migrant-friendly hospitals

Subproject C

Staff training towards cultural competence

Evaluation report

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migrant-friendly hospitals

Executive summary

The project

Within the framework of the MFH project a lack of cultural competences of hospital staff has been identified by needs assessments as main problem areas in the participating European hospitals. Therefore training staff towards cultural competence to better handle cross cultural encounters has been selected on basis of international scientific literature as solution. Staff training towards cultural competence is acknowledged by experts as a quality assurance measure that improves health care services for patients of diverse cultural backgrounds. As direct aims of the project improving hospital staffs awareness, knowledge, skills and comfort level relating to the care of a diverse patient community have been determined.

Nine European hospitals participated in the staff training project: Seven out of the group have been able to implement training within an agreed timeframe and are subject of this evaluation report. In one hospital training has already be accomplished as a standard intervention and therefore it participated on the project by sharing its experiences. One hospital was at the time of the agreed project deadline still implementing and its measures are therefore not included in this evaluation.

Evaluation

The training intervention has been carried out on basis of a review / Pathway of effective interventions based on international knowledge on staff training. That Pathway served as a “quality standard” against which actual implementation has been compared. An evaluation instrument/questionnaire to measure changes on staffs awareness, knowledge, skills and comfort level, as well as staff satisfaction with and impact of the training has been applied. Focal persons measure documentation and interviews provided relevant information for benchmarking. Five criteria for evaluation have been applied:

1. Feasibility / acceptability of the training
2. Quality of the training
3. Effectiveness of the training
4. Cost effectiveness
5. Sustainability

Success of the training intervention has been evaluated on basis of two criteria:

- The ability of attracting a large number and professional mix of staff and
- The effectiveness of the training.

Those two criteria are presumed rather independent and pilot hospitals could achieve different degrees of successfulness concerning participation and effectiveness.

Results: Feasibility

The example of seven pilot hospitals demonstrate that cultural competence training courses are feasible in a wide range of hospitals all over Europe. As important requirements for feasibility have been acknowledged:

- The commitment of an organisational team / project group
- Approval / (strong) support of the general hospital management and department management / department heads
- Gaining understanding / acceptance by staff / participation
- Arranging time, place, human resources (e.g. trainers) and other facilities for training.

The table below pictures an overview on the extend of the training intervention in the 7 evaluated hospitals:

	H1	H2	H3	H4	H5	H6	H7
Nr. of courses	2	2	1	1	2	1	2
Duration	3 weeks	10 weeks	10 weeks	2 weeks	10 weeks	2 weeks	6 and 2 weeks
Hours	10	10	13	6	10	15	12 and 9
Nr. of partici-pants	39	19	16	6	22	17	24
Partici-pating staff	Doctors Nurses Other staff	Doctors Nurses Other staff	Nurses Other staff	Doctors Nurses Other staff	Nurses Other staff	Doctors Nurses Other staff	Doctors Nurses Other staff
Targeted depart-ments	Psychiatric admission, emergency internal med	Internal med., surgical ward	Obstetric, haema-tology, emergency clinical laboratory	no specific depart-ment targeted	X-ray, radiograph y, health promotion, nursing	Emerg-ency, paediatric, gynaeco-logy, obstetrics	Cardio thoracic surgery, oncology

Experienced difficulties mainly allocated to the narrow project timeline have been: Targeted departments could not be motivated for cooperation; arranging working shifts limited participation in courses that stretched over more than one day; intermittent support from part of management and mobilising certain professional groups to attend training could not be obtained.

Conclusions from experienced difficulties: The need for clear and determined communication work at a preliminary stage, communicating the importance of training and reassuring support from all persons having an influence on staff turned out to be vital. Concerning training participation, the absence of some professional groups and management could cause limitations on the impact of training on every day practice and the overall establishment of cultural competence in healthcare delivery at the hospital.

Results: Quality

The quality of the cultural competency training depends on the following interdependent aspects:

- Timeframe and structure
- Content and process
- Staffs composition
- Competences of the trainer / team of trainers

Hospitals experiences made apparent that timeframes and training structures that include follow ups to enable experiential learning have a highly constructive effect on staffs ability to take leaned cultural competence into practise and then discuss upon experiences and therefore nurture further personal cultural competency developments. The different training designs of the European hospitals demonstrated that highly practical problem based training approaches, ideally on the basis of a specific need assessment and experiential learning designs have proved most effective in increasing staffs skills and comfort level. The competences and the composition of the trainer / trainer teams (e.g. inviting cultural mediators) strongly influenced the training quality as well as its outcome. Concerning combined or separate training for staff a tendency towards separate training for individual departments was recognisable following the first training experiences. But choices on the training participants profile need to be adjusted to the hospital culture as the experience of a successful interdisciplinary approach in one pilot hospital pictures.

Results: Effectiveness

The effectiveness of cultural competence training on staffs awareness, knowledge, skills and comfort level as well as their satisfaction with the training and the self rated impact could be demonstrated as positive changes in all questioned areas have been evident.

Concerning the criteria of the ability to attract a large number and professional mix of staff, the participating pilot hospitals succeeded in inviting participants to different degrees, as the numbers and profiles of participants varied a lot, between 39 (H1) and 6 (H4) participants.

The experiences of the hospitals indicate that decisions on training content and design are having consequences on the training effect as best shown by the training focal point of developing skills: Developing skills as part of the training will subsequently affect staffs skills for appropriately, effectively, efficiently and sustainable handling of diversity positively. High skills improvement is believed to correlate with the length of the training timeframe and experiential learning, as staff can practise upon newly learned skills, bring back experiences into the course and are encouraged for further skills development. The trainers competencies and teaching methods are also believed to have an influence on the development of skills. Participants satisfaction with the training depends a lot on the level of expectations and in case of long timeframes, the time for reflection on the

training subjects and already gained practical experiences. Staffs satisfaction can be summed up as high in most hospitals, even in a couple of cases training could not completely meet all staffs expectations.

While most training attendees of the European hospitals reported an high impact, the self rating on the impact on every day work practise varied according to hospitals training approaches. Again decisions on the training design and content, including timeframe, participants profile and certainly the ability of trainer(s) to equip participants with competences that they can use in everyday work encounters are believed to affect the rating.

Results: Cost effectiveness

While the additional / external costs of the training comparing to other hospitals training activities have been considered medium or even low, all hospitals stated the organisational costs of planning and organising the training have been high. But this were developmental costs that will decline once training has become routine within the hospitals organisation. Training was considered worthwhile in all hospital as problems within the workspace and workforce concerning cultural diversity aspects have been evident and a positive impact of the training is highly plausible. Planning training in advance with high support from the hospitals management and organising training by departments as well as choosing a less time consuming training concept are proposals for a more cost effective training.

Results: Sustainability

Cultural competency activities will stay an issue that will be addressed in all pilot hospitals, even in some cases decisions concerning the exact form of continuation of the training were still outstanding, respectively the future planning has not been finalised by the time this report was written. But intentions of the training organisers to modify training - its extend and design – have been evident. Main modifications are concerning the targeted units: concentration on single or similar departments is favoured, the training timeframe: 10 hours have been considered too long and the curriculum: a stronger focus on practical issues. Sustainability through integrating cultural competency training as standard implementation into the CPE could be already accomplished by the time of this report by two pilot hospitals. Concerning the inclusion of cultural competence into the hospitals quality system, its integration as an overall aim is highly accepted among the participating hospitals but incorporation is a long term process that exceeded the pilot project frame. Summing up the results: Quality work is in progress.

Proposed consequences of the evaluation results

The experiences of the European project partners, their successfulness in implementing training and the training outcomes are very encouraging: Training will make a positive difference on staffs awareness, knowledge, skills and comfort level. The difficulties the participating hospitals faced and

their decisions concerning future training intervention advocate a reshaping of the training approach. Instead of an extensive integrated training as practised by most hospitals during these pilot phase a two level approach might be considered:

1. Generic basic training
2. Practical cultural competence development as part of the quality management on department level

A basic introduction into the subject of cultural competence, increasing staffs (self-) awareness and receptivity to diverse patient populations as well as their knowledge and basic skills concerning matters of diversity to enable them to better handle cross cultural encounters should be the aim of the generic basic training. Finding practical solutions for existing and appearing problems, developing cultural competency routines for service provision and improving existing ones, can be targeted at the level of quality management on the department level. Organising “mirror meetings” where patients of diverse backgrounds, health care staff and community representatives are working together to help guide the delivery of cultural competent care, including cultural competency issues in team meetings and staff rounds, case discussions on department level, etc. are some examples of practical cultural competency developments that can take place on the department level. Cooperation with diversity contact persons as well as expert advisers on the subject of diversity issues might be necessary involvements.

This two level approach combines interventions on the personal and the organisational level and can ensure personal as well as organisational developments toward cultural competence and should be thought as long term developmental measures.

1 Introduction

"Cultural competence" has been acknowledged by experts as an important skill for health care professionals. Cultural competence is the ability of health care professionals (some argue also of organisations / systems) to provide good quality care to patients with diverse values, beliefs and behaviours, to work effectively in cross-cultural situations (adapted from the standard definition Cross et al. 1989). Given the specific nature of health care services competences of health care professionals contribute heavily to the quality of health care of minority / migrant groups. Thus implementing cultural competence training is recommended as a quality assurance / improvement measure in countries with diverse populations like the United States, Canada and Australia. In Europe training of hospital staff towards cultural competency is still in a stage of development, although there are some examples of implementation and effectiveness, e.g. The Bradford Experience[1].

The Intervention

On the basis of a needs assessment and a review of effective interventions[2], the MFH project partners decided to implement and evaluate cultural competence trainings as one of the three European subprojects.

The direct aim of the cultural competency training was

- to improve hospital staffs awareness, knowledge, and skills, relating to care of patients from diverse backgrounds
- increase staffs comfort level with cross cultural health care encounters

Thus, the courses were expected to make a contribution to quality improvement of everyday practice in the participating hospitals – hospital services are expected in the middle and long run to take diverse cultural expectations better into account. A proposal to include further change management measures in the subproject was rejected in the European meeting in Reggio September 2003. This lead to the decision to stick to a more limited intervention and also to evaluate primarily the direct effects of the training on staff – and not to try to monitor changes in everyday practice.

To support the participating hospitals, especially those who did not have systematic experiences with cultural competence training for staff, LBISHM had collected international knowledge on staff training towards cultural competence. This expert knowledge has been submitted to the participating hospitals to provide guidance for implementation in two documents:

1. Pathway for implementation and evaluation
2. Modules for staff training towards cultural competence

As participating European hospitals are quite heterogeneous in their organisational structures, their hospital culture, staff composition and their

[1] Khan 2003
[2] Bischoff 2003

(migrant) population, and the time available for implementation in the framework of the MFH-project was rather short, the agreement was to accept that the hospitals would follow this guidance as good as their local situation allowed.
In this evaluation report, the Pathway and the Modules serve as a “quality standard” against which actual implementation is compared. In addition, the specific expectations of the local focal persons have been further criteria against which the actual implementation and the experiences were compared.

Project partners
Within the Migrant Friendly Hospitals Project, nine out of twelve European hospital participated on the staff training towards cultural competence project. Those nine hospitals are:

- Academic Medical Center of the University of Amsterdam (AMC-UvA) • The Netherlands, NL. Focal person: Hanneke HARTOG
- Hospital Punta de Europa • Algeciras-Cádiz, Spain, ES. Focal person: Antonio SALCEDA de ALBA
- Bradford Hospitals NHS Trust • Bradford, United Kingdom, GB. Focal person: Dilshad KHAN
- Kaiser Franz-Josefs-Spital • Vienna, Austria, AT. Focal person: Karoline KANDEL
- Hôptial Avicenne • Paris, France, FR. Focal person: Olivier BOUCHAUD
- Uppsala University Hospital, Psychiatric Centre • Uppsala, Sweden, SV. Focal person: Manuel FERNANDEZ
- James Connolly Memorial Hospital • Dublin, Ireland, IR. Focal person: Angela HUGHES
- Presidio Ospedaliero della Provincia di Reggio Emilia • Reggio Emilia, Italy, IT. Focal person: Alice BERTOZZI and Corrado RUOZI
- Immanuel Krankenhaus GmbH – Rheumaklinik Berlin-Wannsee • Wannsee, Germany, DE. Focal persons: Beate LIESKE and Werner SCHMIDT

At the time of this report the participating hospitals AT, DE, FR, ES, IR, IT, SV had successfully completed training within the timeframe agreed between the coordinators and the participating hospitals and their implementation experiences are focused upon in this evaluation report.

