

**End of Life Care for the Hmong Population:
A Cultural Competency Educational Program for Hospice Nurses**

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Abstract

Introduction: The number of Hmong people living in the United States is increasing rapidly. Considering their unique perspective regarding life and death, it is essential that hospice nurses are educated to provide culturally competent care. **Methodology:** A pre-post test pilot project was used to measure the effect of a cultural competency class regarding Hmong people for hospice RNs. The IAPCC-R tool with skill, awareness, encounters, knowledge, and desire subscales, measured nurses' cultural competence at pre-, immediate, and three months-post interventions. **Results:** Baseline total scores indicated participants (n=9) were culturally aware (50-74/100). No significant changes at immediate or three months-post in the total score were noted. Only the awareness subscale significantly increased at post ($p=.041$) and three months ($p=.039$). An upward trend in total scores suggested higher cultural competence. **Discussion:** More research is needed regarding the impact of education on hospice nurses' cultural competence of the Hmong population.

Keywords: evidence-based practice and cultural competency, cultural competency in end of life, Hmong

End of Life Care for the Hmong Population:

A Cultural Competency Educational Program for Hospice Nurses

The number of Hmong people, a Southeast Asian refugee group, has greatly increased in the United States. In recent years, it is estimated there are nearly 300,000 Hmong people which represents a 175% increase from 1990-2010 (Pew Research Center, 2017; Pfeifer & Thao, 2013). Some regions have experienced an even greater increase. For example, in the Midwest alone there are 127,000 Hmong, an increase of 227% over two decades (Pfeifer, Sullivan, Yang & Yang, 2012). The growing population of Hmong in the U.S. challenges nurses to develop an understanding of their unique perspectives of life, death, and healthcare needs to provide the highest quality of care.

The Hmong people who sought refuge in the United States after the Vietnam War have considerably different healthcare beliefs from those of Westernized medicine (Carteret, 2012). Even though Hmong patients use both traditional and Westernized medicine, they are still somewhat distrustful of Western medicine (Bengiamin, Chang, & Capitman, 2011). Existing language barriers, a lack of provider cultural competency (Bengiamin et al, 2011), and holding on to traditional concepts that illness is caused by spirits and soul loss (Capps, 1994) may contribute to this distrust. Their decision on whether to use Western healthcare providers or traditional healers is based on whether they believe the illness is spiritual or not (Lor, Xiong, Park, Schwei, & Jacobs, 2017).

Unlike the Western perspective that life is a journey with a beginning and an end, traditional Hmong people believe life is a continuous journey (Culture Care Connection, 2008).

Death is viewed as a transitional phase from the physical to the spiritual world. A person is destined to live to a certain age, and once that age is reached, death will occur. However, the Hmong people believe their soul will eventually reincarnate. It is important that the healthcare provider understand that elaborate religious ceremonies are conducted on behalf of a dying patient. The Hmong family needs to be involved in all decision-making, and the use of the traditional shaman, a healing practitioner who acts as an intermediary between the spiritual and material world (Vang, n.d.), should be respected. Strings or charms designed to ward off evil spirits should not be removed (Cobb, 2010). To prevent soul loss, medical treatments are preferred over surgical treatments (Carteret, 2012). Withholding life-prolonging interventions is seen by many Hmong families as disrespectful, and many believe that helping the patient face and accept death is often antithetical to a healthy relationship with family members (Her & Schroepfer, 2016).

It is important that traditional Hmong-American patients die at home due to their belief in household spirits and the spirit altar – a belief that stems from the practice of animism and ancestor worship (Gerdner, 2010). The altar is normally maintained by the eldest male child and functions to serve and please the household spirits known to keep the home and its residents safe. Hmong people believe that when elders die in the home, the family of that home will acquire good fortune (Gerdner, 2010).

Considering the increased number of Hmong people in the U.S. and their different healthcare perspectives, it is imperative that nurses have the knowledge to be able to provide culturally competent care to this group. There is a substantial body of literature indicating culturally competent care may increase quality health care (The Joint Commission [TJC], 2012), enhance patient outcomes (Coolen, 2012; Gordon et al. 2014; Institute of Medicine (IOM), 2002;

Joo, 2014; Lie, Lee-Rey, Gomez, Bereknyei, & Braddock, 2011; Like, 2011; Majumdar, Browne, Roberts, & Carpio, 2004; Weech-Maldonado et al., 2012), and improve patient satisfaction scores (Agency for Healthcare Research & Quality (AHRQ), 2013; Castro & Ruiz, 2009; Gordon et al., 2014; Jongen, McCalman & Bainbridge, 2017; Lie et al., 2011; Millicent, Ubogaya, Chen, Wint, & Worrall, 2016; Renzaho, Romio, Crock, & Sonderlund, 2013). It is a firmly held belief that cultural competency education provides an avenue to decrease healthcare disparities which often occur when patients and providers do not share common cultural beliefs and customs (Beach et al., 2005; Brach, 2000; Truong, Paradies, & Priest et al., 2014). In spite of this large body of literature, no studies related to culturally competent care specific to the Hmong population could be found. Given their unique perspective regarding death, hospice nurses must be prepared to provide culturally appropriate end of life care to this growing population. Therefore, the purpose of this pilot project was to explore the impact of cultural competency education on participants' cultural competency scores.

