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Comparing cultural competence in graduating Master of Social Work and Nursing students

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COMPARING CULTURAL COMPETENCE IN GRADUATING MASTER OF SOCIAL WORK AND NURSING STUDENTS

A Project

Presented to the

Faculty of

California State University,

San Bernardino

In Partial Fulfillment

of the Requirements for the Degree

Master of Social Work

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ABSTRACT

The objective of the study was to compare cultural competence between graduating Bachelor of Nursing students and Master of Social Work students. The study participants consisted of 107 students who were graduating from either the MSW program or the Bachelor of Nursing program at California State University, San Bernardino. Participants were asked to complete a cultural competence survey and quantitative data analysis was utilized to compare cultural competence among the respondents. The results of this study support the hypothesis and suggest that MSW students are slightly more culturally competent upon graduation than nursing students. The findings of the study contribute to social work knowledge concerning the cultural competence levels of graduating MSW and nursing students. This information might be used to improve the curriculum of both disciplines.

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First, we would like to thank our families for having the patience and support to get us through this project. We would also like to thank Dr. Liles for providing us supervision for this research project and for all of the knowledge and support that he has shared with us. We would also like to thank Tim Thelander for helping us with the formatting of this project. In addition, we would also like to thank Bill Gayk for all of your help with analyzing the statistics; we truly would have been lost without your expertise.

DEDICATION

This project is dedicated to my wonderful husband Chris and my sweet children Maddie and Tyler. You have offered me the love, support, and freedom to embark on this crazy endeavor and the encouragement to finish it. I love you guys more than anything. To my mom Kathy, you have been such an encouragement and help during this time. I am so thankful for you. To my Dad, I know that you have been watching over me and I miss you each and every day. I know you will be watching with a great big smile as I graduate.

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CHAPTER ONE

INTRODUCTION

Chapter one discusses the importance of social workers and nurses providing culturally competent services to diverse populations in medical settings. This chapter addresses the significant value in integrating cultural competence education in social work and nursing curricula. A discussion is included pertaining to the laws and regulations that are currently established to help ensure that culturally competent services to diverse populations are implemented. Chapter one also states the purpose of the study and its significance to social work practice. The objective of the study was to compare cultural competence between graduating Bachelor of Nursing students and Master of Social Work students.

Problem Statement

The demographics of the United States are rapidly changing and creating a unique population of people with diverse cultural and ethnic backgrounds. Individuals differ in traditions, beliefs and religions and the decisions they make are influenced by these values. Often, people are confronted in making medical decisions

and choose interventions that are influenced by their cultural beliefs. In medical settings clinicians (social workers and nurses) often work as part of interdisciplinary teams and provide services to patients with diverse backgrounds. It is essential for nurses and social workers to provide culturally sensitive services to increase effective medical care outcomes.

It is vital for the profession of social work to study cultural competence and the impact it has in medical settings. Research can be used to improve the cultural competence education of social work and nursing students in an effort to effectively provide services to diverse populations. Educators believe that cultural competence training is imperative to integrate into curriculum. Cultural competence education in nursing and MSW programs are requirements for successful completion of both programs and are necessary for the accreditation of those programs. An objective of the curriculum is to provide both MSW and nursing students with an increased knowledge in cultural competence that will be beneficial in their professions and to effectively provide culturally sensitive services.

According to Betancourt, Green, Carrillo, and Ananeh-Firempong II (2003), when medical providers fail to integrate culturally competent services, the health care outcomes of the patients served are negatively impacted. There is often an increase in the lack of trust between the patients and clinicians and occasionally non-compliance with medical interventions which can be serious and even life threatening. Collaboration between social workers and nurses is crucial in medical settings and each discipline has a different expertise to contribute to the welfare of the populations they serve. Nurses work closely with patients and are responsible for providing medical services, interventions, and assisting physicians to increase the health and well-being of their patients. Social workers' responsibilities consist of effectively assessing, intervening, and providing supportive services and resources that empower their client's right to self determination and help to improve their quality of life.

To some extent laws and regulations provide a practice framework for medical settings to adhere to in order to provide culturally competent services to diverse populations. The U.S Department of Health and Human

Services and its subsidiary Office of Minority Health (OMH) have developed the national standards for culturally and linguistically appropriate services (CLAS). First, it mandates that clinicians be culturally sensitive when providing services and speak in the patient's preferred language. Second, according to these standards it is necessary for medical settings to have employees and clinicians who represent the populations that they are serving. Third, it is important to provide cultural and linguistic training and education to all employees that can assist them in providing effective services to diverse populations (U.S. Office of Minority Health, 2001).

Purpose of the Study

The purpose of this research project was to compare cultural competence between graduating Bachelor's of Nursing and Masters of Social Work students. It was important to conduct this research because in medical settings these two disciplines work together as part of interdisciplinary teams and have direct contact with the culturally diverse patients they serve. To be an effective medical provider cultural competence is

necessary and must be respectfully incorporated into the services and care provided. The objective of the research was to provide a cultural competence survey to MSW and nursing students who were expected to complete their respective programs in June of 2011 and to measure their levels of cultural competence upon graduation.

The study was conducted at California State University, San Bernardino (CSUSB). Cultural competence surveys were provided to 107 CSUSB students. This included 52 MSW students from the School of Social Work and 53 Bachelor of Nursing students from the Department of Nursing who were expected to graduate in June of 2011. Quantitative data collection was gathered through the distribution of surveys. These surveys helped to measure the participants' level of cultural competence upon graduation.

Significance of the Project for Social Work

The generalist model in social work practice is an approach used by social workers to help individuals, families and groups. This model is strengths based and empowers the client to identify and use their personal strengths to make successful changes to overcome the

challenges that they are facing. The phases of the generalist model consist of engagement, assessment, planning, intervention, evaluation, termination and follow up (Hernandez, Mizrahi & Davis, 2011, Refining the Generalist Framework, ¶6). When social workers are assessing their clients' needs it is important for them to take a holistic approach and this cannot be done without having an understanding of the culture of the individual and/or family to which one is providing services. During the intervention phase social workers need to take into consideration an individual's culture when providing services in an effort to make the interventions appropriate and culturally sensitive. This will aid in creating services that have a higher likelihood of meeting the needs of the clients.