The Academic Medical Center of the University of Amsterdam, NL conducted within the project phase a “mirror meeting” (as a quality monitoring instrument) to define training needs and to develope an extensive training program for medical students, nurses, physicians and other health care workers. The evaluation questionnaire CCCTQ-PRE provided by LBI was used as a diagnostic instrument, but so far not as evaluation instrument for the training intervention. At the time of this report training implementation was still in progress and therefore their experiences have not been included in this evaluation.

Bradford Hospitals NHS Trust, GB shared its extensive experience with the group as cultural competence training has already been realised in its organisation.

General evaluation criteria

For evaluating staff training towards cultural competence five criteria have been applied:

1. Feasibility / acceptability of the training – Was training feasible in the expected extent?
2. Quality of the training – Could training be developed in the basis of international knowledge as outlined in the Pathway?
3. Effectiveness of the training – Could training affect staffs awareness, knowledge, skills and comfort level in a positive direction? Could staffs' satisfaction be obtained? Did training have a (perceived) impact on staff ability to cope with their work situation?
4. Cost effectiveness – How cost effective was the training?
5. Sustainability – To what extent has cultural competence training been integrated in continuous professional education / quality assurance / development in the hospital?

Information collection for evaluation and benchmarking

1. Feasibility, quality, cost-effectiveness and sustainability of the training has been evaluated on the basis of information received from measure documentation sheets provided by LBI, progress reports by focal persons and trainers and interviews / bilateral communication between LBI and the focal persons.
2. For evaluating effectiveness of the training, a standardised instrument has been used. The instrument has been developed on the basis of the "Clinical Cultural Competency Questionnaire - CCCQ" kindly provided by Robert Like[3] to measure changes in self-rated awareness, knowledge, skills and comfort levels and was distributed to the participants in a before / after the training design. The post-questionnaire included also some questions concerning satisfaction with the course and a question asking for the (expected) impact on everyday practice. For detail on the evaluation questionnaire please see appendix section 10.1.

Some methodical remark concerning the evaluation: The results are not a proof for the effectiveness of cultural competence training but indicators for its feasibility and the plausibility of its effectiveness in a certain direction.

[3] CCCQ adapted with permission from Robert C. Like (2001). Center for Healthy Families and Cultural Diversity,
Department of Family Medicine, University of Medicine and Dentistry of New Jersey-Robert Wood Johnson Medical School, Project sponsored by Aetna Foundation 151 Farmington Avenue Hartford, CT 06156 USA http://www.aetna.com/foundation/main_mission.htm

Project biography / timeline

October 2002: Start of the MFH project

November 2002 – April 2003: Review of effective models

Febrary – March 2003: Carrying out Needs Assessments and NA analyses in pilot hosptials

April - May 2003: Selection of 3 common European subprojects, one of it is Subproject C: Staff training towards cultural competences on basis of NA results and the review

May - June 2003: Development of guidelines and manuals for subprojects and decisions on local implementation of European subprojects

September 2003: Training workshop in Reggio Emilia, Italy, Emilia Romagna Region. Decisions on the extend of the training intervention

October 2003: LBISMH provides Pathway for implementation and evaluation and Modules for training

November 2003 – January 2004: Planning and preparation of staff training towards cultural competence

December 2003: Adaptation of evaluation instruments CCCTQ-PRE and CCCTEQ-POST, translation into languages of project partners

February 2004: EU implementation workshop - mutual support, dimensions of evaluation design and instruments

February – June 2004: Implementation and evaluation of staff training towards cultural competence in the pilot hospitals

June – September 2004: Evaluation of the training, data analysis

September 2004: Benchmarking meeting in Dublin

December 2004: Final conference: Presentation of project results, launch of European Recommendations

March 2005: Final publications, project end

2 Feasibility of cultural competency training

Seven of the eight European hospitals who had planned to implement cultural competency training actually managed operation within the agreed timeframe between January and June 2004 and thus **demonstrate feasibility of this intervention in a wide range of hospital types all over Europe.** Only one partner was at the time of this draft report still implementing and thus could not be included in this evaluation. It that single case it turned out that feasibility of implementation within the agreed timeline was not possible.

Implementing the training included a number of preparatory steps and was carried out by sub-project co-ordinators supported by project groups and overall focal persons of the local MFH projects. The main steps were:

- Obtaining the managerial support for the training project and obtaining funds for the training sessions.
- Getting staffs acceptance / participation
- Making decisions concerning the number of training courses and the approach of inviting participants by choosing selected departments or communication to all hospital staff.
- Finding human resources for conducting the training (trainer / team of trainers).

2.1 Gaining acceptance / support from hospitals management

Pathway recommendations:
Following principles and experiences from change management, getting hospital managements permission, approval and support in the initial planning phase of the training and ensuring funding has been considered vital by the Pathway. Agenda-setting at the management level – in meetings, conferences, symposia, etc., to raise awareness and providing information, has been advised.

Hospitals experiences:
The project coordinators from all seven pilot hospitals reported support from the overall hospital management for the training implementation in the initial planning phase. But this support was not quite unambiguous / stable: In two cases (H1, H3), a lack of active support by the general nursing management was reported. Also in H3 changes on the managerial level happened and thus support had to be reconfirmed. **As a general rule most of the managerial support was theoretical, e.g. verbal / written support with little operational support.**

Financially support from the hospital for the training organisation has been made available to varying degrees:

- The permission to use of hospitals facilities (rooms, technical support) could be obtained by all training organisers.
- Funding for trainers / teams of trainers have been made available in two hospitals (H1, H6, H7) and partly in one hospital (H4). In the three other cases (H2, H3, H5) trainers / team of trainers worked on a voluntary basis. In the case of H4 hospitals internal persons conducting the training and it was therefore considered as part of the regular financed working time.

In all hospitals, the focal persons reported on a lot of the training organisation work done on a voluntary basis by themselves as well as by the project groups.
Decisions on the use of hospital funds are also a necessary part of the section 2.3.

2.2 Targeting specific departments as measure to increase relevance for management and staff

Pathway recommendations:
After obtaining support from the general hospital management canvassing for department management / heads support and cooperation was considered useful for training feasibility and to further staffs participation. Therefore the Pathway recommended to select departments and not to make an open call. This approach accepted also the fact that everyday practice in most hospitals is determined on the department level, thus also reducing the risk of too much resistance arising from a top-down overall organisational approach. The Pathway advised against an overly non-obligatory, volunteer-based approach as it embraces the risk that staff might not attend because it expects no organisational impact.
In a first step organising training for 2-3 model departments that volunteer for the course was advised. The “selected department approach” also should enable a better, more practical focus on the training and support staff expectations that training results would be considered relevant in everyday practice, at least in the participating departments.

Hospitals experiences:
The **selected department approach** has been considered by most of the pilot hospitals as useful because **concentrating on smaller units did enable a more efficient operating and helped getting the department heads support**:

- Four hospitals that opted for a selected department design (H1, H2, H6, H7) were able to carry out their plans. In selecting, they turned to departments according to their migrant patient population and to

department managements' willingness and interest in releasing staff for participation and generally in cooperation.
- In one case (H5) compromises within the department selection (in vs. outpatient setting) had to be made, departments with similar patient settings have been targeted in the initial planning phase but departments with different patient settings did finally cooperate.
- Selecting departments and additionally keeping an open approach to all other hospital staff has proved feasible by one project partner (H3).

An **unselected department approach**, targeting all hospital staff, was practised by one hospital partner (H4). As it resulted in **difficulties getting staff committed to attend**, the focal person expressed the intention to concentrate in future on specific departments as support from the department heads is considered necessary to raise participation number.

2.3 Getting staff acceptance / participation: Benefits

Pathway recommendations:

To ensure staff acceptance / participation, the Pathway had advised:
- To get management support on the overall hospital and department level (also discussed in section 2.1 and 2.2)
- To define participation as voluntary, but to heavily champion it by (department) management
- To allow for participation in training during regular working time
- To grant credits for CPE (Continuous Professional Education) for those participating

Thus the Pathway recommended to clear-cut the relevance of the forthcoming training. For getting staff to participate and to cooperate, communicating the following aspects was suggested:
- Cultural competence as skill to help staff members handle problems created by cultural diversity
- Training is about staff and their problems, they are the focus of interest
- Staff satisfaction will improve quality of care which indicates positive consequences for patient care

Hospitals experiences:

A call on staff to participate was organised using a variety of approaches:
- Letter of support by hospital management was forwarded to medical and nursing head staff. Written information, presentation of project

within daily staff meeting at one department and lobbying of project group were major efforts (H1).
- The department heads were informed by the hospital director and the participants were invited by subproject coordinators (H2).
- Hospitals directors support and project group efforts: Staff information sheet, notice board (H3).
- Information was transported through the hospitals continuous education program to the head nurses in each department (H4)
- Department heads did the invitation and in departments where uptake was slow, the program was further promoted by the health promotion coordinator (H5)
- Support from the directorial board could be obtained (H6).
- Support from the directorial board and invitation through members of staff (H7)

Training was provided in working time in six hospitals (H1, H2, H4, H5, H6; H7) but some staff also visited the training out of working time H1 and H2. Organising training out of working time has been successfully in H3, referring to the high interest and commitment of some staff.
In some cases credits for continuous professional education have been provided:
- In the pilot hospitals H4 and H6 training could fully be integrated in the hospital internal continuous professional education.
- In H1 CPE credits were given only for nurses.
- In H3 credits for CPE have been promised by the nursing direction but were not realised at the end.

Nevertheless **acceptance of a need for cultural competence training** by hospital staff was **not always easy to gain.** Partners experienced that motivating staff for participation turned out to be a rather demanding task and accounted for considerable effort for staffs invitation and communication with all relevant involved persons. Only two hospitals (H1 and H2) could achieve participation to the planned extend.
- Even though H1 did experience various acceptance stages: Low interest from the professional group of nurses at the beginning, also attributed to resistance towards the project from the nursing management. Then an increase of interest and finally a high demand for participation especially from the psychiatric department with an balanced attendance of nurses and physicians could be registered, possibly created by information about the trainer who has been well known among psychiatric staff
- Focal person from H2 reports of a lot of communication work to further participation.
- The emotional, political and social climate following experiences with terrorism had been considered a potential treat to one training organisation (H3), but did surprisingly hardly affect participation.

- As parallel organised activities of the MFH project did absorb staffs interest the need for further activities was difficult to communicate (H5).
- Some important professional groups (physicians) could not be motivated to participate in H3 and H5.

To raise physicians participation a training approach that concentrates on physician relevant diversity subjects and that relates to physicians way of reasoning has been considered as possible helpful by one of the focal person. Certain credits that are of relevance to the targeted profession, e.g. financial rewards or free time have been suggested by another focal person. Consideration has to be given to the aspect that gaining the acceptance of different professional groups might require different strategies / arguments (according to the individual hospital culture).

Organisational difficulties that limited participation or full attendance of all training modules had been reported in H1, H4, H5 and H6:

- as the timeline for inviting participants was considered as too short to arrange shifts and staff shortages and busy work load were evident (H1, H4, H5, H6).
- In H1 the trainer got ill and the co-trainer could not take over, therefore the planned training date could not be kept by and an additional date could only be attended by a minority of the participants. Staffs duty rotas have been very tightly calculated and therefore not flexible enough to enable postponements, according to the focal person.

