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Developing a Culturally Relevant Mental Health Assessment for

Persons of African Descent

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Abstract

Problem: Persons of African descent have lower access to mental health care, are less likely to receive needed care, and are more likely to be misdiagnosed, experience severe disease, and to receive mental health care through primary care than non-Hispanic Whites. **Context:** Cultural norms related to mental health as well as the lack of culturally congruent health care delivery contribute to lower mental health care access and uptake among persons of African descent.

Interventions: Campinha-Bacote's cultural competence model and the BATHE technique provided the theoretical framework for the development and implementation of a nurse practitioner (NP) (n = 4) administered culturally tailored mental health assessment intervention for patients (n = 87) of African descent at a primary care center. **Measures:** Outcome measures used to assess the impact of the intervention were NP adherence to the use of the assessment, patient mental health referrals within the clinic, and NPs' and patients' perceived usefulness and cultural relevance of the intervention. **Results:** NP adherence to the use of the assessment was 100%. Twenty-one patients were referred to mental health care during the intervention. All NPs and the majority of patients reported the assessment to be culturally relevant and useful.

Pearson's two-tailed correlations found a significant ($p < .001$) relationship between patients' beliefs that their culture or faith helped them deal with mental health and comfort in discussing mental health with providers and in patients' favorable rating of the mental health assessment.

Conclusions: The theoretically grounded brief culturally-tailored mental health assessment was found to be relevant and useful in the mental health assessment and referral of patients of African descent and appeared to be sustainable for routine use in the project organization and likely transferable to other settings and populations.

Keywords: culturally congruent care, mental health assessment, African descent

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Introduction

Problem Description

Although depression and other mental health disorders are highly prevalent in the United States population, a majority of individuals with mental health needs fail to access needed care because of barriers such as the lack of available mental health providers, general lack of access to health care, the stigma of mental illness, cost barriers, cultural barriers, and other barriers (Wrenn et al., 2017). Persons of African descent, a category that includes both African Americans/Blacks and the Black, African immigrant population, have lower access to mental health care and are less likely to receive needed mental health care than non-Hispanic white Americans (Hayes et al., 2017; Woods-Giscombe, Robinson, Carthon, Devane-Johnson, & Corbie-Smith, 2016; Suntai, Lee, & Leeper, 2020). In addition to being less likely than non-Hispanic Whites to receive mental health care, persons of African descent are more likely than non-Hispanic whites to be misdiagnosed or undiagnosed, more likely to experience severe disease when diagnosed, more likely to receive care through a primary care clinic, less likely to receive specialty care, and less likely to receive adequate care (Jones, Huey, & Rubenson, 2018).

According to the most recent U.S. Bureau of the Census (2019) data, the Black population in the United States represents 13.4% of the total population, making persons of African descent the second largest racial/ethnic minority behind Hispanics/Latinos in the United States. The total population of persons of African descent in the United States includes a growing number of African immigrants whose presence is not immediately reflected in the census data. Driven by economic push and pull factors as well as family reunification, between 2000 and 2013, the Black African immigrant population increased threefold in the United States, from a little less than 500,000 to almost 1.5 million Black African immigrants, predominantly from

Nigeria, Ethiopia, Ghana, Kenya, Somalia, and Liberia (Olukotun, Gondwe, and Mkandawire-Valmu, 2019). These African immigrants often face double cultural barriers in accessing care, encompassing both the cultural barriers they face related to their racial minority status in the US and their cultural isolation as a member of a marginalized Black immigrant population (Olukotun et al., 2019; Omenka, Watson, & Hendrie, 2020).

In addition to the social determinants of health that contribute to many of the health inequities experienced by persons of African descent in the US, cultural factors and barriers play a major role in the disparate mental health access, disparate mental health care, and disparate mental health outcomes of persons of African descent (Abdullah & Brown, 2011; Eylem et al., 2020; Holden et al., 2014; Swierad, Vartanian, & King, 2017; Woods-Giscombe et al., 2016). Cultural norms among some persons of African descent discourage individuals from actively seeking mental health care, even in the face of self-perceived need (Omenka et al., 2020; Suntai et al., 2020; Woods-Giscombe et al., 2016). For example, Woods-Giscombe et al. (2016) documented the prevalence of the “superwoman” schema among African American women that imposes obligations to project strength, suppress emotions, and resist feelings of vulnerability. Among African immigrant populations, the cultural/social norm is to “hide in the shadows” and so as not to stand out or call attention, and this also discourages seeking or accepting mental health care (Olukotun et al., 2019). Numerous researchers who have investigated cultural and attitudinal aspects of persons of African descent’s approach to mental health/illness have documented high levels of mental illness stigma in this population (Abdullah & Brown, 2011; Eylem et al., 2020; Haynes et al., 2017; Lee-Tauler et al., 2018; Omenka et al., 2020; Wrenn et al., 2017).

While cultural norms related to mental illness and mental health sometimes work to discourage persons of African descent seeking out or accepting (if offered and/or accessible) mental health care, there is also strong evidence that there are external and systemic cultural and culturally-related barriers to mental health care for these individuals. Notably, discrimination and cultural insensitivity may discourage providers and health care professionals from offering mental health care or conducting mental health assessments of persons of African descent (Eylem et al., 2020; Lee-Tauler et al., 2018; Haynes et al., 2017; Shorkey, Windsor & Spence, 2009). Primary care providers, who increasingly serve as the main gatekeepers to mental health care in the US health care system, are less likely to conduct mental health assessments and less likely to make referrals to specialty mental health providers for patients of African descent as compared to non-Hispanic white patients (Haynes et al., 2017; Lee-Tauler et al., 2018; Watson-Singleton, Black, & Spivey, 2019; Wrenn et al., 2017). At the same time, persons of African descent are more likely to reach out to Black clergy for help with mental health issues than they are to seek mental health care from primary care or specialty mental health providers (Haynes et al., 2017; Stansbury, Marshall, Hall, Simpson, & Bullock, 2018; Tillotson, Doswell, & Phillips, 2015).

The mental health access and treatment disparities for persons of African descent is a significant problem for the health of this population. The lower rates of access to mental health care and care-seeking behaviors among persons of African descent exacerbates and/or contributes to other health, social, family, and economic problems experienced by this population (Holden et al., 2015; Woods-Giscombe et al., 2016). On the other hand, access to effective mental health care can lead to dramatic improvements in individuals' quality of life and overall health and well-being (Holden et al., 2014; Jones et al., 2018). The mental health access

disparity for persons of African descent also represents a significant problem for NPs in primary health practice. As previously noted, primary health care providers have increasingly become the main gatekeepers for access to mental health care and mental health services. Primary care providers have an ethical obligation to provide access to mental health services for all of their patients who may need such services (Haynes et al., 2017; Holden et al., 2015; Wrenn et al., 2017).

The nursing profession has affirmed an ethical and an evidence-based obligation to provide culturally sensitive care to all patients (Holden et al., 2015; Jones et al., 2018; Tucker et al., 2014). Culturally-sensitive and/or culturally-competent interventions have been demonstrated to lead to improved patient health outcomes and reductions in health disparities for patients of African descent in a wide range of health concerns including chemical dependency treatment, depression treatment, health promotion, anxiety, and initiation of mental health care (Haynes et al., 2017; Jones et al., 2018; Lee-Tauler et al., 2018; Swierad et al., 2017; Tucker et al., 2014; Woods-Giscombe et al., 2016). NPs trained in appropriate culturally sensitive mental health assessment practices have the opportunity to address cultural barriers to mental health care among persons of African descent, and therefore also help to address mental health care disparities in this population.

The setting for this Doctor of Nursing Practice (DNP) project was an outpatient care center in Sacramento, California and a member of the Northern California-based River City Medical Group (RCMG). The organization's stated mission is to recognize and meet the needs of the community and to address its patients with creative and culturally sensitive care solutions. The center operates as an Independent Physician Association that mainly serves the Medi-Cal population. As one of the largest Medi-Cal IPAs in Northern California, RCMG functions as a

bridge between health plans, patients and care providers, enabling people to access health care and connect with other needed support resources. The site was selected for this project because it serves a primarily black patient population. About 70% of the clinic patient populations are blacks of African descent. A needs assessment revealed strong support among providers for a culturally sensitive approach to care, including mental health assessment and referrals. At the same time, the needs assessment revealed that providers were not using any specific culturally adapted assessments despite the fact that the organizational mission commits to addressing its patients with culturally sensitive care solutions.

Available Knowledge

How can providers at the outpatient care center address the need to provide culturally sensitive mental health assessment for patients of African descent? The population, intervention, outcome, and time (PICOT) question for this DNP project was: Among U.S. adult outpatients of African descent with known or suspected mental health needs (P), does a culturally-tailored program (I) compared to a usual care mental health assessment such as the PHQ-9 (C) improve patient uptake of mental health treatment, increase mental health referrals for patients, and/or improve mental health assessment outcomes (O) over a period of three months (T)?

The PICOT question guided the literature review. CINAHL, PubMed, Cochrane, Psych Info, and Evidence-Based Journals were searched with the limits/filters of adults, English language, peer-reviewed, full-text, and published within the past 15 years. Keywords used in the search included mental health, culturally tailored, culturally sensitive, African, African-American, minorities, blacks, African immigrants, mental illness, mental health assessments, and culture. Only primary research studies (qualitative and quantitative), systematic reviews (with or without meta-analysis and/or meta-synthesis), and clinical practice guidelines published in the

past 15 years in peer-reviewed English language journals and research/evidence focus on U.S. settings and adult populations were eligible for selection. Reviews, opinion articles, editorials, quality improvement projects, and studies focused on children/adolescent populations or on populations in non-U.S. countries were excluded from the search. More than 100 articles initially met these eligibility criteria. The selection pool was narrowed further by prioritizing articles published within the past five years and focusing on articles that best met the parameters of the topic as defined in the PICOT question.

A total of 15 articles were selected for review and evaluation using the Johns Hopkins Nursing Evidence-Based Practice (JHNEBP) model (Dang & Dearholt, 2017). See Appendix A for an Evaluation Table summarizing the level and quality of the evidence presented in these 15 studies. The JHNEBP model was selected as the appraisal tool based on the model's powerful problem-solving approach to clinical decision-making. All but one of the articles selected were published within the past five years. The studies selected for appraisal included one Level III systematic review and meta-analysis of cross-sectional studies (Eylem et al., 2020), one Level II systematic review with qualitative meta-synthesis (Lee-Tauler et al., 2018), one Level III systematic scoping review with qualitative meta-synthesis (Omenka et al., 2020), three Level III mixed methods studies (Shorkey, Windsor, & Spence, 2009; Wrenn et al., 2017; Young & Ramirez), one Level II quasi-experimental study (Tucker et al., 2014), two Level III quantitative descriptive studies (Steinfeldt et al., 2020; Suntai et al., 2020); and six Level III qualitative studies (Haynes et al., 2017; Olukotun et al., 2019; Stansbury et al., 2018; Swierard, Vartanian, & King, 2017; Watson-Singleton, Black, & Spivey, 2019; Woods-Giscombe et al., 2016).

