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Cultural Competence to Decrease Advanced Stage Breast Cancer Diagnosis in an Appalachian Kentucky Population

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Walden University

College of Health Sciences

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Deborah Heard Stakelin

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

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Walden University
2018

Abstract

Cultural Competence to Decrease Advanced Stage Breast Cancer Diagnosis in an

Appalachian Kentucky Population

by

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RN-MSN, Walden University, 2013

ADN, Midway College, 2004

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

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Abstract

Despite American College of Radiology guidelines for breast cancer screening, the Appalachian Kentucky population has an increasing number of advanced stage breast cancer diagnoses related to a delay in mammogram screening initiation. A potential contributing factor for the delay in screenings is a lack of culturally competent care to support the need for early detection of breast cancer in the identified population. The purpose of this staff education project was to improve the knowledge base and skill set of health care employees concerning the most advantageous practice to increase cultural competence in the health care setting. A practice-focused question related to cultural competence through staff education as well as current research served as the foundation for this evidence-based project. Leininger's cultural care theory, Knowles's adult learning theory, and Kirkpatrick's 4 levels of training evaluation provided guidance for the project. Using the cultural competency checklist of 20 questions, the pre- and posttest responses of participants ($n = 14$) in the employee orientation setting were assessed to determine the outcomes of the staff education project. Statistical analyses were performed using a 2-sample proportion hypothesis test for each result, positive and negative responses, and a mean hypothesis test on weighted responses. In each statistical analysis, a significance level of .05 (5%) was reported. As a result of the statistical outcomes, permanent implementation of a staff education program to increase cultural competence, create social change through cultural awareness, and aid in decreasing advanced stage breast cancer diagnoses in the Appalachian Kentucky population was recommended.

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Dedication

Throughout my entire life there have been two individuals that have provided support, guidance, and prayer for me on an hourly, daily, and weekly basis. They have encouraged me to pursue my dreams and believed in me regardless of the task at hand. Thank you mom and dad for your constant love and encouragement. I love and respect you both more than you will ever know!

How do you eat an elephant? One bite at a time.....Love, Deb

Acknowledgments

“¹¹ For I know the plans I have for you,” declares the LORD, “plans to prosper you and not to harm you, plans to give you hope and a future. ¹² Then you will call on me and come and pray to me, and I will listen to you. ¹³ You will seek me and find me when you seek me with all your heart.” Jeremiah 29:11-13 New International Version (NIV)

“He says, “Be still, and know that I am God; I will be exalted among the nations, I will be exalted in the earth.” Psalms 46:10 (NIV).

First and foremost, I would like to thank God for His unwavering love and guidance to me throughout my life. I would also like to thank my husband and family for your love, understanding, and support throughout this educational journey. This degree has not been earned alone. Each one of you has had a significant part in completing this task and I am beyond grateful to you all.

A very special thank you to Dr. Burton for understanding my passion for education to aid in reducing breast cancer diagnoses and for guiding me through this project. You have been an invaluable partner throughout DNP project. Professors have the opportunity to mold and shape students. I am thankful that I was privileged to be molded by your compassion and love for the nursing profession. Thank you always.

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Section 1: Nature of Project

Introduction

Determining the cause of advanced stage breast cancer diagnosis involved identifying underlying reasons for avoidance of recommended breast health screening protocols. Breast cancer was identified as the most common type of cancer diagnosed in women and was the second most prevalent cause of cancer related deaths (World Health Organization, 2017). These statistics are known to be greater in the Appalachian Kentucky population where women often forego recommended screenings resulting in advanced disease at the time of diagnosis (Blackley, Behringer, & Zheng, 2012). As such, a health problem related to advanced stage breast cancer in the Appalachian Kentucky population was the foundation for a doctoral project. Although various factors contribute to advanced breast cancer diagnoses, the information found in the following content identified the lack of culturally competent care within the population and supported the need for a staff education program to improve positive patient outcomes and decrease advanced stage breast cancer in the Appalachian Kentucky population.

Problem Statement

The American College of Radiology (ACR) (2015) provided guidelines related to breast cancer screening recommendations for women. The ACR guidelines stated that annual mammograms beginning at the age of 40 was the standard recommendation; however, often times Appalachian Kentucky women do not have the screenings, increasing the risk of delayed detection of breast cancer (Yao, Lengerich, & Hillemeier, 2012). As a result, the Appalachian Kentucky population had a 3.31 times larger rate of

advanced breast cancer diagnoses due to late stage screening initiation (Anderson et al., 2014). Although current research supported the recommendation for annual mammograms, the perceived benefits of screening mammograms in the Appalachian Kentucky population have not increased the adherence to mammogram guidelines (VanDyke & Shell, 2016).

Current breast cancer data related to advanced disease at the time of diagnosis supported the need for improved care in the Appalachian Kentucky population. According to American Cancer Society (ACS, 2016), in 2016, there were approximately 247,000 new breast cancer diagnoses in the United States. Although this statistic reflected a decrease in the general population, the Appalachian Kentucky population had not seen a proportional decline in cases (Yao et al., 2012). To accelerate the decline ratio in advanced stage breast cancer diagnoses, the Appalachian Kentucky population was in need of culturally competent care to increase public awareness, provide educational resources, and offer a greater availability of mammography services (Vyas et al., 2011).

Considering the needs of the Appalachian Kentucky population, a gap in nursing practice existed concerning a lack of culturally competent care to support the need for early detection of breast cancer through mammogram screenings and decrease morbidity and mortality rates due to advanced stage breast cancer diagnoses. The identified population traveled a minimum of 1 hour from a predominant Appalachian Kentucky culture to a different culture to receive care. As a result, the afore-mentioned gap in nursing practice was the focus of this evidence-based practice (EBP) project. Identifying a way to reduce the gap and improve the provision of culturally competent care had the

potential to improve the overall wellbeing of individuals. Leininger's culture care theory discussed the importance of providing culturally competent care to improve patient outcomes in people of similar and varying backgrounds (Leininger & McFarland, 2010). Use of Leininger's theory served as a foundation to reach the long-term goal of developing a staff education program to improve culturally competent care in the health care setting.

In the culture care theory, Leininger (2010) identified the act of caring as an important aspect of nursing (Leininger & McFarland, 2010). During the span of a nursing career, Leininger (2010) determined that without cultural knowledge influencing the care provided to patients, an important aspect of the care that supported healing, compliance, and wellness was missing. As a result, Leininger developed a theory with a focus on providing culturally competent care that was significant and meaningful for individuals from similar cultures as well as from various backgrounds (Leininger & McFarland, 2010). Leininger suggested that culturally competent care occurred when nurses and patients worked as a team to develop actions and goals that resulted in positive outcomes and were most beneficial for the patient. Use of Leininger's theory in the development of a staff education program for the Appalachian Kentucky population provided a basis to establish a trusting relationship between the identified population and health care provider resulting in improved patient outcomes.

Purpose Statement

The purpose of the DNP staff education program was to improve the knowledge base and skill set of clinical and non-clinical employees in the outpatient health care

setting concerning the most advantageous practice to increase cultural competence in the health care setting. Although there was not a specified model to address the development of a staff education program of this nature, Knowles' Adult Learning theory served as a framework to determine effectiveness of the program for adult learners (Knowles, 1984). In addition, Kirkpatrick's four levels of training evaluation (2016) provided ongoing evaluation throughout the program development process, demonstrating the outcomes in relation to the stated objectives of the program, particularly concerning the influence on social change. Finally, the cultural competence self-assessment checklist developed by the Central Vancouver Island Multicultural Society (Colorado Initiative, 2015) served as a tool to assess individual skills, self-knowledge, and awareness regarding personal interactions with patients, staff, and other employees. The inclusion of key stakeholders in the development, implementation, and evaluation processes was an integral part of the program. Each aspect of the program revolved around answering an EBP question specific to the needs of the identified population.

