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Evidence-Based Interdisciplinary Cultural Competence Training In Public Health

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EVIDENCE-BASED INTERDISCIPLINARY CULTURAL COMPETENCE TRAINING IN PUBLIC HEALTH

by

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Abstract

The United States is quickly becoming more racially and ethnically diverse, and the associated health disparities are growing at an alarming rate. Culturally competent care and services can help reduce these disparities by enhancing the quality of care for all clients, especially those at risk for disparities. A public health workforce that is well-equipped with knowledge of cultural competence and the tools to practice it will be able to better meet the needs of the changing populations with which they work. To effectively improve the cultural competence of interdisciplinary public health teams, evidence-based interdisciplinary training is needed to provide effective and appropriate training for a variety of disciplines and roles such as nursing, nutrition, environmental health, and administrative support. To address this need, a comprehensive literature review was completed, followed by an analysis and discussion of the evidence to determine the best practices for development of an interdisciplinary cultural competency training program that can be used by local and state health departments. Based on the best practices that were determined, an interdisciplinary cultural competence training program for public health professionals was developed. This training program will subsequently be delivered to the Grand Forks Public Health Department and possibly to other agencies or at public health conferences.

"The U. S. is getting bigger, older, and more diverse." We have more than doubled in population since 1950, due to "increased births, decreased deaths, and increased net immigration." Not only is the population growing in number, but also in age. A rapidly growing proportion of the population is aged 65 and older. Furthermore, we are becoming more racially and ethnically diverse (Shrestha, & Heisler, 2011, p.2). These changing demographics are especially concerning when examining the growing health disparities in our nation. A health disparity is a difference in health that is related to a disadvantage(s) in social, economic, and/or environmental factors, leading to adverse effects in specific populations that have experienced significant health related obstacles in their lives. These obstacles, according to the Phase I report: Recommendations for the Framework and Format of Healthy People 2020, are generally based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other traits for which people are historically discriminated or excluded (as cited in U. S. Department of Health and Human Services, 2010). Health disparities have been the focus of one of Healthy People's overarching goals for each of the past two decades. In 2000, the focus was on reducing health disparities, while 2010 reached for a greater goal of eliminating health disparities. Healthy People 2020 takes this a step further in its goal "to achieve health equity, eliminate disparities, and improve the health of all groups." A wide variety of broad factors, or social determinants of health, play a key role in addressing this goal. Some of these include socioeconomic status, the physical environment, discrimination, literacy levels, quality education, availability of healthy food, safe and appropriate housing, health insurance, access to clean water, access to affordable and reliable public transportation, and availability of and access

to culturally sensitive health care providers (U. S. Department of Health and Human Services, 2010).

Culturally competent care and services are greatly needed with the changing demographics of our population and the persistent health disparities among racial and ethnic minorities. Cultural competence can help reduce disparities by enhancing the quality of care for all clients, especially those at risk for disparities. Furthermore, having increased knowledge of cultural competence and the tools to practice it will better equip public health professionals to meet the needs of the changing populations with which they work. Various cultural competence trainings are readily available for public health nurses, such as the *Culturally Competent Nursing Care: A Cornerstone of Caring* program put out by the U. S. Department of Health and Human Services, Office of Minority Health (n.d.a). While this training is appropriate and effective for public health nurses, it is not appropriate for all public health professionals because it is specific to nurses and the type of interaction they have with clients. Public health departments employ interdisciplinary teams, who work together to try to improve the health of populations. To effectively improve the cultural competence of interdisciplinary public health teams, evidence-based interdisciplinary training is needed to provide effective and appropriate training for a variety of disciplines and roles such as nursing, nutrition, environmental health, and administrative support.

Purpose

The purpose of this project is to: 1) identify best practices in interdisciplinary cultural competence training applicable to public health and 2) utilize those best practices to develop a cultural competence training program that is inclusive and appropriate for an interdisciplinary public health audience. Using evidenced-based data related to interdisciplinary cultural

competence training in public health will help ensure effective training, improved cultural competence of public health professionals, and increased frequency and quality of culturally competent care and services. This may, in turn, lead to improved health, decreased disparity, improved client satisfaction, enhanced organizational efficiency, and increased potential of public health agencies to meet accreditation standards.

Significance

Cultural competence is crucial for all public health professionals. Not only does it allow them to better serve the public, but it also is professionally recognized as a critical aspect of public health in a number of ways. The Core Competencies for Public Health Professionals, as outlined by The Council on Linkages Between Academia and Public Health Practice, a coalition with representatives from 17 national public health organizations, are widely accepted as essential skills for the broad practice of public health, reflecting how public health organizations work together to protect and promote health in the community. They serve "as a starting point for academic and practice organizations to understand, assess, and meet education, training and workforce needs" and are frequently utilized in identifying and meeting workforce development needs at both local and state public health agencies (The Council on Linkages Between Academia and Public Health Practice, 2010, p.1). These competencies are organized into eight domains, one of which is cultural competency skills. They are also broken out into three tiers based on the level in which a public health professional practices. Only the entry level competencies for cultural competency skills will be listed here as they provide a general overview and do not differ greatly from the other two levels. Furthermore, most public health professionals practice at this level. According to these competencies, an entry level public health professional should be able to:

> 1. Incorporates strategies for interacting with persons from diverse backgrounds, 2. Recognizes the role of cultural, social, and behavioral factors in the accessibility, availability, acceptability and delivery of public health services, 3. Responds to diverse needs that are the result of cultural differences, 4. Describes the dynamic forces that contribute to cultural diversity, 5. Describes the need for a diverse public health workforce, and 6. Participates in the assessment of the cultural competence of the public health organization. (The Council on Linkages Between Academia and Public Health Practice, 2010, p. 8)

Another way in which cultural competence is recognized professionally as a critical aspect of public health is through public health accreditation. The Public Health Accreditation Board (PHAB), a "nonprofit organization dedicated to advancing the continuous quality improvement of Tribal, state, local, and territorial public health departments," began developing its accreditation program in 2007. A beta test of the program was completed in 2009-2010, and in July of 2011 Version 1.0 of the PHAB Accreditation Standards and Measures and the Guide to National Public Health Department Accreditation were released to the public. In September 2011, the national public health department accreditation program was officially open for applications (PHAB, 2011). Given this, many local and state public health departments are currently in preparation for or beginning the process for accreditation. Cultural competence plays a crucial role in their ability to obtain accreditation. The PHAB's standards and measures are linked to compliance with the National Standards on Culturally and Linguistically Appropriate Services (CLAS) put out by the Office of Minority Health (see Appendix A). These CLAS standards apply directly to eight of the 12 domains in Version 1.0 of the PHAB Accreditation Standards and Measures, more specifically 12 standards and 20 measures (see

Appendix B) (Zeleznak, Berg, & Dahl, 2011). The CLAS standards are focused primarily on health care organizations, where they should be integrated throughout the organization and in partnership with the community the organization serves. These standards are organized into three categories: Culturally Competent Care (Standards 1-3), Language Access Services (Standards 4-7), and Organizational Supports for Cultural Competence (Standards 8-14). The complete listing of these standards can be found in Appendix A. The standards in the Language Access Services category are mandatory for all agencies receiving Federal funding. The rest of the standards are considered guidelines, which Federal, State, and national accreditation agencies are encouraged to adopt as mandates. Standard 14 is the one exception. It is considered a recommendation, which health care organizations are encouraged to voluntarily adopt (U. S. Department of Health and Human Services, Office of Minority Health, 2007).

Based on all of this, cultural competence is a crucial part of public health. It is clearly recognized as an expectation for entry level public health professionals, meaning that all public health professionals should be functioning at or above these entry level competencies. In addition, it also plays a major role in public health accreditation. Any public health agency applying for accreditation is going to need documentation of staff cultural competence training. The importance placed on cultural competence by these entities further demonstrates the importance of ensuring a culturally competent public health workforce.

Theoretical Framework

Campinha-Bacote's model, The Process of Cultural Competence in the Delivery of Healthcare Services, is the theoretical framework that guides this independent study project (Campinha-Bacote, 2007). Josepha Campinha-Bacote is recognized internationally for her expertise and leadership in the area of cultural competence. Her model is widely utilized within

nursing as well as many other health and human service related fields. It also pulls from a number of fields as it "blends the fields of transcultural nursing, transcultural medicine, medical anthropology, cross-cultural psychology, theology and hospital administration," drawing on the work of theorist from each of these fields (Campinha-Bacote, 2007, p. 16).

The assumptions of this model are:

1. Cultural competence is a process, not an event; a journey, not a destination; dynamic, not static; and involves the paradox of knowing (the more you think you know; the more you really do not know; the more you think you do not know; the more you really do know).
2. The process of cultural competence consists of five inter-related constructs: cultural desire, cultural awareness, cultural knowledge, cultural skill and cultural encounters.
3. The spiritual and pivotal construct of cultural competence is cultural desire.
4. There is variation within cultural groups as well as across cultural groups (intra-cultural variation).
5. Cultural competence is an essential component in rendering effective and culturally responsive care to all clients.
6. All encounters are cultural and sacred encounters. (Campinha-Bacote, 2007, p.20)

Cultural desire is a healthcare professionals desire, or "want to" rather than "have to", take on an active role in the process of becoming culturally competent. This newest of the model's five constructs focuses on one's motivation according to *The Process of Cultural Competence in the Delivery of Healthcare Services: A Culturally Competent Model of Care*, 3rd Edition (as cited in Campinha-Bacote, 2007). Campina-Bacote first utilized this construct in her 1998 version of the model; it was not a part of the earlier 1991 version. Then in 2002, she

incorporated a new image into the model, a volcano, which provided a visual representative of the role of cultural desire. Cultural desire comes from the core of an individual with a genuine motivation that bubbles up, erupting and flowing out from the individual. It causes them to seek out cultural encounters, grow in their cultural knowledge, strengthen their skills in conducting culturally sensitive assessments, and be humbled as they continue in the process of cultural awareness. The theorist sums up this construct well when she describes it as "the fuel necessary to draw us into a personal journey towards cultural competence" (Campinha-Bacote, 2007, p. 26).