The article that best addressed the PICOT question was the Level II systematic review of literature with qualitative meta-synthesis using PRISMA standards by Lee-Tauler et al. (2018).

The authors used PRISMA standards to review 29 U.S.-based studies (RCTs, quasi-experimental, program evaluation, historical comparison) for the purpose of identifying interventions to improve the initiation of mental health care among racial-ethnic minorities, including persons of African descent. Seven of the 29 studies included in the review reported that the interventions used both improved patients' mental health outcomes and contributed to a reduction in disparities. Six of the seven models that resulted in improved outcomes used an integrated care model that blended primary/general care with mental health services. Three of the seven studies associated with reduced disparities were culturally and linguistically adapted, using culturally sensitive adaptations such as scripted stories and visual representations involving the same ethnic group as the patients, language adaptation, culturally sensitive training of providers, and the incorporation of culturally-based illness beliefs.

A number of studies reviewed examined cultural barriers to mental health treatment or cultural factors in perceptions of mental illness in persons of African descent and other ethnic/racial minorities. In their qualitative descriptive study, Haynes et al. (2017) sought to develop an understanding of mental health and barriers to treatment from the perspective of rural African Americans as a basis for developing culturally appropriate treatment approaches. Based on seven focus groups with 50 participants, Haynes et al. (2017) found that stressful living conditions, poverty, stigma of mental illness, racism, and unemployment were all perceived as negatively affecting mental health, while social support, education to increase mental health literacy, and the use of religious outreach were perceived as positively affecting mental health. Shorkey et al. (2009) conducted focus groups with 39 experts in African American culture and chemical dependence to develop a tool for assessing and planning culturally competent chemical dependency treatment for African Americans. These researchers identified six reliable

dimensions of culturally competent care: 1) family involvement; 2) staff and program cultural diversity; 3) counselor traits; 4) linkage; 5) community/faith services; and 6) agency cultural expression (Shorkey et al., 2009). In their qualitative study examining stressors, mental health concerns, and coping strategies of undocumented African immigrant women, Olukotun et al. (2019) interviewed 24 Black African women. Three major themes were identified: 1) experiencing stressors (economic vulnerability, isolation); 2) mental health implications (feeling sad, lack of peace, feelings of anxiety and fear); and 3) coping strategies (e.g., finding trusted people, relying on religion) (Olukotun et al., 2019). In their study examining the healthcare experiences and needs of African immigrants in the United States, Omenka et al. (2020) identified two predominant themes: 1) the influence of culture on the provision of healthcare and 2) the overwhelmingly negative experiences of African immigrants with the American healthcare system. Omenka et al. (2020) found that African immigrants experienced healthcare stigma, especially as it related to mental healthcare. Among the cultural barriers that African immigrants faced were the lack of culturally competent providers, the biased/hostile provider attitudes, and the African immigrants' distrust of the US healthcare system (Omenka et al., 2020).

Relying on religion, particularly in terms of relying on Black churches and clergy, was a major theme related to coping with mental health issues. In their qualitative study of the influences of ethnic (African) and mainstream cultures and health behaviors of African Americans, Swierard et al. (2017) found that the factors that seemed to facilitate healthy behavior included affordability, social support, and spirituality, while high cost, lack of access, and the experience of discrimination were primary barriers to engaging in healthy behaviors (Swierard et al., 2017). Omenka et al. (2020) also found that traditional beliefs, religiosity, and

spirituality were also found to be important culturally-bound factors that could both facilitate and impede access to and participation in healthcare treatment and African immigrants.

A few studies tested or in some way assessed culturally sensitive interventions. In their quasi-experimental study, Tucker et al. (2014) tested the effects of a culturally-sensitive community health promotion program on patients' blood glucose (all participants had type 2 diabetes), BMI, blood pressure, treatment adherence, and overall stress levels. The majority of participants, 91 of 130, were African Americans. The participants in the intervention group who received the culturally-sensitive intervention had significantly ($p < .05$) lower BMI, diastolic BP, and physical stress than the participants in the control group (Tucker et al., 2014). Eylem et al. (2020) conducted a systematic review and meta-analysis of 29 cross-sectional studies with 193,836 participants, including 35,836 racial minorities to summarize the evidence of the differences in mental illness stigma among racial groups as part of a broader objective to be able to make recommendations on mental health treatment for racial minorities. Eylem et al. (2020) found that racial minorities (primarily Blacks, persons of African descent held more mental illness stigma concerning common mental diseases than racial majorities. The authors noted the need to tailor anti-stigmatization programs to the culture of the racial minority (Elyem et al., 2020). Steinfeldt et al. (2020) surveyed clinical supervisors ($n = 139$) at substance use disorder centers about their perceptions on the importance of providing culturally sensitive treatment and the importance of matching clients with racially/ethnically similar counselors. The overwhelming majority of respondents said that it was either "very important" (72%) or "somewhat important" (22%) to provide culturally sensitive care. Suntai et al. (2020) examined racial disparities in substance use treatment in 6,653 older adults (age 65 years or greater) who reported to a substance use treatment program in the US in 2017 and found that Black/African

American older adults were significantly ($p = .003$) less likely to complete substance abuse treatment than Whites. The researchers argue that the evidence of persistent racial disparities in substance use treatment and treatment completion indicate the need for an investigation of cultural factors in practice (Suntai et al., 2020).

Two studies developed recommendations on the development of culturally responsive interventions for persons of African descent. Watson-Singleton, Black, and Spivey (2019) developed recommendations for a culturally-responsive mindfulness intervention for African Americans based on their qualitative study with seven African American women who had completed mindfulness training. The major recommendations for increasing the cultural relevance/sensitivity of the intervention were the use of African American facilitators; reflecting cultural values within the content of the intervention; using culturally-familiar terminology; providing culturally-tailored resources, focusing on holistic health, including spiritual elements, and offering programs in culturally-approved settings, such as Black churches (Watson-Singleton et al., 2019). In their mixed methods study, Wrenn et al. (2017) sought to identify factors important to patients, practitioners, and clinic administrators when developing patient-centered, culturally-tailored integrated care models (mental health treatment of depression and family practice care) in a family health center mainly serving patients of African descent. Important factors identified included practitioner involvement in the community, culturally-tailored education and culturally sensitive communication about mental health during clinical encounters, and the importance of addressing stigma related to mental illness and mental health care (Wrenn et al., 2017).

Woods-Giscombe et al. (2016) utilized the superwoman schema framework to understand and develop culturally appropriate interventions to mitigate disparities in mental health services

among African American women. This qualitative study relied on secondary analysis of data from eight previously conducted focus groups. The results of the thematic analysis found that the factors contributing to African American women's underuse of mental health care included a perceived need to present an image of strength, to suppress emotions, to resist the appearance of vulnerability and dependence, motivation to succeed, and a tendency to prioritize caregiving over self-care (Woods-Giscombe et al., 2016).

The available knowledge indicated that persons of African descent face numerous barriers and obstacles to accessing mental health care and suffer many disparities in both access to mental health care and in mental health outcomes (Haynes et al., 2017; Shorkey et al., 2009). Cultural factors, including stigmatization of mental health care and mental health problems, distrust of providers, a lack of providers of African descent, and the lack of culturally sensitive or culturally relevant mental health assessments are among the factors that perpetuate the observed disparities (Omenka et al., 2020; Swierard et al., 2017; Watson-Singleton et al., 2019). There is moderate to strong evidence in the literature that culturally sensitive mental health assessments and mental health care protocols are associated with increased access to and utilization of mental health care as well as improved patient outcomes (Lee-Tauler et al., 2018; Suntai et al., 2020; Tucker et al., 2014; Watson-Singleton et al., 2019; Wrenn et al., 2017). In adapting mental health assessments and care protocols for persons of African descent, evidence from the literature suggests the need to address mental health stigma, religiosity and spirituality, racism, and the limited number of mental health providers of African descent (Eylem et al., 2020; Lee-Tauler et al., 2018; Suntai et al., 2020). Programs that were found to be particularly effective in improving access and reducing disparities among persons of African descent were those that tailored anti-stigmatization efforts to the African culture, considered the prominent role of religiosity and

local religious leaders, and made efforts to match clients with racially similar counselors and providers (Eylem et al., 2020; Suntai et al., 2020; Tucker et al., 2014; Watson-Singleton et al., 2019).

Theoretical Framework

Since Leininger first developed the Sunrise model of culture care, nursing theorists have developed a number of models of cultural competence that can guide researchers and practitioners in research or practice initiatives concerning culturally sensitive care (Albougami, Pounds, & Altaibi, 2016; Holden et al., 2014; Mahoney, Carlson, & Engebretson, 2006). The theoretical framework that guided this DNP project is Campinha-Bacote's (2002b) "The Process of Cultural Competence in the Delivery of Healthcare Services", originally developed in the 1990s and called "The Culturally Competent Model of Care" and then revised with the new name in 2002.

Campinha-Bacote's (2002a, 2002b) model was selected over other available models of cultural competence because Campinha-Bacote's theoretical framework was specifically developed for application in mental health/psychiatric settings and because Campinha-Bacote's model has been specifically applied to Africa/Black minorities (Campinha-Bacote, 2002a, 2002b). Although the model was initially specifically aimed at application by psychiatric nurses, the model is designed so that it can be used by any healthcare provider, regardless of specialty (Albougami et al., 2016; Campinha-Bacote, 2002a). Moreover, Campinha-Bacote's model is directed specifically at providers and clinical practice, versus researchers or nursing students. In explaining the aim of developing the model, Campinha-Bacote (2002b) stated that it "is one model that health care providers can use as a framework for developing and implementing culturally responsive health care services" (p. 181).

As its name implies, a distinctive aspect of Campinha-Bacote's (2002b) model is that cultural competence is viewed as a *process* not as an event or a static condition. As such, Campinha-Bacote (2002a) stated that this process of cultural competence requires that "nurses view themselves as *becoming* culturally competent, rather than *being* culturally competent" (p. 183). Five interdependent constructs constitute the process of cultural competence: 1) cultural awareness, 2) cultural knowledge, 3) cultural skill, 4) cultural encounters; and 5) cultural desire (Campinha-Bacote, 2002b). The figure below illustrates the model.