Methods

Design and Measures

This one group, pre-test, post-test pilot project used the Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-Revised (IAPCC-R) to measure cultural competency. The IAPCC-R is a 25-item Likert electronic questionnaire (25-100 points), which measures the five interdependent concepts of: cultural knowledge (obtaining a knowledge foundation regarding a particular culturally diverse group), skill (the ability to

collect relevant cultural data based on the patient's problem and performing a culturally based physical and psycho-social assessment), awareness (a self-examination of cultural beliefs), desire (the desire and motivation to engage in the process of learning how to appropriately care for culturally diverse patients), and encounters (actively engaging in cross-cultural interactions). Each concept is represented by responses to subscale items, with scores ranging from one to twenty (1-20) (Campinha-Bacote, 2002, Transcultural C.A.R.E. Associates, 2015). The nurse's overall level is indicated by the total score, with higher scores indicating higher levels of cultural competency (Delgado et al., 2013). The total score levels are assigned as culturally proficient (91-100), culturally competent (75-90), culturally aware (51-74), and culturally incompetent (25-50). In at least 25 studies, the tool was found to be reliable with Cronbach's alpha scores consistently ranging from .64 to .92 (Transcultural C.A.R.E Associates, 2015). Construct validity has been addressed by Capell et al. (2008) and Mesler (2013); content validity has been addressed by Katner (2006).

Demographic information collected included the level of nursing education, race/ethnicity, total years in nursing, travel outside the United States, and number of previous cultural competency classes previously attended. To measure nurses' understanding of how cultural beliefs affect care, four questions regarding healthcare customs, religious viewpoints, and specific diseases of the Hmong patient were included on the questionnaire. These questions, which were adapted from questions used with healthcare professionals in Minnesota, were based on a 4-point Likert scale (Culture Care Connection, 2008). Tool validity or reliability has not been established on these questions.

Setting and Sample

After review and approval by an institutional review board, this investigation took place at a large hospice in a Midwestern metropolitan city. Referrals to this hospice came from area hospitals and the community at large. Of the 565 patients cared for in 2013, 27% came from culturally diverse patient populations.

Nurse volunteers from the hospice were invited to participate in this study. Participants were chosen from a convenience sample of English-speaking and associate or bachelor's degree prepared nurses. Exclusion criteria included non-English speaking nurses, advanced practice registered nurses, nursing assistants, physicians, and all other allied health providers.

Intervention

To investigate the effects on hospice nurses' cultural competency, an educational program was designed based on Campinha-Bacote's five cultural competency subscales: cultural awareness, encounters, skill, desire, and knowledge. In a two-hour, face-to-face educational class, cultural differences in healthcare values, beliefs, and customs were addressed through use of a PowerPoint presentation, short video clips, psychomotor exercises, and reflective activities. Healthcare values of the Hmong population were presented throughout the class to exemplify differences in customs and beliefs. The educational presentation addressed the following: a) the background of the cultural competency movement, governmental regulations, cultural assessment tools, and healthcare disparities; b) research findings regarding implementing cultural competency programs; and c) cultural competency and interventions.

Data Analysis

Participants completed the IAPCC-R and the four questions regarding Hmong healthcare prior to (CC1), immediately after (CC2), and three-month post (CC3) educational program. To assess statistical differences from pre- to post-tests at the significance level of $p < .05$, the

Wilcoxon Signed Rank test was used to analyze survey results. A Kruskal-Wallis analysis was employed to determine whether there were any statistically significant differences in sample demographic characteristics.

Results

Nine volunteer participants attended the educational class; the majority were Caucasian (89%) and bachelor prepared (67%). Eighty-nine percent of participants had at least 11 years of nursing experience. Six participants stated they had travelled outside of the United States, and all participants had attended at least one cultural competency class in the past. Demographic characteristics of participants did not differ significantly across CC1, CC2, and CC3, suggesting no influence on cultural competency (see Table 1). Only eight completed the immediate post-test (CC2) and three-month post (CC3) surveys; missing data from all three surveys was not included in the analysis.