Cultural awareness is an attitudinally based construct that requires intentional and thorough examination of one's personal biases, stereotypes, prejudices and assumptions about others who differ from oneself (Campinha-Bacote, 2007). It is influenced by one's personal cultural heritage, the culture of one's discipline, as well as organizational culture. To explain this construct, Campinha-Bacote references Purnell's *Transcultural Diversity and Health Care* to explain the stages of cultural competence, referring to them as a continuum. In the first stage, an individual is unaware of their lack of cultural knowledge. The next stage of the continuum is conscious incompetence, wherein the individual is completely aware of their lack of knowledge. When an individual puts forth a conscious effort to learn about their client's culture, they are in the conscious competence stage. The final stage, unconscious competence, is when an individual spontaneously responds to a client from another culture in a culturally appropriate manner (as cited in Campinha-Bacote, 2007).

Another construct in this model is cultural knowledge, which according to *The Process of Cultural Competence in the Delivery of Healthcare Services: A Culturally Competent Model of Care*, 3rd Edition (as cited in Campinha-Bacote, 2007) can be described as the process of

searching out and gaining additional education about a variety of cultural groups. In seeking out knowledge it is important to consider a variety of sources as well as integrate three key aspects of health: health-related beliefs and cultural values, disease incidence and prevalence, and treatment efficacy (Lavizzo-Mourey, 1996).

The construct of cultural skill can be defined as the ability to assess for pertinent cultural data related to the needs of a given client. This also includes the capability to complete an accurate and culturally sensitive physical assessment. There are many cultural assessment tools that can act as guides within this construct. However, the model recommends that five steps be followed in preparation for conducting a cultural assessment:

1. Review several cultural assessment tools;
2. Consider your discipline's and specialty's purpose in conducting an assessment;
3. Consider your personal assets and liabilities as an interviewer;
4. Integrate selected questions from specific cultural assessment tools that will augment your existing assessment form to yield culturally relevant data; and
5. Establish your own personal style of incorporating cultural content into your patient assessment, as per *The Process of Cultural Competence in the Delivery of Healthcare Services: A Culturally Competent Model of Care*, 4th Edition (as cited in Campinha-Bacote, 2007, p.50).

Cultural encounters are the final construct and are the intentional engagement and interactions with clients from diverse cultural backgrounds (Campinha-Bacote, 2007). These interactions can help prevent stereotyping and refine or modify one's existing beliefs about other cultures. However, it is important to not generalize these encounters to entire cultural groups. Also, it is important to remember that every encounter is a cultural encounter (Campinha-Bacote,

2007). Cultural differences are not exclusive to ethnic groups. For instance, each health care or health-related field has its own cultural norms, and interacting with a health or health-related professional outside one's field is a cultural encounter. This construct also encompasses the issue of linguistic competence, because language differences amplify cultural differences. In order to have an effective cultural encounter, one must be linguistically competent. This includes, but is not limited to, determining the client's language preference, assessing for limited-English proficiency, utilizing effective cross-cultural communication techniques, and providing interpretation services and translated written materials as appropriate (Campinha-Bacote, 2007).

This model arranges these five constructs into a mnemonic, Awareness, Skill, Knowledge, Encounters, and Desire, where one is encouraged to consider the following question: "In caring for my patients, have I 'ASKED' myself the right questions?" (Campinha-Bacote, 2007, p. 85). This question and more specific questions for each construct can be used to assess one's level of cultural competence. The model also provides a more formal assessment tool in its Inventory For Assessing The Process of Cultural Competence Among Healthcare Professionals – Revised (IAPCC-R) (See Appendix L.) (Campinha-Bacote, 2007).

In the initial literature search for this project, it was quite clear that many of the studies used this model to guide their training programs. The assessment tool created by Campinha-Bacote was also frequently used to evaluate these trainings. These finding solidified the selection of this model to guide this project. The model has provided structure for this project in a couple of different ways. The five constructs were used to analyze the studies, specifically in looking at the content covered in each training program as well as the outcomes by which the

training programs were measured. This model was then used to guide the development of the interdisciplinary cultural competence training module, the final product of this project.

Definitions

Cultural and linguistic competence: "Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in crosscultural situations. based on *Towards A Culturally Competent System of Care Volume I.* (as cited in U.S. Department of Health and Human Services, Office of Minority Health, 2001).

Cultural Awareness: "The deliberate self-examination and in-depth exploration of our personal biases, stereotypes, prejudices and assumptions that we hold about individuals who are different from us" (Campina-Bacote, 2007, p. 27).

Cultural Competence: "The ongoing process in which the healthcare professional continuously strives to achieve the ability and availability to work effectively within the cultural context of the patient (individual, family, community)" from Campina-Bacote's The Process of Cultural Competence in the Delivery of Healthcare Services: A Culturally Competent Model of Care (4th Edition) (as cited in Campina-Bacote, 2007, p. 15).

Cultural Desire: "The motivation of the healthcare professional to 'want to' engage in the process of becoming culturally competent; not the 'have to'" from Campina-Bacote's The Process of Cultural Competence in the Delivery of Healthcare Services: A Culturally Competent Model of Care (3rd Edition) (Campina-Bacote, 2007, p.21).

Cultural Encounters: "The act of directly interacting with clients from culturally diverse backgrounds" (Campina-Bacote, 2007, 71).

Cultural Knowledge: "The process of seeking and obtaining a sound educational base about culturally diverse groups" from Campina-Bacote's The Process of Cultural Competence in the Delivery of Healthcare Services: A Culturally Competent Model of Care (3rd Edition) (Campina-Bacote, 2007, p. 37).

Cultural Proficiency: "Takes the process of cultural competence a step further by employing staff and consultants with cultural expertise, ensuring assessment and training efforts, and reviewing policies and procedures to ensure the inclusion of culturally competent language" (Rose, 2011, p.157).

Cultural Sensitivity: "An awareness of and respect for a patient's cultural beliefs and values" (Rose, 2011, p.157).

Cultural Skill: "The ability to collect relevant cultural data regarding the client's presenting problem, as well as accurately performing a culturally based, physical assessment in a culturally sensitive manner" from Campina-Bacote's The Process of Cultural Competence in the Delivery of Healthcare Services: A Culturally Competent Model of Care (4th Edition) (Campina-Bacote, 2007, p. 49).

Culturally and linguistically appropriate services: "Health care services that are respectful of and responsive to cultural and linguistic needs" (U.S. Department of Human Services, Office of Minority Health, 2001).

Culturally and Linguistically Appropriate Services (CLAS) standards: "The collective set of CLAS mandates, guidelines, and recommendations issued by the HHS Office of Minority Health intended to inform, guide, and facilitate required and recommended practices related to culturally and linguistically appropriate health services. These standards were developed based on an analytical review of key laws, regulations, contracts, and standards

currently in use by Federal and State agencies and other national organizations, and refined with significant input from a nationwide public comment process and the guidance of two national project advisory committees. The CLAS standards serve several purposes. They provide a common understanding and consistent definitions of culturally and linguistically appropriate services in health care. They offer a practical framework for the implementation of services and organizational structures that can help health care organizations and providers be responsive to the cultural and linguistic issues presented by diverse populations" (U. S. Department of Health and Human Services, Office of Minority Health, 2001).

Culture: "That complex and whole which includes knowledge, belief, art, morals, law, custom and any other capabilities and habits acquired by man as a member of a society" from *Primitive Culture* (as cited in Campina-Bacote, 2007, 9-10). "The thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. Culture defines how health care information is received, how rights and protections are exercised, what is considered to be a health problem, how symptoms and concerns about the problem are expressed, who should provide treatment for the problem, and what type of treatment should be given. In sum, because health care is a cultural construct, arising from beliefs about the nature of disease and the human body, cultural issues are actually central in the delivery of health services treatment and preventive interventions. By understanding, valuing, and incorporating the cultural differences of America's diverse population and examining one's own health-related values and beliefs, health care organizations, practitioners, and others can support a health care system that responds appropriately to, and directly serves the unique needs of populations whose cultures may be different from the prevailing culture" as explained by

personal communication from Michael Katz (as cited in U. S. Department of Health and Human Services, Office of Minority Health, 2001).

Health Disparity: "A particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion" according to the *The Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020. Phase I report: Recommendations for the framework and format of Healthy People 2020. Section IV. Advisory Committee findings and recommendations* (as cited in U. S. Department of Health and Human Services, 2010).

Health Equity: The "attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities" as defined by the *National Partnership for Action to End Health Disparities. The National Plan for Action Draft. Chapter 1: Introduction* (as cited in U. S. Department of Health and Human Services, 2010).

Diversity: "The makeup of the workforce of a given healthcare organization; this includes ethnic and racial backgrounds, age, physical and cognitive abilities, family status, sexual orientation, socioeconomic status, religious and spiritual values, and geographic location and all of the dimensions and differences between people" (Rose, 2011, p.157-158).