The following table presents the total number of training participants in the European hospitals:

	H1	H2	H3	H4	H5	H6	H7	Total
Nr of training participants	39	19	16	6	22	17	24	149

The percentage of participants that could attend the training fully or only partly is documented below. Fully attendance of the training is believed to be necessary to provide proper quality of the training / continuation and to reflect upon the trainings effectiveness. **Training modules should be complementary and continuation can only be provided by full attendance.**

Attendance	H1	H2	H3	H4	H5	H6	H7
Fully	50%	55%	40%	83%	9%	63%	90%
Partly	50%	45%	60%	17%	91%	37%	10%

Training participants profile is only available from those participants who completed the questionnaires and were willing to provide demographic details:

	H1	H2	H3	H4	H5	H6	H7	Total
Nurses	13	13	6	4	7	6	19	64
Physicians	12	3	-	1	-	5	2	20
Other staff	4	3	7	1	15	6	2	36

Training participants have been mainly from the following department:

Hospital	Departments
H1	Psychiatric dept, admission and emergency, internal med.
H2	Internal med., surgical ward
H3	Obstetric department, haematology, emergency dept, clinical laboratory
H4	Haematology, parasitology, rheumatology, emergency dept
H5	X-ray dept, radiography, health promotion, nursing dept
H6	Emergency dept, paediatric dept, gynaecology, obstetrics dept
H7	Cardio thoracic surgery dept, oncology

2.4 Number of courses

Pathway recommendations:
The Pathway advised to conduct in a first step one or two courses to train staff from selected departments that volunteer for the project. This was expected to serve as pilot for a system to train all relevant staff.

Hospitals experiences:
One (H3, H4, H6) or two course turns (H1, H2, H5, H7) have been implemented in all hospitals within the evaluation timeline. Some focal persons felt that the timeline set by the European project organiser for evaluation did not leave space for more than one or two courses to get evaluated. On the other hand some organisers used the timeline for obtaining first training experiences (cultural competency training to the extent realised in the MFH project was a new experience to all hospitals) and concrete plans for further training interventions were depending on the gained experiences. **Decisions on course numbers have been made according to staffs availability and the number of staff that did register for participation.** The hospitals did provide all the necessary facilities that the courses could be conducted within the hospitals premises.

2.5 Recruiting a trainer / team of trainers

Pathway recommendations:
Training towards cultural competence was advised to be best conduced by an experienced trainer or a trainer team. The Pathway pointed out a series

of criteria the trainer(s) should accomplish (this will be discussed in section 3.4 below).

Hospitals experiences:
All participating hospitals were able to recruit a trainer (H2, H5, H6) or a trainer team (H1, H3, H4, H7). Additional human resources have been mobilised by including cultural mediators in the training by H2, H3, H6. The influence of the trainer / team of trainers on the training quality will be discussed in section 3.4. **Finding and recruiting a suitable, competent trainer / team of trainers has been experienced as arduous task by those organisers, who had no previous references of trainer / team of trainers.**

2.6 Summary

The summary in table 1 provides an overview of important tasks that have been set in progress by very committed focal persons and organisational teams and the problems they faced:

Requirements for training feasibility	Important tasks and beneficial aspects	Experienced difficulties
Managerial support	- Getting hospitals management permission, approval and support - Increasing relevance for management/staff by targeting departments - Agenda setting at the management level - Ensuring funding	- Change in management (re organisation) - Conflict among senior management - Verbal, written management support with little organisational support - Relevance of cultural competence no priority for management
Getting staff acceptance / participation	- Participation heavily championed by (department) management - Participation during regular working time - Credits for CPE - Clear cut relevance for training	- Unselected department approach - difficulties in getting staff committed to attend - Organisational difficulties of getting staff released for training – full attendance not obtained - communicating relevance of training - Low attendance of specific professional groups (physicians)
Resources	- Providing necessary resources, e.g. organising rooms, materials	

	- Recruiting trainer/s	

Table 1: Requirements for training feasibility

3 Quality of training

The quality of staff training towards cultural competence is described by four main aspects:

- The timeframe of the training
- The training content and its' reference to practical hospital relevant problems
- Staffs composition
- Trainer competences

The following chapter shows the measures set by the pilot hospitals concerning the above aspects and details to what extend compromises had been made in training implementation that might influence the training quality. Looking at any expected or unexpected consequences of conformity with the **extensive integrated training** recommended by the Pathway and possible deviations from this guidelines, are part of this report. As the quality of the training is believed to influence the training effectiveness different training implementation strategies should provide an important basis for analysing training outcome / effectiveness.
Of course, quality is a complex issue. For pragmatic reason we use the model suggested in the Pathway as "standard".

3.1 Timeframe and structure of the training

Pathway recommendations:
A four module training structure with overall approximately 10 hours course time has been suggested by the Pathway. For best results, it was advised not to leave more than a one weeks gap between module 1 and 2. Module 3 (Follow up 1) was suggested to be staged four weeks after module 2. Module 4 (Follow up 2) should have been conducted four weeks after module 3. It was stressed that best results will be achieved by running through the full course.
Suggested timelines for specific modules:
Module 1: 3 hours (or 4 hours)
Module 2: 3 hours (or 2 hours)
Module 3 (Follow up 1): 2 hours
Module 4 (Follow up 2): 2 hours
The reason for suggesting the initial training session to last 3 or 4 hours was to enable participants to really get into the subject of cultural competence and diversity. To run through a full training content as discussed in the chapter 3.2 needs a certain amount of time, 10 hours overall have been regarded reasonable. The time lag between module 2 and 3 as well as 3 and 4 should enable participants to practice the newly learned competence,

discuss upon their experiences and enforce further development of skills on the basis of experiences in everyday practice.

Hospitals experiences:
Organisational difficulties concerning the release of staff from their work shifts have been experienced by all hospitals to different extents and had influenced the chosen timeframes.

- Two (H2, H5) of the evaluated hospitals have chosen the recommended design with a time lag of approximately 2,5 month, with a gap of one month between module 3 and 4. This training design has been highly approved of by organisers and trainers as to their account that training design did allow participants not just to get confronted with the subject of cultural diversity within the course but also did foster experiences with the newly learned competences. **The importance of follow ups has been acknowledged.** Practising and reflecting the training contents and finally discussing it with the training group and subsequently sharing experiences was one advantage, another one was to accompany staff on their emotional journey. Different stages of development could be identified: Starting out from a promising atmosphere of departure at the beginning of the training once possible resentments are broken down, high expectations, getting back to practical every day work, certain amount of frustration, then again positive experiences and in the end development of a realistic view of possibilities and limitations of what can be achieved within the constraint of every day practice.
- One pilot hospital (H3) had in the initial planning phase chosen a three module design but added another one due to high interest and requests for extension from the training attendees. The timeframe was approximately 2,5 month. Module 3 and 4 were open for interaction but not exclusively designed as experiential learning.
- In H7 a training design with six modules has been chosen. The timeframe has been for one course (oncology dept.) six weeks and for another course (thorax dept.) two weeks. Experiential learning was part of each module.
- H1 did provide a three module training within a timeframe of less than a month. Module three was not exclusively designed as experiential learning.
- Training organised in a timeframe of two days without any follow up modules has been in one case (H6) reasoned with the limited availability of the trainer, who could only offer two days for attendance, and in the other case (H4) a more extended training was considered as too time consuming (staffs availability could not be obtained). The time gap between the two arranged training days was in both cases 2 weeks.

Concerning the lengths of the training units, not to extend 2 hours training time on one day have been advised by some hospitals (H4, H5), as they

experienced that training attendees could not keep their concentration up for longer time duration.

The table below lists up the number of courses as well as timeframe and amount of hours of the training.

	H1	H2	H3	H4	H5	H6	H7
Nr. of courses	2	2	1	1	2	1	2
Duration	3 weeks	10 weeks	10 weeks	2 weeks	10 weeks	2 weeks	6 and 2 weeks
Hours	10	10	13	6	10	15	12 and 9

3.2 Training content and process

Pathway recommendations:
Awareness, knowledge and skills have been suggested to form the framework of the training and be transmitted in the first two modules:

- **Raising Awareness** to increase self-awareness and receptivity to diverse patient populations and to increase awareness of participants own biases and experiences with diversity.
- **Providing Knowledge** about problems concerning staffs encounter with diversity, offering (model) solutions and expanding knowledge and competence to work effectively in a multicultural environment and serve diverse consumers.
- **Developing Skills** in the area of cultural competence: Skills that enable health care staff to assess their own responses, biases and cultural preconceptions on an ongoing basis. Skills as communication tools and strategies to elicit patients social, family and medical histories, as well as patients health beliefs, practices and explanatory models. Skills for negotiating conflicting patient / provider perspectives.

Module 3 and 4 were suggested to be designed as follow ups. Follow ups to enable **experiential learning** have been recommended as highly effective for the training outcome and for a sustainable and successful development within the hospital:

- **Experiential learning** to share experiences about actions taken in everyday practice resulting from the initial training. Problem discussion and developing further skills should be part of the agenda.

The training content should be based on specific problems / experiences that participants have encountered in their workplace and in providing service to diverse consumers. The content of the training should be as close as possible to the hospitals problem reality. Needs assessment on department level were advised to be conducted as results are considered

important material for developing a design based on actual problem for the training.

The course should promote cognitive and emotional learning, which suggests the use of diverse and interactive educational methods such as case studies, role plays (up to drama elements), discussions, panel discussions to demonstrate different perspectives, the use of guest speakers on certain topics, etc. Diversity of educational methods also recognizes participants' different learning styles.

Hospitals experiences:
Training contents have been designed **considering the counties' and hospitals' specific situation** in all participating hospitals, e.g. referring to the hospital specific migrant patient populations and the countries immigration situation.

Table 2 shows a list of the main problems of the hospitals that should be solved by the training, and the training content:

Hospital	Main problems	Training content
H1	- communication problems - lack of knowledge about different ethnicities - need for more support of staff when dealing with cross cultural encounters	- conceptions and models of illness/disease - aspects of migration - perception of non verbal communication - sensitisation of own reactions and perceptions
H2	- language barriers and cultural misunderstandings	- raising awareness – pointing out own and different views, values and environmental conditionings - deeper view for issues disease and illness, especially referring to main migrant group - communication tools - experiential learning-
H3	- cultural communication barrier - low voice of social forces inside the administrative / bureaucratic structure of hospital	- legal status of immigrants, immigration in the country, a profile of immigrants in health areas - stages of the migratory process - prejudices and stereotypes - concepts of time, space and health in different cultures referring to main migration group - interaction with migrant patients
H4	- understanding cultural reasons for non compliance - understanding cultural	- knowledge on historical data regarding own countries migration, social organisation of migrants,

	reasons to explain patients behaviour - compliance to treatment and follow up - communication between patients and staff - health education	disease anthropology - links between psyche and body - problems with different languages and expression of pain and suffering, depression and anxiety referring to main migrant group
H5	- awareness of the importance of cross-cultural patient care - communication problems	- defining & understanding the concepts of culture and diversity - exploring changing demographics / global context / migration - exploring cultural 'self' / our own culture' - defining cultural competency and its relevance to healthcare -exploring cultural understandings of health & illness - cultural significance & universal functions of food - examining origins of racism as a form of discrimination - exploring the importance linguistically appropriate services - developing and enhancing cross – cultural communication - exploring the development of community partnerships
H6	- communication problems between staff and foreign patients - difficulties in diagnosis and treatment of foreign patients - prejudices and ignorance towards foreign patients	- from multicultural society to an intercultural approach - body, health, disease and medicine in a pluralistic health system - the care pathway of the foreign patient - cultural diversity as a challenge for health services - taking care as intercultural strategy
H7	- lack of routines in translation / interpreting - lack of knowledge about basic epidemiological issues in migrant groups in the own hospital area - lack of knowledge on other cultures	- culture and health care - migrant groups in own country - migration process and mental health - migration, culture, refugee trauma and mental health - religion and health care, importance of rituals - religion and mental health

Table 2: Main problems of pilot hospitals and training content

The efforts of carrying out needs assessments have proved worth while by those focal persons who could enforce the need assessment results, as training issues that reflect upon staffs practical work experiences and relevance are agreed to encourage participation and acceptance, but conducting NA's has also considered an additional time consuming expense.