The inclusion of an EBP question related to decreasing advanced stage breast cancer morbidity and mortality rates in the identified population was: Can a staff educational program influence knowledge and self-perception of the ability to improve culturally competent care and ultimately decrease the number of advanced stage breast cancer deaths in the Appalachian Kentucky population? The practice-focused question was the foundation of a doctoral project aligning with the staff education manual (Walden University, 2017). The long-term goal of the program was to utilize culturally competent care to identify the best method to ensure adherence to the ACR mammogram

recommendations, increase the detection of early breast cancers, and decrease morbidity and mortality rates in the Appalachian Kentucky population. Accomplishing this goal requires ongoing staff education in culturally competent care of the Appalachian Kentucky patients.

Providing culturally competent care to the Appalachian Kentucky population involved understanding the thoughts and beliefs of the population. Leach, Schoenberg, and Hatcher (2011) pointed out that trust in individuals outside of the Appalachian Kentucky population was a deterrent to receiving appropriate breast screenings; therefore, using culturally competent health care providers was critical to address needs of the patients. As a result, a staff education project to increase cultural competency related to the Appalachian Kentucky population was of significant importance to increase timely mammogram screenings and decrease advanced stage breast cancer diagnoses. As a DNP-prepared nurse, identifying methods for improvement in healthcare, such as an educational enhancement program for identified populations, was critical in progressing future initiatives in nursing and health care and aided in identifying the nature of the doctoral project.

Nature of Doctoral Project

The DNP project was a staff education program related to improving cultural competency in the healthcare setting. The program was multidisciplinary in nature, included member stakeholders to ensure optimal participant benefits, and had the potential for permanent implementation into the orientation process of all newly hired employees. The program development centered on a need within a health care

organization with the goal of improving patient care outcomes. As such, a needs assessment conducted by a team of member stakeholders including the senior director of operations, assistant director of human resources, and manager of new employee orientation identified a need to improve cultural competence in the health care setting. According to Kettner et al. (2017), performing a needs assessment provided the ability to match the identified need with a service to meet the need.

The needs assessment revealed that Appalachian Kentucky patients seen at various locations of the organization often traveled approximately one hour to obtain health care such as screening mammograms (P. Hicks, personal communication, May, 30, 2018). This finding was critical as data provided by the CDC (2016) reported an elevated rate of breast cancer diagnoses in the Appalachian Kentucky population. Although the potential challenges such as inadequate resources both personally and within the community could deter in the Appalachian Kentucky population from having mammograms (Schoenberg, Kruger, Bardach, & Howell, 2013), a need within the organization was identified related to improving cultural competency to reduce advanced stage breast cancer diagnoses in the recognized population. As such, identifying the cause of advanced stage breast cancer diagnoses in the Appalachian Kentucky population involved examining accessible healthcare, education, and values of the people.

Use of Leininger's cultural care theory to assess the needs of the population was a critical component of this aspect of the program (Leininger & McFarland, 2010). Leininger posited that three modes of care known as preservation, accommodation, and repatterning guide nurses in the provision of care (Leininger & McFarland, 2010). These

aforementioned modes influence the ability of nurses to provide culturally competent care and foster cultural competency in nurses themselves. In addition to the needs assessment, other critical aspects of the staff education program process were to develop a practice-focused question, involve stakeholders, and create goals within the organization.

Including organizational stakeholder members in the development of goals and objectives was a critical part of program development. Hodges and Videto (2011) stated that involving stakeholder members in the decision making process was imperative as these individuals experience the effects of the proposed goals, plans, objectives, and outcomes of the program. The member team to guide my project was composed of the senior director of operations, assistant director of human resources, and the manager of new employee orientation. Although personal involvement on the team was inevitable, the team was responsible for ensuring the program was initiated, implemented, and utilized in the future. According to Hodges and Videto (2011), this inclusion should encompass initial discussions of assessment, planning, and organization. Kettner, Moroney, and Martin (2017) added that the development of goals must focus on identifying what was causing the problem, what needed to be done to address the problem, and how to accomplish the task with the greatest success. Each of these aspects required the incorporation of evidence-based literature and addressed the initial identified need during the planning and developing stages of the staff education program.

Following the development of the practice-focused question, discussion with team members concerning the needs of the organization as well as the program goals was

necessary. The contents of this discussion set the foundation for attaining a commitment of support from the leadership within the organization and provided the opportunity to develop learning objectives. Additionally, development of the program involved identification of necessary methods and theories to support the utilization of previously developed, tested, and validated educational materials. For this DNP staff education program, Knowles's Adult Learning Theory served as the primary theoretical model for the planning and development process (Knowles, 1984).

Verification of the program with organizational leaders and end-users involved utilization of a questionnaire. The team members assumed responsibility for the questionnaire, located in Appendix A, in a team meeting in which guidance was given based on the questions according to Kirkpatrick's four levels of training evaluation criteria (2016). Revisions to the program occurred based on the results of the questionnaire. Following the necessary revisions, a presentation to the staff of the staff education program provided the opportunity for discussion and validation of the usability of the program. Finalization of the educational program, including an additional questionnaire review, occurred prior to seeking institutional review board approval through Walden University and the organization. Leaders within the organization provided feedback regarding the use of the staff education program. Once approved, a project team comprised of key stakeholders implemented the program during the new employee orientation training process.

Following the delivery of the educational program, an evaluation using Kirkpatrick's Four Levels of Training Evaluation (Kirkpatrick & Kirkpatrick, 2016),

located in Appendix C, was used to determine the effectiveness of the program.

According to Kirkpatrick (2016), the value of the training program was identified using the four model levels known as reaction, learning, behavior, and results. Each level of the model measured the degree to which the identified component was achieved. The model was used before program implementation, during the program, and after the program training was complete (Kirkpatrick & Kirkpatrick, 2016). This evaluation process helped to maximize the value of the training as well as demonstrated the results of the program.

Using Kirkpatrick's model (2016), the evaluation process involved having the participants complete a paper-based questionnaire. The purpose of the questionnaire was to assess the amount of learning obtained from the program. Analysis of the evaluation results determined the effectiveness of the program. The analysis process occurred through interpretation of the results in relation to the applicability of the staff education program within the organization.

Procedures to assure the integrity of the evidence included entering the data from the paper-based form into a computerized format utilizing double data entry to ensure accuracy of the manually entered information. Gliklich, Dreyer, and Leavy (2014) pointed out that entering data manually could result in unforeseen error; therefore, the utilization of double data entry provided an assurance of correct information for the project. Prior to input of the data, a review for the completeness and accuracy occurred. These steps in the analysis process assisted in answering the practice-focused question of can a staff educational program influence knowledge and self-perception of the ability to provide culturally competent care to decrease advanced stage breast cancer. Although the

initial evaluation was a part of the staff educational program, team members will continue the evaluation process 6 months following the program implementation and again at the 1 and 2 year marks.

Communicating the results of the project to the organizational leaders also included recommendations for project implementation within the new employee orientation process. Information was given in a presentation and included a synthesis of the findings and recommendations. Utilization of data obtained through the project was presented to support the need for the staff education program on a permanent basis. Following completion, the findings were presented as final DNP project. Ultimately, my purpose in the project was to address the gap in nursing practice related to a lack of culturally competent care in the Appalachian Kentucky population through the implementation of a specific and significant staff education program.

Significance of Project

Various health issues are prevalent throughout the country today. Healthy People 2020 (U.S. Department of Health and Human Services, 2010) identified high priority national health issues as well as goals to address the problems. These goals and specific objectives for each issue focus on improving health outcomes in the national population. One issue identified in Healthy People 2020 was breast cancer (Health and Human Services, 2010). Of particular interest for the DNP staff education program was breast cancer in the Appalachian Kentucky population.