Interpretation: "To turn oral/spoken words into one's own or another language" (Rose, 2011, p.159).

Linguistic Competence: "The capacity of an organization and its personnel to communicate effectively and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities, and the ability to communicate effectively and accurately with individuals whose primary language is not English" (Rose, 2011, p.159).

Social Determinants of Health: A wide variety of broad factors that play a key role in addressing the Healthy People 2020 goal "to achieve health equity, eliminate disparities, and improve the health of all groups." Some of these include socioeconomic status, the physical environment, discrimination, literacy levels, quality education, availability of healthy food, safe and appropriate housing, health insurance, access to clean water, access to affordable and reliable public transportation, and availability of and access to culturally sensitive health care providers (U. S. Department of Health and Human Services, 2010).

Stereotypes: "Exaggerated beliefs or fixed ideas about a person or group of people" (Rose, 2011, p.161).

Translation: "To turn written word into one's own or another language" (Rose, 2011, p.161).

Process

My interest in this topic grew out of a variety of intercultural experiences and was augmented by my participation in the educational program *Culturally Competent Nursing Care: A Cornerstone of Caring* (U. S. Department of Health and Human Services, Office of Minority

Health, n.d.a). After completing the course, I desired to share the information with others, which is why I decided to become a facilitator for the aforementioned educational program. In working in a local health department, I saw the benefit this would have for my co-workers. However, we are an interdisciplinary team, and this program is focused on nurses. Furthermore, the only other educational programs the Office of Minority Health had available were for physicians or disaster preparedness personnel. Since then they have added other educational programs and there are also a variety of discipline specific educational programs available from other resources. Regardless, most of the educational programs I was able to find do not focus on non-nursing public health disciplines. In addition, I found it very difficult to find anything that focused on public health as an interdisciplinary team. This concerned me, as all public health professionals need cultural competence training, and providing education in an interdisciplinary fashion has proven effective at increasing knowledge as well as collaboration and teamwork. In my public health experience, I have seen the cultural differences between disciplines acts as a barrier for true collaboration and teamwork amongst these professions. For this reason, I decided to focus this independent study project on interdisciplinary cultural competence training in public health.

For this project an extensive literature search was conducted with a variety of databases, including PubMed, CINAHL, Cochrane, and Google Scholar. The University of North Dakota's Chester Fritz Library was also searched in an effort to include literature from all public health disciplines. A variety of key words and key word combinations were utilized in the search, including interdisciplinary, multidisciplinary, interprofessional, public health, environmental health, administration, nutrition, nursing, cultural competence, cultural awareness, and cultural sensitivity. These searches were also limited to English language articles published between 2000 and 2011. The references of articles found to be applicable were then reviewed for

possible additional articles and information. Internet sites for reputable and well-known organizations were also searched, including the Center for Disease Control and Prevention, American Public Health Association, National Association of County and City Health Officials, Agency for Health Research and Quality, Association of State and Territorial Health Officials, Office of Minority Health, Evidence Based Practice for Public Health, New York - New Jersey Public Health Training Center, Public Health Foundation, University of Washington – Northwest Center for Public Health Practice, The Cross Cultural Health Care Program, National Institute of Environmental Health Sciences, Environmental Education and Training Partnership, National Public Health Training Centers Network, National Center for Cultural Competence, U.S. Department of Health and Human Services, American Academy of Pediatrics, Association of Schools of Public Health, Transcultural C.A.R.E Associates, National Multicultural Institute, Medical University of South Carolina, University of Southern California - Evidence Based Culturally Competent Care, The Provider's Guide to Quality and Culture, The California Endowment, Transcultural Nursing Society, and Think Cultural Health. In addition, various text books that related to cultural competence in public health were reviewed. The articles as well as the website and textbook information were then examined, and a comprehensive literature review was completed, followed by an analysis and discussion of the evidence to determine the best practices for development of an interdisciplinary cultural competency training program that can be used by local and state health departments. Once the literature was reviewed and best practices were determined, an interdisciplinary cultural competence training module for public health professionals was then developed (See Appendix N.). This training module will subsequently be delivered to the Grand Forks Public Health Department and possibly to other agencies or at public health conferences.

Review of Literature

A number of articles and other resources were found that focused on interdisciplinary cultural competence training or public health discipline specific cultural competence training. However, very few of them focused on interdisciplinary cultural competence training in public health. For this reason, this literature review is divided into two sections interdisciplinary cultural competence training literature and public health cultural competence training. In addition, all of the scientific studies have been summarized into tables that can be found in Appendix C.

Interdisciplinary Cultural Competence Training Literature

The literature on interdisciplinary cultural competence training provides extensive guidance and recommendations for effective training. In a report compiling principles and recommendations for cultural competence training, Gilbert (n.d.), stresses the importance of focusing on process-oriented tools and concepts that can be used to facilitate effective communication with all clients. In the past, cultural competence training was focused more on teaching about the attitudes, values, beliefs, and behaviors of specific cultural groups (Betancourt & Green, 2010). This categorical type of training is often what health professionals want, because it is frequently seen as quick facts that are easily usable when needed. However, this type of training commonly leads to stereotypes and oversimplification of cultural groups. Because of this, cultural competence trainings have evolved to focus more on developing cultural skills and a framework for assessing sociocultural factors that are important to the client. It is important to develop a framework for assessing sociocultural factors rather than relying on quick culture specific facts (Betancourt & Green, 2010). However, culturally specific information can be taught while still avoiding stereotypes, such as folk illnesses within certain populations;

ethnopharmocology; disease incidence, prevalence and outcomes within specific populations; the Tuskegee Syphilis Study and segregation's impact on African Americans; the effect of war and torture on specific refugee populations; and common cultural and spiritual practices that may interfere with prescribed treatments (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2010).

Even with the question of general versus specific information, there are some guidelines that help pull both of these together. All content and subject matter for cultural competence training should fall into three categories: knowledge, attitudes, and skills. These three inter-related elements work together like a three-legged chair to create a culturally well-balanced individual (Gilbert, n.d.). The studies in this literature review frequently utilized these elements together. Overall, the results of these studies demonstrated the effectiveness of cultural competence training across disciplines for improved cultural knowledge, awareness, skill, and competence with the strongest evidence for knowledge. See Appendix C: Table C.1. for a breakdown of how many studies support each of these elements. Unfortunately, the extant literature lacks studies that compare different training program or methods. Moreover, many of the studies reviewed provided minimal information on the content and methodology that was used in providing the cultural competence training. Those that did provide information generally reported a multi-faceted approach, using a diverse set of training strategies, such as lecture, discussions, interactive exercise, case study analysis, journaling, genograms, selected readings, audio-visuals, and simulation to help balance the elements of cultural knowledge, awareness and skill (Gilbert, n.d.; Papadopoulos, Tilki, & Lees, 2004; Mancuso, 2011). One great example of this is based on the fact that didactic teaching can be less effective for cultural competence training. However, supplementing didactic material with case studies and hand-on clinical skills

improves the effectiveness of the training and the balance between knowledge, awareness, and skill (Betancourt & Green, 2010).

Cultural competence training can be best learned through an interdisciplinary framework and context, where discipline specific knowledge and skill can be shared to better facilitate group learning (Gilbert, n.d.). It is important for health professionals to work across disciplines in order to provide effective and culturally competent care, which is why interdisciplinary cultural competence training is so beneficial. Each discipline has its own professional culture that affects every aspect of how the profession interacts with the world, including clients and other professionals. One of the challenges to interdisciplinary training is profession-centrism, or professional centric thinking, and the best way to combat this is through curriculum that promotes interprofessional cultural competence (Pecukonis, Doyle, & Bliss, 2008). However, joint cultural competence and interprofessional education can actually help break down barriers between discipline specific cultures. The process of developing culturally competent values, attitudes, and skills, logically leads participants to apply these same skills and attributes to their interaction and collaboration with participants from other health disciplines, which can help promote attitudes of tolerance towards other disciplines and minimize the tendency to establish professional barriers as students are socialized into their respective professional disciplines (Hamilton, 2011). These benefits of interdisciplinary training can be further enhanced by bringing in community members and indigenous healers as informants, lecturers, and training team members (Gilbert, n.d.).

Another important element to effective cultural competence training is closely examining the organization and participants. A good training program should be respectful of organizational policies and professional accreditation and practice organization guidelines. It

should also be designed to meet the training needs of the organization and participants (Gilbert, n.d.; Papadopoulos, Tilki, and Lees, 2004; Mancuso, 2011), especially taking into consideration the participants' current level of competence (Gilbert, n.d.). Cultural competence training should also be progressive in nature. It should initially cover general concepts, basic information, and raising awareness, but in time should focus more on developing cultural skills and incorporating increasingly complex cases and clinical scenarios. Further, cultural competence training should be integrated into other education whenever possible to help communicate its importance and applicability to all aspects of client care and service. In the end, a balance of cross-cultural knowledge and communication skills provides the best approach for cultural competence training (Betancourt, et al., 2010).

The best approach for training evaluation is to focus on both the instructional program and participant learning. The effectiveness and usefulness of the training should be evaluated by participants, trainers, facilitators, guest speakers, and anyone else directly involved with the training. This information should then be used to continually refine and improve the training program. In addition to evaluating the training, it is also important for participants to self-evaluate their level of cultural competence related to knowledge, awareness, and skills. Ideally, this should be done at various points throughout the cultural competence training process (Gilbert, n.d.).

