Improving Interprofessional Practice & Cultural Competence with Interprofessional Education

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CENTER FOR HEALTH SCIENCES

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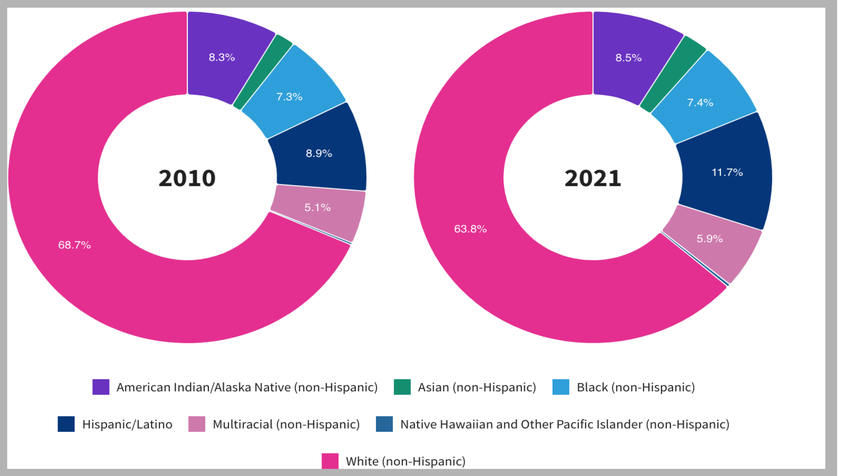
INTRODUCTION

Cultural Competency (CC) involves a person's awareness, empathy, and mindfulness of another's background including gender, sexual orientation, race, ethnicity, and religion in order to provide healthcare in an equitable manner.[1] Many resources have been targeted to recruiting health care workers for Indian Health Services in Oklahoma for the over 500,000 Native Americans from 39 federally recognized tribes (Figure 1). [2] However, minimal focus has been placed on CC with regards to Native American populations in future health providers. [3] Within educational programs, CC can serve to optimize learning, reduce bias, increase awareness of disparities, and improve communication.[4]

Figure 1: Ethnicity population data comparison in Oklahoma from 2010 and 2021.



OBJECTIVES

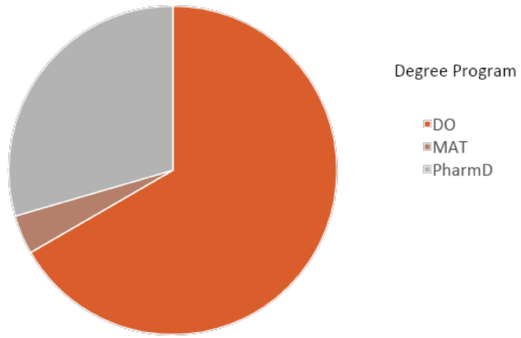
To identify the impact of a Diversity, Equity, and Inclusion IPE single-day event on the perceptions of interprofessional practice and ability to provide culturally competent care in students enrolled in Doctor of Osteopathy (DO), Pharmacy, and Athletic Training (AT) education programs.

METHODS

An experimental pre- and post-design utilizing measures of CC knowledge with the conference as the intervention. Participants included students (205 pre and 200 post) enrolled in healthcare programs at two Midwestern universities who completed the Tool for Assessing Cultural Competence Training (mTACCT) that included three CC presentations and two case studies with small group discussions. Due to uneven sample sizes in the pre- and post-test, and violations of normality and homogeneity of variance, Kruskal Wallis tests were used to assess differences in the intervention.

RESULTS

Participants



Key Findings

- ✓ Students recognized a deficiency in their cultural competency but demonstrated a desire for greater understanding.
- ✓ Students improved their ability to identify bias and stereotyping in healthcare

Table 1: Chi square results.

Item	X^2	DF	Sig
Disparities 1: Define race, ethnicity and culture	12.26	4	0.02
Disparities 2: Identify patterns of national data	18.15	5	0.00
Disparities 3: Describe patterns of health disparities	24.56	4	0.00
Disparities 4: Identify key areas of disparities	39.24	4	0.00
Disparities 5: Discuss barriers to eliminating health disparities	56.87	5	0.00
Disparities 6: Concretize epidemiology of disparities	32.42	5	0.00
Disparities 7: Gather and use data	32.64	4	0.00
Disparities 8: Critically appraise literature on disparities	28.17	5	0.00
Disparities 9: Recognize disparities amenable to intervention	28.78	4	0.00
Disparities 10: Value eliminating disparities	42.19	4	0.00
Bias 1: Identify how race and culture relate to health	31.15	4	0.00
Bias 2: Identify healthcare provider bias and stereotyping	45.45	4	0.00
Bias 3: Demonstrate strategies to address/reduce bias	34.19	4	0.00
Bias 4: Describe strategies to reduce provider bias	40.74	5	0.00
Bias 5: Show strategies to reduce bias in others	48.86	4	0.00
Bias 6: Value the historical impact of racism	57.59	4	0.00
Communication 1: Recognize patients' healing traditions and beliefs	51.32	4	0.00
Communication 2: Describe cross-cultural communication	57.68	4	0.00
Communication 3: Discuss race and culture in the medical interview (history)	44.17	4	0.00
Communication 4: Elicit a culture, social, and medical history	56.08	5	0.00
Communication 5: Use appropriate assessment tools	68.89	4	0.00
Communication 6: Elicit information in family-centered context	69.52	4	0.00
Communication 7: Use negotiating and problem-solving skills	75.97	4	0.00
Communication 8: Assess and enhance adherence	65.39	4	0.00
Communication 9: Respect patient's cultural beliefs	128.9	3	0.00
Communication 10: Nonjudgmental listening to health beliefs	146.7	3	0.00

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CONCLUSION

Though outcomes were significant, research indicates that CC should be incorporated in all levels of curricula for students to have sufficient understanding for application to patient centered care. Practitioners in Oklahoma may encounter patients from varying cultures including Native American nations. Cultural Competence efforts may improve healthcare in Native Oklahoma. Cultural competence (CC) training was found to significantly increase awareness of and ability to neutralize biases regarding CC. Vital aspects of CC such as students' ability to identify key areas of disparity (Disparity 4), identify healthcare provider bias and stereotyping (Bias 2), and non-judgmental listening to health beliefs (Communication 10) were greatly enhanced. Healthcare providers' abilities to help close the equity gap necessitates their ability to identify problems, assess one's own culpability, and create logistical solutions to non-equitable care. Negating provider bias should help decrease negative stereotyping across the intersectionality of population providers are likely to encounter. As well, improved provider listening may potentially lead to greater understanding of patient healthcare autonomy. Continued emphasis on CC should be stressed throughout the education process across all healthcare professional training programs. Healthcare outcomes specifically in Oklahoma should see a stark increase in competent and empathetic providers with continued educational commitments in the graduate level.

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