The population health problem of breast cancer was expected to result in approximately 317,000 newly diagnosed breast cancer cases in 2017 (American Cancer

Society [ACS], 2017). According to the Centers for Disease Control and Prevention (CDC), regardless of ethnicity or race, breast cancer was noted as the second most common type of cancer found in women (CDC, 2016). In addition, statistics reported by the CDC (2016) stated that in 2013 there were 230,815 newly diagnosed breast cancers in the female population. Considering these staggering statistics, breast cancer was recognized as a significant health problem by the Office of Disease Prevention and Health Promotion (ODPHP, 2011), the U.S. Preventive Services Task Force (USPSTF, 2016), the American Cancer Society (ACS, 2017), and the ACR (2015).

The Appalachian Kentucky population was of particular concern in relation to advanced stage breast cancer diagnoses. Identifying the cause of advanced stage breast cancer in the Appalachian Kentucky population involved examining accessible healthcare, education, and values of the people. Fleming, Love, and Bennett (2011) pointed out that women in rural Appalachia Kentucky were more likely to focus on family and day to day living than the personal healthcare needs addressed through recommended screenings. As a result, Appalachian Kentucky women reported a 10% increased cancer mortality rate related to advanced breast cancer diagnoses compared to other populations (Blackley et al., 2012). These statistics supported the need for a staff education program that included stakeholders in the program development and implementation process to insure success of the program and improve culturally competent care.

Development of the DNP multidisciplinary staff education project involved employees from across the organization. According to Kettner et al. (2017), the

involvement of stakeholders in the design process was critical to the outcome of the project. Analyzation of the factors for facilitation included representatives from human resources, corporate compliance, new employee orientation, and departmental managers and directors. These representatives had the potential to positively impact the health problem of advanced stage breast cancer by aiding in the implementation of a staff education program to increase culturally competent care. As a result, the potential for transferability of positive outcomes in other healthcare settings through staff educational programs was a possibility. These results then had the potential for recognition across the country resulting in positive global social change.

Summary

Decreasing advanced stage breast cancer diagnoses in the Appalachian Kentucky population required identifying the cause of the problem and determining the most advantageous method to address the issue. The previously stated information supported the need for an evidence-based doctoral project to increase culturally competent care for the purpose of decreasing advanced stage breast cancer diagnoses. Implementing an evidence-based program to address the identified needs of the population had the potential to improve morbidity and mortality rates in the Appalachian Kentucky population. The information contained thus far provided insight into the need for the models, theories, and concepts necessary to support the relevance of the DNP program.

Section 2: Background and Context

Introduction

The ACR (2015) provided guidelines related to breast cancer screening recommendations for women; however, Appalachian Kentucky women often forego the screenings, increasing the risk of delayed detection of breast cancer (Yao et al., 2012). As a result, the Appalachian Kentucky population had an increased number of advanced-stage breast cancer diagnoses (Anderson et al., 2014). Considering the needs of the Appalachian Kentucky population, a gap in nursing practice existed concerning a lack of culturally competent care to decrease morbidity and mortality rates due to advanced stage breast cancer diagnoses. The following information contains evidence such as concepts, models, and theories to support the need for a staff education DNP program to increase culturally competent care.

Concepts, Models, and Theories

Determining the most advantageous theory to use during program planning and development involved detecting and examining a problem as well as the target population affected by the problem. Hodges and Videto (2011) pointed out that identifying an appropriate theory was critical to the success of a program. In the target population of Appalachian Kentucky women where advanced stage breast cancer was prevalent, the concern for culturally competent care to aid in decreasing the disease was significant (Blackley et al., 2012). According to Fleming et al. (2011), knowledge barriers and attitudes demonstrating a minor concern for screening protocols influence the compliance of women in the Appalachian Kentucky population and can result in the identification of

breast cancers at a more advanced stage. As a result, the need for evidence-based theories and models to improve patient outcomes was imperative to the overall health of the identified population.

The use of evidence-based models in the health care setting provided guidelines for practice and a framework for program development and implementation. The primary theoretical model for the planned staff education program related to increasing culturally competent care was Knowles' adult learning theory (Knowles, 1984). Knowles, known as an American educator, developed five assumptions regarding the traits of adult learners that included self-concept, adult learner experience, readiness to learn, orientation to learning, and motivation to learn. In addition, Knowles (1984) posited that there were four principals applicable to adult learning: learning is centered on problems rather than content, past experiences form a basis for learning, adults need to be a part of the planning and evaluation process, and adults like to learn about subjects that have personal relevancy. Use of the Knowles' theory served as a basis for the staff education program in the health care setting and assisted in providing understanding of the adult learner while helping to improve outcomes related to decreasing the number of advanced breast cancer diagnoses in Appalachian Kentucky women.

In addition to Knowles's theory, Leininger's Culture Care Theory provided guidance throughout the program (Leininger & McFarland, 2010). The culture care theory focused on the importance of caring in the nursing profession. Leininger developed a model centered on care which assumed that caring was the fundamental nature of nursing and was a critical component of overall health. In the culture care

theory, Leininger posited that without caring, curing does not occur. Leininger stated that culturally competent care only occurred when the values of a population were known and utilized by healthcare professionals to improve outcomes of the identified population. According to Leininger, culturally competent care supported and enabled patients to achieve a positive wellbeing through behaviors that were meaningful to the cultural. This concept was important in developing a staff education program that focused on the Appalachian Kentucky population, which was known to have tendencies to avoid care from individuals with different cultural backgrounds (Fleming et al., 2011).

Selection of the theories developed by Leininger and Knowles reflected the understanding that there was a direct correlation between learning and caring, and the level at which individuals could provide culturally appropriate care (Leininger & McFarland, 2010; Knowles, 1984). Leininger (2010) pointed out that care provided to a specific population required nurses to know and understand cultural factors of the identified population and provide care according to the identified views. Leininger's theory further stated that individuals receiving care that was not harmonious with his or her personal beliefs could result in cultural conflicts, stress, and noncompliance. As such, the aforementioned theories served as a guide throughout the project and aided in identifying the relevancy of the program in nursing practice.

Relevance to Nursing Practice

Nurses providing care at the DNP level have the capability of identifying characteristics of population health issues, conducting research, and becoming agents of positive social change. Identifying reasons for a lack of culturally competent care in the

Appalachian Kentucky population involved examining accessible healthcare, education, and values of the people. Kettner et al. (2017) pointed out that performing a needs assessment of the previously mentioned factors provided the ability to match the identified need with a service to meet the need. Although this task may seem simple, potential challenges such as inadequate resources both personally and within the community can deter women in the Appalachian Kentucky population from having mammograms (Schoenberg et al., 2013).

An additional challenge pointed out by Fleming et al. (2011) was that women in rural Appalachia Kentucky were more likely to focus on family and day to day living than the personal health care needs addressed through recommended screenings. Of particular concern was the potential cultural barrier that existed between varying populations. This barrier can contribute to a decreased adherence to recommended guidelines for healthcare screenings. As a result, the implementation of a staff education program to address cultural competency in health care providers of women in the Appalachian Kentucky population was warranted.

Local Background and Context

The health issue of breast cancer affects thousands of women annually. Regardless of ethnicity or race, breast cancer was the second most common type of cancer found in women (CDC, 2016). According to statistics reported by the CDC (2016), in 2013 there were 230,815 newly diagnosed breast cancers in the female population. As a population health problem, the need for breast cancer evaluation at the local level can occur by identifying various characteristics associated with the person,

place, and time (Laureate Education, Inc., 2012). The person aspect related to a population that was being affected, which for the purpose of this discussion, focused on women in the Appalachian Kentucky population.