The following interdisciplinary cultural competence training literature is divided into three categories based on the population of focus. First, three systematic reviews will be reviewed. This is then followed by the literature on trainings at the professional level and finally the pre-professional level.

Systematic reviews. The first systematic review by Beach et al. (2005) examined 34 English language studies from 1980 through June 2003, looking at both the effectiveness and cost of the trainings. They found the evidence for improving knowledge to be excellent with 17 of 19 studies demonstrating a beneficial effect. As for improving the attitudes and skills they noted good evidence with 21 of 25 beneficial for changing attitude, and 14 of 14 for skill. Improved patient satisfaction post-training was also considered to be good with three of three studies demonstrating a beneficial effect. They also noted little to no evidence for post-training improvement in patient adherence, patient health status outcomes and cost of training. This is primarily because most of the studies reviewed did not address these issues or did not address them completely. It also should be noted that only four of the studies they examined involved interdisciplinary trainings.

Bhui, et al. (2007) also completed a systematic review of cultural competence training programs. Their focus was on trainings for mental health professionals; however, they were only able to find nine studies that met their criteria of implementation of a cultural competence model of mental health care and an evaluation of the training published in English since 1985. They looked at a number of factors related to these training programs, including methodology, definition of cultural competence, mandatory or discretionary nature, teaching and learning methods, organizational processes, and quantitative outcomes. They noted that only three of the studies they reviewed provided quantitative outcomes, only one of which demonstrated a change in attitudes and skills post-training. They also pointed out that none of the studies they reviewed examined client experience or outcomes, but one demonstrated clinician satisfaction.

The last systematic review was completed by Chipps, Simpson, and Brysiewicz (2008) with a focus on community-based rehabilitation. They found one systematic review, the

aforementioned Beach et al. (2005), and five studies that met their criteria of randomized controlled trials, quasi-experimental studies, and evaluation studies published in English after 1990. They also excluded studies of trainings at the pre-professional level and those without a specific targeted cultural-training program. They noted positive outcomes for most training programs, but expressed concern about small sample size and poor design. They concluded that the articles they reviewed demonstrated sufficient beneficial evidence to recommend providing cultural competence training to community-based professionals to increase cultural knowledge, improve cultural attitudes, and increase patient satisfaction. However, they noted the strongest evidence supported training for cultural knowledge (Chipps, Simpson, & Brysiewicz, 2008).

Two of these reviews provided further discussion on training content and methodology. Bhui et al. (2007) and Beach et al. (2005) both commented that few of the reviewed studies published the methods used in teaching their training programs. Beach et al. (2005) further noted a lack of research comparing different methodologies, all demonstrating little evidence as to what type of training is most effective. Bhui et al. (2007) also noted a lack of evidence as to which approaches are more effective for different health disciplines. Regardless, since a positive effect is noted with almost all studies, it was suggested that any intervention may be effective. Based on the reviewed studies, it seems that trainings may be effective regardless of length, general or specific content, and experiential or nonexperiential nature (Beach et al, 2005). Lectures are used to provide large amounts of information and are generally considered cost effective. Case study discussion can encourage participant interaction and challenge attitudes and behaviors. Role-playing helps bring to light stereotypical attitudes and facilitate behavioral change. Videos portray different perspectives, improve awareness, and demonstrate communication techniques. Film and other arts may also encourage attitudinal change and

facilitate thoughtful discussion (Bhui et al., 2007). Based on all of this, a method that uses multiple teaching modalities would likely be most effective.

Professional. A variety of interdisciplinary cultural competence training articles were found that focused on professional level trainings. The first study by Khanna, Cheyney, and Engle (2009) examined a four hour cultural competency workshop based on key topics as recommended by the Institute of Medicine, including the Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards. This study utilized a retrospective post-then-pre evaluation method, wherein participants completed a questionnaire that asked them to rate their knowledge and skill post-training and also looking back to their pre-training level. For the 43 health care providers and health administrators who participated in this study, there was a statistically significant change for both cultural knowledge and skill. The authors further report that post-workshop the participants were able to:

> describe the diversity spectrum and define culture; distinguish among culture, race, and ethnicity; identify and describe intercultural and intracultural diversity; distinguish between cultural generalizations and stereotypes; define cultural competency and examine its individual and institutional underpinnings; explain the cultural competency continuum and reflect upon their position on the cultural competency continuum; and describe the importance of using explanatory models during patient-provider communication. (Khanna, Cheyney, and Engle, 2009, p. 887).

Finally, limitations for this study were not discussed by the authors; however, the small sample size does limit the study's generalizability.

Another study evaluated a three hour cultural competency training program called CARE Columbus (Cultural Awareness and Respect through Education) (McDoughle, Ukockis, & Adamshick, 2010). This training program is based upon four interlocking principles:

> 1. Consider and reflect on the patients'/clients' health and cultural issues and concerns. 2. Accept and understand that patients'/clients' cultural differences, practices, and perspectives will impact their health care experience. 3. Recognize and build familiarity with individual patients'/clients' cultural norms, beliefs, and attitudes towards health care. 4. Execute a proactive, culturally sensitive health care intervention that supports patients'/clients' recovery and respects their cultural values without compromising the quality of their health care and medical treatment. (McDoughle, Ukockis, & Adamshick, 2010, p. 756-757)

This study utilized a program questionnaire that was completed by 379 participants, including physicians, nurses, public health educators and program coordinators, licensed social workers, health care and human services support staff, and administrators. The questionnaire utilized a five-point rating scale, on which the training's overall rating was 4.5, signifying improved knowledge and skill. Participants also were asked to provide comments on the strengths and/or weaknesses of the program and complete a questionnaire on worksite implementation. The comments on strengths and weaknesses focused primarily on self-reported changes in attitudes and knowledge, suggested training program improvements, and recommendations regarding the length of the training. Most of the comments on the length of the training recommended extending the training beyond the four hour workshop. Worksite action plan development and implementation was reported among 39% of the 33 participants who completed this questionnaire. The authors note that this small sample size limits the

generalizability of this data. They also comment on the $45 cost that was attached to this program versus free online training programs, such as the Department of Health and Human Services, Office for Minority Health's Think Cultural Health (www.thinkculturalhealth.org/). They recommend comparative studies that evaluate the effectiveness of different training methods or combined methods.

Papadopoulos, Tilki, and Lees (2004) describe a model, Cultural Competence in Action Project, that consists of four sections: awareness, knowledge, sensitivity, and competent practice. They also delineate a training program based on the model and evaluate its effectiveness through pre and post-assessments. Of the 35 mental health professionals who took the pre-assessment, scores indicate that 24 were culturally aware, 10 culturally safe, and one culturally competent. The post-assessment was completed by 18 participants with the majority remaining culturally aware. Four participants moved up to culturally safe, but two moved down to culturally aware. One major limitation of this study was the small number of participants who completed the post-assessment. The authors also concluded that they may have noted a greater improvement if a second post-assessment was done a few months later. This would have allowed the participants additional time to reflect on what they had learned and apply it to their practice.

Papadopoulos, Tilki, and Lees (2004) also outlined principles for effective cultural competence training based on their study. They recommend an organization wide approach and involvement of participants in training program planning to minimize resistance common with compulsory mandates. They also stress the importance of organizational commitment to cultural competence, including implementation of necessary structures, policies, and support for employees. This includes allowing staff adequate time to truly focus on cultural competence training and trainers adequate time to develop trust and rapport. Another recommendation by the

authors is to develop a clear framework for the training and remember the importance of the learning process. They also note that participants frequently desire specific information about key cultural groups, but trainings should focus more on challenging ethnocentric beliefs, practices and unknown prejudices. Self-awareness is recommended as a great non-threatening way to begin a training. Teaching and learning methods should be designed to meet the diverse learning styles of participants. The authors also stress the importance of providing a safe environment to explore prejudice attitudes and behaviors without attacking individuals. It is also important to allow for time to debrief and deal with feelings of guilt related to ethnocentricity and newly revealed prejudice, including how to turn these into strengths. The benefits of pre and post-training assessment of cultural competence are also stressed. These include providing information on participant's levels of cultural competence, indicating the effectiveness of the training, and providing participants with a measure of their progress. Furthermore, they recommend evaluating training programs and sharing lessons learned. The authors conclude that following these recommendations will lead to effective cultural competence training and as a result better client care.

Schim, Doorenbos, and Borse (2006) examined a cultural competence training program focused on hospice staff. They utilized a quasi-experimental, longitudinal, crossover design with eight different hospice agencies randomized into two study groups. The 130 participants, representing 10 different disciplines, were assessed pre-training, after the first intervention or control program, and after the crossed-over intervention or control program. The intervention program was a one hour educational session, titled "Cultural Consideration in the End-of-Life Care", which included primarily didactic material with some time allotted for questions and group discussion. This training program covered the concepts of cultural diversity, cultural

knowledge, cultural awareness, and cultural competence behaviors. The control program was a one hour session on ethical and legal issues in end-of-life care. The pre-test demonstrated similar cultural competence levels between both groups. The post-tests for both groups demonstrated increased competence after each round with more significant increase in competence with the intervention program. Of further interest is the continued increasing competence level of the first intervention group, noted through the second post-test which was administered three to four months later. The authors also noted that, based on their results, increased competence was shared across a variety of disciplines. They explained that their results helped support the effectiveness of even short cultural competence trainings like this one-hour session; however they did state that further dose specific research is warranted. One final limitation to this study was the 23 participants who dropped out after the pre-test.

