ASSESSING CULTURAL COMPETENCE AMONG HIV PROVIDERS IN A LARGE URBAN HEALTH CENTER

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Introduction

The Midwest AIDS Training + Education Center (MATEC) embarked on a significant capacity building MAI-funded project with a local, federally-qualified health center that serves minority patients living with HIV/AIDS.

As part of the work plan, MATEC Illinois partnered with clinic leadership to establish training priorities and offer targeted training to staff, including training in cultural competence using the LEARN model. The entire clinic team was required to attend the Cultural Competence training.

Methods or Activities

The Cultural Competence training process incorporated all staff over a series of half-day training sessions. Leadership at the clinic made the training a requirement for all staff. A n assessment instrument was crafted and tailored specifically to the training content, including knowledge acquisition and confidence in acquired skills.

At each training, the instrument was administered as both a pretest, and an immediate post test assessment to all attendees. Since this occurred on the same day, assessment of behavior change was not possible. However, it was possible to assess both knowledge and self-reported skill acquisition as a direct result of the training.

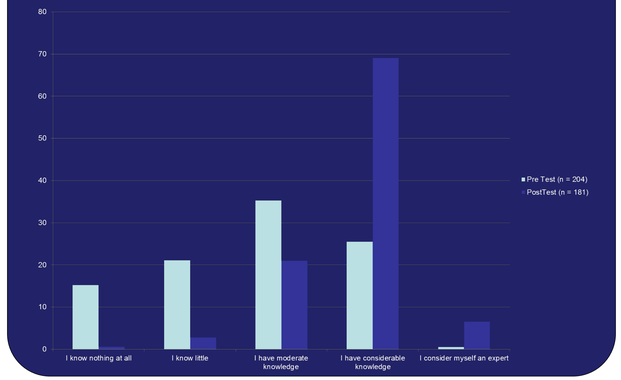
Data was entered into an excel spreadsheet and then transferred to SPSS v. 16 for cleaning and analysis. Basic frequencies and descriptive statistics were computed for each question. The following is a synopsis of the highlights of the findings as collected, with a focus on changes prompted by the training sessions.

Results

A total of 207 pre-test assessments were collected. The group included physicians, physician assistants, registered nurses, APN/Nurse practitioners, substance use counselors, mental health counselors, health educators, case managers, managers, clerical staff, patient health advocates, peer counselors, transportation staff, medical assistants/phlebotomy, and others. Despite attempts to collect a post-test from all training attendees, a total of 182 were collected and over ten percent in each group were big-six.

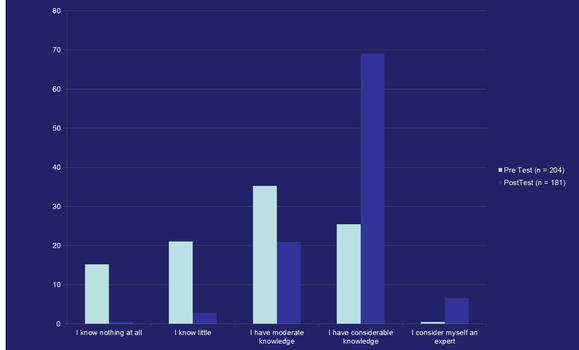
Several items were created to assess provider knowledge of cultural competency, and how it relates to providing quality care in an HIV care setting. Respondents were asked to consider each item, and choose the corresponding option on a five-point scale. Providers were also asked to rate their confidence level with key skills taught in the training. Dramatic changes in both knowledge and self-reported confidence were noted from the pre to the post test. The following three charts reveal some of these key changes. All data are presented in valid percentages, to account for missing data in each item.

What it means to be culturally competent in an HIV Care Setting

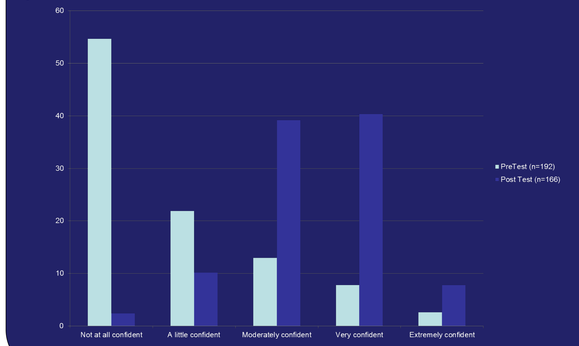


Results

The link between cultural competence and quality of care



Explaining to a co-worker how to use the LEARN Model with patients



Discussion

Although the previous charts represent only a fraction of the data, knowledge and self-reported confidence increased on all items. Similar patterns were noted when separating the big six providers from the group. These results support the use of a half-day, skill-based training model in cultural competence for its ability to produce knowledge change and build confidence in providers to use important tools, such as the LEARN Model, when connecting with HIV-positive patients or those living with AIDS.

Lessons Learned

It is feasible to train and assess a very large clinic staff in cultural competence, with proper buy in from clinic management.

Physician audiences often have their own training needs and are best trained separately from other staff.

Although behavioral change could not be measured with this design, results indicate positive shifts in knowledge and skill acquisition, necessary precursors to behavior change.

Future Directions

To follow up with training in Cultural Competency with LGBTQ and substance-using populations, as prioritized by training participant on an open-ended portion of the assessment.

To consider other models for assessment, such as an outcomes based survey 4-6 weeks after the training to assess behavior change, or a patient pre/post survey to validate self-reports by providers.

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