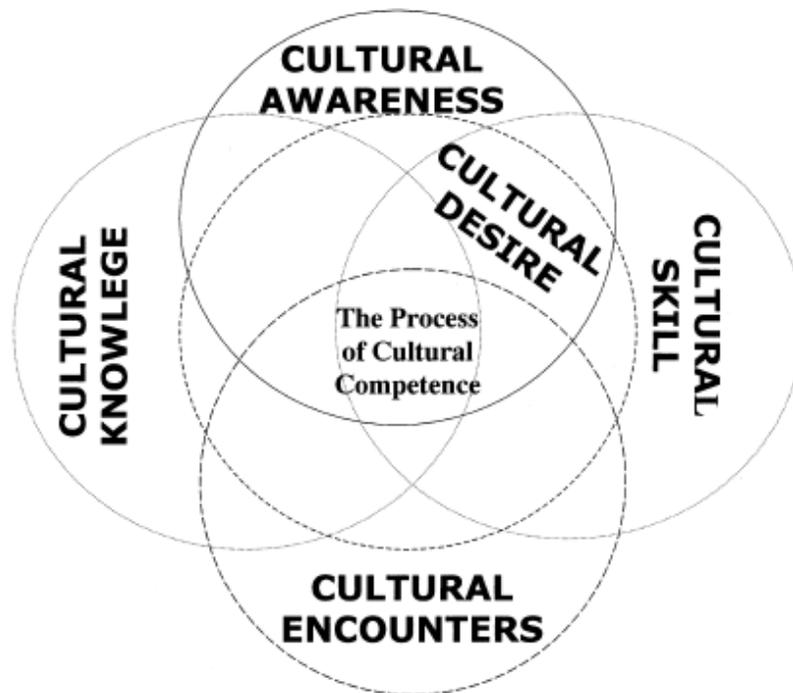


Figure 1. The process of cultural competence in the delivery of healthcare services. From *The Process of Cultural Competence in the Delivery of Healthcare Services* (3rd ed., p. 7.), by J. Campinha-Bacote, 1998, Cincinnati, OH: Transcultural C.A.R.E. Associates. Copyright 1998 by J. Campinha-Bacote. Reprinted with permission of the author.

As illustrated in the figure, the five constructs have an overlapping, interdependent relationship with one another. It is not possible to just work on one element of cultural competence; all five elements must be addressed. Cultural awareness entails self-examination and deep exploration of one's own culture and background. Cultural awareness can also be called "cultural humility" (Campinha-Bacote, 2002a, p. 183). Cultural knowledge describes the process of obtaining

education on diverse cultural and ethnic groups. Cultural skill is defined as the ability to collect relevant cultural data on the client's problem and the ability to conduct cultural assessments.

Cultural encounters refer to the process of engaging in cross-cultural interactions. Cultural desire, the fifth construct in the model, "is the motivation of the health care provider to *want* to, rather than *have* to, engage in the process of becoming culturally aware, culturally knowledgeable, culturally skillful, and familiar with cultural encounters" (Campinha-Bacote, 2002b, p. 182).

This project addresses all five constructs in Campinha-Bocote's (2002b) model. The needs assessment confirmed that the NPs have cultural desire, in that they have expressed a desire to be able to provide culturally relevant care to the persons of African descent who comprise the majority of the patients at the clinic. The development and the deployment of the culturally relevant mental health assessment will enable the NPs administering the assessment to engage in the process of cultural competence, becoming culturally aware, building cultural knowledge, developing cultural skill through the cultural encounters of the mental health assessment with patients of African descent at the clinic. Campinha-Bocote's (2002a, 2002b) model provides the theoretical framework for the use of the BATHE technique of patient-centered medical interviewing as a culturally-relevant component of the mental health assessment and the intervention in this project. The BATHE technique is a patient-centered psychotherapeutic technique and rough screening for anxiety, depression, and situational stress (Lieberman & Stuart, 1999). The evaluation plan in this project also reflects the underlying theoretical framework from Campinha-Bocote's (2002b) cultural competence. The NP participants' progress in the process of cultural competence will be evaluated through both self-assessment and patients' assessment of the cultural relevance of the assessment. For the

evaluation phase of the project, the Kirkpatrick Four Levels of Training Evaluation Model was used to assess NPs' learning and acceptance of the assessment intervention as well as to evaluate patients' perceptions of the assessment intervention (Tan & Newman, 2013). The Kirkpatrick Model thus serves as the CQI Model for this DNP project. The post-intervention 4-item NP and patient assessment forms were developed based on the Kirkpatrick model and using psychometric testing development procedures.

Specific Aims

The purpose of this DNP project was to improve the mental health assessment of patients of African descent at a primary care center through the implementation of a culturally-tailored assessment program. Through implementing culturally relevant mental health assessments, the project aims at positively influencing access to mental healthcare and ultimately mental healthcare outcomes among persons of African descent at a primary care center.

The project goal was to implement a culturally informed and relevant screening, brief intervention, and referral to treatment (SBIRT) process within primary care for persons of African descent. SBIRT is an established public health framework approach to persons at risks for substance abuse disorders, addiction, alcohol abuse, depression, anxiety, and other mental health disorders (Dwinnells, 2015; Hargraves et al., 2017). The SBIRT approach has been widely applied in public and private substance abuse and mental health clinical settings, as well as in community health centers (Dwinnells, 2015). SBIRT provided the underlying process framework for the implementation of culturally relevant mental health assessments by primary care nurse practitioners (NPs) who have undergone training in the use and implementation of culturally relevant mental health assessments for individuals of African ancestry. The culturally-relevant

mental health assessment training was developed through the use of training NPs in the BATHE technique of patient-centered medical interviewing (Leiberman & Stuart, 1999).

The specific aims of the DNP project were to use a culturally tailored mental health assessment to improve the mental health assessment of persons of African descent by increasing nurse practitioners' adherence to the culturally tailored assessment from zero to 90%, generating 10 or more patients of African descent mental health care referrals (none were made pre-intervention) by the end of the intervention period, and receiving favorable assessments of the usefulness and cultural relevance of the mental health assessment intervention by the majority of both NPs administering the intervention and the patients of African descent who undergo the assessments.

Methods

Context

The setting for the project intervention was an outpatient care center that primarily serves Medi-Cal patients who are of African descent. Overall, about 70% of the patients seeking care at the center are blacks of African descent. The primary stakeholders for this DNP project were the care center providers, including the four Nurse Practitioners (NPs), the organizational leadership, the patients of African descent attending this care center, and the families of these patients. The organizational leadership consists of the outpatient center physicians, nurse practitioners, and the clinic manager who oversees the clinic activities.

The initial needs assessment revealed that the organizational leadership and care center providers were aware of and open to the need for change, and recognized the need to provide culturally relevant mental health assessments. The leadership and providers recognized the dissonance between the organization's mission to provide high quality patient-centered care and

its lack of culturally-focused assessments and care protocols for its patient population comprised mainly of Medi-Cal patients of African descent. The needs assessment revealed that organizational leaders were aware of the unmet mental health needs and the barriers to mental health care access faced by patients of African descent. There was a belief among providers that increasing the cultural relevance of assessments and other aspects of patient care was a necessary element of patient-centered care. There was thus an overall readiness for change, or at least recognition of the need for and urgency of making changes to increase the cultural competency of services for the organization's patient population. The overall organizational climate and culture and the readiness for change among the provider stakeholders supported implementation of the project and appeared to increase the likelihood for achieving project change objectives (Evans et al., 2016; Hower et al., 2020).

The outpatient care center and its parent organization, River City Medical Group, follow an integrated care model. The organizational leaders and providers have made a commitment to the provision of patient-centered care. The organization's mission is to recognize and meet the needs of the community and to address its patients with culturally sensitive care. A needs assessment revealed a strong need for culturally sensitive mental health assessments and referrals for the predominately black patient population. Despite the support for culturally sensitive care among the organization leaders and the centers providers, the providers did not at the time of project initiation use any specific culturally adapted mental health assessments with its patients. The clinic used (and continues to use) the Patient Health Questionnaire 9 (PHQ-9) as part of their routine mental health assessment of all patients. The PHQ-9 is a well-validated, brief, self-reported diagnostic and severity measure of depression but it does not include any support for the patient's cultural needs; nor is the PHQ-9 considered to be a culturally-sensitive assessment tool

(Pinto-Meza et al., 2005). The use of the PHQ-9 also did not appear to increase access to mental health care or increase referrals to mental health care for the outpatient center's patients of African descent, as there were no mental health care referrals for patients of African descent in the months preceding the intervention.

Intervention

The project intervention consisted of the development and implementation of a culturally informed and culturally-relevant screening, brief intervention, and referral to treatment (SBIRT) process for patients of African descent at the outpatient primary care center. The SBIRT approach has been widely applied in both public and private substance abuse and mental health clinical settings (Dwinnells, 2015; Hargraves et al., 2017). SBIRT provided the underlying process framework for the implementation of culturally relevant mental health assessments by primary care nurse practitioners (NPs) who underwent training in the implementation of the culturally relevant mental health assessment for persons of African ancestry that was developed for this project.

The culturally-relevant mental health assessment intervention was developed through the use of BATHE technique of patient-centered medical interviewing as part of the mental health assessment. Developed by Lieberman and Stuart (1999), the BATHE technique is a psychotherapeutic procedure and rough screening test for anxiety, depression and situational stress disorders. It is comprised of four specific questions about a patient's background, affect, troubles, and handling of the current situation, followed by an empathetic response from the provider/questioner (Lieberman & Stuart, 1999). See Appendix J for an outline of the BATHE questionnaire. Holden et al. (2014) proposed the use of the BATHE technique as part of a comprehensive, culturally centered integrated care model for addressing mental health disparities

among ethnic minorities. Campinha-Bacote's (2002b) cultural competence process model provided the underlying theoretical framework for the development of the BATHE-based mental health assessment intervention.

A gap analysis conducted prior to project implementation revealed the absence of any culturally-relevant mental health assessment at the care center despite strong support for culturally-sensitive care from both clinic providers and the organization's leadership. Consistent with evidence from the literature demonstrating disparities in mental health care access and treatment among non-white populations, the gap analysis found that ethnic minority patients, particularly those of African descent, experienced disparities in mental health care access, referral, and treatment (Eylem et al., 2020; Lee-Tauler et al., 2018; Olukotun et al., 2019; Wrenn et al., 2017). A needs assessment found the need for culturally-relevant care to be the primary need for the center's patients of African descent. The lack of culturally-sensitive methods for assessing primary care patients with mental health needs was found to be a significant barrier to mental health care access in patients of African descent. The culturally-relevant mental health assessment intervention aimed at addressing the identified gaps in care revealed through the gap analysis. See Appendix B for the complete gap analysis.

The NPs at the outpatient center were trained in the use of the BATHE technique/assessment and its subsequent implementation with patients of African descent. The DNP student project leader, who conducted the training, had no direct contact with the clinic patients. The four clinic NPs conducted the mental health assessments and collected data from patients. Patient data and personal information were anonymized prior to forwarding to the DNP student project leader for analysis. The intervention thus consisted of both a training for the NPs and an intervention (carried out by the NPs) of a culturally-relevant mental health assessment for

clinic patients of African descent. The intervention was carried out over a three month (12-week period) and followed by a post-intervention assessment for the NPs and clinic patients. Major milestones included project approval by the chair and committee, project initiation, completion of NP training, project intervention with patients (trained NPs' use of culturally-relevant assessments with patients of African descent), conclusion of intervention, and completion of evaluation. See Appendix C for a Gantt Chart depicting the project schedule.