Identifying the place or area of occurrence, as referred to by Friis and Sellers (2014), involved determining the location where the population problem occurred most frequently such as state to state and urban versus rural area comparisons. In newly diagnosed breast cancer cases, the CDC (2016) reported an elevated rate of breast cancer diagnoses in the Appalachian Kentucky population. Identifying the cause of advanced stage breast cancer in the Appalachian Kentucky population involved examining accessible healthcare, education, and values of the people. Although current research supported the recommendation for annual mammograms, the perceived benefits of the screening mammogram in the Appalachian Kentucky population have not increased the adherence to mammogram guidelines (VanDyke & Shell, 2016).

Current breast cancer data related to advanced disease at the time of diagnosis supported the need for improved care in the Appalachian Kentucky population. According to ACS (2016) statistics, the number of late stage breast cancer diagnoses in the Appalachian Kentucky population equaled 34.1%, whereas the percentage of non-Appalachian Kentucky advanced stage breast cancer diagnoses equaled approximately 28.9%. Although this statistic reflected a decrease in the general population of 30.5%, the Appalachian Kentucky population had not seen a proportional decline in cases with only a 17.5% decrease (Yao et al., 2012). To accelerate the decline ratio in advanced stage breast cancer diagnoses, the Appalachian Kentucky population was in need of culturally

competent care to increase public awareness, provide educational resources, and offer a greater availability of mammography resources (Vyas et al., 2011).

The problem identified in the Appalachian Kentucky population was a reflection of evidence supporting the need for culturally competent care. In the identified population, advanced stage breast cancer was prevalent; hence, the concern for health care providers familiar with the cultural norms of the Appalachian Kentucky population to provide culturally competent care was significant (Blackely et al., 2012). To improve outcomes in the identified population, the use of Leininger's theory was beneficial in addressing the problem due to the premise that there was a direct correlation between cultural understanding and the level at which nurses provide culturally appropriate care (Leininger & McFarland, 2010). As a result, an educational program to increase cultural competency was needed.

Role of the DNP Student

The doctoral project took place in the multidisciplinary outpatient health care setting. The clinic provided multidisciplinary care in various locations across the state. For the DNP project, the member team and I were at the main location which housed the corporate compliance, human resources, and new employee orientation departments. The chosen preceptor for the project was the senior director of operations for the clinic and served on numerous boards and committees. Upon contact, the prospective preceptor was supportive and eager to serve in the preceptor capacity for the DNP project.

My personal role in the DNP project was to develop and oversee a doctoral project to increase cultural competency in nursing practice. With the approval of the

member team comprised of the senior director of operations, assistant director of human resources, and the manager of new employee orientation, I developed a staff education program for use at the new employee orientation phase of employment to increase the awareness of the need for cultural competence in the healthcare setting. I was unaware of any participants in the program or clinic setting that I had a relationship with outside of the healthcare setting. As developer of the staff education program, I served as a resource for questions that arose regarding the DNP project.

Helping to decrease the number of Appalachian Kentucky women diagnosed with breast cancer through the implementation of a staff education program was a task that is personal to me. Not only did I realize the need, as is evidenced by research literature, I am a Kentucky resident and a breast cancer survivor. Although my outcome has been positive to date, many women in the Appalachian Kentucky population are not as fortunate as I am. As a result of my diagnosis, I have a heightened awareness of other women that may not have the access to care that I have had. It was my goal to use my past experience, evidence-based literature, and this doctoral project to benefit others in need of culturally competent nursing care.

Role of the Project Team

The project team members had a critical role in the development and implementation of the DNP project. Initially, the team members developed an impact evaluation. The team members assumed responsibility for the pre- and posttest questionnaires based on the cultural competence self-assessment checklist (Colorado Initiative, 2015) and were in control of the project. The project team considered obtaining

a psychometrics on this the cultural competence-self-assessment checklist at a later date. As the DNP student, I oversaw the project; however, the team members were responsible for implementation and ongoing evaluations. Finally, the team members determined the implementation of the project on a permanent basis. As was noted in the previously stated responsibilities, team member participation was of significant importance to the success of the project.

Summary

A DNP project focusing on the decrease of advanced stage breast cancer through culturally competent nursing required the identification of concepts, models, and theories. The understanding of these foundational project aspects provided insight into the relevance of the project as well as the role of the DNP student in project development. Throughout this section of the doctoral proposal, I gained a greater understanding of the intricacies of the final DNP project. I looked forward to discussing the collection and analysis of evidence as I moved forward in the DNP proposal process.

Section 3: Collection and Analysis Evidence

Introduction

Current breast cancer data related to advanced disease at the time of diagnosis supported the need for improved care in the Appalachian Kentucky population. According to statistics provided by the ACS (2017), approximately 317,000 newly diagnosed breast cancer cases occurred in the United States in 2017. Although this statistic reflected a decrease in the general population, the Appalachian Kentucky population did not see a proportional decline in cases (Yao et al., 2012). To decrease the number of advanced stage breast cancer diagnoses, the Appalachian Kentucky population was in need of culturally competent care to increase public awareness, provide educational resources, and offer a greater availability of mammography services (Vyas et al., 2011). The purpose of the this staff education project was to improve the knowledge base and skill set of health care employees concerning the most advantageous practice to increase cultural competence in the health care setting. The following contents include information concerning the collection and analysis of evidence to support the need for a DNP project related to decreasing advanced stage breast cancer through culturally competent nursing.

Practice-Focused Question

The population health problem of breast cancer was expected to result in approximately 41,000 deaths in the United States related to the disease in 2017 (ACS, 2017). This statistic supported the need for eradication of breast cancer through an interdisciplinary approach much like the initiative implemented by Snow to wipe out

smallpox (Centers for Global Development, n.d.). To support breast cancer eradication, the ACR (2015) established guidelines recommending women have annual screening mammograms beginning at the age of 40; however, not all women adhere to the ACR recommendations. This was particularly true in the Appalachian Kentucky population where the number of advanced-staged breast cancer diagnoses was disproportionate to that of other populations (Anderson et al., 2014). Considering the needs of the Appalachian Kentucky population, a gap in nursing practice existed concerning a lack of culturally competent care to support the need for early detection of breast cancer through mammogram screenings and decrease morbidity and mortality rates due to advanced stage breast cancer diagnoses.

The purpose of the DNP staff education program was to improve the knowledge base and skill set of health care employees concerning the most advantageous practice to increase cultural competence in the health care setting. Knowles's adult learning theory (1984) served as a framework to determine effectiveness of the program for adult learners and Kirkpatrick's Four Levels of Training Evaluation (2016) provided ongoing evaluation throughout the program development process, demonstrating the outcomes in relation to the stated objectives of the program, particularly concerning the effect on social change. The inclusion of an EBP question related to decreasing advanced stage breast cancer morbidity and mortality rates in the identified population stated: Can a staff educational program influence knowledge and self-perception of the ability to improve culturally competent care and decrease the number of advanced stage breast cancer deaths in the Appalachian Kentucky population? The long-term goal of the program was

to utilize culturally competent care to identify the best method to ensure adherence to the ACR mammogram recommendations, increase the detection of early breast cancers, and decrease morbidity and mortality rates in the Appalachian Kentucky population. Accomplishing this goal requires ongoing staff education in culturally competent care of the Appalachian Kentucky patients.

Sources of Evidence

Sources of evidence to answer the practice-focused question included a staff education program related to increasing culturally competent care. The multidisciplinary program was a part of the orientation process of new employees in the outpatient healthcare setting. The organization oversaw the educational activities to address the need for a cultural competency in new employee training for the purpose of improving patient care. Additionally, the project required ethical approval from the institutional review board (IRB). The use of pre and post-test, evidence-based literature, and public information served as additional sources of evidence for the program. Appropriate steps for obtaining ethical approval as described in the Walden Manual for Staff Education Project (2017) guided the IRB approval process.