The knowledge that was gained by conducting this study helps to identify areas of weakness in cultural competence training curriculum of each professional training program. These areas of weakness could be useful in improving the curriculum and training concerning cultural competence of these disciplines at the university level. This in turn could help both programs produce graduates who will be better able to effectively

provide culturally competent care to the clients they serve. The hypothesis for the study was that MSW students are more culturally competent than Bachelor of Nursing students upon graduation.

Summary

Chapter one introduced how important it is for social workers and nurses to be culturally sensitive when providing services to diverse populations in medical settings. When clinicians incorporate their knowledge of a patients' culture and provide culturally sensitive care it can increase the effectiveness of the medical outcome for the patients. This chapter included the importance of implementing cultural competence education into the social work and nursing curriculums. In addition, this chapter addressed the laws and regulations that mandate agencies to provide culturally sensitive education and services. Lastly, this chapter addressed the purpose of the study and the significance it has for social work practice.

CHAPTER TWO

LITERATURE REVIEW

Introduction

Cultural competence is defined "as a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross cultural situations" (U.S. Department of Health and Human Services, 2005, ¶ 1). The above definition guides the discussion of cultural competence and its significance in medical settings for this study. A brief overview of the statistics pertaining to ethnic diversity in America follows. The ways in which the concept of cultural competence is applied in health care and the laws and regulations guiding its use in medical settings is also discussed. An overview is provided concerning studies that suggest cultural competence can and is taught in academic settings. The academic accreditation requirements and individual codes of ethics in regards to nursing and social work education and practice are discussed. This chapter concludes with an overview of the importance of the interdisciplinary

team in medical settings and the value of cultural competence within it.

Ethnic Diversity in America

The demographics in the United States are quickly changing and in turn change the way medical care is provided by clinicians. In 2000, it was projected that White Americans would make up 81% of the population; Hispanic Americans would make up 12.6%, followed by Blacks 12.7% and Asians 3.8%. It is estimated that by the year 2050, White Americans will account for 72.1% of the U.S. population, followed by Hispanics 24.4%, Blacks 14.6%, and Asians 8% (U.S. Census Bureau, 2004). In response to the growing cultural diversity in America it is even more important that both nurses and social workers who are entering into the health care profession, receive cultural competence education and are able to integrate cultural competence into the care they provide.

Cultural Competence

Cultural competence is made up of four components that are essential in providing culturally competent care in medical settings. These include 1) an individual's knowledge of their own beliefs and existence without

allowing it to influence those who come from a different background, 2) indicating an understanding of and education on other cultures, 3) valuing and accepting differences in cultures, and 4) one's ability to adjust the care provided to align with a patients culture (Purnell & Paulanka, 1998).

Cultural competence involves clinicians recognizing and having knowledge of the ways that one's culture is influencing their behaviors and beliefs concerning their health. Second, it takes into consideration how patients' values impact how they choose to receive healthcare. A third component to cultural competence is that it requires the clinician to respect and consider a patient's culture and beliefs and apply them to the services that are offered. This is done in an effort to provide outstanding health care to culturally diverse populations (Betancourt et al., 2003). Finally, cultural competence has also been defined as one's ability to respond to cultural diversity, sensitivity, and awareness through their actions (Schim, Doorenbos, Benkert, & Miller, 2007).

When linguistic or cultural barriers arise between the patient and medical provider this often results in

negative outcomes for the patient. These may include a lack of trust between the patient and clinician, patient dissatisfaction, non-compliance with medical interventions and negative health results (Betancourt et al., 2003).

There are two primary reasons why educators believe that cultural competence training is crucial to incorporate into nursing curriculum. First, there are negative outcomes associated with medical care providers failing to provide culturally competent services. Second, there is an increasing ethnic diversity in the United States and providers need to be able to integrate their cultural competence education to provide effective interventions (Cordell, 2004).

It is believed that when culturally congruent care is provided a patient's health outcomes, communication and compliance with medical interventions is improved. There is also a decrease in financial costs to the health care provider (Schim et al., 2007). When medical providers are able to offer care that is culturally competent, disparities in health care are reduced and barriers to the patient's ability to access medical care begins to be reduced (Pacquiao, 2008).

Laws and Regulations

The U.S. Department of Health and Human Services (HHS) and its subsidiary Office of Minority Health (OMH) collaborated and developed the national standards for culturally and linguistically appropriate services (CLAS). These national standards encompass many aspects of cultural competence in health care settings. Standards one thru three focus on health care providers and their ability to offer culturally competent care. These three standards involve providing care that is compatible with their patients' cultural beliefs and practices concerning their health care and for the services to be provided in their preferred language. Organizations that provide health care should have ways to hire, retain and promote staff throughout the entire organization that is representative of the demographics of their service area. It also stipulates that health care organizations offer ongoing training and education in how to provide culturally and linguistically appropriate services to all staff (U.S. Office of Minority Health, 2001).

Cultural Competence in Education

According to Colvin-Burque, Zaugazaga, and Davis-Maye (2007), cultural competence can be taught in academic settings. This study suggested that social work mentors and educators have a responsibility to implement cultural competence into the curriculum. This aids social work students in developing their cultural knowledge of individuals from differing backgrounds and encourages sensitivity to the diverse populations to which they will provide services. It is essential that social workers and students build an awareness of their personal cultural background. If they fail to do so, it can have a negative impact on the quality of services that they provide.

This study utilized a cultural competence assessment tool called Self and Other Awareness Project (SOAP). The objective of SOAP is to increase social work student's knowledge in regards to "specific cultural groups, while increasing self-awareness and cultural sensitivity" (Colvin-Burque et al., 2007 p. 224). This model brings awareness to cultural competence issues within oppressed populations; as it is critical for social work students to receive education on oppressed groups in an effort to prevent discrimination.

Kardong-Edgren and Campinha-Bacote (2008), support the notion that cultural competence can be taught. Their study measured the level of cultural competence in bachelor of nursing students at four different nursing programs and in their curriculum. To accurately measure if the four different curriculums were effective, the students were asked to complete an Inventory for Assessing the Process of Cultural Competency Among Healthcare Professionals-Revised (IAPCCC-R) prior to graduating and upon completion of the program. The research concluded that all four programs had a positive increase of cultural competence knowledge upon graduation. It also found that nursing students who had taken additional classes in anthropology outside of the program scored higher in the IAPCCC-R.