As indicated by the Work Breakdown Structure (see Appendix D), the major work of this project was divided into four phases. Phase one involved the formulation of the study question inquiry and a literature review to identify barriers and disparities in the mental health care of patients of African descent. Phase two entailed identifying an organization to serve as the project facility and presenting the project plan to stakeholders. Another major task during phase two was the development of the culturally relevant mental health assessment. Phase three of the project was the intervention, including the pre-training of the NPs. Phase four included the post-intervention project evaluation and the report to stakeholders and the project committee.

Appendix E details the communication matrix associated with the work breakdown. The DNP student project leader communicated and consulted with the Chair and Committee members prior to and following project implementation. After presenting the project proposal to the Committee and receiving approval, the DNP student project leader reviewed the project plan with organizational stakeholders and gained their approval and support. The project intervention was developed with feedback from key organizational stakeholders and the DNP project committee. Implementation was carried out with communication between the DNP student project leader and the NPs, who alone communicated directly with patients. Following completion of the intervention phase, the DNP student project leader conducted the project

evaluation and prepared the assessment for communication back to organizational stakeholders and onto the Chair and Committee.

A strengths-weaknesses-opportunities-threats (SWOT) analysis was conducted prior to implementation of the project and is included as Appendix F. Primary strengths of the project included its high level of viability, top leadership support, the fact that it was deemed realistic to implement, the likelihood that the program would enhance the skill and knowledge of primary care providers at the clinic, and that the project and the use of the assessment would strengthen patient-provider trust and relations, as well as the organizational capacity to provide culturally-relevant patient-centered care (Evans et al., 2016; Mata et al., 2021). The main weaknesses in the project included the lack of data documentation for tracking, the absence of any baseline data on culturally sensitive mental health assessments, patients' lack of trust of primary care providers, and concerns that staff might lack motivation to carry out the assessments. The SWOT analysis revealed that there were opportunities to improve mental health awareness, decrease resistance to mental health treatment, reduce healthcare costs, improve the readiness of providers to manage mental health in the primary care setting, along with possible application to patients from other (non-African descent) cultures. Possible threats to the success and sustainability of the project included the potential lack of staff adherence to including the cultural part of the assessment, lack of effective tools or procedures for monitoring progress, pre-existing patient-provider mistrust, and lack of patient education.

The budget plan for the project is included as Appendix G. Necessary resources for the project were minimal and included access to the Internet for research and data analysis. The DNP student project leader utilized her own computer with internet access so no expenditure was required for this resource. The NP providers at the clinic participated in the project and

conducted the assessments at no cost beyond their existing salaries. Other needed resources included funds for gas/transportation, printing, stationery, and snacks during training. There was no charge for the facility use. The single biggest line item in the budget was \$3,250 to cover 50 hours of student labor at \$65 per hour. The other costs included \$40 for office materials, \$30 for snacks, and \$60 for gas expense, bringing the total projected budget to \$3,380.

A prospective cost-benefits analysis was conducted based on available published data on mental health treatment costs as well as telephone inquiries to local inpatient providers (Bensink et al., 2013). See Appendices H and I for full details on this analysis. A recent review of the average costs of psychiatric inpatient hospitalization treatment as well as the costs of emergency department (ED) visits for mental and substance use disorders suggests that an effective culturally-relevant mental health assessment that results in increased referrals to more cost-effective outpatient mental health treatment and/or to the avoidance of emergency department visits for mental health disorders would result in significant cost savings benefits with outpatient treatment (Owens et al., 2019). Data from 2017 showed that the average cost per mental and substance use disorder visits to the emergency department was \$530 and that the total service delivery costs exceeded \$5.6 billion, or more than 7% of total emergency department visits in 2017 (Karaca & Moore, 2020). Data from 2006 indicate that costs for inpatient psychiatric treatment for mental health disorders ranged from \$4,356 to \$8,509 for 4.4 to 11 days treatment for depression, bipolar disorder, and schizophrenia (Stensland et al., 2012). More recent Agency for Healthcare Research and Quality (AHRQ) data on inpatient stays involving mental and substance abuse in 2016 found a national average per person cost for mental health and substance use disorders of \$7,100 and 6.4 days (Owens et al., 2019).

The DNP student project leader researched current (2020/21) emergency department and inpatient psychiatric costs in the region of the project site outpatient center. Patients in mental health crisis who present at or are transported to the local emergency department (ED) incur daily costs of \$3,800 and spend an average of two days prior to transfer to a psychiatric facility, thus leading to ED charges of \$7,600. Daily rates at a local psychiatric inpatient facility are \$1,350, with the average length of stay 5 to 6 days. Assuming a five-day stay in a psychiatric inpatient unit, this would be \$6,750, added to the initial ED charges of \$7,600, bringing the average minimal cost per patient per mental health crisis to \$14,350. With increased severity, longer hospital stays are necessary. The average length of stay for patients with a diagnosis of bipolar disorder or schizophrenia is 11 days (Owens et al., 2019). This would raise the per person cost of inpatient treatment to \$19,700. This figure does not include the costs of medications or possible electroconvulsive treatment or other psychiatric therapies. Also not included are additional costs related to comorbidities or costs from an extended stay in the ED or general hospital as a result of comorbidities and/or difficulty placing in a psychiatric facility. Appendix H provides per person projected costs and cost savings for outpatient versus inpatient treatment based on three levels of severity and a potential for electroconvulsive therapy (ECT) treatment for severe depression.

As shown in Appendix H, timely, appropriate referral to outpatient mental health treatment as a result of culturally relevant mental health assessment could result in significant cost savings. Given that most of the outpatient center's patients have Medi-Cal coverage, current Medi-Cal reimbursement rates for psychiatric outpatient care were used to calculate potential cost savings versus ED- and psychiatric inpatient-based treatment. At current (as of April 2021) Medi-Cal reimbursement rates, the cost of a comprehensive psychiatric evaluation (upon referral

to a specialty mental health provider) and seven days of crisis-care level outpatient therapy would total \$905 (State of California, 2021). Medi-Cal and most Medicare Advantage and private insurance plans provide coverage for 20 outpatient psychotherapy visits per year, with additional coverage available for crisis management or additional medication management. While ECT, an effective treatment sometimes used for severe depression, can only be provided on an inpatient basis, the outpatient provider can refer the patient for brief (3 day or less) hospitalization and ECT treatment at a significantly lower cost than traditional inpatient psychiatric care. As noted in Appendix H, one year of outpatient mental health treatment is projected to have cost savings of \$11,745 to \$16,145 per patient as compared to one week to 11 days (including 2 days in the ED) of inpatient psychiatric treatment. It should also be noted that the cost of inpatient psychiatric treatment, and the comparative cost savings from treatment in an outpatient/community setting, can rise precipitously if the patient is not stabilized upon discharge from the inpatient facility and is readmitted (Roos et al., 2018).

Study of the Intervention

The impact of the intervention was evaluated in terms of NPs' adherence to the use of the culturally tailored assessment, mental health referrals within the clinic, and the outpatient center's capacity to deliver culturally relevant mental health assessments to patients of African descent as indicated by patients' and NPs' appraisal of the usefulness and cultural relevance of the mental health assessment intervention. Outcomes were assessed primarily quantitatively via calculation of NP adherence to use of the assessment, tallying of post-intervention mental health referrals, and post-intervention brief survey assessment for the NPs and patients that asked for their rating/assessment of the usefulness/value of the culturally adapted mental health assessment. These post-intervention assessments are available as Appendices M and N. NPs'

appraisal of the usefulness and cultural relevance of the mental health assessment intervention was also assessed qualitatively through post-intervention debriefing with the NPs.

Measures

The project aimed at improving the cultural competence of NPs who conduct mental health assessments of patients of African descent at a primary health care clinic and to increase the cultural relevance of mental health assessment for patients of African descent. Three quantifiable, measurable outcome measures were used to assess the impact of the intervention and its potential contribution to improving the cultural competence of the NPs and the cultural relevance of mental health assessments for patients of African descent.

1. NP adherence to use of culturally tailored mental health assessment for patients of African descent. Prior to the intervention, NPs used the PHQ-9 and did not use any culturally tailored mental health assessment. The goal was to achieve 90% NP adherence to the use of the culturally tailored mental health assessment throughout the intervention period. NP adherence to the use of the culturally tailored mental health assessment was monitored throughout the project and the rate of adherence was calculated at the end of the intervention period.
2. Patient mental health referrals within the clinic. There were no mental health referrals for patients of African descent during the months preceding the intervention. The target goal was for the generation of 10 or more patients of African descent mental health care referrals during the intervention period. At the end of the intervention period, the number of mental health care referrals made and completed will be calculated.
3. Perceived usefulness and cultural relevance of the mental health assessment intervention. Outcome measures that directly assessed the impact of the intervention on the cultural

competency of providers in delivering mental health assessments to patients and on the cultural relevance of mental health assessments to patients of African descent included a measure of patients' assessment of the influence of their own culture on their perception of and approach to mental health. This measure is included as Appendix L, data collection tool. Nurse Practitioners' and patients' post-intervention assessment of the usefulness of the BATHE technique and related assessment support mechanisms in increasing the cultural relevance of mental health assessments was measured through a NP and a patient post-intervention assessment. The assessment tool developed was theoretically grounded in the Kirkpatrick model, which served as the CQI model for this DNP project. The post-training assessment was administered to the learners using the Kirkpatrick Four Levels of Training Evaluation Model. The first level measures how engaged the participants were, how actively they contributed, and how they helped the presenter to identify areas that need reinforcement. Level one has a series of questions and level two measure how much the trainees have learned (Tan and Newman, 2013). Level three helps the evaluator understand how the participants apply their training. Level four analyzes the final result of the practice. See Appendix K for a depiction of the Kirkpatrick Model. The NP and patient post-intervention 4-question assessment forms, included as Appendix M (NP) and Appendix N (patient) were developed based on the Kirkpatrick model and using psychometric testing development procedures (Fishman & Galguera, 2003). Both assessment forms utilize a 5-level Likert rating scale (1 = strongly disagree, 5 = strongly agree).

Analysis

Quantitative and qualitative analysis were used to assess the impact of the intervention on the outcomes and to evaluate the success of the project in achieving its aims of increasing the cultural competence of NPs to deliver mental health assessments to patients of African descent. Data analysis were conducted using Statistical Package for the Social Sciences (SPSS) software. Frequencies were run to compute the means, standard deviations and ranges of all items used. Pearson's two-tailed correlations were run to assess if the items had a linear association with each other. Cronbach's alpha was computed to determine if items in the data collection tool or patient post-intervention assessment correlated well enough to average them into a multi-item scale. If alpha was > 0.70 , items could be averaged to build a scale. The items for the patient post-intervention scale (with item 8 reverse-scored) had Cronbach's alpha of .82, and as a result, the items were averaged into a post-test rating scale. The patient post-test rating scale was also correlated with the four items in the data collection tool using Pearson's two-tailed correlations. A one-tailed t-test was also run to compare means of the NP and the patient post intervention assessments for statistical difference. The item or scale means for the NPs were used as the referents to which the item or scale means of patients were compared.