Available data sources for use in gathering information about culturally competent care related to breast cancer included a review of information in bibliographical, organizational, and commercial databases (Friis & Sellers, 2014). These databases included information published by health and government organizations. The CDC (2016) provided statistical data to demonstrate trends in breast cancer cases specifying race, age, and location by state as well as incidence rates of breast cancer

diagnoses and death rates associated with the disease. The ACS (2016) also provided annual statistical data on breast cancer diagnoses and deaths related to the disease. These sources provided complete population coverage, as described by Friis and Sellers (2014), and demonstrated strength in studying breast cancer morbidity and mortality events. The use of each of these resources was beneficial in completing the task of identifying information to support the DNP project and provided a foundation for analysis and synthesis of the information.

Analysis and Synthesis

Analysis of the effectiveness of the staff education project was in the form of a pre and post test in accordance with the levels of evaluation described in the Kirkpatrick's levels of evaluation. The evaluation was in the form of a paper-based pre-test, located in Appendix A. The goal of the pre-test was to evaluate the knowledge of the participant prior to and following the cultural competency project. Batch scores of the pre and post-test provided data for the completion of a test to statistically measure the benefit of the program. Evidence of the effectiveness of the project occurred through the interpretation of results and determination of applicability of the program in the organization to advance social change in the future. To assure the integrity of the evidence, procedures to manage outliers and missing information were taken.

The DNP staff education project implementation occurred in the staff orientation setting. The number of new employees participating in the orientation process at a given time was relatively small, numbering less than ten. Procedures to assure the integrity of the evidence included entering the data from the paper-based form into a computerized

format utilizing double data entry to ensure accuracy of the manually entered information. Gliklich et al. (2014) pointed out that entering data manually can result in unforeseen error; therefore, the utilization of double data entry provided an assurance of correct information for the project. Prior to input of the data, a review for the completeness and accuracy occurred. These steps in the analysis process assisted in answering the practice –focused question: Can a staff educational program influence knowledge and self-perception of the ability to improve culturally competent care and decrease the number of advanced stage breast cancer deaths in the Appalachian Kentucky population?

Communicating the results of the project to the organizational leaders also included recommendations for project implementation within the new employee orientation process. Information was given in a systematic presentation and included a synthesis of the findings and recommendations. Utilization of data obtained through the project was presented to support the need for the staff education program on a permanent basis. Following completion, the findings were presented as final DNP project.

Summary

Developing a DNP staff education project involved identifying a need, developing a plan to address the need and implementing the plan to improve patient outcomes. The staff education project to decrease advanced stage breast cancer in the Appalachian Kentucky population addressed a need and provided a means to aid in the reduction of the disease through cultural competence. Through a greater cultural awareness, nurses and health care providers significantly influence identified populations and truly become

agents of social change. The DNP project provided an opportunity to improve patient outcomes and increase awareness of the need for culturally competent care in the Kentucky Appalachian population.

Section 4: Findings and Implications

Introduction

Breast cancer was the most common type of cancer diagnosed in women and the second most prevalent cause of cancer-related deaths in 2017 (World Health Organization, 2017). Although ACR (2017) guidelines recommended mammograms beginning at the age of 40 years, often Appalachian Kentucky women did not have the screenings, resulting in a 3.31 times more significant rate of advanced breast cancer diagnoses due to late-stage screening initiation (Anderson et al., 2014). Considering the needs of the Appalachian Kentucky population, a gap in nursing practice was identified concerning a lack of culturally competent care to support the need for early detection of breast cancer through mammogram screenings. The purpose of the DNP staff education program was to improve the knowledge base and skill set of clinical and non-clinical employees in the outpatient health care setting concerning the most advantageous practice to increase cultural competence in the health care setting. The inclusion of an EBP question related to decreasing advanced-stage breast cancer morbidity and mortality rates in the identified population stated: Can a staff educational program influence knowledge and self-perception of the ability to improve culturally competent care and ultimately decrease the number of advanced stage breast cancer deaths in the Appalachian Kentucky population? The practice-focused question was the foundation of the doctoral project aligning with the Staff Education Manual (Walden University, 2017).

Sources of evidence used to answer the practice-focused question included a staff education program related to increasing culturally competent care. The multidisciplinary

program was a part of the orientation process of new employees in the outpatient health care setting. The use of pre and posttest, evidence-based literature, and public information served as sources of evidence for the program. Additional data sources for gathering information about culturally competent care related to breast cancer included a review of information in bibliographical, organizational, and commercial databases (Friis & Sellers, 2014). These databases included information published by health and government organizations such as the CDC (2016), which provided statistical data to demonstrate trends in breast cancer cases specifying race, age, and location by state as well as incidence rates of breast cancer diagnoses and death rates associated with the disease. In addition, statistics obtained from the ACS (2016) provided annual statistical data on breast cancer diagnoses and deaths related to the disease resulting in complete population coverage, as described by Friis and Sellers (2014), and demonstrated strength in studying breast cancer morbidity and mortality events.

Findings and Implications

Analysis of the effectiveness of the staff education project occurred through the utilization of a paper-based pre and post-test, located in Appendix A, and in accordance with the levels of evaluation described in the Kirkpatrick's Four Levels of Training Evaluation (2016). The goal of the tests focused on the assessment of participant knowledge prior to and following the cultural competency project. Use of batch scores to statistically measure the benefit of the program obtained from the pre and post-test provided data to complete a *t*-test. Statistical analyses were performed using a 2-sample proportion hypothesis test for each result individually, a 2-sample proportion test on the

positive and negative responses, and a 2-sample mean hypothesis test on weighted responses where answers were weighted 1 through 4. In each of these tests, the null hypothesis (H_0) was that there was no difference between the pre- and posttests. In each statistical analysis, the null hypothesis was rejected with a significance level of .05 (5%). As such, the results identify sufficient evidence to conclude the project improved participant outcomes, particularly when examining the movement from negative to positive answers as well as the overall weighted mean of answers. Interpretation of the results offered evidence of the effectiveness of the project and applicability of the program in the organization to advance social change in the future. To assure the integrity of the evidence, procedures to manage outliers and missing information were taken.

The DNP staff education project took place in the staff orientation setting. Data for the project was collected for a period of 1 month. Double data entry from the paper-based form into a computerized format occurred to assure the integrity of the evidence. Gliklich et al. (2014) pointed out that entering data manually can result in unforeseen error; therefore, the utilization of double data entry provided an assurance of correct information for the project. Prior to input of the data, a review of completeness and accuracy occurred. Each of these steps in the analysis process assisted in answering the practice –focused question: Can a staff educational program influence knowledge and self-perception of the ability to improve culturally competent care and decrease the number of advanced stage breast cancer deaths in the Appalachian Kentucky population?

The findings of the project suggested that the staff education program to improve cultural competence was beneficial and resulted in a reported increase in cultural

competency. Although the anticipated outcome of the project was one of positivity, the final outcome confirmed the affirmative impact staff education can have on cultural competency. The results supported permanent implementation of a cultural competency component in the new orientation process. As a result, the potential to positively impact employees, patients, and the healthcare organization as a whole was evident.

The findings of the project supported the implementation of a staff education program to increase cultural competency; however, the number of participants was less than initially thought. Initially, the projection of participants numbered between 25 and 30. The actual number of participants totaled 14, less than half the anticipated amount. This decreased number could have had an impact on the findings and outcomes of the project as a higher sample number could have resulted in a greater or lesser significance. Additionally, the pre and post-test surveys were given as an anonymous survey in the new employee setting. Considering the possibility of new employees desiring to portray values reflective of cultural competency at the time of hire to a new employer, results might have been different if the program occurred as a part of other required annual computerized training in which employees print a certificate of completion. Annual completion of the program would require the answers given by employees remain anonymous as was initially stated in the DNP employee staff education project criteria.