- Most of the participating hospitals (H1, H2, H3, H5, H7) did conduct a **need assessment** to identify training needs and include results in the training content. In one case (H1) the need assessment results were delivered too late to be included into the training content. In H7 NA´s have been conducted, but not at the trained departments, and some results have been included in the training design, other needs have been communicated by department heads, so a practical / problem based training approach could be organised.
- H6 did not conduct any need assessments, as the timeframe for organising was considered too short, the intention in carrying out NA's in future has been expressed by the focal person as their contribution to organising a training with practical relevance was evident.
- H4 has not conducted any NA as it was considered too time consuming and hospital needs have been well known to the organisers.

Keeping the **balance between theoretical** (awareness, knowledge) **and practical training issues** (skills, practical problem approach) could be achieved according to focal persons in H2, H3, H5 and H7. Different approaches were:

- Boosting the practical training part by mainly focussing on developing skills for effectively handling of diversity (H2). This approach has been highly recommended by the focal person.
- Concentrating the training content on the issues of awareness and attitudes and considering training as a basic introduction to the subject of cultural competence and diversity has been performed by H6 for organisational reasons. Skills have not been included in the training content. Future interventions in H6 are planned including a more practical approach, stressing the development of skills.
- A predominantly theoretical approach has been practised by the trainer of H1. The need of a more practical approach has been recognised by the focal person.
- Theoretical lectures were underlined with practical examples in H4. Discussion of practical problems in clinical situations, case discussion was happening but practising upon skills could not be done in the short timeframe of 6 hours total training time.

Choosing an **interactive teaching design** has been **depending highly on the trainers / team of trainers competences** to involve participants, but not only so, as the decisions for the training process should have been made by the organisers in cooperation with the trainer / team of trainers. All hospitals experiences endorse the need for an interactive and highly practical training design. Organisers and trainers provide a very comprehensible view and process description on how discussions, group activities and case studies encourage active participation and increase interest. The importance of an interactive teaching style to create an open atmosphere that fosters communication was evident.

3.3 Composition of staff attending the training / Participant profile

Pathway recommendations:
Further choices had to be made concerning separate or combined training for staff. The Pathway suggested to consider combining workforce with similar practice realities, as they share similar problem areas. E.g. physicians, advanced nurse practitioners and physician assistants could be combined in a training class and hospital based nurses might be taught in a separate class. As the training content was advised to be developed on basis of experienced problems within the workspace the suggested staff separation permits a more practice-specific proceeding. Also training success has been considered to be strongly affected by the openness of communication culture practiced in hospital. The composition of training participants should consent to people speaking frankly during the course, which might be more likely among people with similar work experience.

Hospitals experiences:
Six hospitals (H1, H2, H3, H4, H5, H6) have chosen a training design to mix staff from different departments and various professions.
The practical training experience lead to the following suggestions concerning staff mix:

- A focus on single departments is considered more effective by the focal person of H1 as a more specific training, modelled on department specific needs and problems, can be realised.
- To combine departments with similar patient experiences, e.g. only departments with in patients setting was advised by the focal person of H5 for future interventions.
- Separate training for each discipline / profession has been suggested by the trainer of H5 for further intervention, even though training multidisciplinary groups as an introduction into the subject of cultural competence has been considered beneficial.

In one case mixing departments and professions was highly recommended:

- The organisers of H2 did approve very much of the interdisciplinary training design mixing departments and professions. They noticed that participants did profit highly from each others different experiences, but they also reasoned that necessary preparation work, calling in essential support from all professional groups and departments for an interdisciplinary training, has provided a fertile ground for a successful teamwork within the training. The focal person referred also to the specific organisational culture which places great emphasis on team work and good cooperation between the departments and professions.

H7 has trained two departments separately. So professions, but not departments have been mixed. The focal person of H7 approved very much of that design as the practical relevance of the departments have been considered quite different and separating the departments could guaranty a strong focus on each departments problems.

3.4 Competences of the trainer / team of trainers

Pathway recommendations:
The following competences of the trainer / trainer teams were considered relevant:

- Good knowledge of and background in cultural diversity issues
- Good process competence
- Familiarity with the routines and procedures in a hospital, so that trainer / team of trainers can relate well to the challenges of everyday work for the various professions represented
- Skills in facilitation and management of diverse opinions, as the subject cultural diversity raises strong feelings
- Carefully facilitate the sharing of feelings, so the workshop does not become a “group therapy” session.

The Pathway advised that of course the training content has to be co developed by trainer / team of trainers and training organisers.

When selecting a trainer / team of trainers the module draft suggested that consideration should be given in choosing a mixed-ethnicity or mixed-gender training team.

Hospitals experiences:
All European hospitals **experiences underline that trainers have an tremendous effect on satisfaction and outcome of the training** and basically confirm the demands stated in the guidelines.

- The experiences of hospital H2 pictured how resentments and scepticism towards the training, including the feeling that it is all about migrants needs and concerns as well as high expectations to receive explicit instructions on how to behave in cross cultural situations could be neutralized by the competent and sensitive trainer. After breaking the “ice” an open communication climate was created and constructive interactive training work was possible.
- In H1 two kind of difficulties have been experienced and are believed to have had a negative impact on the training outcome: Firstly, problems with the head trainers personality e.g. communication problems, not enough flexibility and non committal attitude. Time pressure made it difficult to find a suitable trainer. The head trainer took a very psychiatric and rather theoretical approach to the subject of cultural competence which was especially from participant other than from the psychiatric department criticized. Secondly as the head trainer could not meet an appointment, postponing the training date created not only dissatisfaction on the side of staff (only a minority could attend the postponed training) but also continuation difficulties for the co trainer. Still the co trainer who was responsible for the more practical issues of the training has been very appreciated by participants. Having learned from that experience, the focal person of H1 advised multiple preliminary talks before hiring a trainer and a written contract to ensure agreed conditions.
- Hospitals that selected a multi trainer approach (H1, H3, H4, H7) or an approach with cultural mediators (H2, H3, H6) needed to ensure coherence. In the case of H3 the trainers were operating one by one, so that the issues overlapped only when necessary for the audience, and the modules were independent and co-ordinated by one of the trainers. Coherence was ensured during the planning phase.
- Hospitals that have chosen a trainer from university setting (H1, H6, H7) advised for future interventions to also include trainers with hospital relevant practical experiences and / or cultural mediators into the training process. H7 did have one trainer from the own hospitals background and one from an university setting and would chose for future intervention both trainers from the internal hospital setting. Practical health care experiences of the trainer is expected to improve the training situation especially when it comes to work on skills and finding solutions for everyday work problems. **Cultural mediators / migrant community representatives did enhance views from the users side and hospital experiences demonstrate high interest from staff towards that approach** (H2, H3, H6). Including representatives of migrant population as experts in the training team - they should not conduct the training themselves, but be integrated in certain stages of the training has been considered as useful intervention by H1. In H1 the co trainer had an ethnic background from the predominating migrant group and has been well accepted by the participants.

3.5 Summery

Table 3 sums up aspects of training quality, important tasks and difficulties that have been experienced by the participating hospitals.

Quality of the training depends on:	Important tasks and beneficial aspects	Experienced difficulties
Timeframe of training	- Training provided in modules with initial training and follow ups – time lag about 2,5 month - Follow ups to enable experiential learning have been highly acknowledged	- Organising training in recommended length and intervals due to staff shortages and thigh duty rotas - Ensuring full attendance / continuation could not be provided
Training content	- Practical relevance: Including need assessments results in training content - Awareness, knowledge, skills and raising comfort level - Balance between theoretical and practical training issues - Interactive teaching design	- Needs assessments as additional, time consuming effort - Developing skills not defined as an explicit aim - Too theoretical training approach carried out by trainer
Staffs composition	- Deciding on separate or mixed training of departments and professions according to hospitals culture	- In a mixed training responding to specific departments / professions problems and needs is more difficult to be realised
Trainer competences	- Good knowledge of and background in cultural diversity issues - Good process competence - Familiarity with the routines and procedures in a hospital - Skills in facilitation and management of diverse opinions and feelings	- Difficulties in finding a trainer the has all required competences

Table 3: Quality of the training

Table 4 sums up the **advantages of and considerations for separate** (by departments or professions) **or cross training** (training everyone together):

Staff training	Pros	Considerations
Separate training (by departments or professions)	- better concentration on department/professions specific needs and problems - participants have similar practise realities - allows people to speak frankly during the course, which might be more likely among people with similar work experience. - learning models, thinking styles and practise realities of different clinical specialties might require different approaches – this can be rather realised in separate training	- every day work conflicts and personal conflicts might be taken along easier among staff that are highly involved with each other
Cross training (training everyone together)	- general introduction to the issue of cultural competence has same relevance to all staff - staff will profit from each others experiences - work practise demands in many cases cooperation between dept. and professions, so cross training corresponds with real life practise	- good interpersonal communication climate is beneficial - strong communication work of the organisers in advance to ensure staffs cooperation is recommended - great emphasis to team work/good cooperation between dept. and professions

Table 4: Separate training versus cross training

4 Effectiveness of training

Improving health care for migrants and ethnic minorities are expected long term effects of the training. But within this project evaluation the focus has been set on changes of hospital staffs competences as short term outcomes: Effects caused by the training were expected on the dimensions awareness, knowledge, skills and levels of comfort in specific situations related to cultural competence issues.

The effect of getting the interest / motivation for participation of departments and staff has been discussed in section 2.3., but needs to be pointed out as an important indicator for training success at this stage of the report again. The most successful in getting staff to attend the training has been H1, with a comparatively high participation of 39 persons and a mixed selection of

doctors, nurses and other staff. H7 has achieved the second highest participation. H5 the third highest, but in the case of H5 not all professional groups could be invited.

The effectiveness of staff training towards cultural competence was measured on basis of the self rated information given by participants in a before and after the training questioning design and retrospective questions about satisfaction with the training. Standardised questionnaires, CCCTQ-PRE and CCCTEQ-POST, adapted from an instrument developed by R. Like, have been used for evaluation (see appendix 10). Furthermore, results of the impact of the training as stated by participants after the training will be accessible in this report, but actual effects on everyday practice could not be measured within the project timeline.

The results are summing up the changes of all participants within each hospital and are therefore a group comparison. Individual changes on the dimensions awareness, knowledge, skills and comfort level have not been analysed at this stage and might be concealed by the group comparison, e.g. if one participants' awareness has increased and another ones' has decreased to the same score, the balance of the group will be 0 and strong individual changes have not been identified.

Some further preliminary, methodical comment: Results can only point out directions, as hospitals have been quite heterogeneous and the training implementations did differ a lot in the structures (contents and timelines) and the organisers intentions in what effect they wished to create and the problems they addressed within the training were of various nature. Also the number and composition of participants did vary a lot. In certain cases only few participants attended the courses and even less filled in questionnaires. Results with a low total number of cases are less stable but are still contributing to the overall picture. See the table below for the total of cases.

Number of staff attending the training and total number of filled in questionnaires:

	H1	H2	H3	H4	H5	H6	H7	Total
Nr of training participants	39	19	16	6	22	17	24	149
Filled in CCCTQ-PRE	29	13	13	6	22	17	19	119
Filled in CCCTEQ-POST	21	15	12	4	12	15	18	97

After a descriptive analysis of the result tables, interpretations for differences of effects are sought, going back to the previous chapter of quality and figuring out its influence on the training outcome.

4.1 Participants satisfaction with the training

Asking for participants' satisfaction with the cultural competence training has been carried out after the training when they were asked to fill in the CCCTEQ-POST. Question F2 did ask: "Overall, how satisfied were you with the quality of these cultural competency training sessions?" Table 5 details the percentages of participants self rating on satisfaction concerning the training and the total of numbers.