The final study that looked at professional-level interdisciplinary cultural competence training was based on Campinha-Bacote's model. This study examined the effectiveness of a cultural competence workshop among 28 nursing and allied health faculty. This small sample size was a major limitation of this study. Campinha-Bacote's Inventory for Assessing the Process of Cultural Competence Among Healthcare Professions (IAPCC) was used to assess the faculty members competence level pre-workshop and through four post-workshop evaluation points: immediately afterwards, three months post-intervention, six months post-intervention, and 12 months post-intervention. The mean scores increased with each subsequent evaluation, demonstrating the process of cultural competence continued well after the training. At pre-test four faculty were culturally competent, 23 were culturally aware, and one was culturally incompetent. At the 12 month evaluation, 21 faculty completed the IAPCC with the results showing 10 to be culturally competent and 11 to be culturally aware. The authors did note that

the faculty was able to discuss diversity issues quite openly among themselves. One final note of interest, pointed out by the authors, was that after this study the faculty were quite interested in incorporating Campinha-Bacote's model into their curriculum and classroom interactions (Wilson, Sanner, & McAllister, 2010).

One additional article was found to provide some insight into interdisciplinary cultural competence training at the professional level. Mancuso (2011) describes the process used by one hospital to develop and implement a customized, integrated approach to cultural competence. Campinha-Bacote's model was used to guide this process in engaging individuals in readiness to learn and supporting behavioral changes, with the purpose of promoting health equity and cultural proficiency. The importance of customization of trainings and efforts to create organizational cultural competence in order to meet the specific needs of the staff and the community served were emphasized. For instance, the cultural breakdown of the community was examined and four focus group discussions were conducted to identify learning needs of nursing staff. This hospital utilized computer modules for annual staff cultural competence training with different modules required for clinical and nonclinical staff. In addition, Campinha-Bacote's model was used to guide additional training during nursing skills days. These included a poster presentation, information on transcultural assessment and accessing interpreters, introduction of a reference manual on specific culture and training on how to appropriately utilize it, and discussions on caring for diverse patients. The first day focused on key concepts of cultural competence and raising cultural awareness and sensitivity. Each successive day built a foundation for the next, enhancing participants' readiness to engage in more culturally proficient interactions. The second skills day focused on utilizing interpreters and translated consent documents, including interpreter role-playing. The third day focused on

cultural skills and the complete cultural encounter, incorporating all five of Campinha-Bacote's constructs. This skills day was also used to promote a three hour cultural competence program for nurses, but was open to all disciplines. This cultural competence program was also based on the specific needs of the organization and Campinha-Bacote's model. It included demographic information of the population served; reflection on how personal values and beliefs influence on interactions with the public; self-evaluation activities; guided imagery to promote self-reflection on bias; small group discussions; didactic content on patient and provider behaviors that contribute to health disparities; strategies to maximize trust and solicit essential information through patient interviews; role playing related to utilizing interpreters followed by group discussion; didactic content to improve cultural knowledge related to how differences affect interactions, care practices, approaches to education and decision making; case study discussion; and open discussion on experiences in providing care to culturally diverse populations. Additional identified needs were met through an interpreter training and an informal education session provided by a specific cultural group within the community. The author also notes that continued cultural competence education and efforts to improve organizational cultural competence are ongoing, as cultural competence is a process, not a onetime event.

Pre-professional. Even though this project looks to develop interdisciplinary cultural competence training for public health at the professional level, pre-professional studies were also reviewed as they provide additional insight into effective training methodologies.

The first study (Brown, et al., 2008) examined a 10-week elective course focused on interprofessional education and cultural competence training. The course was case-based and primarily didactic with small group and whole class discussion. It also utilized videos and guest speakers. The course was open to graduate and undergraduate nursing, pharmacy, social and

allied health students and taught by an interdisciplinary faculty team. The course was evaluated through two questionnaires, one that focused on interprofessional education and the revised version of the Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals (IAPCC-R), both administered pre and post-course. These evaluations were completed for two cohorts in 2006 and 2007. In the first year, 32 students (96.9%) completed the IAPCC-R, and in 2007, 30 students (62.5%) completed it. The results from this questionnaire demonstrated that the students, as a whole, moved from cultural awareness into the culturally competence range. When broken out by educational program, no difference was noted in the mean scores. It should also be noted that the results from the questionnaire that focused on interprofessional education also demonstrated improvement as a result of this course. The authors outlined two limitations of this study: the one-group design and the subjectivity of the questionnaires utilized, as it is a self-assessment preformed by each participant.

Horowitz, Vanner, and Olowu (2006) examined an interdisciplinary educational intervention designed to increase: cultural self-awareness; knowledge and understanding of diverse cultures, including cultural influences on health behaviors and use of services; communication skills with diverse populations; and clinical skills for culturally competent practice. This two-part course was offered to students and faculty within the disciplines of occupational therapy, physical assistant, physical therapy, nursing, social work, and medicine. Part one was a four hour session, titled "Moving Toward Cultural Competency", that incorporated lecture, small-group self exploration, and case studies. Part two was a two hour interactive community forum, titled "Addressing Diverse Client Needs", wherein panelists shared their perspectives and experience followed by a facilitated dialog between panelists and participants. Occupational therapy students completed pre and post-program tests to evaluate

this program. Results from the 15 paired tests revealed a slightly significant improvement in the mean scores for values and attitudes and no significant difference for the mean communication scores. Unpaired test showed no significant difference for any of these. The authors explain that this difference is likely due to the paired group being primarily first year students and the unpaired primarily second year. The second year students are more likely to have been previously exposed to cultural competence issues in their previous course work, which may have affected how much they learned from this training. These occupational therapy students also responded to open-ended questions, reporting increased insight and understanding of other cultures. A program evaluation was the only evaluation method that was applied to all participants, 56 students, faculty, and guests who attended part one and 81 who attended part two. These forms demonstrated a significant difference in perceived knowledge for both sessions. The generalizability of this study is limited due to the small sample size, especially with the pre and post-test group.

Melamed, Wyatt, Padilla, & Ferry (2008) focused on pre-health and humanities students and evaluated a course titled "Cultural Aspects of Medicine," that included both classroom education on cultural competency and cross-cultural communication skills and a hospital-based volunteer clinical experience. The classroom component consisted of four hour weekly seminars that paired lecture with small group discussion and role playing, covering a variety of topics: cultural beliefs, medical communication, health inequity, role of religion in health care, cultural aspects of grieving, art and music as forms of communication in healing, cultural perspectives from health care professionals, and global conflicts effect on health. The clinical component involved two to three hours each week visiting with patients in order to allow student to practice talking to patients from different cultures and try out the techniques they learned in the

classroom. The students' knowledge related to cultural competency was evaluated through a pre and post-test with post-test scores statistically significantly higher in both paired and unpaired groups, showing improved cultural knowledge post-training. The greatest improvement was noted for those with the lowest pre-test scores, meaning that those who had the lowest level of knowledge pre-training gained a greater proportion cultural knowledge at the time of the post-test. In addition, participants demonstrated a high value placed on the course and an interest in continued cultural competence training through their post-training comments. According to the authors, this study was limited by the convenient availability of experts, a small budget, limited curricular time to cover a large amount of information, and a lack of validated evaluation tools. Despite these weaknesses, this unique curriculum did demonstrate improved cultural competence in students prior to any formal clinical training.

Munoz, DoBroka, and Mohammad (2009) developed a pilot cultural competence course for junior and senior nursing, education, and social work students utilized a multidisciplinary teaching model and two cultural competence models: Campinha-Bacote's model and Bennett's developmental model of intercultural sensitivity. This seven-week pilot course utilized two-hour weekly sessions that consisted of lecture and a variety of interactive learning methods to build upon the foundation of a prerequisite course: "Cultural Pluralism and Global Awareness". Some of the learning methods used were assigned readings and written response papers, role-playing, interacting with guest speakers, and reflective class discussion. The student's reflective papers were examined along with course evaluations to evaluate the effectiveness of this course. The findings from the qualitative review of these papers demonstrated growth in cultural competence, specifically improved awareness of other cultures, recognition and acceptance of responsibility for stereotypes and attitudes, broadened cross-cultural knowledge and perspectives, and

stimulation of critical thinking skills. The limitations of this study include a reported small sample size, which the authors failed to quantify, and a lack of measureable evaluation data.

Musolino, et al. (2009) examined an interdisciplinary educational program called, "Cultural Competency and Mutual Respect" that consisted of four two-hours modules entitled: "Relationships & Cross-Cultural Conflict", "Disparity of Care", "Solutions to Cultural Clashes", and "Cross-Cultural Communications". Campinha-Bacote's IAPCC-R was used for a pre/post evaluation of both the intervention and control groups. Program participants included students from the following disciplines: medical (100), nursing (140), and physical (36) and occupational (11) therapy, and pharmacy (53). The control group data was collected from 36 physical therapy and 100 medical students, who did not participate in an educational program. The results from this study showed that medical, physical therapy and pharmacy students attained significantly higher scores for attitudes, knowledge, and skills, but not encounters and desire. Nursing students did not achieve statistically significant scores, but they only completed two of the four modules each semester. This drawing out the material over two semesters may have negatively affected their learning outcomes. Control group students scored lower than intervention group students from the same disciplines. Post-test scores for all intervention group students showed progress towards cultural competence, but not yet achieving cultural competence in mean score values. Only one student achieved cultural proficiency. The authors recommend curricular enhancement related to cultural encounters and cultural desire to improve progression towards cultural proficiency. One way they intend to do this is through additional case study scenarios and role-play. According to the authors, the generalizability of this study was limited by the convenience sample, even with a control group for comparison.