The American Nurses Association's (ANA) established a code of ethics for nurses and nursing students to abide by to help guide them in their profession. The ANA code of ethics provision section 1.2 (Relationship to Patient) states that nurses need to be aware of cultural diversity and effectively deliver "nursing services for human needs and values without prejudice" (p.3). Thus, the beliefs and cultures of the patient should be considered and

respected when providing nursing services (American Nurses Association, 2005).

Cultural competence education in nursing curriculum is a requirement for accreditation in nursing programs (Kardong-Edgren & Capinha-Bacote, 2008). There are five essential elements concerning cultural competence that nursing students need in order to become nursing professionals and have the ability to effectively work as part of an interdisciplinary team. Nursing students need to be able to apply the knowledge they have learned in regards to social and cultural factors in medical settings. Second, nursing students must have relevant information when providing medical care that is culturally competent. Third, nursing students need to be able to accomplish positive quality outcomes for diverse populations. Fourth, nurses need to be able to advocate on behalf of vulnerable populations in an effort to eliminate health disparities. Finally, nursing students need to continue to add to their knowledge of cultural competence (Calvillo, Clark, Ballantyne, Pacquiao, Purnell, et al., 2009).

It is essential that nursing students are trained in cultural competence and understand how to effectively

provide care that is culturally sensitive. This will help meet the needs of the diverse populations that they will be working with. Nurses work intimately with their patients and the beliefs that the nurses hold concerning culture has an impact on the quality of care that they provide. This is why professors of nursing believe it is imperative to teach cultural competence to their students (Cordell, 2004).

Social workers have an ethical responsibility to their clients to provide culturally competent care. This is specified in section 1.05 of the National Association of Social Workers (NASW) code of ethics. These responsibilities encompass the social worker recognizing the strengths that each culture has and having an understanding of culture and the impact it has on society and behavior. Social workers should also be educated on the culture of the clients that they are serving. They need to provide culturally sensitive services to diverse populations. As social work professionals they should receive education and gain understanding in "social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political

belief, religion, immigration status and mental or physical disability" (NASW, 2011, Cultural Competence and Social Diversity, ¶ 3).

For social work programs to receive accreditation the curriculum must include cultural competence. The Council on Social Work Education (CSWE) provides accreditation to social work programs at the university level. In section 1.2 under achievement of purposes it acknowledges that social work education should prepare social workers to work with respect, knowledge and skills in regards to diverse populations. The discussion of diversity is covered in section 4.1 and mentions that social work programs should integrate curriculum that encourages respect, understanding, and affirmation of diverse backgrounds. It acknowledges that students need to have an understanding of how interconnected one's culture is with their identity. Therefore, professional social workers should be able to provide assessments and interventions that help meet the individual needs of diverse populations (Council on Social Work Education, 2004).

Disparities in Providing Health Care and Interdisciplinary Practice

Cultural competence is applied to health care in an effort to eliminate the racial and ethnic disparities that arise when providing medical care to individuals from diverse cultural backgrounds (Betancourt et al., 2003).

According to Chin (2000), the need for culturally competent services arose from clinicians' inability to effectively respond to the needs of diverse populations. The article suggests that medical providers have been unsuccessful in their attempts at meeting the needs of disenfranchised populations. This is despite the attention that had been made on the importance for providers to respond to cultural diversity.

Interdisciplinary teams in medical settings increase the likelihood of positive outcomes for patients. Interdisciplinary practice is characterized by differing professions having an appreciation and understanding of the importance of each other's roles. They collaborate in making decisions, setting goals, and care planning during meetings that are conducted on a regular basis in an effort to provide quality comprehensive care to patients

(Pecukonis, Doyle, & Bliss, 2008). The degree to which patient outcomes are effective is influenced by how well the interdisciplinary team work together. An effective team has four primary components which include leadership, communication, conflict resolution and coordination of care (Temkin-Greener, Gross, Kunitz, & Mukamel, 2004). Coordination of care in medical settings is of special importance and this includes its members' knowledge and ability to provide culturally competent care.

Theoretical Orientation

Nursing and MSW students who will be working with diverse populations in medical settings have been educated on cultural competence and what it means to provide culturally competent care. Multicultural theory was chosen as the theoretical orientation for this study because it suggests that clinicians choose their service approach based on the client's cultural perspective and life experiences (Lesser & Pope, 2007). This is done in an effort to ensure that individuals are treated with equality regardless of their cultural background (Lenard, 2010). The theory focuses on how one's "personal biases, values, interests and worldview" stem from their culture

and how they perceive others (Locke, 1998, p.2). It provides a theoretical framework for clinicians to utilize when working with diverse populations and assists them in gathering information that they can use to effectively provide culturally sensitive services (Locke, 1998).

Multicultural theory provides a framework for clinicians to recognize and incorporate "the impact of various cultural factors on clients' presenting issues"; this information helps guide professionals in implementing culturally appropriate interventions (Constantine, 2001, p. 358). In addition, the model emphasizes the importance of viewing the client in regards to the community that they identify themselves with. It is important that the clinician be able to provide culturally sensitive care to diverse populations (Lesser & Pope, 2007).

Summary

As discussed, cultural competence is fundamental in providing quality medical care. Cultural competence education is a requirement for both nursing and MSW curriculum. When working as part of an interdisciplinary

team, social workers and nurses increase the quality of care they provide when they integrate culturally sensitive services into their practice. Cultural competence is a significant indicator of providing excellent medical care and decreasing health care disparities among oppressed populations.

CHAPTER THREE

METHODS

Introduction

Chapter three explains the study design that was utilized in this research project. This includes the purpose of the study, the research hypotheses, rationale and limitations to the methods used. A discussion of how participants were selected and the location of the study are addressed. This section discusses how data was collected and the survey tool that was utilized. The protection of human subjects is included and the importance of providing the participants with an informed consent and debriefing statement is explained. Last, this chapter discusses the data analysis that was used in this research.

Study Design

The purpose of the research was to compare cultural competence between graduating nursing and MSW students. The data was gathered using quantitative measures by having nursing and MSW students take a Self-Assessment of Cultural Competence survey. The purpose of the survey was to measure the participants' level of cultural

competence. The assessment tool contained 11 questions and utilized a Likert scale with four possible answers. They included *almost always, often, sometimes,* and *almost never*. Each possible answer was assigned a level of measurement between 4 and 1; with 4 being almost always, 3 often, 2 sometimes, and 1 almost never. The highest possible score was 44 and the lowest 11. The results of the surveys were entered into and analyzed in Statistical Package for the Social Sciences (SPSS).