Country	Not at all	A little	Some-what	Quite a bit	Very	Total in numbers
H1	0%	33%	19%	38%	10%	21
H2	0%	7%	20%	47%	27%	15
H3	0%	0%	25%	42%	33%	12
H4	0%	0%	0%	25%	75%	4
H5	0%	0%	0%	25%	75%	12
H6	0%	0%	0%	60%	40%	15
H7	0%	0%	0%	14%	86%	7

Table 5: Participants satisfaction with the training

- Four hospitals (H4, H5, H6, H7) could record 100% quite or very satisfied participants.
- Three quarters of all participants in H3 stated quite or complete satisfaction with the training, the remaining quarter was after all somewhat satisfied.
- H2 did account of a small percentage of little satisfied training attendees, but the main part felt quite or very satisfied.
- One third of all participants have only been little satisfied with the training in H1 and less than half of the attendees have been quite or very satisfied.
- There are no training attendees who were not at all satisfied.

Consideration needs to be given when looking at the results that H3 and H5 did not have the rather critical professional group of physicians involved. Concerning the total number of participants, the higher the number the more different views are reported – and vice versa.

Focal persons from H3, H4, H5, H6 and H7 confirmed the results with their personal impression that training was highly approved of by the attendees.

Focal persons from H1 and H2 gave their view of possible reasons for staffs less euphorically rating of satisfaction:

- The project coordinator of H1 attributes critical results mainly to the organisational problems caused by head trainers sick leave and the following postponing of the arranged training date. As duty rotas can not be changed on short time notice, a great amount of the participants were not able to attend the postponed date which amounted into dissatisfaction. And furthermore the head trainers teaching methods have been too theoretical and the content was very much psychiatrically orientated. So high expectation of participants from the psychiatric department have not been fully met and at the same time the course content was too psychiatric oriented for those coming from other departments. Even though a positive climate during the course was noticeable, the co trainers and her more practical teaching methods have been taken up positively by staff and also the wish for continuation and follow ups has been expressed.
- In the case of H2 the project coordinators have been quite satisfied with the results and believed that the time structure of the course (2,5 month) participants did allow participants to get a more realistic view of the training as follow ups did allow practical experiences with the newly learned competences. The trainer of H2 explained that training participants did expect at the beginning of the training to receive instructions and solutions on how to cope with intercultural encounters. But training was very much about sensitisation and analysing values and attitudes as well as working on concepts – that contradicted original expectations.

4.2 Awareness of influence of culture on peoples' self and others perception and behaviour

To pictures the results from the hospitals the average score[4] that participants reached when answering questions concerning awareness, knowledge, skills and comfort level has been calculated in order to enable a clear record of directions of change.

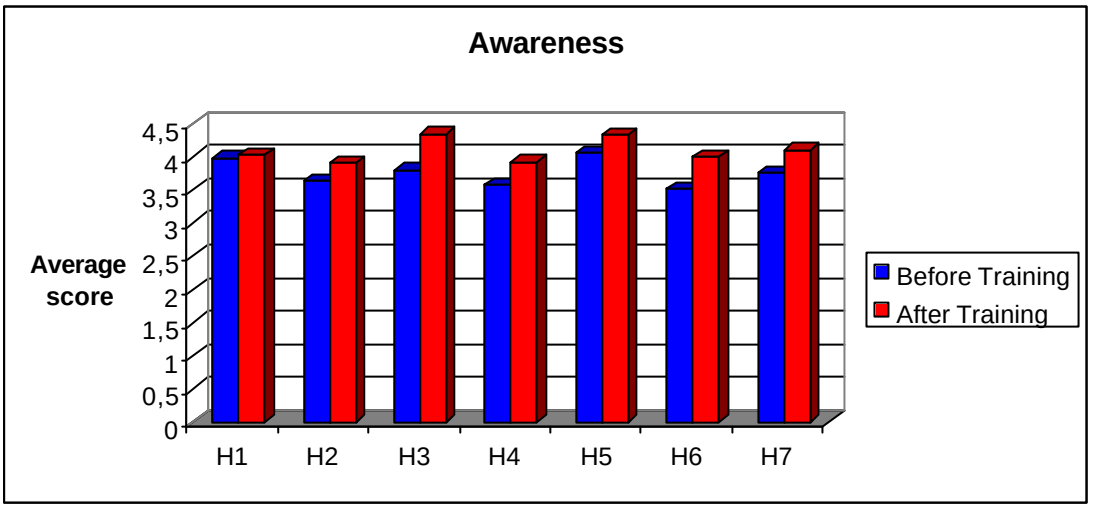


Table 6: Effectiveness of the training on staffs awareness concerning aspects of cultural diversity

All hospitals did to a certain extent include awareness into their training schedule, in the case of H6 targeting awareness and attitudes have been the general training aim.

Participants awareness of influence of culture on peoples' self and others perception and behaviour has been in all European hospitals quite high already before the training as all participants rated being somewhat and quite a bit aware on the questioned subjects.

- An increase in awareness has been possible in all participating hospitals, although in the case of H1 awareness only raised by 0,04 points. But the awareness baseline in H1 was already at the beginning of the training quite high (second highest of all participating hospitals).
- The participants of H3 accounted of the highest increase in awareness, followed by H6.

[4] The scale ranges from 1 to 5. 1 = not at all, 2 = a little, 3 = somewhat, 4 = quite a bit, 5 = very

4.3 Knowledge concerning important aspects of cultural diversity

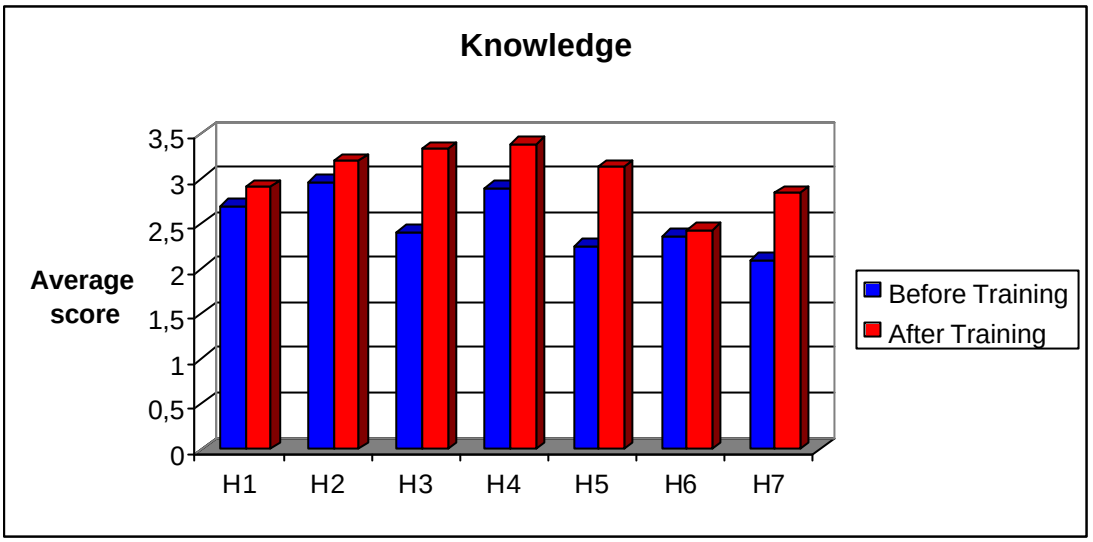


Table 7: Effectiveness of the training on staffs knowledge concerning important aspects of cultural diversity

All hospitals, except H6, have included knowledge concerning important aspects of cultural diversity in their training program.

The self perceived knowledge on subjects of cultural diversity has increased within all training participants from the project partner hospitals.

- In three hospitals (H1, H2 and H4) the knowledge level at the training start can be considered quite high (average score is higher than 2,7) comparing to the other hospitals, but has not increased significantly.
- Hospitals with a lower knowledge starter level - below 2,5 average score - (H3, H5, H7) could create a higher increase except H6.
- Reasons for the low increase in knowledge by training participants of H6 are presumed in the training design and content as training was organised as a general introduction in the subject of cultural competence targeting attitudes and awareness.
- The highest raise of the knowledge level could be obtained by H3.
- Looking at the knowledge level after the training, the average score of four European hospitals (H2, H3, H4, H5) shows that staff feels to know almost “quite a bit” concerning cultural diversity.

4.4 *Skills for appropriately, effectively, efficiently and sustainable handling of diversity*

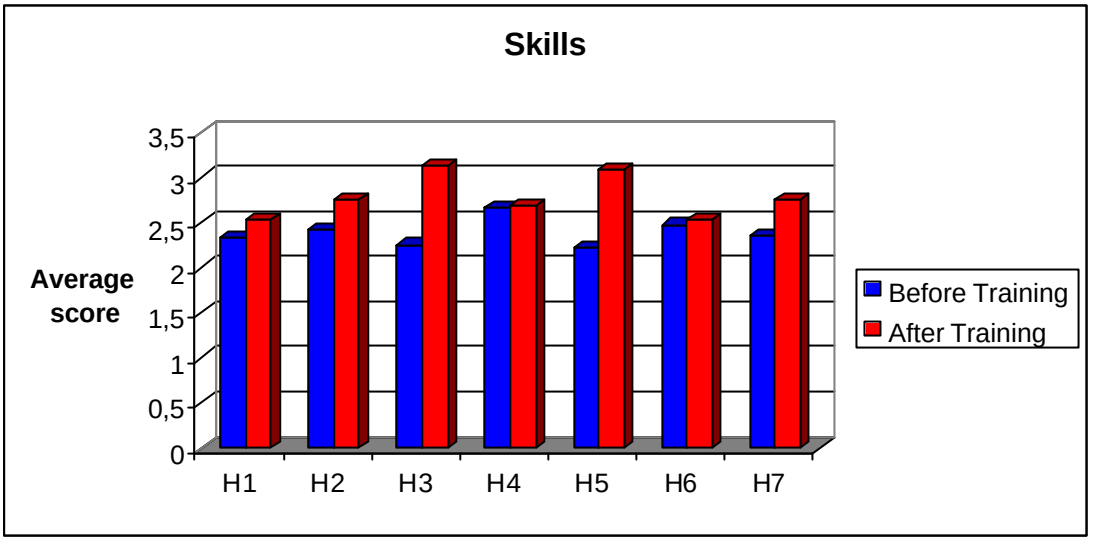


Table 8: Effectiveness of the training on staffs skills for handling diversity

Skills for appropriately, effectively, efficiently and sustainable handling of diversity have been improved within all training participants.

- Participants from H3 and H5 show the highest increase on the skills level. The focal person of H3 reported that a considerable effort was made by the subproject coordination team to find training issues that reflect upon participants practical work experience and relevance. Focal person of H5 and trainer statements from that hospitals gave an account of the high status that skills and an interactive teaching design had within the training content. The missing professional group of physicians in H3 and H5 is mentioned again in this place.
- The second highest increase is evident in H7.
- The third highest improvement was assessed in H2. The focal person explained that the Pathway guidelines have been considered as too theoretical and efforts for an interactive teaching design with highly practical content have been made.
- H1 did also have a comparatively high skill level at the start of the training and could only raise it to a small percentage. The focal person of H1 reported difficulties with the teaching methods of the trainer: A too theoretical and too psychiatric orientated approach did not leave enough space for practising upon skills that would have been considered sufficient by all training attendees.
- In two cases (H4 and H6) only a very slight increase can be noticed. Both hospitals have not included skills in their training content and therefore not practised upon. In H4 the timeframe of the training was too short to include practising on skills and the start level was comparatively high. In H6 training has been considered only as an

introduction into the subject of cultural diversity and competence and creating awareness and reflecting participants existing attitudes have been the main assets of the training content.

Summing up the above results on the skills level, it is evident that if skills are targeted in the training and appropriate designs are chosen, skills will also improve.