Mean scores were as follows: CC1=66, CC2=72, and CC3=69. These scores did not differ significantly from CC1-CC2, CC1-CC3, or CC2-CC3. With a possible range of 0-100, these scores represented cultural awareness (51-74). There were no significant changes in nurses overall IAPCC-R scores between CC1-CC2, CC1-CC3, CC2-CC3, or in the four questions on Hmong Healthcare (see Table 2 & Table 3). Analysis of the subscales demonstrated a significant increase in participants' cultural awareness between measurement points C1-C2, and points C1-C3; however, there were no significant statistical differences in cultural desire, knowledge, encounters, or skill.

Discussion

It was hypothesized that, following the intervention, participants' posttest scores for the overall and five subscales would be significantly higher than the pretest scores. However,

changes in cultural awareness levels were found to be significant only between both CC1-CC2 and CC1-CC3 measurement points. However, participants' mean pretest scores were already in the higher range of cultural awareness indicating cultural competency (see Table 2).

While there were no statistically significant differences between the pre- and post-scores for the subscales of skills, encounters, knowledge, or desire, the overall cultural competency scores did increase from C1 to C2 and these scores were maintained at C3. This suggests the educational intervention may have had a clinical relevant benefit to improving nurses' overall cultural competency.

In a study of 98 staff on a patient care unit, the IAPCC-R was used to measure the impact of cultural competency training on their cultural competence (Delgado et al., 2013). Participants mean scores in the cultural awareness category remained similar at baseline, three-month posttest and six-month posttest. There was a significant increase in participants' overall cultural competency between baseline and three-month posttest and six-month posttest scores. In another study, twenty-eight educators of nursing and other allied health students were administered the IAPCC prior to and immediately after a cultural competence workshop, as well as at three, six and twelve months post-class (Wilson, Sanner, & McAllister, 2010). The educators' mean scores increased significantly at each measurement point which demonstrated increased cultural competency.

Although the intervention in this investigation did not yield significant improvement in overall IAPCC-R scores in contrast to previous studies, similarities between the studies exist. In comparison, the inclusive mean score for all cultural competency subscales between this pilot study and the Delgado et al. (2013) study were similar. In both studies, participants had significant changes in the cultural awareness subscale. In this investigation, the mean score for

cultural awareness measured several points higher at all measurement points than the means for cultural awareness in the Delgado study. In the Wilson and colleagues (2010) study, overall cultural competency scores improved significantly at all measurement points. This pilot study's total cultural competency scores improved at CC2 and were maintained at CC3, but the increase was not statistically significant.

Limitations

Differences between observed and expected outcomes may be due to several factors. Initially, it was anticipated 30 nurses would participate in this study. Three weeks before the intervention, two of the intended hospice offices closed leaving this pilot study with only nine participants. One variable collected from the demographics that may have influenced the IAPCC-R scores was participants' previous exposure to a wide array of culturally diverse experiences either through work, travel, or education. These factors limit the ability to generalize findings to other settings except those with similar characteristics. A threat of testing was related to the pretest which may have sensitized the participants to the expected outcome.

Other issues arose during the implementation of the intervention that may have affected the participants' emotional state. The class started one hour late and there were several interruptions during the intervention. Five participants left the class 30 minutes early and were unable to view the CD video clip until the following day. Lastly, participants frequently forgot their passwords and had difficulty accessing the online measurement tool.

Conclusions

As the nation becomes more culturally diverse, healthcare providers are caring for patients with vastly different beliefs and customs, thus delivering quality healthcare to all is a major ethical consideration (Betancourt, Corbett, & Bondaryk, 2014, Chater & Tsai, n.d., IOM,

2002). One growing group with differing customs and beliefs at the end of life are the Hmong, a people rich in animistic belief systems and ancestral worship (Gerdner, 2010). When caring for the Hmong patient, healthcare providers should understand that elaborate religious ceremonies are conducted on behalf of the dying patient, and family members need to be involved in all decisions (Culture Care Connection, 2008). Clinging to the belief that powerful household spirits help the dying patient transition peacefully into eternal life, it is important that the Hmong patient die at home (Gerdner, 2010).

Although this study size is small, the results of this study reveal an increase in participants' cultural awareness and an overall increase in participants' cultural competency. To generalize these results to a broader population of hospice nurses, this study should be repeated with a larger participant group. Investigating the effects of educational programs on hospice nurses' cultural competency is merely the first step to implementing a comprehensive program. Engaging nurses in the continual quest to become culturally competent ultimately enhances skills to render quality care to dying Hmong patients.