The rationale for using a quantitative approach is that "Quantitative research involves counting and measuring of events and performing the statistical analysis of a body of numerical data" (Russian Communication Association, 2002, Quantitative Method, ¶ 1). A limitation of using a quantitative approach is that participants may not answer truthfully. In order to avoid this, the participants were informed that the research was confidential and their honesty was "key" to the research findings. The hypothesis for this study was that MSW students are more culturally competent than nursing students prior to graduating from their respective programs.

Sampling

The research was conducted utilizing non-random purposive sampling. One hundred and seven students from CSUSB participated in this study. The participants consisted of 55 Bachelor of Nursing students and 52 MSW students. To take part in the research participants must have been enrolled in the winter quarter of 2011 with an expected graduation date of June 2011.

Data Collection and Instruments

Data was collected through the distribution and completion of the Self-Assessment of Cultural Competence survey. The survey included 11 statements that required the participants to read and select the one answer that best applied to their cultural beliefs. The survey utilized an interval level of measurement through a Likert scale that included four possible responses; they are *almost always, often, sometimes, almost never* (Association of University Centers on Disabilities, 2010) (See Appendix A). Participants were provided an informed consent prior to completing the surveys. Along with the survey the participants were instructed to fill out a demographic questionnaire that asked them to circle their

age range, gender, ethnicity and identify their major (See Appendix B). A debriefing statement was provided upon completion of the survey.

The hypothesis was tested using a between-group design. The independent variable in the study was participant program. The participants were MSW students and nursing students. The dependent variables were the responses that the participants gave and measured their levels of cultural competence. A total of four t-tests were used to analyze and compare the cultural competence in graduating MSW and Nursing students. In addition, chi-squares were run to determine if certain questions influenced the results of this study.

The instrument utilized in this study was the Self-Assessment of Cultural Competence survey (See appendix A). This tool was adapted by Goode from the Association of the University Centers on Disabilities (AUCD) Multicultural Councils Assessment of Organizational Cultural Competence (Association of the University Centers on Disabilities, 2010). Goode represents Georgetown University which partnered with the National Center for Cultural Competence (National Center for Cultural Competence, 2010).

Richardson, one of the authors of the original assessment, stated via email that due to lack of funding there has been no studies performed to test the reliability and validity of this tool (Association of the University Centers on Disabilities, 2004). However, permission was granted to use this tool with a request to provide the research findings to her (Appendix E). The assessment tool was further modified by Joanna Rubio and Jamie Webb to better suit the study participants that the research was conducted on.

Procedures

Data was gathered By Joanna Rubio and Jamie Webb, using a sample of CSUSB nursing and MSW students. First, the study gained approval from CSUSB'S Institutional Review Board (IRB). The IRB consist of educators who take the appropriate steps to "protect the rights and welfare of human participants as subjects in the research" (California State University, San Bernardino, 2009, ¶ 1). The application included the purpose for the research, an original copy of an informed consent and a debriefing statement.

Permission was requested and granted to solicit participants from the nursing department and the School of Social Work during the winter quarter of 2011. Once approval was obtained surveys were provided to the nursing and MSW students. Permission was obtained from the professors of both disciplines to conduct the surveys prior to instruction time. Verbal instructions were provided prior to the survey being distributed. To protect the confidentiality of the participants a liaison was asked to distribute the surveys to their peers. Approximately 10 minutes after distributing the surveys the liaison gathered them and placed them in an envelope that was provided.

An informed consent was provided to the participants which explained the purpose of the study. The participants were informed that they had the right to stop participating in the study at any point and could skip any questions that they did not want to answer. After providing and receiving a signed consent the students were asked to complete the survey. The survey took approximately 15 minutes to complete. The students were thanked for their participation and received information on how to obtain the research findings once

the project was completed. This information was included in the debriefing statement (Appendix D).

Protection of Human Subjects

In order to ensure that the ethical issues of this research project were dealt with adequately and to reduce any potential harm to the study participants, the study underwent a human subject review by the Institutional Review Board. It was important that the confidentiality of the participants were protected. This was accomplished by providing the participants with an informed consent and instructing them to place an "X" where a signature is required for participation (Appendix C). To avoid any breach of confidentiality, the completed surveys were kept in a locked safety deposit box at the home of Jamie Webb.

Data Analysis

A quantitative approach was utilized to test the hypothesis. The results of the survey were entered into SPSS and analyzed. The hypothesis was tested using a between-groups subject design.

The independent variable in the study was the participants' respective program and is nominal data. A

bivariate correlational approach was used because it showed the significant correlations that the study would further investigate. The dependent variable was the overall score of the participants on the Self-Assessment of Cultural Competence survey. This tool uses a Likert scale. The level of measurement was interval due to the four possible answers to each question in the survey. Multiple T-Tests were utilized to determine if there were any cultural competence differences between graduating MSW and nursing students. Finally, multivariate analysis was used to determine other factors that were believed to have influenced the findings.

Summary

Chapter three addressed the study design that was utilized in the study. This section described the proposed sampling process, the steps of data collection, and the survey that was used in this research. The chapter discussed the protocol for how participants were solicited and the criteria for participation. Finally, the protection of human subjects and data analysis was explained.

CHAPTER FOUR

RESULTS

Introduction

Chapter four discusses the findings of the study. A two-tailed t-test was performed to determine which discipline was more culturally competent as measured by the Self-Assessment of Cultural Competence survey. T-tests were run to identify if there were correlations between demographics and the cultural competence of the students. Chi-squares were run on each of the individual survey questions and two of the eleven questions were identified as having a significant impact on the cultural competence between the MSW and nursing students.

Presentation of the Findings

A *t*-test suggests that there is a statistically significant difference between the cultural competence of nursing students ($M = 34.09$, $s = 4.3$) and MSW students ($M = 35.85$, $s = 4.79$), $t(1.98)$, $p = .050$, $\alpha = .05$. The results support the hypothesis that MSW students are more culturally competent than nursing students as measured by their respective scores on the Self-Assessment of Cultural Competence survey (see table 1).