Sasnett, Royal, and Ross (2010) evaluated an interdisciplinary cultural experience training with two educational components. The first component, a didactic component, was based on two models: The Purnell Model and Campinha-Bacote's model. This was complemented by a cultural engagement component that consisted of a series of self-assessment exercises, including exploration of family healing traditions, stereotyping, intercultural communications, and culturally competent health care delivery; specific key activities including case studies, a genogram, a grocery store ethnography activity, and a windshield tour activity; and interdisciplinary team home visits. Based on these home visits, students completed case write-ups and care plans which were evaluated using the domains and factors from Purnell's model. These case write-ups demonstrated use of a larger range of domains from Purnell's model with a mean of 6.68 domains per case versus 6.14 for the pre-implementation group and 15.80 factors identified per case versus 15.03 pre-implementation. However, this improvement is small, especially given the possible 12 domains and 79 factors, demonstrating significant room for further growth. Regardless, the authors do report that as a result of this cultural experience, the students gained improved understanding of the cultural background of clients and a willingness to integrate cultural issues into their health assessments. One statistically significant finding from this study was an increased identification of spiritual and family factors. However, these results may have been affected by a dramatic post implementation enrollment shift, wherein the nursing, health education, and social work students more than doubled. This is an important consideration as nursing students tend to be much stronger in these two areas. The authors also point out that Purnell's model may not have been the best choice for evaluation as it does not delineate key factors that define cultural sensitivity. For instance, a good technician could easily incorporate a wide variety of domains and factors without demonstrating cultural

sensitivity. The authors note that another model may have provided different results. They also stress the importance of continued exposure and training related to cultural competence and that measuring this type of training over a longer time period may provide more positive results.

Public Health Cultural Competence Training Literature

There is limited literature on cultural competence training in public health, and what is available is largely discipline specific. This section will review one public health promising program, a few discipline specific articles, and a text book. The text book provides the most applicable and complete guidance on cultural competence training in public health.

The Suffolk County Department of Health Services (2009) was recognized by the National Association of County and City Health Officials (NACCHO) for their promising program: Implementing the CLAS Standards: A Local Health Department's Journey. As part of this promising program they utilized two research evaluation studies to assess patient satisfaction pre- and post-cultural competence workshops. Their workshops focused on both health disparities and cultural competence and were provided to all staff in their department from executive staff to frontline providers and general staff. They utilized an online training program for providers that was offered through the Office of Minority Health and also offered a Building Bridges Cultural Competence Training program onsite. They also trained their bilingual staff as interpreters. This program involved more than just cultural competence training. It used the CLAS standards to improve the cultural competence of the entire organization. It is a great example of the importance of a commitment to organizational cultural competence and the extensive organizational change that is needed above and beyond cultural competence training.

Public health nursing. Cooper Brathwaite (2005) evaluated a very interesting public health nursing focused cultural competence program that was based on Campinha-Bacote's

model. It consisted of five weekly two hour sessions titled "An Introduction of Transcultural Terms and Overview of the Model", "Cultural Awareness", "Cultural Knowledge", "Cultural Skill", and "Cultural Encounter", followed by a booster session one month later that involved discussing participants experiences and ability to apply the concepts to practice. The study results indicated a significant increase in the level of cultural competence with the progression of the course, including further increase at a 3 month follow up evaluation. These responses also included reports of integrating course content into practice with 50% reporting a change in behavior and 50% reporting increased awareness.

Enviromental health professionals. In reviewing the literature, only one study was found that looked at environmental health professionals. However, a promising program and online cultural competence training were also found to provide some guidance on educating this population on cultural competence.

Galván and LaRocque (2010) utilized a pre/post evaluation with retrospective pretest to evaluate environmental education forums in 28 states with 191 total workshop participants. Each workshop included discussion of intercultural models, case study analysis, intercultural simulation, and customized group skill-building and reflection activities. Participants reported less ethnocentric and more ethnorelative perspectives at the end of the workshop.

Stratford Health Department (2004) has been recognized by NACCHO for their promising program: Food Smart Program. This program was designed to address the need for language and culturally appropriate food safety education in an area with a number of Asian food establishments that had a history of problematic inspections. The program focused primarily on bringing in a Chinese food safety educator to provide education to the non-English speaking food service staff. This person also provided training to the environmental health inspectors, a group

for whom cultural competence training is not frequently offered. Much of their cultural competence education was focused on the specific population with which they were working and included basic Chinese words and phrases and information on the cultural influences that affected their communication with the Asian establishments. Based on this program they concluded that it is crucial to have food safety instructors who speak the language and understand the culture of the group to whom they are presenting and that inspection staff have input into the training curriculum and approaches.

The online educational program "Communicate to Make a Difference: Exploring Cross Cultural Communication" is promoted on the National Environmental Health Association website. Reeves (n.d.) explains that this program focuses on the development of an ethnic restaurant inspection case study that engages participants in analyzing the situation and deciding how to best deal with challenges presented. It also promotes the importance of analyzing each situation separately.

Based on these three resources, case studies and population specific information appear to be important when educating environmental health professionals on cultural competence. However, they also seem to recognize the importance of more general cultural competence trainings, especially in regards to communication and skill-building.

Public health textbook guidance.

The textbook, *Cultural Competency: For Health Administration and Public Health,* provides very comprehensive and public health specific guidance on cultural competence training. One key recommendation is that a cultural competence assessment be done prior to any training to identify weaknesses and strengths of the public health organization. This information should then be used to determine the training needs. For this assessment to be truly beneficial it

should measure attitudes about provision of services to diverse clients/customers from staff at every level of the organization. It is also important to make sure that the assessment tool to be used has been tested and its reliability and validity established in order to ensure the efficacy of the data collected. Repeat assessment should be conducted regularly to monitor attitudinal changes and any additional needs or concerns that should be addressed through additional training (Rose, 2011).

Rose (2011) recommends that cultural competence trainings in public health should include an overview of health disparities, key cultural competence terms, different cultural perspectives on health and illness, approaches to reduce or eliminate discriminatory and culturally and linguistically insensitive and inappropriate practices, techniques for properly accessing and working with interpreters, and the importance of integrating cultural competence into public health organizations. It is also important for mid to upper level management to be trained, but with a slightly different emphasis. Their training should focus on improving awareness of health disparities, ensuring human resource skills are developed for cross-cultural assessment, learning to communicate and negotiate from a cultural vantage point, comprehending the importance of adequate resource allocation to support organizational cultural competence efforts, sharing insight into the importance cultural competence benchmark development and rewarding successes, and the impact of current accreditation and legal requirements related to cultural competence.

When providing cultural competence training to public health staff, regardless of their level of practice, it is important to incorporate all three of the following approaches. The first approach is the knowledge-based approach, which includes specific information related to cultural competence, such as definitions of culture, race, ethnicity, linguistic competence, and

related concepts; details about cultural specific health-seeking behaviors; and so forth. Attitude-based approaches are more focused on improving awareness of attitudes, values, and beliefs about other cultures and views on language and other specific cultural and linguistic factors that affect the quality of care and service provided to clients/customers. Lastly are the skill-building approaches. These approaches look to develop specific skill sets that will prepare individuals to effectively communicate and interact with non-English speakers. They also usually involve identifying when an interpreter is needed and how to work with one as well as how to discuss cultural nuances with clients/customers to ensure that they are treated with respect and feel valued and appreciated (Rose, 2011).

Rose (2011) also provides some guidance on recommended training methods that incorporate all three approaches. Her first recommendation is that a glossary of cultural competence terms be provided as part of training materials to allow participants to refer to them as needed. One of the best ways to establish attitudes, behaviors, and practices that enable public health professionals and organizations to best serve their culturally diverse communities is through case studies. Case studies can help facilitate understanding through information sharing and application of key terms and concepts to actual or hypothetical scenarios. In addition to case studies, other interactive exercises that utilize role playing or discussion can also incorporate all three approaches. See Appendix D. Sample Training with Modules (Rose, 2011).

It is also important to discuss organizational cultural competence as a part of training, including information on what needs to be done on an organizational level to support and enhance the training efforts. For instance, policies may need to be developed and support gained from governing boards. Cultural competence should be a part of the organizational culture and integrated into the strategic plan (Rose, 2011).

Another key recommendation from Rose (2011) is to utilize regular evaluation for all aspects of training to track progress over time. Each training session should close with participants filling out an evaluation on the session. These evaluations can be very helpful in guiding future training efforts. In addition, many public health organizations use customer service evaluations. Adding questions specific to the quality of culturally competent services can be a great method to evaluate the impact of cultural competence training. Cultural competence is an ongoing process, and evaluation of it should be as well. It should be designed to meet the organization's goals and at the least look to identify strengths and weaknesses through both an evaluative survey tool and cultural competence question in customer satisfaction surveys (Rose, 2011).

Discussion

The evidence from the literature review provides excellent support for cultural competence training in general. There also is a significant amount of literature that supports interdisciplinary cultural competence training, both at the professional and pre-professional level. However, there is a significant lack of literature on interdisciplinary cultural competence training in public health. There are a few articles that address discipline specific cultural competence training in public health, but the only source that truly addresses interdisciplinary cultural competence training in public health is the textbook by Rose (2011). Regardless, all of the evidence combined does provide some good guidance for developing an interdisciplinary cultural competence training program for public health. Part of what adds to this is the congruence between the recommendations from interdisciplinary literature and public health literature, which will be further explained throughout this section.