The DNP student project leader conducted a debriefing interview with the NPs following the completion of the intervention. The NP participants were asked to reflect on their experience in using the culturally relevant tool as well as to reflect on patients' feedback on cultural influences and mental health and the usefulness of the culturally sensitive mental health assessment. The results of the debriefing were analyzed qualitatively using inductive reasoning. The interview data were manually coded and themes identified and reported in the results.

Ethical Considerations

The project did not involve the DNP student project leader interacting with or collecting data from patients. The facility manager stated in the letter of approval (see Appendix O) that the DNP student project leader would have no contact with participants, and this protocol was maintained throughout the project. The anonymity and confidentiality of participants were guaranteed. All patient-related data were anonymized and blinded from the DNP project leader. All participation was purely voluntary. Participants were not offered or provided any monetary or non-monetary incentives for participation or for completing assessments. The design and implementation of the project aligned with the principles of the American Nurses Association (ANA) (2015) *Code of ethics* as it pertained to patient's right to privacy, dignity, and justice. The project also aligned well with Jesuit values including the view that learning is a "culture of service that respects and promotes the dignity of every person" (USF, n.d.). The purpose and aims of the proposed project were also consistent with the Jesuit value of *cura personalis* or care of the whole person, a value that describes the respect for "every individual's intellectual, physical, and spiritual health and autonomy" (USF, n.d.). The value of *cura personalis* thus strongly supports efforts to improve the cultural sensitivity and cultural relevance of mental health assessments for patients of African descent.

Results

Participants

All four NPs at the outpatient center participated in the project and completed training in the use of culturally sensitive mental health assessments using the BATHE technique with patients of African descent. A total of 87 patients of African descent participated in the NP-directed mental health assessments. The four NPs and all 87 patients also completed the post-intervention assessment.

Outcome #1: NP Adherence to the Use of Culturally Tailored Assessment

The NPs reported 100% adherence to use of the culturally tailored portion of the assessment with the 87 patient participants. Outcome #1 goal of 90% or greater NP adherence to the use of the culturally tailored mental health assessment was thus met.

Outcome #2: Patient Mental Health Referrals

Prior to the intervention, the outpatient primary care clinic did not make any mental health referrals for patients of African descent. During the intervention, 21 referrals to mental health were made based on the assessment, exceeding the project goal of 10 or more referrals during the intervention period. However, only nine of the 21 referrals resulted in providers' acceptance of the patients for evaluation and treatment. It should be noted that mental health referrals for the center's patients are complicated and rendered more difficult because the majority of these patients have Medi-Cal as their primary insurance coverage. Many psychiatrists do not accept Medi-Cal insurance and this has the effect of creating a barrier to the successful (completed) mental health referral of these patients, particularly if their mental health assessment results indicate the need for an evaluation and/or treatment by a psychiatrist versus non-MD mental health provider.

Outcome #3: Perceived Usefulness & Cultural Relevance of the Assessment

Surveys were collected from 87 patients and four NPs. Table 1 displays the frequencies for the items in the patient data collection tool that assessed patients' perspectives on the role of culture in mental health and mental health treatment. Items number 1, 3, and 4 had mean scores indicating that on average participants agreed with the item statements, while item 2, which asked patients to say if they were comfortable discussing their mental health with their care provider, had a mean response indicating a more neutral position on this item.

Table 1

Frequencies for Items in the Data-Collection Tool

Data-collection tool (items arranged from highest mean to lowest mean)	<i>N</i>	<i>M</i>	<i>SD</i>	Range
3. Culture or faith practices help me deal with sadness, bad experiences or troubles	87	4.32	0.93	1-5
1. Culture has perspective on mental-health therapy/counseling	87	4.24	0.96	1-5
4. Likely to seek treatment (and comfortable doing so) for any mental-health issues I have	87	3.62	1.11	1-5
2. Comfortable discussing my mental health with my care provider	87	3.43	1.43	1-5

Items scored 1 = Strongly disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, 5 = Strongly agree

Seventy-three patients (83.9%) agreed or strongly agreed that culture had a perspective on mental health therapy while 75 patients (86.2%) reported that their cultural or faith practices helped them deal with mental health issues. Patients were much less likely to report that they were comfortable discussing their mental health with their care provider or seeking treatment for any mental health issue that they might have. Only 38 patients (43.6%) agreed or strongly agreed that they were likely to seek treatment (and were comfortable doing so) for any mental health issues that they might have, while 30 patients (34.4%) indicated that they were neutral on this

item. Fifty-one patients (58.6%) agreed or strongly agreed that they were comfortable discussing their mental health with their provider, while 26 patients (29.8%) strongly disagreed or disagreed with this statement.

Pearson's two-tailed correlations were run to ask if the items on the patient data collection tool had a linear association with each other. The analysis showed a significant positive correlation between items 3 and 4, $r(N = 87) = .33, p < .001$. Patients who said their culture or faith gave them a way to deal with sadness, bad experiences, or troubles were also more likely to say that they felt comfortable discussing their mental health with a care provider.

Table 2 presents the results of the NPs' and patients' post-intervention assessments. On average patients and NPs agreed or strongly agreed that they favorably evaluated the assessment.

Table 2

Frequencies for Items in the Data-Collection Tool

Post-assessment rating scales	Patients			NPs		
	<i>N</i>	<i>M</i>	<i>SD</i>	<i>N</i>	<i>M</i>	<i>SD</i>
Total Post-Rating (V5-V8r averaged)	87	4.13	0.92	4	4.69	0.13
5. Rate the BATHE assessment highly	87	3.98	1.24	4	5.00	0.00
6. Assessment addressed patient mental-health concerns	87	4.17	1.01	4	3.75	0.50
7. Assessment questions are culturally focused	87	4.17	1.22	4	5.00	0.00
8. Length of the assessment is too short (reversed)	87	4.21	0.92	4	5.00	0.00

Items scored 1 = Strongly disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, 5 = Strongly agree

The four NPs were unanimous in strongly agreeing that the assessment questions were culturally focused and in rating the BATHE assessment form highly. None of the NPs thought that the assessment was too short. The NPs were less certain (mean score of 3.75) in their appraisal of

how well the assessment addressed patients' mental health concerns. Patients, on the other hand, were confident that the assessment addressed their mental health concerns, with 40 patients (45.9%) strongly agreeing and 32 patients (36.7%) agreeing that the assessment addressed their mental health concerns. Fifty patients (57.4%) strongly agreed that the assessment questions were culturally focused and another 20 patients (22.9%) agreed that the assessment was relevant to their culture. The patients believed that the assessment was an adequate length and 65 patients (74.7%) either strongly agreed (40) or agreed (25) that they would rate the assessment form very highly.

The patient post-test rating scale was also correlated with items in the data collection tool using Pearson's two-tailed correlations. The rating scale correlated positively and significantly with item 3, $r(N = 87) = .23, p = .03$, and item 4, $r(N = 87) = .49, p < .001$. Patients had more positive post-intervention ratings if they reported that culture or faith practices help them deal with sadness, bad experiences, or troubles, or if they said they were likely to seek treatment (and felt comfortable doing so) for any mental-health issues they have. Patients indicating greater comfort with practices for dealing with mental-health issues were probably especially open to an assessment asking about their experience with an intervention using such practices.

NP Post-Intervention Debriefing

The DNP student project leader conducted a short (~20 minutes) focus group debriefing session with the NPs following the intervention. Consistent with their responses on the post-intervention survey, the NPs spoke favorably about the culturally-focused BATHE mental health assessment. They rated the form highly. One NP stated that "not enough is understood about mental health" and indicated that a more culturally-focused mental health assessment (versus the standard PHQ-9 screening) was likely more effective in identifying mental health needs. Another

NP stated that “cultural beliefs have a huge impact on mental health and treatment.” The NPs noted that the patients overall had a strongly positive response to the assessment. Three of the NPs stated that they believed that the success of the intervention was based in part on the timing of it. Specifically, they noted that the COVID pandemic had increased mental health stresses and brought many people closer to a mental health crisis. The NPs speculated that this rendered the patients more responsive to the BATHE technique. The NPs said that the patients were able to talk about the stress and the fears brought on by the pandemic. The patients also used the assessment as an opportunity to talk about losses of family members and/or friends, as well as about job losses and financial burdens related to the pandemic. At the same time, the NPs stated that patients were reticent about discussing their mental health, reluctant to seek or accept help, and expressed a lack of trust in the system.

Discussion

Summary

The purpose of this DNP project was to improve the mental health assessment of patients of African descent at a primary care center through the implementation of a culturally-tailored assessment program by NP providers. The project goal to implement the culturally informed and relevant screening, brief intervention, and referral to mental health treatment for persons of African descent was achieved. Moreover, the project specific aims related to generating mental health care referrals for patients of African descent and receiving favorable assessments of the usefulness and cultural relevance of the mental health assessment by the majority of both the administering NPs and the patients of African descent were met.

Four NPs at the primary care center reported 100% adherence to the use of the culturally tailored assessment with 87 patients of African descent, exceeding the goal of 90% or greater NP adherence. During the intervention, 21 referrals to mental health care were made based on the assessment, exceeding the project goal of 10 referrals, although only 9 of the 21 referrals resulted in providers' acceptance of the referred patients. A majority (83.9%) of patients agreed or strongly agreed that culture had a perspective on mental health therapy and 86.2% reported that their cultural and/or faith practices helped them deal with mental health issues. Patients expressed hesitancy about seeking treatment for mental health issues. The results of Pearson's two-tailed correlations ($r[N = 87] = .33, p < .001$) indicated that patients who reported their culture or faith helped them deal with mental health issues were more likely to say that they were comfortable discussing their mental health with a care provider than patients who did not report the importance of culture in dealing with mental health. Both NPs and patients favorably evaluated the mental health assessment and deemed it to be culturally relevant. Patients, to a greater extent than NPs, affirmed that the assessment was effective in addressing their mental health concerns. The results of Pearson's two-tailed correlations indicated that patients who had reported that their culture or faith helped them deal with mental health issues or said that they were comfortable seeking mental health treatment were significantly ($p < .001$) more likely to express positive post-intervention ratings. During the post-intervention debriefing, NPs reiterated their belief that cultural beliefs have a significant impact on mental health and treatment.

The 100% NP adherence rate to the new assessment provided evidence that the NPs found the assessment easy to use and expeditious to deploy. Patients did not believe that the assessment was too brief. Although the brevity and convenience of the assessment contributed to the successful outcomes, the most important contributing factor was the reliance on the BATHE

technique framework. The patient-centered technique helped to put patients at ease and encouraged them to reflect on how their culture affected their mental health, while at the same time assisting the NPs in conducting a culturally relevant mental health assessment. This patient-centered approach was particularly important in a patient population that has expressed a cultural reticence towards seeking assistance for mental health issues from health care professionals. The results of the analysis showing a statistically significant relationship between patients' comfort in seeking mental health treatment and patients' belief that their culture or faith helps them deal with mental health issues suggests that the provision of culturally congruent healthcare facilitates patients' engagement in their own healthcare and improves provider-patient relations. Moreover, the success of the brief assessment used in this project suggests that brief, culturally-tailored assessments can be developed for other purposes, such as screening for substance use disorders, child abuse or neglect, and safety at home. The project results have important implications for advanced nursing practice, demonstrating that FNPs without special training in mental health nursing can conduct effective, brief, culturally relevant mental health assessments.