The project findings revealed the potential to affect individuals, communities, institutions, and health care systems. Findings of the project suggested that individuals of various cultural backgrounds benefit from employees possessing a greater sense of cultural competency as discussed by Leininger (2010). This positive finding could be

translated to affect communities, institutions, and whole health care systems. The outcomes of the program suggested that providing patient-centered care through cultural awareness and sensitivity had the potential to improve positive patient outcomes and increase the overall health of varying populations.

The positive change related to the staff education project also has implications for positive social change. According to the CDC (2016), regardless of ethnicity or race, breast cancer was the second most common type of cancer found in women. Considering these staggering statistics, breast cancer was recognized as a significant health problem by the ODPHP (2011), the USPSTF (2016), the ACS (2017), and the ACR (2015). The Appalachian Kentucky population was of particular concern in relation to advanced stage breast cancer diagnoses. Identifying the cause of advanced stage breast cancer in the Appalachian Kentucky population involved examining accessible health care, education, and values of the people. Fleming et al. (2011) pointed out that women in rural Appalachia Kentucky were more likely to focus on family and day to day living than the personal healthcare needs. The results of the DNP project supported the need for a staff education program to create positive social change in the Appalachian Kentucky population.

Recommendations

The statistically significant results of the staff education project supported a recommendation for permanent implementation of the program in the outpatient new employee orientation healthcare setting. A basis for the practice guidelines to direct the implementation of the program was found in the *Guidelines for Implementing Culturally*

Competent Nursing Care (Douglas et al., 2014). Douglas et al. (2014) posited that nurses should have an understanding of different cultures, possess an educational preparedness of various cultural beliefs and traditions, implement culturally competent care through communication skills, and provide evidence-based care founded on tested and proven research. Implementation of the program utilizing criteria discussed by Douglas et al. (2014) revealed the potential to address the gap in nursing practice and improve patient outcomes in the Appalachian Kentucky population. The guidelines discussed by Douglas et al. (2014) are applicable universally and can serve as a resource for multidisciplinary practice; however, use of the guidelines does not supersede legal requirements or ethical codes in nursing practice as designated by nursing governing bodies.

Implementation of the staff education program should continue to be in the new employee orientation setting. This setting allowed a pre and post-test of individuals entering the work setting. The development phase of the project has been completed. As such, the furtherance of the program should not require additional planning for administrative personnel.

Contribution of the Doctoral Project Team

The project team members were a critical component in the development and implementation of the DNP project. Multidisciplinary team members provided invaluable insight into the inner workings of the project site and worked cohesively to ensure the project occurred on schedule and on time. Although the oversight of the project was a personal responsibility, the team members were responsible for the pre and post-test questionnaires based on the Cultural Competence Self-assessment Checklist (Colorado

Initiative, 2015). The project team was responsible for obtaining psychometrics on the Cultural Competence-Self-assessment Checklist and assumption of responsibility for permanent implementation and ongoing evaluations. As such, the team member participation was of vital importance to the success of the project and permanent implementation.

Strengths and Limitations of the Project

The purpose of the DNP staff education program was to improve the knowledge base and skill set of clinical and non-clinical employees in the outpatient health care setting concerning the most advantageous practice to increase cultural competence in the health care setting. The strengths of the project included the evidence-based research to support a staff education project as well as the multidisciplinary team approach and support of the outpatient health care organization in developing and implementing the final product. Additionally, the validation of statistical significance through data analysis revealed the importance of staff education in the new employee orientation setting. Conversely, the low number of participants and awareness that a more significant amount could have revealed a different outcome signified a weakness of the project. Additionally, conducting the project in a setting where new employees may strive to represent positive personal values of cultural competence rather than actual values could have been detrimental to the outcomes resulting in skewed statistical data. Finally, the time constraints of the DNP project completion was a factor in the number of participants included in the study.

To address the possible limitations, implementation of the permanent program at the end of the new employee probationary self-evaluation period may provide a greater understanding of the actual cultural values of the employee. Additionally, gathering data at the end of probation could also increase the number of participants. Time constraints of the DNP project did not allow for data collection further than one month of time. As such, allowing a greater amount of time would include a greater number of participants and add to the statistical data for interpretation.

Recommendations for future projects similar in nature include research to determine the likelihood of skewed data resulting from time constraints prior to project implementation. Additionally, the identification of the number of participants prior to project initiation to ensure the total amount is representative of the population. Finally, utilization of experienced gained from the initial DNP project design, development, implementation, and analysis processes provided an invaluable resource for further projects. Addressing each of these limitations has the potential to strengthen future projects and achieve the intended goal successfully.

Section 5: Dissemination Plan

Following completion of the DNP project, plans for project dissemination included communication of the project results to the organizational leaders. This information also included recommendations for a cultural competency program implementation process within the new employee orientation process. Information was given in a presentation and included a synthesis of the findings and recommendations. Utilization of data obtained through the project was presented to support the need for the staff education program on a permanent basis. Ultimately, the purpose of the dissemination plan was to address the lack of culturally competent care in the outpatient healthcare setting through the implementation of the specific and significant staff education program developed for the organization.

The staff education project identified the potential for dissemination to additional new employee orientation audiences such as inpatient health care organizations, ambulatory care facilities, and in the educational setting. The primary theoretical model for the staff education project was related to increasing culturally competent care through Knowles's Adult learning theory (Knowles, 1984). Knowles (1984) posited that there are four principals applicable to adult learning: learning is centered on problems rather than content, past experiences form a basis for learning, adults need to be a part of the planning and evaluation process, and adults like to learn about subjects that have personal relevancy. Utilization of the Knowles' theory as a basis for the staff education program in various settings provides an understanding of the adult learner while helping to improve outcomes.

In addition to Knowles's theory, Leininger's Culture Care Theory (Leininger & McFarland, 2010) provided guidance and insight into the importance of caring. In the Culture Care Theory, Leininger posited that without caring, curing does not occur (Leininger & McFarland, 2010). Leininger stated that culturally competent care only happens when the values of a population are known and utilized by health care professionals to improve outcomes of the identified population. Selection of the theories developed by Leininger and Knowles reflected the understanding that there is a direct correlation between learning and caring, and the level at which individuals can provide culturally appropriate care (Leininger & McFarland, 2010; Knowles, 1984). Leininger (2010) pointed out that care provided to a specific population requires individuals to know and understand the cultural factors of the identified population and provide care according to the identified views. As such, the theoretical foundation of the staff education project was transferable to various settings in which the goal is to improve the overall cultural competency of healthcare providers.

Analysis of Self

Throughout the DNP educational program, I have seen significant growth as a practitioner and scholar. The initial introduction into the program was somewhat overwhelming as I realized the scope and depth of the study that lay ahead. With the progression of each class, I soon began to develop a greater capacity to delve deeper into the foundational concept of EBP and the significance it has on patient care, advancement of the nursing profession, and scholarly research. As a result of the completion of the

DNP curriculum, I have a greater understanding and confidence in my ability to practice at an advanced level.

Continual focus on project design, development, implementation, and dissemination has been a focus throughout each class. The practicum project learning experience has been an invaluable tool to prepare for future project endeavors in the healthcare setting. Each practicum experience has served as a building block for project development and equipped me with the ability to lead projects in the future using the insight gained through the development of the DNP project. Notably, the ability to detect, assess, and analyze areas of concern prior to project initiation. The DNP project process enabled me to visualize healthcare issues from a new perspective and opened my eyes to the various complexities and layers of successful project implementation. As a result, I am a stronger scholar, leader, and practitioner.