Interdisciplinary Cultural Competence Training

Interdisciplinary cultural competence training is very well supported throughout the literature reviewed. All of the interdisciplinary studies demonstrated beneficial outcomes in their findings, adding support to the argument for interdisciplinary cultural competence training. Gilbert (n.d.) describes this as the best way to learn cultural competence, explaining that professionals from different disciplines can share their knowledge and skills enhancing group learning. This interdisciplinary learning can also help break down cultural barriers between disciplines and help them learn to better understand each other. Furthermore, since health professionals regularly work across disciplines to provide quality care and services to a diverse clientele, strengthening these relationships provides an added benefit to the quality of their collaboration (Hamilton, 2011). These benefits of interdisciplinary training can be further enhanced by bringing in community members and indigenous healers as informants, lecturers, and training team members (Gilbert, n.d.). As for applying this information to the public health setting, Rose's (2011) only discipline specific guidance is for covering some additional information for upper management. Aside from this, her recommendations for cultural competence training in public health are universal and not discipline specific.

Multi-Faceted Approach

Part of what adds to the congruence between the recommendations from interdisciplinary literature and public health literature is that they both support a multi-faceted approach. The literature lacks training comparison studies, and many of the studies reviewed provide minimal information on the content and methodologies used in providing cultural competence training. However, those that did provide information generally reported a multi-faceted approach. Papadopoulos, Tilki, and Lees (2004) and Mancuso (2011) both specifically recommended a multi-faceted approach.

Lectures, case studies, group discussions, and role play are the training approaches most frequently mentioned in the reviewed studies. See Appendix C. Table C.1. for a breakdown of how many studies utilized each of these. Each of these approaches play a key role in providing a comprehensive training program. Lectures are used to provide large amounts of information and are generally considered cost effective. Case study and discussion-based activities can encourage participant interaction and challenge attitudes and behaviors. Role-playing helps bring to light stereotypical attitudes and facilitate behavioral change (Bhui et al., 2007). Combined they provide a well supported multi-faceted approach. However, there are other approaches mentioned in the literature that are worth considering when developing an interdisciplinary cultural competence training program for public health. For instance, Bhui et al. (2007) recommends videos, films, and other art forms to improve awareness, facilitate thoughtful discussion, and demonstrate communication techniques. Additional approaches from the reviewed literature include: journaling, genograms (Gilbert, n.d.), selected readings (Gilbert, n.d.; Munoz, DoBroka, & Mohammad, 2009), written papers (Munoz, DoBroka, & Mohammad, 2009), a glossary of cultural competence terms (Rose, 2011), guest speakers (Brown, et al., 2008; Munoz, DoBroka, & Mohammad, 2009), an interactive community forum (Horowitz, Vanner, & Olowu, 2006), a grocery store ethnography activity, a windshield tour activity (Sasnett et al., 2010), self-assessment exercises (Sasnett et al., 2010; Mancuso, 2011), computer modules, poster presentations, a reference manual on specific culture, guided imagery to promote self-reflection on bias (Mancuso, 2011), customized group skill-building and reflection activities (Galván & LaRocque, 2010), simulation (Gilbert, n.d.; Galván & LaRocque, 2010), clinical based interaction with diverse patients/clients (Melamed, Wyatt, Padilla, & Ferry, 2008), interdisciplinary team home visits (Sasnett et al., 2010), and a one-month post-training booster

session to discuss participants experiences and ability to apply the concepts to practice (Cooper Brathwaite, 2005).

Curricular Content

Both the interdisciplinary and public health literature point out the value of combining training on general concepts and skills with culture specific information. Health professionals frequently want the culture specific information to use as a quick reference. However, this can be dangerous, as it can lead to generalizations and stereotypes. The literature recommends cautiously combining some of this information with process-oriented tools and concepts to promote development of cultural skills and a framework for assessing sociocultural factors that are important to the client (Papadopoulos, Tilki, & Lees, 2004; Gilbert, n.d.; Betancourt & Green, 2010; Betancourt, Green, Carrillo, & Ananeh-Firempong, 2010). Reeves (n.d.) provides a great example of how this combination can work. Her program focuses on an ethnic restaurant inspection case study but also promotes analysis of each situation independently. Rose (2011) also recommends combining general information, such as definitions of culture, race, ethnicity, linguistic competence, and related concepts, with culture specific information related to such areas as health-seeking behaviors.

These knowledge-based approaches need to be balanced with attitudinal- and skill-based approaches. This three-legged approach is utilized in some way by every literature source reviewed. Gilbert (n.d.) and Rose (2011) pull in both the interdisciplinary and public health view with their matching recommendations that all training content should fall into one of these three categories: knowledge, attitudes, and skills. According to Rose (2011), attitude-based approaches are more focused on improving awareness of attitudes, values, and beliefs about other cultures and views on language. Papadopoulos, Tilki, and Lees (2004) recommend self-

awareness activities as a great non-threatening way to begin a training, but for this to be effective it must be done in a safe, non-threatening environment and with time to debrief afterwards. The final approach, skill-building, is focused on developing effective communication skills, interpreter utilization skills, and the ability to make clients feel valued and appreciated while discussing cultural nuances important to them (Rose. 2011).

One method of ensuring that these three approaches are equally incorporated is by utilizing Campinha-Bacote's model to design cultural competence trainings, a method used by six of the reviewed studies (See Appendix C.). To improve progression towards cultural proficiency for future trainings, one of these studies recognized the need to enhance their curriculum related to cultural encounters and cultural desire. They suggested additional case study scenarios and role-playing, two attitude- and skill-based approaches, to reach this goal (Musolino, et al., 2009). This helps demonstrate how Campinha-Bacote's five constructs, cultural desire, cultural awareness, cultural knowledge, cultural skill, and cultural encounter, lend themselves perfectly to these three approaches. Incorporating all five constructs will help ensure the three approaches are well-balanced. One great example of this is how Mancuso (2011) utilized Campinha-Bacote's model to guide a multi-faceted, facility-wide training program. The first training day of this program focused on cultural knowledge, awareness, and sensitivity and was followed by two additional training days, focused on cultural skills and encounters. Efforts related to cultural desire were intertwined throughout the training program.

When designing an interdisciplinary cultural competence training program for public health, it is also important to consider the CLAS standards, especially since these standards are the basis for the cultural competence expectations for public health accreditation. These standards were instrumental in the development of the U. S. Department of Health and Human

Services, Office of Minority Health's (n.d.a) training program: *Culturally competent nursing care: A cornerstone of caring*. Khanna, Cheyney, and Engle (2009) also used the CLAS standards as a guide for the key topics of their training. These standards were used an even greater extent by The Suffolk County Department of Health Services (2009), as they guided an organizational cultural competence change process. Standards four through seven, the language access services standards, are of particular importance as they required by law. These standards demonstrate the importance of including training on assessing for need, accessing, and appropriately utilizing interpreters (Rose, 2011). Mancuso (2011) recommends interpreter-focused role-playing followed by group discussion to ensure participants are prepared to meet these standards.

Training Evaluation

As for evaluation of the training, some of the studies utilized a multi-point evaluation, which demonstrated continued growth in cultural competence well after the trainings were competed (Cooper Brathwaite, 2005; Schim, Doorenbos, & Borse, 2006: Wilson, Sanner, & McAllister, 2010). In another study, Papadopoulos, Tilki, and Lees (2004) concluded that they may have noted a greater improvement with a second post-assessment few months later, as this would have allowed the participants additional time to reflect on what they had learned and apply it to their practice. Cooper Brathwaite (2005) actually found that at three-months post-intervention participants reported an integration of course content into practice with 50% reporting a change in behavior and 50% reporting increased awareness. Based on this, it seems that both the interdisciplinary and public health literature support regular, progressive evaluations for cultural competence training programs.

Evaluation of both the training and participants are also supported by both groups of literature, as each study evaluated one or both of these. Gilbert (n.d.) explains that focusing evaluation on both the program and participant learning provides the best approach for training evaluation. The effectiveness and usefulness of the training should be evaluated by everyone directly involved with the training to provide guidance for continued refinement and improvement of the training program. Rose (2011) recommends that each training session conclude with participants filling out an evaluation on the session. In addition to program evaluation, it is also important for participants to self-evaluate their level of cultural competence related to knowledge, awareness, and skills. Gilbert (n.d.) recommends this self-evaluation be completed at varying points throughout the training process.

Another interesting recommendation for evaluation was customer service surveys, especially since this is something regularly utilized by many public health organizations. Rose, (2011) suggests that these surveys be modified to include questions specific to the quality of culturally competent services to provide an avenue for evaluating the impact a training program has on the population served. The Suffolk County Department of Health Services (2009) provides a great example for this, as they utilized two research evaluation studies to assess patient satisfaction pre- and post-cultural competence workshops. The pre-assessment was also used to help identify cultural competency learning needs within the department.