The plan for dissemination includes presentation of the results of the project to the leadership and staff at the project site, possible poster presentations at conferences, and publication of an article in a peer reviewed journal. The first-choice journal for submission is the *Journal of Transcultural Nursing*, a peer-reviewed journal that publishes research, theory development, education, and clinical practice articles related to culture and nursing as well as on the delivery of culturally congruent health care. This present project, which demonstrated NP primary care providers' implementation of a culturally relevant mental health assessment with patients of African descent, appears to be well-suited to publication in a journal that focuses on culturally congruent health care. The second-choice journal for submission is the *Journal for*

Nurse Practitioners. The culturally relevant assessment used in this project was designed for use by primary care providers, such as FNPs, and thus the article would be appropriate for publication in the flagship journal of the American Association of Nurse Practitioners. Given that the culturally focused assessment specifically concerns mental health, the article would also be suitable for a mental health nursing journal. Thus, a third potential target journal for article submission is the *Journal of the American Psychiatric Nurses Association (JAPNA)*.

Interpretation

The results of this project confirmed the results of studies finding that patients of African descent often express reticence to seek help for mental health issues, and are not always comfortable discussing mental health concerns with healthcare providers (Eylem et al., 2020; Lee-Tauler et al., 2018; Sunai et al., 2020). Stigmatization of mental illness and mental health treatment, distrust of providers, and the lack of culturally sensitive mental health assessments as well as the lack of culturally congruent providers are among the reasons cited for why persons of African descent may be reluctant to seek help for mental health issues (Omenka et al., 2020; Swierard et al., 2017; Watson-Singleton et al., 2019). Comments from the NPs during the post-intervention debriefing suggested that the patients in this project expressed a general distrust of providers as well as a reluctance to discuss mental health issues. At the same time, the use of the culturally tailored mental health assessment appeared to be effective in both encouraging patients to talk to providers about their mental health concerns, and perhaps more critically, encouraging primary care NP providers to provide appropriate referrals to mental health evaluation and treatment.

The results must be interpreted in the context of the primary care setting, the patient population, and the background environment of the COVID-19 pandemic. The patient population

in this project were persons of African descent who were also low income and covered by Medi-Cal. Prior to the implementation of the intervention, the primary care center had not been referring any of its patients of African descent to mental health care evaluation and treatment. During the intervention, the NPs referred 21 patients for mental health care. However, only 9 of the 21 referrals were accepted by the mental health providers. Eleven referrals were rejected based on the patient's Medi-Cal coverage. It seems likely that patients who were already distrustful of providers and reticent about seeking help for mental health issues would be discouraged by the failure to obtain timely mental health care after indicating their need for assistance.

Another important contextual factor to consider in this project was the impact of the COVID-19 pandemic. There is growing evidence from the literature that the COVID-19 pandemic has extracted a profound toll on individuals' mental health as well as their physical health (Fitzpatrick et al., 2020). While evidence suggests that COVID-19 is traumatizing to all the populations it ravages, some population groups, including persons of African descent, are disproportionately affected by the COVID-19 pandemic (Snowden & Snowden, 2021; Wakeel & Njoku, 2021). In addition to disproportionately affecting the population in terms of incidence and severity of disease, COVID-19 further traumatizes persons of African descent through decreased access to testing, disease management, and vaccination and through higher burdens of grief related to the higher mortality rates in the population as well as the increased economic burdens related to the pandemic (Wakeel & Njoku, 2021). Moreover, the pandemic-related restrictions have reduced access to churches and other culturally important supportive institutions and community members that persons of African descent have historically relied upon to assist with mental health concerns. In this project, the NPs noted during the debriefing that many of the

patients spoke about losing family members and about COVID illnesses among their friends and family (and themselves) and the stress that this caused. Indeed, three of the four NPs hypothesized that the patients' COVID-related trauma contributed to the success of the assessment intervention in that their traumatic feelings encouraged them to talk about mental health concerns.

Based on both the cost-benefit analysis and the responses of the NPs and the patients to the use of the culturally tailored mental health assessment, the intervention has the potential to produce significant cost savings if the culturally tailored assessments generate appropriate referrals and the patients are able to receive appropriate outpatient treatment for their mental health concerns. The projected cost savings are based on the assumption that the failure to obtain timely and effective outpatient mental health treatment may eventually lead to some of these patients requiring emergency crisis care and inpatient psychiatric treatment (Owens et al., 2019). The direct and opportunity costs of implementing the culturally tailored mental health assessment were minimal. The NPs were able to quickly master the BATHE technique and found the assessment to be effective and culturally relevant for the patients of African descent. The assessment intervention was very brief and the NPs were able to easily integrate it into the PHQ-9 screening without creating an undue burden on their time. The findings of the study, indicating the effectiveness of the brief, culturally relevant mental health assessment supports the conceptual framework underlying the BATHE assessment and its focus on a patient-centered approach (Lieberman & Stuart, 1999). The process of the NPs building cultural competence through the cultural encounter of the mental health assessment intervention supported Campinha-Bocote's (2002a, 2002b) cultural competence model, theoretical framework used in this project.

The high level of NP and patient acceptance and approval of the culturally relevant mental health assessment, along with the ease of its administration, bode well for its sustainability in the primary care center organization. The brevity and ease of use of the assessment suggests that the NPs will continue to use the assessment and that new NPs as well as physicians and other providers at the primary care center, can be easily trained to use the assessment.

Limitations

There were a number of important limitations with this project. Only four NPs at one primary care center participated in the project. Based on this small sample, it is not possible to generalize the NP-related results of the project to other providers (NP or other healthcare professional). In terms of the patient responses to the culturally tailored assessment, it is not known if these results can be generalized to patients of African descent in other primary care centers or to patients from other cultures or backgrounds. There were limitations related to the non-research status of the project and the DNP student project leader's lack of contact with the patients or patient data. Patient responses to the assessment are known only through the responses to the surveys and by NP debriefing comments. Although all patients were of African descent, no other patient-related data were collected or analyzed, so it is unknown how factors such as gender, age, family status, physical health, mental health history, or other patient-related factors may have affected the patients' rating of the assessment and/or responses to questions about culture and mental health. The patients' status as primary Medi-Cal beneficiaries was also a significant limitation in this project as demonstrated by the fact that only 9 of 21 referrals were accepted by mental health providers.

There were a number of methodological limitations in the project. The lack of any baseline data made it difficult to assess the true impact of the assessment intervention on mental health referral rates and/or patient uptake of mental health treatment. The lack of any follow-up and access to patient data was a limitation in assessing the longer-term impact of the use of the culturally sensitive mental health assessment. These methodological limitations, and the limited amount and scope of data collected during the project necessarily also limited the use of inferential statistics to test the effect of the intervention.

Conclusions

This DNP project demonstrated the viability of using Campinha-Bacote's (2002a, 2002b) cultural competence model and the BATHE technique to develop and implement a brief NP-led culturally-tailored mental health assessment for persons of African descent, a population group that has historically faced numerous barriers to accessing and accepting mental health care. The NP and patient responses to the assessment intervention suggests that the routine use of the assessment within the study site organization is sustainable and will continue to lead to appropriate referrals to mental health care for the center's patients of African descent. Moreover, the brevity, strong theoretical framework, and high level of provider and patient support for the relevance and usefulness of the assessment implies that the assessment can be used in other health care settings including other primary care centers, community health centers, urgent care, home health care, and specialty care. The assessment could potentially be used not only for the assessment of persons of African descent in other healthcare settings, but also in the assessment of persons from other cultural backgrounds.

Further study is needed to address the many limitations noted in this project. It will be especially important to explore how other patient-related factors, including demographic factors

such as age and gender, affect patients' acceptance of the assessment and their perceptions of its cultural relevance and usefulness in addressing mental health concerns. Future investigations should also systematically investigate the effect of the implementation of the culturally sensitive mental health assessment on mental health referrals, patient uptake of mental health treatment, and patients' willingness to discuss mental health issues with providers. Another necessary area for future study concerns NPs' and/or other healthcare providers' progress in developing cultural competence as a result of implementing culturally sensitive assessments such as the one used in this project.

Other Information

The Relevance of the COVID-19 Pandemic

This project was carried out during the COVID-19 pandemic. The pandemic disrupted routine healthcare procedures, significantly added to the workload and stress of the healthcare professionals who participated in or supported this project, and resulted in the imposition of distancing and infection control policies and practices that fundamentally disrupted and constrained provider-patient interactions. Notably, the mandatory use of masks for patients and providers during all interactions as well as the distancing requirements undoubtedly impeded interpersonal communication and increased the level of difficulty in implementing a culturally relevant mental health assessment. Additionally, it should be recognized that the target patient population (persons of African descent) were among those persons who have been disproportionately affected by the COVID-19 pandemic. While the COVID-19 pandemic thus presented a number of challenges in carrying out this project, there was also evidence that pandemic-related stressors may have encouraged some of the patients to discuss mental health issues with the NPs during the intervention.

Funding

There were no funding sources for the project. The DNP student project leader self-funded incidental expenses related to transportation, refreshments, and computer use. The DNP student project leader's salary was calculated for the purpose of the budget estimate, but the student project leader received no compensation for any work on this project. The NP providers did not receive any payment for their participation in the project. Furthermore, the project site organization did not cover any expenses related to this project. No conflict of interest has been declared by the DNP student project leader, the NP provider participants, the project site organization, or any employees of the project site organization.