4.5 Comfort level within cross cultural encounters and situations

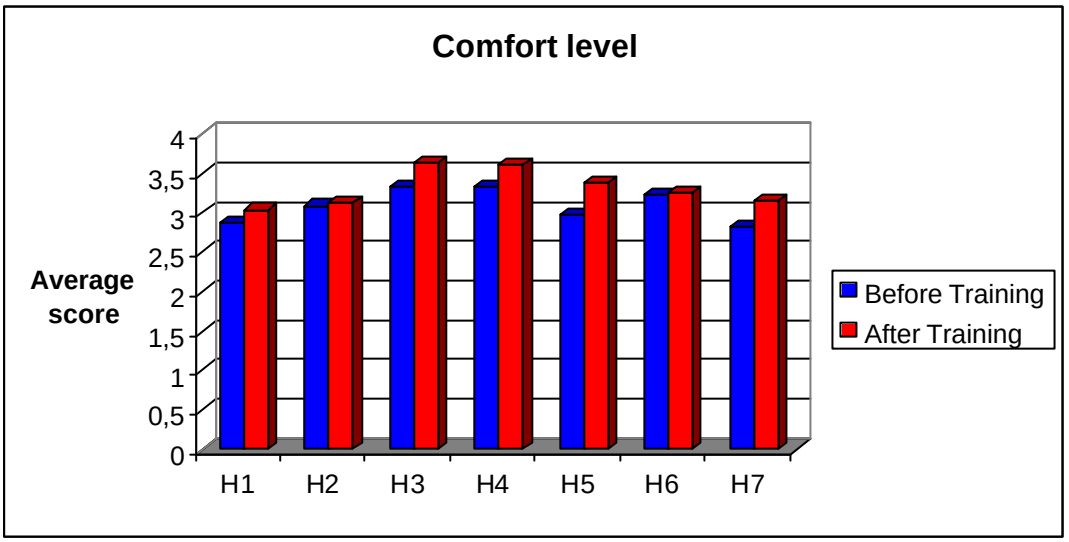


Table 9: Effectiveness of the training on staffs comfort level concerning cultural diversity encounters

Raising the comfort level within cross cultural encounters and situations was possible in all participating hospitals, but only to a comparatively small extent.

- The starting position concerning the comfort level has been in all participating hospitals quite similar (the average scores are between 2,8 and 3,4).
- H5s' training participants' comfort level has improved the most. Followed by training attendees of H7 and H3. These three hospitals were also able to get the highest increase in skills. The assumption is that providing staff with skills for handling diversity will also have a positive effect on their comfort level.
- In H2 and in H6 only a very slight raise in average comfort level is to be observed.

4.6 Impact of the cultural competence training

The impact of the cultural competence training is analysed according to the information that staff provided in the questionnaire: The raise of interest on the subject of cultural competence and the self rated ability to cope with the work demands. Measuring the actual impact on the every day work practise could not be carried out during the projects timeframe, but beneficial and interfering aspects that may affect training impact in work practices have been pointed out by focal persons.

4.6.1 Impact on every day practice

Self-rated impact on everyday practise

Training participants have been asked at the end of the training in the CCCTEQ-POST: “To what extent do you think the cultural competency training has had an impact on your ability to cope with the demands in your work activities?”

Country	None	A Little	Some	Quite a Lot	Very Signifi-cant	Don’t Know	Total in numbers
H1	10%	19%	38%	24%	10%	0%	21
H2	0%	7%	47%	33%	13%	0%	15
H3	0%	0%	20%	30%	50%	0%	10
H4	0%	0%	25%	25%	50%	0%	4
H5	0%	0%	8%	58%	33%	0%	12
H6	0%	0%	0%	33%	60%	7%	15
H7	0%	0%	29%	43%	29%	0%	7

Table 10: Participants self-rated training impact on everyday practise

- In six hospitals more than 2/3 of all training participants perceived a high or very high impact.
- Only in one hospital (H1) 10% of the questioned persons reported no impact at all.
- Quite a lot and a very significant impact was rated by 93% of participants of H6 and by 91% of training participants of H5.
- In H2 and H1 the highest percentage of rating is on some impact. Within these two hospitals also little training impact was perceived by part of the participants.

Interpretation of differences of training impact has to take into account the timeframe set within the training. Long timeframes e.g. follow ups that took place after one and two month after the first training module will allow participants a more realistic judgement of their abilities to cope with cross cultural encounters in every day work life (as practised by H2, H3 and H5). Participants might have already gone through a process of high expectations, disappointment and scepticism. Training participants who have assessed the impact without getting the chance to practice their skills and without bringing back their new experiences into the training have a less realistic perception of the training impact in their working life (H4 and H6 have chosen a two day training within two weeks timeframe). In case of H6, where practical skills have not been targeted, an high impact on attitudes and awareness is presumed by the focal person to be the reason for the high rates in the above table.

Impact of everyday practise as perceived by focal persons

While the impact of the training on the ability to cope with daily work demands has been assessed by staff after the training, the actual impact could not be measured within this project, but focal persons believe there is a positive impact.

In order to archive a positive and sustainable impact of cultural competence training hospital staff need to have the chance to integrate their newly learned competences (awareness, knowledge, skills and comfort level) on the level of everyday work practise.
While there is no systematic information on how to ensure that newly learned competences of staff can be integrated and maintained in every day work and advance its effectiveness, beneficial and interfering aspects for sustainability of cultural competence at work have been pointed out by the focal persons and are as following:

Beneficial aspects to foster effectiveness and of course sustainability of the cultural competence training on the level of every day work:

- Support from the managerial persons is seen as a crucial aspect to provide a fertile climate. A clear commitment from the top for sustainability that also is communicated to staff has been considered necessary e.g. integrating cultural competence in workforce meetings, having the head nurse demanding cultural competence (H1, H3, H4, H5).
- Having a contact person in the hospital for staff to turn to when problems occur and to obtain feedback. That contact person should be an intermediary between top and basis (H2).
- Getting staff involved in changes: If people do not feel that they get heard, that their needs are being addressed too, they will not be able to cooperate – they need to experience the need for cultural

competency for their own and for migrants sake. This could be achieved by targeting departments (H3).
- Providing informal material as well as pictographs and multilingual services will demonstrate a different perception towards diverse patients (H6).

As interfering aspect the work flow in the hospital with its demand for routines, including a low time budget has been considered (H1).

4.6.2 Impact on staffs interest in cultural competence

Did the training manage to invite staff to the journey of cultural competency? Looking at the effect of the training in raising the interest of attending staff in cultural competence, the following question will provide some information. The question text was: “My desire to learn more about the subject of culturally competent health care has”.

Country	Decreased a Lot	Decreased Somewhat	Remained the same	Increased Somewhat	Increased a lot	Total in numbers
H1	0%	5%	33%	29%	33%	21
H2	0%	0%	20%	60%	20%	15
H3	0%	0%	8%	67%	25%	12
H4	0%	0%	25%	0%	75%	4
H5	0%	0%	8%	17%	75%	12
H6	0%	0%	13%	33%	53%	15
H7	0%	0%	0%	14%	86%	7

Table 11: Training impact on staffs interest in cultural competence

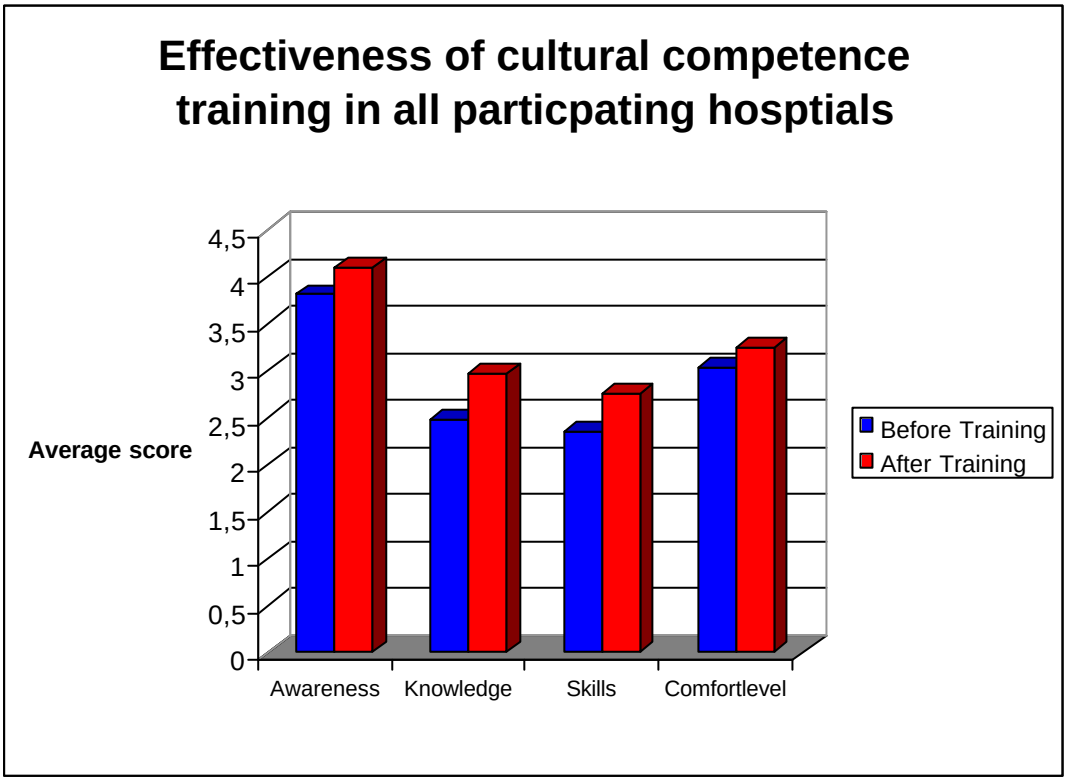
- In all partner hospitals participants quoted an increased interest, though the amount of increase varies.
- The desire to learn more about the subject of culturally competent health care has increased somewhat or a lot by all training attendees of H7.
- 92% of all training participants from H3 and H5 stated that their interest could be raised.
- In H6, H2 more than 2/3, and in H4 2/3 of all participants noticed an increased desire to learn more.
- In H1 62% of the training participants reported increased interest.
- One third of the H1 attendees and one quarter from H4 stated that their interest in the subject of cultural competence remained the same.

- A small percentage of the H1 attendees even quoted that their desire decreased.

These results support reports from all focal persons, that after the training participating staff expressed interest to learn / find out more about cultural diversity and competence.

4.7 Summary

Table 12 offers a **summary of the effectiveness** on raising awareness, improving knowledge, providing skills and increasing comfort level of all participating hospitals. A raise in all targeted areas is evident:



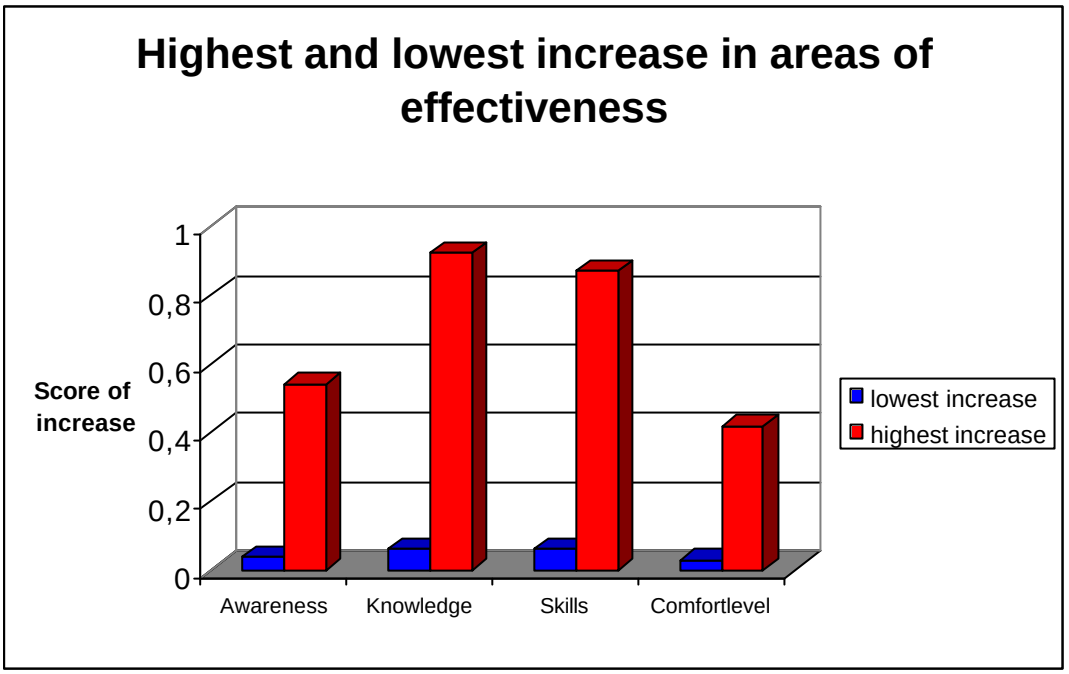
Scale range: 1 = not at all, 2 = a little, 3 = somewhat, 4 = quite a bit, 5 = very
Table 12: Summary of effectiveness of cultural competence training in all participating hospitals