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Table 1. Demographic Statistical Data using the Kruskal-Wallis Analysis

Baseline Demographics	Pretest	Immediate Posttest	3 Month Posttest
	Chi Square df <i>p</i> value	Chi Square df <i>p</i> value	Chi Square df <i>p</i> value
Years in Nursing	.238 2 .888	.214 2 .898	2.38 2 .304
Race	There is only one non-empty group. Kruskal-Wallis Test cannot be performed	1.00 1 .317	.771 1 .380
Nursing Education	.000 1 1.00	.150 1 .699	.429 1 .513
Additional Cultural Competency Classes	.857 2 .651	3.70 3 .300	1.50 1 .221
Travel Outside of the United States	.048 1 .827	.000 1 1.00	3.00 1 .083

Table 2. Cultural Competency in Hospice Nurses Statistical Analysis using the Wilcoxon Signed Ranks Test

Statistical Analysis	Baseline Score N Mean (SD)	Immediate Posttest N Mean (SD)	3 Month Posttest N Mean (SD)	<i>P</i> <i>value</i>
Cultural Competency pretest (CC1)	N 6 66.1 (8.3)			
a. Cultural Encounters	N 7 13.14 (2.0)			
b. Cultural Awareness	N 7 13.9 (1.4)			
c. Cultural Knowledge	N 8 11.6 (2.1)			
d. Cultural Skill	N 8 13.1 (2.0)			
e. Cultural Desire	N 7 15.3 (2.5)			
CC1 to Immediate posttest (CC2)	N 6 66.1 (8.3)	N 8 72.0 (7.75)		.176
a. Cultural Encounters	N 7 13.14 (2.0)	N 8 13.12 (2.1)		.317
b. Cultural Awareness	N 7 13.9 (1.35)	N 8 15.6 (1.9)		.041
c. Cultural Knowledge	N 8 11.6 (2.1)	N 8 12.0 (1.8)		.891
d. Cultural Skill	N 8 13.1 (2.0)	N 8 14.5 (2.1)		.443
e. Cultural Desire	N 7 15.3 (2.5)	N 8 16.8 (1.6)		.197
CC1 to 3 Month Posttest (CC3)	N 6 66.1 (8.3)		N 7 69.7 (4.9)	.713
a. Cultural Encounters	N 7 13.1 (2.0)		N 9 13.2 (1.6)	.786
b. Cultural Awareness	N 7 13.9 (1.4)		N 9 15.3 (2.1)	.039
c. Cultural Knowledge	N 8 11.6 (2.1)		N 8 12.4 (2.1)	1.0
d. Cultural Skill	N 8 13.1 (2.0)		N 8 14.2 (1.5)	.351
e. Cultural Desire	N 7 15.3 (2.5)		N 9 16.3 (1.6)	.167
CC2 to CC3		N 8 72.0 (7.75)	N 7 69.7 (4.9)	.577
a. Cultural Encounters		N 8 13.12 (2.1)	N 9 13.2 (1.6)	.496
b. Cultural Awareness		N 8 15.6 (1.9)	N 9 15.3 (2.1)	.257
c. Cultural Knowledge		N 8 12.0 (1.8)	N 8 12.4 (2.1)	.257
d. Cultural Skill		N 8 14.5 (2.1)	N 8 14.2 (1.5)	.854
e. Cultural Desire		N 8 16.8 (1.6)	N 9 16.3 (1.6)	.480

Table 3. Healthcare Beliefs, Values, and Customs in the Hmong

Statistical Analysis	Baseline Score N Mean (SD)	Immediate Posttest N Mean (SD)	3 Month Posttest N Mean (SD)	<i>P</i> <i>value</i>
Pretest to Immediate Posttest Hmong	N = 8 4.7 (1.4)	N = 8 7.8 (3.4)		.066
Pretest to 3-month Posttest Hmong	N = 8 4.7 (1.4)		N = 7 6.9 (3.0)	.102
Immediate Posttest to 3-month Posttest Hmong		N = 8 7.8 (3.4)	N = 7 6.9 (3.0)	.317

Author Bios

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Margaret Bjelica received her Doctorate in Nursing Practice (DNP) at the University of Missouri in Kansas City in 2016. Her professional nursing experience has included physical rehabilitation, pediatrics, general medical-surgical, perioperative, and hospice. Dr. Bjelica has held a faculty position at Research College of Nursing in Kansas City since 2004. She is certified as an adult clinical nurse specialist (ACNS-BC) and a certified rehabilitation registered nurse (CRRN). Dr. Bjelica holds professional memberships in the Sigma Theta Tau International Honor Society of Nursing and Association of Rehabilitation Nurses. Her specific research interests are cultural competency in healthcare and human trafficking.

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Julie Nauser currently serves as the Dean at Research College of Nursing in Kansas City. She earned a Doctor of Philosophy in Nursing from Indiana University School of Nursing, a Master's of Science in Nursing from University of Missouri in Kansas City, and a Bachelor's of Science in Nursing from Research College of Nursing. Previous scholarly endeavors have been focused on quality of life, heart failure family caregivers, and therapeutic patient education interventions for patients with cardiovascular disorders.