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Appendix A

Evaluation Table

Citation	Purpose	Design/ Method	Sample/ Setting	Intervention/ Variables	Outcomes/ Results	Level of Evidence, Worth To Practice
<p>Eylem, O., de Wit, L., van Straten, A., Steubl, L., Melissourgaki, Z., Danisman, G.T., de Vries, R., Kerkhof, J.F.M., Bhui, K., & Cuijpers, P. (2020). Stigma for common mental disorders in racial minorities and majorities: A systematic review and meta-analysis. <i>BMC Public Health</i>, 20, 879. https://doi.org/10.1186/s12889-020-08964-3</p>	<p>To fill a gap in the literature by summarizing the evidence on the impact of differences in mental illness stigma between racial minorities and majorities.</p>	<p>Systematic review and meta-analysis of cross-sectional studies</p>	<p>29 cross-sectional studies with 193,418 participants (n = 35,836 in racial minorities including African Americans/blacks). 17 of the 29 studies (59%) were set in the USA, 3 in UK, 2 in Australia, 2 in Singapore, 1 in Canada, and 1 each in Nigeria, Korea, Spain, and Germany</p>	<p>All included studies had quantitative cross-sectional designs measuring mental illness stigma about common mental disorders (CMD) among racial minorities (as defined within the country of study setting) in comparison to majorities within those countries. Excluded studies with children/adolescents , and studies investigating stigma related to severe mental health disorders such as schizophrenia</p>	<p>Results on the primary outcome: racial minorities had more mental illness stigma concerning CMD compared to racial majorities.</p> <ul style="list-style-type: none"> - Effect size small but significant ($p < .001$) - Data did not allow for meaningful comparison within subgroups 	<p>Level III, Quality B</p> <p>Good quality Level III systematic review and meta-analysis of cross-sectional studies.</p> <p>Clinically significant in terms of need to tailor anti-stigmatization programs to the culture of the racial minority. Limitations included high risk of bias in 68% of studies</p>
<p>Haynes, T.F., Cheney, A.M., Sullivan, J.G.,</p>	<p>To develop an understanding of mental</p>	<p>Qualitative descriptive</p>	<p>Seven focus groups with 50</p>	<p>No intervention, qualitative study</p>	<p>Stressful living environments</p>	<p>Level III, Quality B</p>

Citation	Purpose	Design/ Method	Sample/ Setting	Intervention/ Variables	Outcomes/ Results	Level of Evidence, Worth To Practice
<p>Bryant, K., Curran, G.M., Olson, M., Cottoms, N., & Reaves, C. (2017). Addressing mental health needs: Perspectives of African Americans living in the rural south. <i>Psychiatric Services</i>, 68(6), 573-578. https://doi.org/10.1177/appi.ps.201600208</p>	<p>health, mental health treatment, and barriers to treatment from the perspective of rural African Americans as a basis for developing culturally appropriate treatment approaches</p>	<p>study, with grounded theory methodology. Data gathered through focus groups using a semi-structured interview guide; Inductive analysis and grounded theory methodology</p>	<p>participants from four stakeholder groups: primary care providers, faith community representatives, college students and administrators, and individuals living with mental illness. -88% of participants were African American. <u>Setting:</u> Jefferson County, Arkansas, located in the Arkansas Delta, a rural, low income area.</p>	<p>Primary issues studied were rural African Americans’ perspectives (and stakeholders’ perspectives) on mental health, mental health treatment, and barriers to treatment.</p>	<p>including poverty, stigma of mental illness, racism, unemployment perceived as negatively affecting mental health, as did family stress and community-level barriers. Stigma, economic factors, and low health literacy major barriers. Participants recommended social support, education to increase mental health literacy, and promote emotional wellness, use of religious outreach recommended</p>	<p>Confirms the need for a culturally appropriate approach to mental health treatment, suggests an important role for Black churches, health literacy education, same-race social support</p>

Citation	Purpose	Design/ Method	Sample/ Setting	Intervention/ Variables	Outcomes/ Results	Level of Evidence, Worth To Practice
<p>Lee-Tauler, S.Y., Eun, J., Corbett, D., & Collins, P.Y. (2018). A systematic review of interventions to improve initiation of mental health care among racial-ethnic minority groups. <i>Psychiatric Services, 69</i>(6), 628-647. https://doi.org/10.1176/appi.ps.201700382</p>	<p>To identify interventions to improve the initiation of mental health care among racial-ethnic minorities.</p>	<p>Systematic review of literature with qualitative meta-synthesis PRISMA standard used to guide review.</p>	<p>29 studies reviewed, in a variety of U.S.-based (primarily urban) settings, including community mental health centers, geriatric clinics, nursing homes, pediatric clinics, primary care settings, safety net clinics, and an oncology clinic. Study methodologies included RCTs, quasi-experimental, single arm, pre/post, program evaluation without control, and historical comparison</p>	<p>Study interventions included policy change, screening, psychoeducation, case management, collaborative care, referral, colocation, natural experiment, care management. Primary outcomes included initial access to or attitudes towards mental health care. Other specific outcomes measured included use of antidepressants, use of psychiatric services, prescription for antidepressants</p>	<p>7 (out of 29) studies reported interventions (screening and referral, colocation of primary care/mental health care, and collaborative care) both improved mental health outcomes and contributed to reduction of disparities. The integrated care model was found to be the most effective in reducing racial-ethnic disparities in the initiation of mental health care.</p>	<p>Level II, Quality B Good quality systematic review with meta-synthesis Limitations included heterogeneity of studies, inability to conduct meta-analysis of results and effect sizes, and difficulty in ascertaining primary target outcome in some studies. Results provided modest support for use of cultural</p>

Citation	Purpose	Design/ Method	Sample/ Setting	Intervention/ Variables	Outcomes/ Results	Level of Evidence, Worth To Practice
						adaptations in provision of mental health services to racial/ethnic minorities.
<p>Olukotun, O., Gondwe, K., & Mkandawire-Valmus, L. (2019). The mental health implications of living in the shadows: The lived experience of coping strategies of undocumented African migrant women. <i>Behavioral Sciences, 9</i>, 127. https://doi.org/10.3390/bs9120127</p>	<p>To examine the stressors, mental health concerns, and coping strategies of undocumented African migrant women in the United States.</p>	<p>Descriptive qualitative study</p> <p>Postcolonial feminist theoretical framework</p>	<p>N = 24 Black, African migrant women from Eastern, Southern or Western Africa, 21 of 24 lived in US Midwest, 3 lived in Eastern or Southern US.</p> <p>19 interviews conducted in-person; 5 interviews conducted via telephone</p>	<p>N/A qualitative study, no intervention</p>	<p>Three major themes identified: 1) experiencing stressors (economic vulnerability, uncertainty, isolation); 2) mental health implications (feeling sad/depressed; lack of peace/anxiety and fear); and 3) coping strategies (finding trusted people, relying on religion/faith)</p>	<p>Level III, Quality A</p> <p>This was a high-quality qualitative study that filled an important gap in the literature on mental health concerns of undocumented migrants by focusing on African migrants (versus Latin)</p> <p>Results highlight the need for culturally relevant mental health</p>

Citation	Purpose	Design/ Method	Sample/ Setting	Intervention/ Variables	Outcomes/ Results	Level of Evidence, Worth To Practice
						screening tools and interventions for this population
<p>Shorkey, C., Windsor, L.C., & Spence, R. (2009). Systematic assessment of culturally competent chemical dependence treatment services for African Americans. <i>Journal of Ethnicity in Substance Abuse</i>, 8, 113-128. https://doi.org/10.1080/15332640902896943</p>	<p>To develop a tool for assessing and planning culturally competent and relevant services to African American clients and their families within the context of chemical dependence treatment</p>	<p>Assessment/evaluation project</p> <p>Mixed methods: Concept mapping (qualitative) with statistical testing for internal consistency of items developed (quantitative)</p> <p>Concept mapping was based on the results of focus group responses</p>	<p>N = 39 experts in African American culture and chemical dependence in eight substance abuse programs serving African Americans and their families in 8 large agencies in Austin/Travis County, Texas</p>	<p>N/A not an intervention</p> <p>Main variables under study were the dimensions of culturally competent (to African Americans) chemical dependent treatment</p> <p>Dimensions were analyzed/tested for internal consistency, face validity, and theoretical cohesion</p>	<p>Six reliable dimensions identified:</p> <ol style="list-style-type: none"> 1. Family involvement 2. Staff and program cultural diversity 3. Counselor traits 4. Linkage 5. Community/Faith services 6. Agency cultural expression 	<p>Level III, Quality C</p> <p>Study identified possible tool for assessing cultural relevance of services to African Americans.</p> <p>Low quality and major limitations including lack of random selection and likelihood of selection bias, small pool of African American possible respondents,</p>

Citation	Purpose	Design/ Method	Sample/ Setting	Intervention/ Variables	Outcomes/ Results	Level of Evidence, Worth To Practice
						and focus in a single geographic area severely limit the generalizability of the study and call into question the reliability and validity of the dimensions identified
<p>Stansbury, K.L., Marshall, G.L., Hall, J., Simpson, G.M., & Bullock, K. (2018). Community engagement with African American clergy: Faith-based model for culturally competent practice. <i>Aging & Mental Health</i>, 22(11), 1510-1515. https://doi.org/10.1080/13607863.2017.1364.343</p>	<p>To examine African American Baptist clergy’s pastoral care to older congregants with mental disorders</p>	<p>Exploratory qualitative study</p> <p>Critical Race Theory as theoretical framework</p> <p>Grounded theory for analysis</p>	<p>N = 18 African American clergy from African American Baptist churches in the rural and urban central Kentucky</p> <p>Data gathered through in-depth, in-person interviews</p>	<p>N/A not an intervention study</p> <p>Explored participants’ pastoral care to predominantly African American congregants with mental disorders</p>	<p>Primary theme emerging from the interviews was that of “shepherding the flock”, used as a model of culturally-relevant pastoral mental health care</p>	<p>Level III, Quality B</p> <p>A good quality qualitative study with a narrow focus on pastoral care. Although focused on pastoral care, results have implications for the Black Church as a culturally</p>

Citation	Purpose	Design/ Method	Sample/ Setting	Intervention/ Variables	Outcomes/ Results	Level of Evidence, Worth To Practice
						relevant partner in mental health care for African/Black Americans
<p>Swierard, E., Vartanian, L.R., & King, M. (2017). The influence of ethnic and mainstream cultures on African Americans’ health behaviors: A qualitative study. <i>Behavioral Sciences</i>, 7, 49. https://doi.org/10.3390/bs7030049</p>	<p>To examine the influence of ethnic (Black) and mainstream cultures and health behaviors (focused on food intake and physical activity) of African Americans</p>	<p>Descriptive qualitative study using thematic analysis with NVivo qualitative data analysis computer software</p>	<p>N = 25 self-identified African Americans recruited from Columbia University (n=18) and Harlem (n=7)</p> <p>In-depth interviews conducted in private setting at Columbia University</p>	<p>N/A not an intervention study</p> <p>Main variables under study were relationship/influence of ethnic (African) and mainstream cultures on participants’ health behaviors (food intake/obesity and physical activity)</p>	<p>Participants reported both mainstream and ethnic culture affected health behaviors</p> <p>Two broad themes with sub-themes: 1) Culturally-derived barrier and facilitators of healthy lifestyle 2) Practical considerations beyond culture when adopting a healthier lifestyle</p>	<p>Level III Quality A</p> <p>This was a high quality qualitative study</p> <p>Although the focus was on physical health behaviors related to physical activity and food intake, the findings on the influence of culture (ethnic and mainstream) have relevance to mental health</p>