Total Number of participants – Effectiveness:

	Awareness	*Knowledge*	*Skills*	*Comfort level*
Before Training	*118*	*120*	*117*	*120*
After Training	*98*	*98*	*96*	*97*

Table 13 shows the **highest and the lowest increase in the areas of effectiveness** summing up results from all participating hospitals. This

enables a closer picture of the range of increase in awareness, knowledge, skills and effectiveness:



Score of increase on the scale range of 1 to 5
Table 13: Summary of highest and lowest increase of training effectiveness

The differences in increase on effectiveness can be explained by decisions concerning training content and design, as best shown by the example of developing skills: Making the development and practise of skills part of the training content will subsequently affect staffs skills positively. All European hospitals that have focused on skills in the training show increases, those that have not / hardly concentrated on skills present only a slight increase. High skills improvement is believed to correlate with the length of the training timeframe and experiential learning, as staff can practise upon newly learned skills, bring back experiences into the course and are encouraged for further skills development. The trainers competencies and teaching methods have also an influence on the development of skills as the example of one hospital shows that the trainer could not refer to all staffs practical work reality and also had chosen a highly theoretical teaching style. For the interpretation of different skills increase, the total number of participants as well as staffs profile (e.g. some missing professional groups) have to be considered.

Impact on staff satisfaction:

Staffs satisfaction with the training – summing up all hospitals participants rating:

Not at all	A little	Somewhat	Quite a bit	Very	Total in numbers
0%	9%	11%	40%	40%	86

Table 14: Summary of all pilot hospitals on staffs satisfaction

Participants satisfaction with the training depended a lot on the level of expectations and in case of long timeframes, the time for reflection on the training subjects and already gained practical experiences. Staffs satisfaction can be summed up as high in most hospitals, even in a couple of cases training could not completely meet all staffs expectations.

Impact on increasing interest on the subject of cultural competence:

The desire to learn more about the subject of culturally competent health care has – summing up all hospitals participants rating:

Decreased a lot	Decreased somewhat	Remained the same	Increased somewhat	Increased a lot	Total in numbers
0%	1 %	17%	36%	45%	86

Table 15: Summary of all pilot hospitals of staffs raise in interest

Impact on every day practice:

Self rated impact on your ability to cope with demands in work activities - summing up all hospitals participants rating**:**

None	A little	Some	Quite a lot	Very significant	Don't know	Total in numbers
2%	6 %	25%	36%	31%	1%	84

Table 16: Summary of all pilot hospitals of self rated training impact on every day practise

While most training attendees of the European hospitals reported a high impact, the self rating on the impact on every day work practise varied according to hospitals training approaches. Again decisions on the training design and content, including timeframe, participants profile and certainly the ability of trainer(s) to equip participants with competences that they can use in everyday work encounters are believed to affect the rating.

5 Cost effectiveness

The costs of the cultural competency training can be made up by

- organisational costs - invested time in planning, organisation and implementation of the training
- costs of trainer / team of trainers
- costs participants working hours

- costs of provided facilities (rooms, training materials, etc.)

To assess the cost effectiveness of the cultural competence training focal persons have been asked to rate all involved costs with other comparatively training activities. Furthermore focal persons point of views, if efforts have been considered worthwhile and what they would do different considering cost effective aspects, have been inquired.

5.1 Training costs

Organisational costs of the cultural competence training (invested time in planning, organisation and implementation) have been rated comparing to other training activities in the hospital on the scale of low, medium and high :

Costs	H1	H2	H3	H4	H5	H6	H7
Low							
Medium							
High	x	x	x	x	x	x	x

Table 17: Organisational costs of the training

- In all hospitals **organisational costs** were considered **high** and could not be expressed in actual financial figures as training organisers invested a lot of energy and voluntary work in planning and implementing. Inviting and motivating staff to attend the courses and getting them released from work demanded high efforts.

Additional / external training costs (mandatory costs of trainer / team of trainers, costs of participants working hours, costs of provided facilities) as rated by focal persons have been comparing to other training activities:

Costs	H1	H2	H3	H4	H5	H6	H7
Low		x	x	x			x
Medium	x				x	x	
High							

Table 18: Additional / external costs of the training

- Medium additional / external costs have been quoted by three hospitals (H1, H5, H6). Staff attendance in H1 was partly out of working time. A trainer on a voluntary basis was operating in H5.
- Low external costs as trainer was not financed by the hospital and staff attendance was partly out of working time were quoted by H2.
- Low extra costs have been stated by H3 as training organisation and implementation was done without any hospital involvement at all, so

there were low mandatory costs. Project coordinators and the trainers / cultural mediators were working voluntary and out of hospital working hours. Staff attended the course out of working time

- Low additional / external costs in H4 were stated as the training organising has been done by the organisers as part of their job within the hospital and one trainer did not charge any fees for his trainer duty. If in future there will be a professional trainer from outside of the hospital the training will get more expensive. Staff attended the training during working time, but as training is accepted as part of the quality policy, there are no additional costs considered concerning staffs working hours.
- In H7 external / additional cost have been rated low, as only expenses for the trainers had to be provided by the hospital and staff was attending the training during working time. The organisers worked on a voluntary base.

5.2 Improvement of cost effectiveness possible?

Assessing if training was after all worthwhile to be implemented and what would be done differently under the viewpoint of cost effectiveness was an important part of the evaluation. Focal persons have stated their perspectives considering cost effectiveness:

Taking a retrospective view on organisation and implementation all focal persons were convinced that training was an important intervention and considered it as a necessary response to the hospitals patient population / migration situation and to problems experience by staff encounters with cultural diversity.

Suggestions for improvements by focal persons are stated as follows:

- Training is expected to be more cost effective and sustainable if the organisational timeframe for planning the courses is longer, e.g. half a year planning in advance, so staff working hours and trainer arrangements can be organised better (H1, H5, H7).
- Training organisation should be done by the department heads to boost participation and cooperation (e.g. head nurses so the nurses will cooperate) and to save organisational time and receive a higher participation (H1).
- Choosing a training design that is less time consuming with an exact analysis of training needs, e.g. KOM-MA training program (H2).
- Taking the pressure due to high organisational work off the training organisers by getting the hospital management highly involved – seeking a commitment from management and demanding efforts from the hospitals organisational level (H3)

5.3 Summary

Training costs	Composition	Hospitals cost rating and reasoning
Organisational costs	Invested time and resources in planning, organisation and implementation	Development costs rated as high, should decline once training has become routine
Additional / external costs	Mandatory costs of: - trainer/team of trainer - participants working hours - provided facilities	Low or medium costs as - trainer/team of trainers worked partly free of charge - staff attended partly out of working time - training included into CPE provided no additional costs

Table 19: Training costs – composition and pilot hospitals cost rating and reasoning

6 Sustainability

Within the Migrant Friendly Hospital Project it was clearly recommended that Migrant Friendliness and cultural competence should be integrated in the hospitals overall organisation and quality culture (as measured by the MFQQ).
Sustainability of the cultural competency training was evaluated by assessing its inclusion on the organisational level (if training has become a standard intervention). Furthermore it has been asked if cultural competences of staff have become part of the hospitals quality system, in order to enable the integration of staffs competences that have been acquired during the training in everyday clinical practise.

6.1 Cultural competence training as standard intervention

The implementation of training as a standard regular intervention and its inclusion in the professional continuous education have been recommended to ensure sustainability. Evaluation results show that not all hospitals managed to integrate training as a standard intervention, but all hospitals want to continue with cultural competency activities in modified ways. Planed modifications of the training and future cultural competency activities are also pointed out in the following sustainability analysis:

- Cultural competence training as standard implementation of the hospital internal continuous professional education program could be organised by two hospitals at the time of this evaluation (H2 and H4).

But in both cases training will be modified. In H2 training with a **strong practical approach** and **integrated in other quality improvement activities will be continued with a smaller timeframe**. Training in H4 will be continued as well with a **less time** consuming frame (2 hours twice) and **concentrating on single departments** instead of targeting all hospital staff at once. The head nurse of each department will be coordinating the training.

All other hospitals (H1, H3, H5, H6 and H7) are planning to continue cultural competence training in a modifies way, in some cases decisions on the precise way of continuation had been still outstanding by the time of this report.

- In H1 training efforts are made to integrate the topic of cultural competence into its continuous medical education program, but probably in different formats and with different methods as practised during the pilot phase. The courses will be designed targeting departments and their specific needs. Exact decisions about its modus of continuation were still outstanding by the time of this report. But one time lectures, discussions and workshops with restricted content are planned as future interventions (e.g. there have been requests for information about specifics and problems of African patients within the hospitals everyday life). The focal person pointed out that organising training in the future as a department internal arrangement might be an option.
- In H3 the medical director is clearly committed to support the continuation of cultural competency activities. Concrete decisions will be made in 2005.
- Training in H5 will be repeated in 2005 again, but in a slightly modified way: It will be **organised smaller and more frequent**, with similar content but **concentrating more on skills**. H5 is planning to get training towards cultural competency into its service plan as a permanent implementation, but as H5 has no overall training organisation (no core education centre, decisions on training are made by individual departments / professions) this has been considered as a difficult task by the focal person. Training will be provided separately for two staff groups (in-patient and out-patient settings), as the needs and perspectives of this two groups are quite different.
- In H6 training will be organised with a **longer timeframe, enriched with practical relevance and solution findings to actual problems**. There are strong intentions to include cultural competence training into the CPE as soon as the training program is defined.
- In H7 training will be continued in April 05 and will be **organised for two special groups**: administrative staff from all hospital departments and staff participating in a child support network.

6.2 Cultural competence as part of the quality system

Making cultural competence part of the quality system can be achieved by integrating it into all quality instruments on organisational level e.g. in policies, written documents, guidelines, but also on department level e.g. workforce meetings, guidelines, etc.

Including cultural competence into the hospitals quality system has been considered by all focal persons as a necessary but also as long term process. Therefore only **work in progress** can be pointed out by some of the pilot hospitals (H2, H3, H5, H6) as they are working on policy papers, written documents and guidelines. In H7 integrating cultural competence in the quality system of the departments is in certain departments in development. In hospitals where the scope for decisions on the quality system is rather small (H1, H4) as they are part of a larger compound and can not determine standards autonomously, changes in the existing quality system have not been considered at this stage of the report.

Within the MFH project the MFQQ (Migrant Friendly Quality Questionnaire) has been developed as an instrument to monitor and assess migrant friendly quality developments of hospital services and part of the questionnaire was aimed at the assessment of cultural competency training and education for staff. Table 20 pictures the experiences with staff training at two points of measuring in the evaluated pilot hospitals, at the beginning of the project 2003 (T1) and towards the end of the project 2004 (T2). Only two hospitals (H1 and H7) did have training experience before the project start, but not in the extend as practiced during the MFH project.

MF training and education for staff	T	H1	H2	H3	H4	H5	H6	H7	SC-EU	Diff. T1-T2
Staff training for MF	T2	+	+	+	+	+	+	+	7	↑
	T1	+						+	2	

Table 20: MFQQ results on MF training and education for staff

6.3 Summary

Summing up the results of the sustainability analysis, it has to be positively pointed out, that the intervention staff training towards cultural competence has been recognised by all training organisers as an effective way to equip staff with important competencies leading towards a more Migrant Friendly health service. After all departing on the cultural competency journey leaves traces. Therefore keeping cultural competence activities on the agenda, modifying the training concept of the pilot phase, is targeted in the hospitals, even some decisions are still outstanding. For important tasks to ensure sustainability and experienced difficulties please see table 20 below.