T-tests were run to see if there were correlations between age classes, minority versus non-minority status, gender and the participants' cultural competence. The results suggest that these variables did not influence an individual's cultural competence in this sample of students. The results from the age class T-test is; participants ages 29 and below ($M = 35.13$, $s = 4.78$) and for participants ages 30 and above ($M = 34.22$, $s = 4.09$), $t(.841)$, $p = .402$, $a = .05$. The results from the gender T-test is; males ($M = 35.06$, $s = 4.66$) and for females ($M = 34.94$, $s = 4.63$), $t(.09)$, $p = .929$, $a = .05$). The T-test results from minority status is; minority ($M = 34.96$, $s = 4.63$) and for non minority ($M = 34.90$, $s = 4.69$), $t(.06)$, $p = .953$, $a = .05$) (see tables 2, 3, 4).

A chi-square was run for each of the questions on the survey to identify which questions had the biggest impact on the findings. The results suggest that questions 1 and 6 of the survey had the most significant impact on the results. The results from the chi-square for question 1 is $\chi = 8.197$, $p < .05$. The results from the chi-square for question 6 is $\chi^2 = 18.898$, $p < .05$ (see tables 5, 6).

Summary

Chapter four addressed the findings of this study and supported the hypothesis that MSW students are more culturally competent than nursing students as measured by Self-Assessment of Cultural Competence survey. This was accomplished using a two-tail t-test. T-tests were also run to determine if there was a relationship between the demographics and cultural competence of the participants and determined that these factors did not influence an individual's cultural competence. In addition, a chi-square was run for each of the eleven questions on the survey. The findings of the chi-square conclude that responses from questions 1 and 6 had a significant influence on the cultural competence of MSW and nursing students.

CHAPTER FIVE

DISCUSSION

Introduction

Chapter five includes a discussion of the findings related to the differential scores by discipline on the Self-Assessment of Cultural Competence Survey. This chapter also identifies the limitations that may have influenced the outcomes of the study. Finally, recommendations for future social work research, practice, and policy are addressed.

Discussion

The purpose of the study was to compare the cultural competence of graduating Bachelor of Nursing and MSW students. Cultural competence is more than a clinician's awareness of how their culture impacts the services that they provide, but it also incorporates the ability for clinicians to provide care that shows an understanding and respect for the culturally diverse clients that they serve. This is supported by the multicultural theory and provides a framework for clinicians to offer services that foster the respect and understanding of the client's

culture. In doing so, clinicians protect their clients' rights and help to prevent disparities when providing services to diverse populations (Lenard, 2010).

In the study the hypothesis was supported with the results from the statistical analyses (t-test). The hypothesis was that MSW students are more culturally competent upon graduation than Bachelor of Nursing students. While the results indicated that there was a statistically significant difference, it is important to note that the cultural competence of MSW students is only slightly higher than Bachelor of Nursing students as measured by the Self-Assessment of Cultural Competence Survey. Multicultural theory supports this assessment and its findings by asking the respondents to reflect on how their cultural beliefs and values influence their professional practice (Locke, 1998).

There were 107 original participants and two of them did not fill out the survey in its entirety. This left 105 respondents; 55 of the participants were nursing students and 52 were MSW students. Ninety-one of the respondents were female and 16 were male. The ages of the participants ranged from 21 to 59, with the median age being 25 (see table 2). The ethnic demographics included

18 Asian/Pacific Islanders, 36 Hispanics, 30 Caucasians, 6 African Americans, 2 Europeans, 14 other's and 1 did not specify (see figures 1, 2, 3, 4).

Questions 1 and 6 of the survey appeared to be the influencing factors which contributed to the MSW students being more culturally competent. The findings from question 1 supports multicultural theory and indicates that MSW students were more aware of how their culture, sexual orientation, and biases impacted their behavior compared to nursing students (Locke, 1998). Question 6 implies that MSW students were more likely than nursing students to utilize interpreters when providing services to clients. (see tables 5, 6).

No relationship was found between minority versus non-minority participants and their level of cultural competence. Minority was identified as Asian/Pacific Islander, Hispanic, African American, and other; non-minority was identified as Caucasian and European. Also, there was no relationship between age class and cultural competence. Age class was separated into participants ages 29 and younger and respondents ages 30 and over. In addition, no relationship was found between

gender and cultural competence. Gender was defined as male versus female (see tables 2, 3, 4).

Limitations and Recommendations for Social Work Practice, Policy and Research

One limitation of the study which may have impacted the results is that the sample size of 107 is small and all respondents were from CSUSB. Future researchers in this area of study are encouraged to utilize larger sample sizes if possible and to study a wider range of professional training programs.

Cultural competence was not measured prior to participants entering their respective programs. Additionally, this may have been a limitation to the study because there was not a baseline level of measurement to compare the findings of the Self-Assessment of Cultural Competence Survey to. This would have indicated if their education contributed to their level of cultural competence. For future research it is suggested that prior to students entering their respective programs a pre test be conducted to create a baseline level of measurement. This would help to identify if the programs increased the cultural competence of their students.

Furthermore, competence is defined as "having enough skill or ability to do something well" (Encarta World English Dictionary, 2009, Definition of Competence, ¶ 1). This would mean that a clinicians' ability to excel in providing culturally competent services would make them culturally competent. This could be a limiting factor in this study because The Self-Assessment for Cultural Competence survey measures one's own evaluation of how their personal beliefs and values influence the care that they provide and not necessarily their ability or skill in cultural competence. It is recommended for future studies that an assessment tool be utilized that measures the participants ability in providing culturally competent services to determine their level of cultural competence.

Another limitation to this study is that MSW students have a higher level of education than bachelor of nursing students. For future research it is suggested that bachelor of social work students be compared with bachelor of nursing students and MSW students with Master's of nursing students. This would allow the education levels to be equivalent and might help determine the extent to which level of training and

education is related to the development of cultural competence.

An additional limitation is that individuals do not want to appear to be culturally incompetent and so participants may have responded in a way that would make them appear more culturally competent. According to Ray (2006), participants "may try to figure out the experiment and behave in a way that will support or sabotage the experiment" (p. 230).

Another limitation to the study was that a column shift occurred in questions 2, 3, 5, 7, 8, and 10 and the responses "often" and "sometimes" were printed very close together on the survey forms. Seventeen respondents confused these responses and failed to separate the different answers and circled both. For participants who circled both responses together a 2.5 variable was assigned instead of leaving out the response completely. A variable of 2.5 was chosen because it was the average number between the two available responses which were 2 and 3.