I currently work in the healthcare setting in a supervisory position. Although my goal is to continue to advance in leadership and management within a healthcare organization, upon graduation, I will seek to obtain employment as an online nursing educator. My longtime goal is to become a nursing instructor at the MSN or DNP level. From a personal perspective, equipping others to carry on the critical task of providing evidence-based, patient-centered care is crucial to the advancement of the nursing profession. I will also seek to become a member, obtain certification, and serve as a leader in the Transcultural Nursing Society.

Completion of the DNP project and program have required numerous hours of study, research, and endurance. Throughout the project, challenges such as a change in

the availability of the initial preceptor and need to find someone with the credentials and willingness to provide guidance to students was critical. Additionally, IRB approval of the project to initiate data collection was a painstaking and timely task. Completion of the project within a limited timeframe to avoid delay in progression of completing the DNP program also increased the challenges of the project. Finally, attempting to maintain a work-life-school balance seemed at times nearly impossible; however, in hindsight, the challenges proved to aid in further personal development as an individual, scholar, and leader.

Summary

The DNP project and program have been an incredible journey. Completing a project focused on staff education to improve knowledge and self-perception of the ability to improve culturally competent care and ultimately decrease the number of advanced stage breast cancer deaths in the Appalachian Kentucky population has been an endeavor that resulted in statistically significant results and positive outcomes. I am incredibly humbled and grateful for the opportunity to address this educational need and look forward to the positive impact I can make as an agent of change in the future. Now begins the time to implement the knowledge gained throughout the DNP educational journey and impart this information to others. Carpe Diem!

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**Cultural Competence
Self-assessment Checklist**

Central Vancouver Island Multicultural Society



Cultural Competence Self-assessment Checklist

This self-assessment tool is designed to explore individual cultural competence. Its purpose is to help you to consider your skills, knowledge, and awareness of yourself in your interactions with others. Its goal is to assist you to recognize what you can do to become more effective in working and living in a diverse environment.

The term ‘culture’ includes not only culture related to race, ethnicity and ancestry, but also the culture (e.g. beliefs, common experiences and ways of being in the world) shared by people with characteristics in common, such as people with disabilities, people who are Lesbian Bisexual, Gay and Transgender (LGBT), people who are deaf, members of faith and spiritual communities, people of various socioeconomic classes, etc.) In this tool, we are focusing on race, ethnicity and ancestry. However, remember that much of the awareness, knowledge and skills which you have gained from past relationships with people who are different from you are transferable and can help you in your future relationships across difference.

Read each entry in the Awareness, Knowledge and Skills sections Place a check mark in the appropriate column which follows. At the end of each section add up the number of times you have checked that column. Multiple the number of times you have checked “Never” by 1, “Sometimes/Occasionally” by 2, “Fairly Often/Pretty well” by 3 and “Always/Very Well” by 4. The more points you have, the more culturally competent you are becoming.

This is simply a tool. This is not a test. The rating scale is there to help you identify areas of strength and areas that need further development in order to help you reach your goal of cultural competence. Remember that cultural competence is a process, and that learning occurs on a continuum and over a life time. You will not be asked to show anyone your answers unless you choose to do so.

While you complete this assessment, stay in touch with your emotions and remind yourself that learning is a journey.

Awareness		Never	Sometimes/ occasionally	Fairly Often/Pret ty Well	Always/ve ry well
Value Diversity	I view human difference as positive and a cause for celebration				
Know myself	I have a clear sense of my own ethnic, cultural and racial identity				

Share my culture	I am aware that in order to learn more about others I need to understand and be prepared to share my own culture				
Be aware of areas of discomfort	I am aware of my discomfort when I encounter differences in race, colour, religion, sexual orientation, language, and ethnicity.				
Check my assumptions	I am aware of the assumptions that I hold about people of cultures different from my own.				
Challenge my stereotypes	I am aware of my stereotypes as they arise and have developed personal strategies for reducing the harm they cause.				
Reflect on how my culture informs my judgement	I am aware of how my cultural perspective influences my judgement about what are 'appropriate', 'normal', or 'superior' behaviours, values, and communication styles.				
Accept ambiguity	I accept that in cross cultural situations there can be uncertainty and that uncertainty can make me anxious. It can also mean that I do not respond quickly and take the time needed to get more information.				
Be curious	I take any opportunity				

	to put myself in places where I can learn about difference and create relationships				
Aware of my privilege if I am White	If I am a White person working with an Aboriginal person or Person of Colour, I understand that I will likely be perceived as a person with power and racial privilege, and that I may not be seen as 'unbiased' or as an ally.				
		1 pt x	2 pt x	3 pt x	4 pt x

Knowledge					
Gain from my mistakes	I will make mistakes and will learn from them				
Assess the limits of my knowledge	I will recognize that my knowledge of certain cultural groups is limited and commit to creating opportunities to learn more				
Ask questions	I will really listen to the answers before asking another question				
Acknowledge the importance of difference	I know that differences in colour, culture, ethnicity etc. are important parts of an individual's identity which they value and so do I. I will not hide behind the claim of "colour blindness".				

Know the historical experiences of non-European Canadians	I am knowledgeable about historical incidents in Canada's past that demonstrate racism and exclusion towards Canadians of non-European heritage (e.g. the Chinese Head Tax, the Komagata Maru, Indian Act and Japanese internment).				
Understand the influence culture can have	I recognize that cultures change over time and can vary from person to person, as does attachment to culture				
Commit to lifelong learning	I recognize that achieving cultural competence involves a commitment to learning over a life-time				
Understand the impact of racism, sexism, homophobia . . .	I recognize that stereotypical attitudes and discriminatory actions can dehumanize, even encourage violence against individuals because of their				
	membership in groups which are different from myself				
Know my own family history	I know my family's story of immigration and assimilation into Canada				
Know my limitations	I continue to develop my capacity for assessing areas where there are gaps my knowledge				
		1 pt x	2 pt x	3 pt x	4 pt x

Skills					
Adapt to different situations	I am developing ways to interact respectfully and effectively with individuals and groups				
Challenge discriminatory and/or racist behaviour	I can effectively intervene when I observe others behaving in racist and/or discriminatory manner.				
Communicate across cultures	I am able to adapt my communication style to effectively communicate with people who communicate in ways that are different from my own.				
Seek out situations to expand my skills	I seek out people who challenge me to maintain and increase the cross-cultural skills I have.				
Become engaged	I am actively involved in initiatives, small or big, that promote understanding among members of diverse groups.				
Act respectfully in cross-cultural situations	I can act in ways that demonstrate respect for the culture and beliefs of others.				
Practice cultural protocols	I am learning about and put into practice the specific cultural protocols and practices which necessary for my work.				

