients attended to**	**No. of copies of resources toolkit at the beginning of the week**	**No. of copies of resources toolkit at the end of the week**	**No. of instances the cultural competence toolkit was utilized**
Week 1					
Week 2					
Week 3					
Week 4					
Week 5					