Both the MSW and Bachelor of Nursing programs appear to be producing students who display a level of cultural competence upon graduation. It is beneficial to the

populations that both programs serve to continue to incorporate cultural competence education into their respective curriculums. Based on the study, nursing students scored slightly lower than MSW students on their use of interpreters and personal cultural awareness (see tables 5, 6). In regards to nursing curricula it might be beneficial to focus on the importance of the students' cultural awareness and how it may impact the care that they provide. Due to the findings, it would be advantageous for nursing curricula to emphasize the importance of the use of interpreters when working with client's from differing languages other than that of the clinician. Additionally, it might be beneficial for MSW curricula to continue to educate their students on the importance of providing culturally competent services in an effort to improve the outcomes of the diverse populations that they serve.

Conclusions

The purpose of the study conducted was to compare cultural competence of graduating Bachelor of Nursing and MSW students. The participants consisted of 107 students from the California State University, San Bernardino. The

results from this research support the hypothesis of the study and suggest that MSW students are more culturally competent than Bachelor of Nursing students upon graduation.

Providing culturally competent care is vital in social work and nursing practice. In medical settings, these two disciplines collaborate and work together as a part of an interdisciplinary team with the objective of providing all patients with exemplary medical care. If providers fail to incorporate culturally competent care they are unable to successfully offer services to the diverse populations whom they serve. Therefore, it is imperative that both disciplines effectively provide cultural competence education to improve the success of the students in their professional careers.

APPENDIX A

QUESTIONNAIRE

Self-Assessment of Cultural Competence

As a member of a profession, the knowledge you have of yourself and others is important and reflected in the ways you communicate and interact. This individual assessment instrument was developed to assist you in reflecting upon and examining your journey toward cultural competence.

The following statements are about you and your cultural beliefs and values as they relate to the profession. Please circle the ONE answer that BEST DESCRIBES your response to each of the statements.

Almost Always Often Sometimes Almost Never

1. I reflect on and examine my own cultural background, biases and prejudices related to race, culture and sexual orientation that may influence my behaviors.

   Almost Always Often Sometimes Almost Never

2. I continue to learn about the cultures of the consumers and families served, in particular attitudes towards disability; cultural beliefs and values; and health, spiritual, and religious practices.

   Almost Always Often Sometimes Almost Never

3. I recognize and accept that the consumer and family members make the ultimate decisions even though they may be different compared to my personal and professional values and beliefs.

   Almost Always Often Sometimes Almost Never

4. I intervene, in an appropriate manner, when I observe other staff engaging in behaviors that appears culturally insensitive or reflects prejudice.

   Almost Always Often Sometimes Almost Never

5. I attempt to learn and use key words and colloquialisms of the languages used by the consumers and families served.

   Almost Always Often Sometimes Almost Never

6. I utilize interpreters for the assessment of consumers and their families whose spoken language is one in which I am not fluent.

   Almost Always Often Sometimes Almost Never

7. I have developed skills to utilize an interpreter effectively.

   Almost Always Often Sometimes Almost Never

8. I utilize methods of communication, including written, verbal, pictures, and diagrams, which will be most helpful to the consumers, families, and others.

   Almost Always Often Sometimes Almost Never

9. I write reports or any form of written communication, in a style and at a level which consumers, families, and others will understand.

   Almost Always Often Sometimes Almost Never

10. I am flexible, adaptive, and will initiate changes, which will better serve consumers, families, and other program participants from diverse cultures.

    Almost Always Often Sometimes Almost Never

11. I am mindful of cultural factors that may be influencing the behaviors of consumers, families, and other program participants.

    Almost Always Often Sometimes Almost Never

Developed by the AUCD Multicultural Council
Adapted in part from Promoting Cultural Diversity and Cultural Competency Self Assessment Checklist for Personnel Providing Services and Support to Children with Special Health Needs and Their Families by Tawara D. Goode, Georgetown University Child Development Center.
Assessment adapted by Joanna Rubio and Jamie Webb, MSW students from CSUSB.

APPENDIX B

DEMOGRAPHIC QUESTIONNAIRE

DEMOGRAPHIC QUESTIONNAIRE

Circle the answer that best applies.

1. What is your age?

2. Are you male or female?

   Male Female

3. What is your major?

   Nursing MSW

4. What is your ethnicity?

   Asian/Pacific Islander
   Caucasian
   European
   Native American
   Hispanic
   African American
   Other

APPENDIX C

INFORMED CONSENT

INFORMED CONSENT

You are invited to participate in a study about cultural competence in graduating Nursing and Master of Social Work students. The study is being conducted by Master of Social Work students Joanna Rubio and Jamie Webb from California State University, San Bernardino (CSUSB), under the supervision of Dr. Ray Liles. The results will be available in CSUSB's library after the summer of 2011. The study has been approved by the School of Social Works Sub Committee of the CSUSB's Institutional Review Board.

The curricula of both Nursing and Master of Social Work programs includes cultural competence education as a requirement for program accreditation. The purpose of this study is to compare the cultural competence of these two disciplines on graduation. If you choose to participate in this study, you will be asked to fill out a survey that asks questions concerning cultural competence. It should take not longer than 10 minutes to complete.

The survey is anonymous and no record will be kept of any identifying information. Your participation is completely voluntary and at any time you may withdraw from the study. You may skip any questions that you do not want to answer. The researchers are the only ones who will see the information from the data gathered from the surveys. The results will be conveyed to the School of Social Work and the Department of Nursing at CSUSB.

There are no personal benefits involved and there are no foreseeable risks to participating in this study. Your participation in this study will help to identify the cultural competence levels of these two programs.

If you have any questions or concerns about this study you may contact Dr. Ray Liles at 909/537-5557 or reliles@csusb.edu.

By marking below, you agree that you have been fully informed about this survey and are volunteering to take participate.

Mark _____ Date _____

APPENDIX D

DEBRIEFING STATEMENT

DEBRIEFING STATEMENT

Thank you for your participation. The survey you just completed was for a study of cultural competence in graduating Nursing and Master of Social Work students. It was conducted by Master of Social Work students Joanna Rubio and Jamie Webb from California State University, San Bernardino (CSUSB) under the supervision of Dr. Ray Liles. The information gathered from this study will help to measure how culturally competent students are on graduation and help identify areas where these programs can improve in their cultural competence education.

If you have any questions or concerns about this study you can contact Dr. Ray Liles (909/537-5557). The results will be in CSUSB's library after the summer of 2011.