Act as an ally	My colleagues who are Aboriginal, immigrants or People of Colour consider me an ally and know that I will support them with culturally appropriate ways.				
Be flexible	I work hard to understand the perspectives of others and consult with my diverse colleagues				
	about culturally respectful and appropriate courses of action.				
Be adaptive	I know and use a variety of relationship building skills to create connections with people who are different from me.				
		1 pt x	2 pt x	3 pt x	4 pt x

Appendix B: Kirkpatrick's Four Levels of Training Evaluation

Kirkpatrick's Four Levels of Training Evaluation in Detail

This grid illustrates the Kirkpatrick's structure detail, and particularly the modern-day interpretation of the Kirkpatrick learning evaluation model, usage, implications, and examples of tools and methods. This diagram is the same format as the one above but with more detail and explanation:

EVALUATION TYPE	EVALUATION DESCRIPTION AND CHARACTERISTICS	EXAMPLES OF EVALUATION TOOLS AND METHODS	RELEVANCE AND PRACTICABILITY
LEVEL 1 REACTION	<ul style="list-style-type: none"> ▪ reaction evaluation is how the delegates felt, and their personal reactions to the training or learning experience, for example: <ul style="list-style-type: none"> ▪ did the trainees like and enjoy the training? ▪ did they consider the training relevant? ▪ was it a good use of their time? ▪ did they like the venue, the style, timing, domestics, etc? ▪ level of participation ▪ ease and comfort of experience ▪ level of effort required to make the most of the learning ▪ perceived practicability and potential for applying 	<ul style="list-style-type: none"> ▪ typically 'happy sheets' ▪ feedback forms based on subjective personal reaction to the training experience ▪ verbal reaction which can be noted and analyzed ▪ post-training surveys or questionnaires ▪ online evaluation or grading by delegates ▪ subsequent verbal or written reports given by delegates to managers back at their jobs 	<ul style="list-style-type: none"> ▪ can be done immediately the training ends ▪ very easy to obtain reaction feedback ▪ feedback is not expensive to gather or to analyze for groups ▪ important to know that people were not upset or disappointed ▪ important that people give a positive impression when relating their experience to others who might be deciding whether to experience same

	the learning		
LEVEL 2 LEARNING	<ul style="list-style-type: none"> ▪ learning evaluation is the measurement of the increase in knowledge or intellectual capability from before to after the learning experience: <ul style="list-style-type: none"> ▪ did the trainees learn what intended to be taught? ▪ did the trainee experience what was intended for them to experience? ▪ what is the extent of advancement or change in the trainees after the training, in the direction or area that was intended? 	<ul style="list-style-type: none"> ▪ typically assessments or tests before and after the training <ul style="list-style-type: none"> ▪ interview or observation can be used before and after although this is time-consuming and can be inconsistent ▪ methods of assessment need to be closely related to the aims of the learning ▪ measurement and analysis is possible and easy on a group scale ▪ reliable, clear scoring and measurements need to be established, so as to limit the risk of inconsistent assessment ▪ hard-copy, 	<ul style="list-style-type: none"> ▪ relatively simple to set up, but more investment and thought required than reaction evaluation <ul style="list-style-type: none"> ▪ highly relevant and clear-cut for certain training such as <ul style="list-style-type: none"> quantifiable or technical skills ▪ less easy for more complex learning such as attitudinal development, which is famously difficult to assess ▪ cost escalates if systems are poorly designed, which increases work required to measure and analyze

		electronic, online or interview style assessments are all possible ▪	
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EVALUATION TYPE	EVALUATION DESCRIPTION AND CHARACTERISTICS	EXAMPLES OF EVALUATION TOOLS AND METHODS	RELEVANCE AND PRACTICABILITY
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<p>LEVEL 3 BEHAVIOR</p>	<ul style="list-style-type: none"> ▪ behavior evaluation is the extent to which the trainees applied the learning and changed their behavior, and this can be immediately and several months after the training, depending on the situation: <ul style="list-style-type: none"> ▪ did the trainees put their learning into effect when back on the job? ▪ were the relevant skills and knowledge used ▪ was there noticeable and measurable change in the activity and performance of the trainees when back in their roles? ▪ was the change in behavior and new level of knowledge sustained? ▪ would the trainee be able to transfer their learning to another person? <p>is the trainee aware of their change in behavior, knowledge, skill level?</p>	<ul style="list-style-type: none"> ▪ observation and interview over time are required to assess change, relevance of change, and sustainability of change ▪ arbitrary snapshot assessments are not reliable because people change in different ways at different times ▪ assessments need to be subtle and ongoing, and then transferred to a suitable analysis tool ▪ assessments need to be designed to reduce subjective judgment of the observer or interviewer, which is a variable factor that can affect reliability and consistency of measurements ▪ the opinion of the trainee, which is a relevant indicator, is also subjective and unreliable, and so needs to be measured in a consistent defined way ▪ 360-degree feedback is useful method and need not be used before training, because respondents can make a judgment as to change after training, and this can be analyzed for groups of respondents and trainees ▪ assessments can be designed around relevant performance scenarios, 	<ul style="list-style-type: none"> ▪ measurement of behavior change is less easy to quantify and interpret than reaction and learning evaluation ▪ simple quick response systems unlikely to be adequate ▪ cooperation and skill of observers, typically linemenagers, are important factors, and difficult to control ▪ management and analysis of ongoing subtle assessments are difficult, and virtually impossible without a well designed system from the beginning ▪ evaluation of implementation and application is an extremely important assessment - there is little point in a good reaction and good increase in capability if nothing changes back in the job, therefore evaluation in this area is vital, albeit challenging ▪ behavior change evaluation is possible given good support and involvement from
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		<p>and specific key performance indicators or criteria</p> <ul style="list-style-type: none"> ▪ online and electronic assessments are more difficult to incorporate - assessments tend to be more successful when integrated within existing management and coaching protocols ▪ self-assessment can be useful, using carefully designed criteria and measurements 	<p>line managers or trainees, so it is helpful to involve them from the start, and to identify benefits for them, which links to the level 4 evaluation below</p>
EVALUATION TYPE	EVALUATION DESCRIPTION AND CHARACTERISTICS	EXAMPLES OF EVALUATION TOOLS	RELEVANCE AND PRACTICABILITY

		AND M E T H O D S	
<p>LEVEL 4 RESULTS</p>	<ul style="list-style-type: none"> ▪ results evaluation is the effect on the business or environment resulting from the improved performance of the trainee - it is the acid test ▪ measures would typically be business or organizational key performance indicators, such as: <ul style="list-style-type: none"> ▪ volumes, values, percentages, timescales, return on investment, and other quantifiable aspects of organizational performance, for instance; numbers of complaints, staff turnover, attrition, failures, wastage, non-compliance, quality ratings, achievement of standards and accreditations, growth, retention, 	<ul style="list-style-type: none"> ▪ it is possible that many of these measures are already in place via normal management systems and reporting the challenge is to identify which and who relate to the trainee's input and influence therefore <p>it is important to identify and agree accountability and relevance with the trainee at the start of the training, so they understand what is to be measured</p> <ul style="list-style-type: none"> ▪ This process overlays normal good management practice ▪ It simply needs linking to the training input type and timing will greatly reduce the 	<ul style="list-style-type: none"> ▪ individually, results evaluation is not particularly difficult; across an entire organization it becomes very much more challenging, not least because of the reliance on linemanagement, and the frequency and scale of changing structures, responsibilities and roles, which complicates the process of attributing clear accountability <ul style="list-style-type: none"> ▪ also, external factors greatly affect organizational and business performance, which cloud the true cause of good or poor results

	etc.	ease by which results can be attributed to the training for scenario people particularly, annual appraisals and ongoing agreement of key business objectives are integral measuring business results derived from training	
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Since Kirkpatrick established his original model, other theorists (for example Jack Phillips), and indeed Kirkpatrick himself, have referred to a possible fifth level, namely ROI (Return On Investment). In my view ROI can easily be included in Kirkpatrick's original fourth level 'Results'. The inclusion and relevance of a fifth level is therefore arguably only relevant if the assessment of Return On Investment might otherwise be ignored or forgotten when referring simply to the 'Results' level.

Learning evaluation is a widely researched area. This is understandable since the subject is fundamental to the existence and performance of education around the world, not least universities, which of course contain most of the researchers and writers. While Kirkpatrick's model is not the only one of its type, for most industrial and commercial applications it suffices; indeed most organizations would be absolutely thrilled if their training and learning evaluation, and thereby their ongoing people-development, were planned and managed according to Kirkpatrick's model.

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