Pre-assessments were done by most of the reviewed studies (See Appendix C.), either simply as a baseline or sometimes to guide the training process. When completed prior to any training they can be helpful in identifying weaknesses and strengths of the public health organization, which can then determine training needs. Ideally, these assessments should measure attitudes about provision of services to diverse clients/customers from staff at every

level of the organization. They should also be repeated regularly to monitor change and identify any additional needs or concerns. When conducting these assessments, it is important to verify the reliability and validity of the chosen assessment tool (Rose, 2011). In the reviewed studies, the most commonly used assessment tool was Campinha-Bacote's IAPCC or IAPCC-R, with four studies making use of it. One study in which this tool was not used, eluded to the fact that it might have been a better option (Sasnett, Royal, & Ross, 2010). Regardless of what tool is use, it is important to remember that cultural competence is an ongoing process, and evaluation of it should be as well (Rose, 2011).

Organization and Participant Considerations

Both literature pools stressed the importance of modifying trainings to fit the needs of an organization and the training participants. Trainings should be designed for an organization wide approach, involving participants in training program planning to promote buy-in at all levels. A good training program should be respectful of organizational policies and professional accreditation and practice organization guidelines (Gilbert, n.d.; Papadopoulos, Tilki, and Lees, 2004; Mancuso, 2011). Teaching and learning methods should be designed to meet the diverse learning styles of participants (Papadopoulos, Tilki, and Lees, 2004), especially taking into consideration the participants' current level of competence (Gilbert, n.d.). For one training, the demographic and cultural breakdown of the community was examined and four focus group discussions were conducted to identify learning needs of nursing staff. Based on identified needs, this training program added an interpreter training and an informal education session provided by a specific cultural group within the community (Mancuso, 2011). The Suffolk County Department of Health Services' (2009) promising program: Implementing the CLAS Standards: A Local Health Department's Journey provides a great example of additional

information that should be discussed as part of cultural competence training. The CLAS standards provide guidance on what needs to be done on an organizational level to support and enhance the training efforts. For instance, policies may need to be developed and support gained from governing boards. In addition, cultural competence should be a part of the organizational culture and integrated into the strategic plan (U. S. Department of Health and Human Services, Office of Minority Health, 2001).

Finally, both the interdisciplinary and public health literature encourage approaching cultural competence training as an ongoing process that requires continued evaluation and adjustment for future training. It should be progressive in nature, starting with general concepts, basic information, and raising awareness. As time or sessions progress, the training should move to a more complex focus, such as cultural skills and increasingly complex cases studies and cultural encounters (Betancourt, et al., 2010; Mancuso, 2011). Mancuso (2011) recommends progressively working through all five of Campinha-Bacote's constructs. The author also notes that continued cultural competence education and efforts to improve organizational cultural competence are ongoing, as cultural competence is a process, not a onetime event. Sasnett, Royal, and Ross (2010) also stress continued cultural competence training and that measuring this type of training over a longer time period may provide more positive results.

In reviewing all of this I was surprised to find myself frequently thinking back to the *Culturally competent nursing care: A cornerstone of caring* (U. S. Department of Health and Human Services, Office of Minority Health's, n.d.a). It really seemed to include everything that was being recommended, but it was nursing focused. Given this, I decided that instead of creating something new, it made more sense to use that program and modify it to fit an interdisciplinary public health audience.

The Interdisciplinary Cultural Competence Training for Public Health

The training that I have put together uses much of the information from the *Culturally competent nursing care: A cornerstone of caring* (U. S. Department of Health and Human Services, Office of Minority Health's, n.d.a). This program, despite being nursing focused, utilizes much of the general content and methodological recommended in through the literature review. For instance, it is strongly based on the CLAS standards, a crucial element for cultural competence training in public health. It utilizes a multi-faceted approach, including lecture, discussion, case-studies, role playing, group projects, journaling, and other interactive activities. It incorporates Campinha-Bacote's model as well as knowledge, attitude, and skill-based approaches. It also covers general cultural competence terms and concepts, interpreter access and utilization, organizational competence (U.S. Department of Health and Human Services, Office of Minority Health, n.d.b). Based on this, I decided that this program as it is does not work for interdisciplinary cultural competence training for public health, but its congruence with many of the findings and recommendations from the literature review does lend it to a starting place for an effective training program that is public health focused. In creating this training, I started with simple modifications, working from a nursing focus to a interdisciplinary public health focus. I did have to remove some information, as it simply could not be modified. One example of this is a statement from the American Nurses Association (ANA) supporting cultural competence training. When I removed items like this, I tried to replace them with something related that was public health focused. For instance, I replaced the ANA statement with the entry level Public Health Professional Competencies (The Council on Linkages Between Academia and Public Health Practice, 2010).

The Grand Forks Public Health Department (GFPHD) is the public health organization to whom this Interdisciplinary Cultural Competence Training in Public Health will be facilitated. Given this, it is important to consider the needs of this local health department. The full time staff of GFPHD consists of 15 nurses, six environmental health practitioners, two dietitians, two mosquito control professionals, five administrative professionals, and one department director. In May of 2011, this department began work on improving cultural competence at an organizational level after a presentation and facilitated discussion at the Grand Forks Public Health Department Strategic Planning meeting. At that meeting the department completed the Organizational Assessment Checklist (See Appendix E.) (U. S. Department of Health and Human Services, Office of Minority Health, n.d.b). Then in June, 2011 at the Nursing and Nutrition Strategic Planning Retreat a cultural competence action plan was created. Eventually, a committee, the Cultural Competence Action Team, was organized to work on the identified department needs. Significant progress has been made on the organizational level; however, the department greatly needs a cultural competence training program that will provide quality education for the entire staff. This explains the department's need for this public health focused interdisciplinary cultural competence training.

The department has identified their needs related to cultural competence, and some of those were specific to cultural competence training: interpreter access and utilization skills; speakers from specific cultural groups; health literacy; and best methods to collect race, ethnicity, and language data. Two of these, interpreter access and utilization skills (See handouts in Appendices H and I.) and health literacy, are covered in the existing content from the *Culturally competent nursing care: A cornerstone of caring* (U. S. Department of Health and Human Services, Office of Minority Health's, n.d.a). The other two required some modifications

to ensure that they were covered. Content from the U. S. Department of Health and Human Services's Implementation Guidance on Data Collection Standards for Race, Ethnicity, Sex, Primary Language, and Disability Status was added to address the identified need: best methods to collect race, ethnicity, and language data (See handout in Appendix G). As for the identified need for speakers from specific cultural groups, this will be met through a post-training panel discussion, featuring community representatives. These community representatives will primarily be from refugee groups, as the Grand Forks Public Health Department works extensively with this population.

Another important aspect of how the *Culturally competent nursing care: A cornerstone of caring* (U. S. Department of Health and Human Services, Office of Minority Health's, n.d.a) was modified to create this Interdisciplinary Cultural Competence Training in Public Health was ensuring that the material was relevant and applicable to all disciplines at the Grand Forks Public Health Department. In addition to the previously mentioned changes to focus more on public health, the original programs nursing specific case studies were replaced with case study discussions that bring in different elements and disciplines within public health. To make these case study discussions even more interactive, I decided to simply put some basic guiding information into the training. Then, closer to the training I will ask staff members who have expertise in the topics or populations addressed in each case study discussion to write up the case study and present it at the training. I will also be available to assist them with this process. This approach will also allow each discipline to have input into the training and also utilize their expertise to facilitate group learning.

The Interdisciplinary Cultural Competence Training in Public Health (See Appendix N.) consists of three sessions that are each two hours in length. It will be delivered on three separate

days with ideally one week or less between sessions. About one month after all three sessions have been facilitated, the post-training panel discussion, featuring community representatives, will take place. Since continued cultural competence training is important, I will work with the Grand Forks Public Health Department to develop a plan for continued training or cultural competence enhancement activities. Some suggestions for this would be monthly book or movie discussions, guest speakers, and case study presentations at staff meetings.

To evaluate this program, I will have participants complete a self-assessment prior to the training, after completion of the third session, and two months post-training. There are a few different tools that will be used for this. One is provided through the *Culturally competent nursing care: A cornerstone of caring* (U. S. Department of Health and Human Services, Office of Minority Health's, n.d.a) and can be found in Appendix J. Another is Campinha-Bacote's Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals – Revised (IAPCC-R) (2007), which can be found in Appendix L. Both of these would serve a similar purpose, and I intend to work with the organization to choose which one works best for them. The reason for this is that the IAPCC-R is an excellent tool that measures where an individual is at in regards to cultural competence, but there is a fee attached to it. The Self-Assessment Checklist is also a good tool, but it does not provide as clear of a measurement of cultural competence. Plus, I have not found any reliability and validity testing that has been done on it, whereas the IAPCC-R has undergone rigorous testing (Campinha-Bacote, 2007). Session three will incorporate two additional assessment tools. The first is a self-assessment tool that relates to involvement in and promotion of organizational cultural competence (See Appendix K.) (U. S. Department of Health and Human Services, Office of Minority Health's, n.d.b). The second is the organizational assessment that was last done about one year ago (See

Appendix E.) (U. S. Department of Health and Human Services, Office of Minority Health's, n.d.b). The final aspect of the evaluation of this training is a training evaluation that participants will be asked to complete at the end of each session (See Appendix M.)

Conclusion

Interdisciplinary cultural competence training in public health is greatly needed. The Interdisciplinary Cultural Competence Training in Public Health that was developed based on the literature reviewed provides an evidenced-based method of providing this type of training. It helps to fill this educational gap for public health professionals. However, cultural competence is a process that requires on-going education and effort focused on growth. This training is a great starting place. All public health professionals should take advantage of trainings like this and work to continue to grow in their cultural competence, to the betterment of the public's health!

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