APPENDIX E

APPROVAL EMAIL TO UTILIZE SURVEY

YAHOO! MAIL Classic

Re: Cultural Competence Assessment Friday, November 12, 2010 10:56 AM

From: "Carolyn Richardson" <crichardson@salud.unm.edu>
To: "chris webb" <webbs_family@yahoo.com>

Dear Chris.
We did not have the funds to do reliability and validity studies, therefore, there are no data available.
You are welcome to use the instrument and we do always appreciate researchers sharing their results with us.
Best wishes on your research and continuing studies.
Carolyn Richardson

Carolyn H. Richardson, Ed.D.
RWJF Center for Health Policy University of New Mexico
505.277.1530
crichardson@salud.unm.edu

>>> chris webb <webbs_family@yahoo.com> 11/12/2010 11:38 AM >>>
Dear Chana Hiranaka and Carolyn Richardson,
Our names are Joanna Rubio and Jamie Webb, we are Master of Social Work students from CSUSB; who are conducting research that compares the cultural competence of nursing and MSW students. We have come across your cultural competence assessment tool and found an adapted version from Tawara Goode. We needing to gain approval to use this and were hoping that you could provide us with your permission to utilize this tool in our research. We were also hoping that you could provide us with any articles you may have concerning the reliability and validity of your cultural competence assessment tool. At the conclusion of our study we would be happy to provide you with the results of our study.
Thank you very much for your time,
Joanna Rubio and Jamie Webb

APPENDIX F

TABLES

Table 1

Group Statistics

	Major	N	Mean	Std. Deviation	Std. Error Mean
ccscale	Nur	53	34.0943	4.30011	.59067
	MSW	52	35.8558	4.79720	.66525

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
ccscale	Equal variances assumed	.802	.373	-1.982	103	.050	-1.76143	.88870	-3.52396	.00110
	Equal variances not assumed			-1.980	101.338	.050	-1.76143	.88963	-3.52615	.00329

Table 2

Group Statistics

	Ageclass	N	Mean	Std. Deviation	Std. Error Mean
ccscale	1.00	79	35.1392	4.78843	.53874
	2.00	24	34.2292	4.09926	.83676

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
ccscale	Equal variances assumed	.319	.573	.841	101	.402	.91007	1.08159	-1.23552	3.05566
	Equal variances not assumed			.914	43.801	.365	.91007	.99519	-1.09586	2.91601

Table 3

Group Statistics

	Gender	N	Mean	Std. Deviation	Std. Error Mean
ccscale	Male	16	35.0625	4.66503	1.16626
	Female	89	34.9494	4.63439	.49124

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
ccscale	Equal variances assumed	.065	.800	.090	103	.929	.11306	1.25965	-2.38516	2.61129
	Equal variances not assumed			.089	20.684	.930	.11306	1.26549	-2.52113	2.74725

Table 4

Group Statistics

	MajMinor	N	Mean	Std. Deviation	Std. Error Mean
ccscale	1.00	72	34.9653	4.63858	.54666
	2.00	32	34.9063	4.69976	.83081

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
ccscale	Equal variances assumed	.004	.951	.060	102	.953	.05903	.98948	-1.90359	2.02165
	Equal variances not assumed			.059	58.838	.953	.05903	.99452	-1.93113	2.04918

Table 5

Crosstab

			Major		Total
			Nursing	MSW	
CC1	Almost Never	Count	2	0	2
		% within Major	3.6%	.0%	1.9%
	Sometimes	Count	21	11	32
		% within Major	38.2%	21.2%	29.9%
	Often	Count	21	20	41
		% within Major	38.2%	38.5%	38.3%
	Almost Always	Count	11	21	32
		% within Major	20.0%	40.4%	29.9%
Total		Count	55	52	107
		% within Major	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	8.197[a]	3	.042
Likelihood Ratio	9.069	3	.028
Linear-by-Linear Association	7.874	1	.005
N of Valid Cases	107		

Table 6

Crosstab

			Major		
			Nursing	MSW	Total
CC6	Almost Never	Count	5	7	12
		% within Major	9.4%	13.7%	11.5%
	Sometimes	Count	15	3	18
		% within Major	28.3%	5.9%	17.3%
	Often	Count	18	8	26
		% within Major	34.0%	15.7%	25.0%
	Almost Always	Count	15	33	48
		% within Major	28.3%	64.7%	46.2%
Total		Count	53	51	104
		% within Major	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	18.898[a]	3	.000
Likelihood Ratio	19.894	3	.000
Linear-by-Linear Association	5.945	1	.015
N of Valid Cases	104		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 5.88.

APPENDIX G

FIGURES

Figure 1

Group Statistics

	Major	N	Mean	Std. Deviation	Std. Error Mean
ccscale	Nur	53	34.0943	4.30011	.59067
	MSW	52	35.8558	4.79720	.66525

Figure 2

Group Statistics

	Gender	N	Mean	Std. Deviation	Std. Error Mean
ccscale	Male	16	35.0625	4.66503	1.16626
	Female	89	34.9494	4.63439	.49124

Figure 3

Statistics

Age

N	Valid	107
	Missing	0
Median		25.00
Percentiles	25	23.00
	50	25.00
	75	31.00

Figure 3 Continued

Age

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	21	5	4.7	4.7	4.7
	22	13	12.1	12.1	16.8
	23	16	15.0	15.0	31.8
	24	14	13.1	13.1	44.9
	25	8	7.5	7.5	52.3
	26	6	5.6	5.6	57.9
	27	4	3.7	3.7	61.7
	28	2	1.9	1.9	63.6
	29	7	6.5	6.5	70.1
	30	5	4.7	4.7	74.8
	31	3	2.8	2.8	77.6
	32	2	1.9	1.9	79.4
	33	1	.9	.9	80.4
	34	2	1.9	1.9	82.2
	35	2	1.9	1.9	84.1
	37	1	.9	.9	85.0
	41	2	1.9	1.9	86.9
	42	1	.9	.9	87.9
	43	1	.9	.9	88.8
	44	1	.9	.9	89.7
	45	1	.9	.9	90.7
	49	1	.9	.9	91.6
	50	2	1.9	1.9	93.5
	52	1	.9	.9	94.4
	54	1	.9	.9	95.3
	58	1	.9	.9	96.3
	59	1	.9	.9	97.2
	99	3	2.8	2.8	100.0
	Total	107	100.0	100.0	