Sustainability	Important tasks and beneficial aspects	Experienced difficulties
Training as standard intervention	- Cooperation with internal education decision makers / management - Inclusion into the continuous professional education (CPE)	- Training as practised in the pilot phase not mature enough, defining training considered necessary - Complex decision making procedures
Cultural competence as explicitly integrated part of the quality system	- Integrating training in all quality instruments on organisational and department level e.g. policies, written documents, guidelines, workforce meetings	- Integration as long term process - Standards concerning organisational policies can not be determined autonomously

Table 21: Sustainability of the training

7 Conclusions

The experiences of the European hospitals that have participated in the MFH training project and evaluation, their successfulness in implementation and the promising results of effectiveness strengthen the pleading for training towards cultural competency as a solution for tensions and difficulties experienced in staff and diverse patient population encounters. Choosing a training approach that relates to the problem realities of staff and finding solutions means taking their and patients concerns seriously. The improvement of awareness, knowledge, skills and comfort level concerning cultural diversity issues as well as the increase of interest on the subject of cultural competence and the self rated rise of the ability to cope with work demands demonstrate the positive extent of the training. Unfortunately measuring the actual impact on the every day work practise could not be carried out during the projects timeframe, but beneficial and interfering aspects that may affect training impact in work practices have been pointed out by focal persons.

The Pathway and Modules provided by LBISMH referred to international knowledge on the subject of cultural competence and provided an **extensive integrated training approach**. The extensive integrated training was supposed to be adjusted to department specific needs of hospital staff and intended to increase awareness, provide knowledge and develop skills responding to actual problems. Experiential learning has been considered a vital module of the training and was to be realised in follow ups, at least one month after the basic training. A trainer / team of trainers with numerous competencies, including among others knowledge of cultural diversity issues and being familiar with hospitals / department specific routines had to be found to conduct the training. The necessary timeframe for an extensive integrated training was considered 10 hours training time over a period of at least 2 month. Although some participating hospitals found it difficult to realise those basic conditions, feasibility and effectiveness of the cultural competence training could be demonstrated within the project timeframe in seven European hospitals.

But the project is not only a story of success, as hospitals did experiences difficulties. The stumbling blocks of the extensive integrated training in the European hospitals have been:

- Finding a competent trainer that combines knowledge of practical heath care work situation as well as knowledge of cultural diversity issues and being a good facilitator, who above all is expert enough to really be accepted as a contribution in quality work on department level.
- Finding practical solutions for relevant diversity problems / developing skills for handling diversity due to heterogeneity of training attendees problem realities, the limited trainer competencies and the training timeframe.

- Fitting in a course of about ten hours lengths in the regular working shifts of hospital staff, as many participants had difficulties to attend the total course.
- Getting acceptance of hospital staff for the training intervention as precondition for (voluntary) participation demanded enormous efforts of the organisers and some professional groups could not be motivated to attend the training.

Another indicator for problems with the extended integrated training concept is the fact that most European pilot hospitals that have decided to continue training, will do so reducing the length of it. In one case a pilot hospital will as well as organise training with a shorter timeframe and perusing a very practical approach responding to specific identified needs, combine training with further quality improvement measures. E.g. having a contact person for cultural diversity issues, who will work together with staff on emerging problems concerning cross cultural encounters and who will cooperate in organising training content on basis of gained experiences. In another case where training will explicitly not be continued in the previous way, the conception for training as department internal arrangement has been considered as possible intervention.

Learning from the successes and the difficulties the project partners faced and taking their experiences serious reshaping the training as a two level quality improvement seems reasonable.

1. **Generic basic training**
2. **Practical cultural competence development as part of the quality management on department level**

Improving hospital staffs cultural competence is advised to be organised on two levels. Firstly on the level of general hospitals continuous professional education system / training system and secondly on the level of quality management within the departments.

Generic basic training is considered an introduction to the subject of cultural diversity and aims at increasing staffs (self-) awareness and receptivity to diverse patient populations as well as their knowledge and basic skills concerning matters of diversity to enable them to better handle cross cultural encounters. Generic basic training of a length of suggested approximately 6 hours should easier be incorporated into professionals busy schedules than an extensive integrated training. Unlike to the extensive integrated training the trainer / teams require general knowledge of the hospital routines, but not departments specific knowledge, as those specific problems will be targeted by the second part of the cultural competence development directly on the department level.

Follow ups that enabled experiential learning have been highly approved by the hospitals in the MFH extended integrated training phase and the wish for a very practical approach has been repeatedly expressed by the training organisers. Those highly acknowledged aspects will be attended to in the practical cultural competence developments as part of the quality assurance on the department level.

Practical cultural competence developments can be organised in e.g. workforce meetings / team meetings and during all other quality assurance activities on the department level. There are numerous options for practical cultural competence developments as part of the quality management on department level that leave space for individual adjusting, as European hospitals are quite heterogeneous in their organisational structure as well as in their needs to respond to social situations / problems experience. Therefore it is recommended for department management to cooperate with expert advisers on the subject of diversity issues and to make cultural competence part of all routine quality improvement measures
In order to illustrate practical cultural competence developments some options are pointed out:

- Practical exercises that enable experiential learning to build up on the initial training e.g. case discussions and role playing.
- Concentrating on finding solutions / developing specific skills for problems concerning diversity encounters, e.g. developing communication skills: asking the right questions in an appropriate manner.
- Developing cultural competency routines for service provision and improving existing ones can be targeted.
- The cooperation with a diversity contact person, who should ideally be supported by a diversity board on the general hospital level.
- Organising “mirror meetings” including patients of diverse backgrounds, health care staff and community representatives to help guide the delivery of cultural competent care.
- Carrying out ongoing organisational cultural competence assessments and creating a plan to meet cultural service needs.

The two level quality improvement approach combines interventions on the personal and the organisational level and can ensure personal as well as organisational developments toward cultural competence and should be thought as long term developmental measures. The development of clinical / interpersonal cultural competence must go hand-in-hand with the development of systematic / organisational cultural competency to ensure long time effectiveness and improvements. Hospital staffs acceptance for the need of personal cultural competences and therefore the acceptance to attend the generic basic training and for further cultural competence activities in the hospital is likely to improve with the department managements willingness and dedication for cultural competence

developments. Like an upward spiral, positive changes and improvements in staffs every day practical reality / on the department level should encourage further cultural competency developments and ongoing learning towards cultural awareness and tolerance.

Finally reassuring all interested parties to adopt cultural competence activities we like to conclude with expert adviser Robert Like's quotation *"the development of cultural competence should be seen as a development journey rather then a final destination." (Like 2004)*

8 Index of tables

Table 21: Sustainability of the training

9 References

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10 Appendix

10.1 Methodical approach

10.1.1 The evaluation questionnaires

For evaluation of effectiveness of the training the staff questionnaires CCCTQ-PRE and CCCTEQ-POST have been developed on basis of the "Clinical Cultural Competency Questionnaire", kindly provided by Robert Like. The original questionnaire was developed to fit training of practising primary care physicians in the USA. Therefore some adjustments had been made to the EU hospital settings (according to overall needs assessment results that have been conducted during the MFH project additional questions have been added and questions relating to the socio-political situation of the USA have been excluded). To adapt the questionnaire for a wider group of hospital staff the category "does not apply" has been added as certain questions of the original questionnaire have been only referring to physicians.

Further modifications of the questionnaires are advisable for future interventions, giving consideration to participants work tasks, e.g. including knowledge, skills and comfort level for individuals not involved in direct patient care activities or developing separate instruments for the main professional health care groups.

The evaluation instrument has been translated by a professional translator service into six languages (Dutch, French, German, Italian, Spanish and Swedish) and in certain cases revised by the project partners. Still improvements of the evaluation questionnaires are suggested as responses from the participating European hospitals indicate that the evaluation questionnaires are very extensive in its length and content and for the purpose of evaluation a shorter version might be sufficient. Also the questionnaires phrasing was advised to be improved, by shortening the single questions and using more simple wordings.

The questionnaires (find full copies of the questionnaires attached further down) have been subdivided in the areas regarding the content:

A. Demographic characteristics
B. Knowledge
C. Skills
D. Encounters/situations
E. Awareness
F. Education and training
G. Impact

Demographical details have been asked only in the PRE questionnaires, in the POST questionnaires asking for the birth date has been included and served as a connecting link.
Areas B, C, D and E have been identical in the PRE and POST questionnaire version, so changes in the questioned areas can be analysed. For this evaluation report, only group comparisons have been used; an analysis of panel data (for a smaller subgroup we can link pre-and post-data and thus analyse patterns of individual change) has not yet been attempted for lack of time.
Area F included different questions in the PRE and POST version, area G was only in the POST questionnaire. The answers to the open questions in areas F and G have been send to the partner hospitals to serve as additional information for their case reports.

10.1.2 Reliability of the questionnaires

The reliability of the scales of the areas B, C, D and E has been measured with the cronbach alpha. The cronbach alpha is a scientifically acknowledged method to test the homogeneity of scales based on a larger number of items that accounts for the inter-correlations of the single question items. The above structure of the areas has been confirmed and kept by, but in the area encounters/situations three questions, D11, D12, D13 have been singled out and have been dealt with separately. In the presentations of effectiveness concerning the comfort level (section 4.5) results from questions D11, D12 and D13 have not been included, but can be viewed in the single question items analysis, see appendix section 10.4.

10.1.3 Analysis of the single questionnaire items

Before aggregating the single questions to the areas awareness, knowledge, skills and comfort level, the average score for all participants of each European hospital of the single question items has been calculated. The scale ranges from 1 to 5.
1 = not at all
2 = a little
3 = somewhat
4 = quite a bit
5 = very

Within the questionnaire the category: 6=does not apply has been defined as missing. The total numbers of answers to the questions are listed as well as the mean and the median. Please see detailed results in appendix section 10.4.

The analysis of the single questions has been used as confirmation for the results of the analysis of the summarised items awareness, knowledge, skills and comfort level as they correlated and has not be interpreted separately.

10.1.4 Analysis of the questionnaire areas awareness, knowledge, skills and comfort level

Within the areas of awareness, knowledge, skills and encounters/situations the average score of all items has been formed for each participating hospital to enable the reader a compact general view and to point out clearly main directions of changes. On the question scale D, questions D11, D12, D13 have not been included. Answers on the category “does not apply” have been listed as missing. The total number of participants for the questioned areas are listed below:

Total Number of participants - Awareness:

	H1	H2	H3	H4	H5	H6	H7
Before Training	28	12	13	6	22	17	20
After Training	21	15	12	4	12	15	19

Total Number of participants - Knowledge:

	H1	H2	H3	H4	H5	H6	H7
Before Training	29	13	13	6	22	17	20
After Training	21	15	12	4	12	15	19

Total Number of participants - Skills:

	H1	H2	H3	H4	H5	H6	H7
Before Training	29	13	11	6	21	17	20
After Training	21	15	12	4	10	15	19

Total Number of participants – Comfort level:

	H1	H2	H3	H4	H5	H6	H7
Before Training	29	13	13	6	22	17	20
After Training	21	15	12	4	11	15	19

In both approaches, the single item and the item areas, group changes are analysed and not individual changes.

10.1.5 Analysis of staff satisfaction and impact

For analysis staff satisfaction and training impact the percentage distribution has been quoted. The total numbers of cases have been stated in the associated tables and correlate in all cases, except H7, with the number of filled in CCCTEQ-POST. In case of H7 only 7 persons filled in part F and G

of the CCCTEQ-POST, as a mix up of the questionnaires caused that the remaining training attendees filled in twice the PRE version.

10.2 CCCTQ-PRE

see separate file

10.3 CCCTEQ-POST

see separate file

10.4 Single question analysis

see separate file