Figure 4

Ethnicity

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Asian/Pacific Islander	18	16.8	17.0	17.0
	Hispanic	36	33.6	34.0	50.9
	Caucasian	30	28.0	28.3	79.2
	African American	6	5.6	5.7	84.9
	European	2	1.9	1.9	86.8
	Other	14	13.1	13.2	100.0
	Total	106	99.1	100.0	
Missing	Missing	1	.9		
Total		107	100.0		

REFERENCES

American Nurses Association. (2005). *Code of ethics for nurses with interpretive statements*. Retrieved June 3,2010,from http://www.nursingworld.org/MainMenuCategories/EthicsStandards/CodeofEthicsforNurses/Code-of-Ethics.aspx

Association of University Centers on Disabilities. (2004). *Cultural Competence*. Retrieved on April 29, 2011, from http://www.aucd.org/docs/councils/mcc/cultural_competency_assmt2004.pdf

Betancourt, J., Green, A., Carrillo, J., & Ananeh-Firempong II, O. (2003). Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Reports, 118*(4), 293-302.

California State University, San Bernardino. (2009). *Institutional review board*. Retrieved on June 7, 2010, from http://irb.csusb.edu/

Calvillo, E., Clark, L., Ballantyne, J., Pacquiao, D., Purnell, L., et al. (2009). Cultural competency in baccalaureate nursing education. *Journal of Transcultural Nursing, 20*(2), 137-145.

Chin, J. (2000). Culturally competent health care. *Public Health Reports, 115*(1), 25-33.

Colvin-Burque, A., Zugazaga, C. B., & Davis-Maye D. (2007). Can cultural competence be taught? Evaluating the impact of the soap model. *Journal of Social Work Education, 43*(2), 223-241.

Constantine, M. G. (2001). Multicultural training theoretical orientation, empathy, and multicultural case conceptualization ability in counselors. *Journal of Mental Health Counseling*, 23(4), 357-372.

Cordell, B. (2004). A spark for cultural competence in nursing. *Community College Journal, 75*(1), 18-21.

Council on Social Work Education (CSWE). (2004). *Educational policy and accreditaton standards.* Retrieved June 6, 2010, from http://www.cswe.org/file.aspx?id=14115

Encarta World Dictionary. (2009). Competent Definition. Retrieved on April, 29, 2011 from http://encarta.msn.com/dictionary_1861599122/competent.html

Hernandez, V., Mizrahi, T. & Davis, L. E. (2011). Generalist and Advanced Generalist Practice. *The Encyclopedia of Social Work*. Retrieved April, 29, 2011, from http://www.oxfordreference.com.libproxy.lib.csusb.edu/views/ENTRY.html?entry=t203.e160&srn=1&ssid=1134352901#FIRSTHIT

Kardong-Edgren, S., & Campinha-Bacote, J. (2008). Cultural competency of graduating us bachelor of science nursing students. *Contemporary Nurse: A Journal for the Australian Nursing Profession, 28*(1/2), 37-44.

Lenard, P. T., (2010). *What* can multicultural theory tell us about integrating muslims in europe? *Political Studies Review*, 8, 308-321.

Lesser, J., & Pope, D. (2007). *Human behavior and the social environment: Theory and practice*. Boston: Pearson Education.

Locke, D. C., (1998). *Increasing multicultural understanding: Comprehensive model* (2nd ed.).Thousand Oaks, CA: Sage Publications.

National Association of Social Workers. (2011). *Code of ethics of the National Association of social work* retrieved on April 15, 2011, from https://www.socialworkers.org/pubs/code/code.asp

National Center for Cultural Competence. (2010). *Planning, implementing and evaluating culturally competent service delivery systems in primary health care settings*. Retrieved on November 12, 2010, from http://www11.georgetown.edu/research/gucchd/nccc/search.html

Pacquiao, D. (2008). Nursing care of vulnerable populations using a framework of cultural competence, social justice and human rights. *Contemporary Nurse: A Journal for the Australian Nursing Profession, 28*(1/2), 189-197.

Pecukonis, E., Doyle, O., & Bliss, D. (2008). Reducing barriers to interprofessional training: Promoting interprofessional cultural competence. *Journal of Interprofessional Care, 22*(4), 417-428.

Purnell, L. D., & Paulank, B. J. (1998) *Transcultural health care: A culturally competent approach.* Philadelphia: F. A. Davis Company.

Ray, W. J. (2006). *Methods towards a science of behavior and experience* (8th ed.). Belmont, CA: Thomson/Wadsworth.

Russian Communication Association. (2009), *Value of professional conversation. Retrieved* on November 7, 2010, from http://www.russcomm.ru/eng/rca_biblio/m/matveev01_eng.shtml

Schim, S., Doorenbos, A., Benkert, R., & Miller, J. (2007). Culturally congruent care: Putting the puzzle together. *Journal of Transcultural Nursing, 18*(2), 103-110.

Temkin-Greener, H., Gross, D., Kunitz, S., & Mukamel, D. (2004). Measuring interdisciplinary team performance in a long-term care setting. *Medical Care, 42*(5), 472-481.

U.S. Census Bureau. (2004). *Projected population of the United States, by race and Hispanic origin: 2000 to 2050*. Retrieved on April 15, 2011, from http://www.census.gov/population/www/projections/usinterimproj/natprjtab01a.pdf

U.S. Department of Health and Human Services. (2005), *What is cultural competency?* Retrieved November 30, 2010 from: http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=11

U.S. Office of Minority Health. (2001). *National standards for culturally and linguistically appropriate services in health care: final report.* Retrieved May 31, 2010, from http://www.omhrc.gov/assets/pdf/checked/finalreport.pdf

ASSIGNED RESPONSIBILITIES PAGE

This was a two-person project where authors collaborated throughout. However, for each phase of the project, certain authors took primary responsibility. These responsibilities were assigned in the manner listed below.

1. Data Collection:

   Team Effort: Joanna Rubio and Jamie Webb

2. Data Entry and Analysis:

   Team Effort: Joanna Rubio and Jamie Webb

3. Writing Report and Presentation of Findings:

   a. Introduction and Literature

      Team Effort: Joanna Rubio and Jamie Webb

   b. Methods

      Team Effort: Joanna Rubio and Jamie Webb

   c. Results

      Team Effort: Joanna Rubio and Jamie Webb

   d. Discussion

      Team Effort: Joanna Rubio and Jamie Webb