Citation	Purpose	Design/ Method	Sample/ Setting	Intervention/ Variables	Outcomes/ Results	Level of Evidence, Worth To Practice
					Factors found to facilitate healthy behaviors included affordability, social support, resilience, spirituality, while high cost, lack of access, and experience of discrimination were seen as barriers.	
<p>Tucker, C.M., Lopez, M.T., Campbell, K., Marsiske, M., Daly, K., Nghiem, K., Rahim-Williams, B., Jones, J., Hariton, E., & Patel, A. (2014). The effects of a culturally sensitive, empowerment-focused, community-based health promotion program on health outcomes of adults with type 2 diabetes. <i>Journal Health Care Poor Underserved</i>, 25(1), 292-307.</p>	<p>To test the effects of a culturally-sensitive community health promotion program designed for adults with T2DM on patients' BMI, BP, blood glucose, treatment adherence, and stress levels</p>	<p>Quasi-experimental Study testing the effects of a program informed by Health Self-Empowerment theory</p> <p>Pre-/post-test designs</p>	<p>N = 130 (including 91 African Americans) adults with T2DM recruited from low income areas in north central Florida</p> <p>Workshops conducted by members of University of Florida Behavioral</p>	<p>Independent Variable: Culturally-sensitive, health empowerment focused, community-based health promotion program tailored for adults with T2DM</p> <p>Dependent Variables: BMI, blood pressure, self-report blood glucose levels, treatment</p>	<p>Participants in the intervention group as compared to participants in the control (usual care) group had significantly ($p < .05$) lower levels of BMI, diastolic BP, and physical stress</p>	<p>Level II, Quality B,</p> <p>This was a good quality study limited by a small sample size, the use of self-report measures, lack of ethnic diversity, and marked gender imbalance</p>

Citation	Purpose	Design/ Method	Sample/ Setting	Intervention/ Variables	Outcomes/ Results	Level of Evidence, Worth To Practice
https://doi.org/10.1353/hpu.2014.0044			Medicine Research team	adherence, stress levels		(women comprised 70% of participants) Study is relevant to practice because it demonstrates the potential power of well-designed culturally- relevant health promotion programs to effect change
Watson-Singleton, N., Black, A.R., & Spivey, B.N. (2019). Recommendations for a culturally-responsive mindfulness-based intervention for African Americans. <i>Complementary Therapy Clinical Practice</i> , 34, 132-138. https://doi.org/10.1016/j.ctc.2018.11.013	To develop recommendations for the development of a culturally-responsive mindfulness intervention for African Americans	Qualitative Thematic analysis of focus group and interview data following 4- week mindfulness intervention with African Americans	N = 7 African American women who had completed mindfulness intervention Setting: Madison, Wisconsin, local community- university partnership center	N/A not an intervention study Main issues explored in interviews and focus groups were participants’ perceptions and reflections on their experience related to their participation in	Major recommended changes to increase cultural relevance of mindfulness intervention to African Americans: use of African American facilitators,	Level III, Quality C Although the study suggests directions for future research on culturally relevant mental health interventions

Citation	Purpose	Design/ Method	Sample/ Setting	Intervention/ Variables	Outcomes/ Results	Level of Evidence, Worth To Practice
		Brigg's mental health utilization model used to guide analysis and develop recommendations		the mindfulness intervention. Thematic analysis focused on identifying internal and external factors that could be modified to increase African Americans' engagement and participation in mindfulness interventions	reflecting cultural values within content, using culturally-familiar terminology, providing culturally-tailored resources, focusing on holistic health, including spiritual elements, and offering programs within culturally-approved settings such as African American churches	for African Americans, the low quality of the study limits its worth to practice. Major limitations include very small sample size, purposive sample from a very small, homogeneous population, self-selection bias due to provision of free therapy and compensation for participation, and other methodological limitations.
Wrenn, G., Kashiah, F., Belton, A., Dorvill, S., Roberts, K., McGregor, B.,	To identify factors important to patients, practitioners, and clinic	Qualitative/ Mixed method, data	N = 33 African American adult patients from	N/A not an intervention	Main themes identified included:	Level III, Quality B

Citation	Purpose	Design/ Method	Sample/ Setting	Intervention/ Variables	Outcomes/ Results	Level of Evidence, Worth To Practice
<p>& Holden, K. (2017). Patient and practitioner perspectives on culturally centered integrated care to address health disparities in primary care. <i>The Permanente Journal</i>, 21, 1-8. https://doi.org/10.7812/TPP/16-018</p>	<p>administrators when developing patient-centered, culturally-tailored integrated care model (mental health treatment for depression and other disorders) in family health center mainly serving African Americans</p>	<p>gathered from focus groups and key informant interviews, along with brief demographic/ patient satisfaction survey</p>	<p>Atlanta, Georgia-based Comprehensive Family Healthcare Center</p>	<p>Focus group and interviews used to discuss health experiences. Main outcome measures were themes related to depression care, perceived unmet cultural needs, and desired adaptations</p>	<ol style="list-style-type: none"> 1. Desire for anonymous support groups in primary care 2. Practitioner involvement in the community 3. A need for more culturally tailored education and culturally sensitive communication about mental health during clinical encounters 4. Importance of addressing stigma related to mental illness and 	<p>This study has worth to practice and relevance to the present project in providing evidence that failures to provide culturally centered care may increase health disparities and reduce African Americans' participation in mental health care as well as relevance in pointing at areas for future research in development of culturally sensitive care.</p>

Citation	Purpose	Design/ Method	Sample/ Setting	Intervention/ Variables	Outcomes/ Results	Level of Evidence, Worth To Practice
					mental health care	Major limitations include somewhat confusing presentation, lack of information about practitioner/administrator participants, use of convenience sample, gender imbalance of participants
<p>Woods-Giscombe, C., Robinson, M.N., Carthon, D., Devane-Johnson, S., & Corbie-Smith, G. (2016). Superwoman schema, stigma, Spirituality, and culturally sensitive providers: Factors influencing African American women’s use of mental health services. <i>Research, Education, and Policy</i>, 9(1), 1124-1144.</p>	<p>To utilize the superwoman schema (SWS) framework to understand and develop interventions to mitigate disparities in mental health service within the context of African American women’s use of mental health service</p>	<p>Qualitative, secondary qualitative analysis of data from eight focus groups</p> <p>Data analyzed via the lens of the superwoman schema</p>	<p>N = 48 African American women from the Southeastern United States</p> <p>(Study was a secondary analysis of data from a focus group with the 48 participants – no direct participants</p>	<p>N/A, not an intervention study</p> <p>Primary issues explored concern barriers and facilitators to African American women’s seeking, accessing, and engaging in mental health care, focusing particularly on care for depression</p>	<p>The SWS conceptual model was found to help explain African American women’s underuse of mental health services as well as racially-based disparities in</p>	<p>Level III, Quality B</p> <p>This study has relevance to practice in providing the worth of the SWS framework as a lens for understanding African American</p>

Citation	Purpose	Design/ Method	Sample/ Setting	Intervention/ Variables	Outcomes/ Results	Level of Evidence, Worth To Practice
<p>https://doi.org/10.2307/26554242</p>		<p>(SWS) conceptual framework</p>	<p>in the present study)</p>	<p>Focus of analysis is also on culturally relevant factors in health behaviors</p>	<p>mental health care. Factors found to contribute to the problem of underuse included obligation to present image of strength, perceived need to suppress emotions, resistance to vulnerability and dependence on others, motivation to succeed, prioritization of caregiving over self-care</p>	<p>female culture and possibly making culturally sensitive adaptations to mental health care The study has a number of important limitations including reliance on secondary analysis as well as the failure to discuss study limitations and possible sources of bias</p>
<p>Young, A.J. & Ramirez, M.L. (2017). I would teach it, but I don't know how: Faculty perceptions of cultural competency in the health sciences: A case study analysis. <i>Humboldt</i></p>	<p>To present the results from a survey of faculty perceptions of cultural competency training at a small, private university focused on health sciences</p>	<p>Mixed methods, Data gathered through researcher-developed</p>	<p>N = 101 faculty members completed survey, demographic data available on 75 respondents</p>	<p>N/A not an intervention study Major issues explored through the survey were faculty members'</p>	<p>-High level of support among faculty members for cultural competency training for</p>	<p>Level III, Quality B Relevant to practice and to the present study in</p>

Citation	Purpose	Design/ Method	Sample/ Setting	Intervention/ Variables	Outcomes/ Results	Level of Evidence, Worth To Practice
<p><i>Journal of Social Relations</i>, 39(Special Issue 39), 90-103. Retrieved from https://jstor.org/stable/10.2307/90007873</p>		<p>survey with quantitative and qualitative components</p> <p>Quantitative data analyzed with univariate and bivariate measures; qualitative data were hand-coded and analyzed thematically</p>	<p>Setting: small private university in major Northeastern city</p>	<p>perception of cultural competency in the health sciences, in both practice and education</p>	<p>STEM and health sciences students</p> <p>-Faculty uncertain how to implement cultural competency training</p> <p>-Need to improve and expand cultural competency training for students and provide faculty with knowledge and skills to teach it</p>	<p>providing evidence of faculty support for cultural competency training while also indicating that faculty are not prepared to provide such training.</p> <p>Major limitations include lack representative sample, bias in survey construction, lack of anonymity for survey respondents, lack of any meaningful measurement of degree to which cultural</p>

Citation	Purpose	Design/ Method	Sample/ Setting	Intervention/ Variables	Outcomes/ Results	Level of Evidence, Worth To Practice
						competency training was or was not provided
<p>Omenka, O., Watson, D.P., & Hendrie, H.C. (2020). Understanding the healthcare experiences and needs of African immigrants in the United States: A scoping review. <i>BMC Public Health</i>, 20(27). https://doi.org/10.1186/s12889-019-8127-9</p>	<p>To examine information about African immigrant health in the US for the purpose of developing lines of inquiry based on the identified knowledge gaps.</p>	<p>Qualitative: systematic scoping review and meta-synthesis.</p> <p>Review followed Arksey & O’Malley’s Scoping Review framework and PRISMA Guidelines</p>	<p>N = 14 studies, including 12 qualitative studies and 2 quantitative cross-sectional descriptive studies.</p> <p>All studies were based in U.S. cities and included non-refugee African immigrant participants from west, north, east, and south Africa.</p>	<p>Systematic scoping review, no intervention.</p> <p>The scoping review was guided by two questions:</p> <ol style="list-style-type: none"> 1) What do we currently know about healthcare experiences and needs of African immigrants in the US? 2) What are the knowledge gaps to guide the development of subsequent inquiries about African immigrant health in the US? 	<p>Two predominant themes were identified:</p> <ol style="list-style-type: none"> 1) The influence of culture on the provision of healthcare 2) Negative experiences of African immigrants with the US healthcare system <p>Subthemes within the cultural theme included traditional beliefs, religiosity and spirituality,</p>	<p>Level III, Quality B</p> <p>This study had direct relevance to practice and to the project, providing evidence of the importance of culture in addressing the healthcare needs (especially mental healthcare) and concerns of African immigrants and confirming that African immigrants report many of the same</p>

Citation	Purpose	Design/ Method	Sample/ Setting	Intervention/ Variables	Outcomes/ Results	Level of Evidence, Worth To Practice
					<p>healthcare stigma, especially related to mental health and to HIV/AIDS, and linguistic discordance.</p> <p>Subthemes in the negative experience of African immigrants included the lack of culturally competent providers, complexity of the system, cost of healthcare, biased/hostile provider attitudes, and Africans' distrust of the US healthcare system.</p>	<p>cultural influences and negative experiences as US citizens of African descent – notably mistrust of the health system, mental health stigma, and importance of religiosity and cultural traditions. Major limitations included the emphasis on qualitative studies, and the exclusion of studies focused on refugees and studies exploring the experiences of African immigrants as</p>

Citation	Purpose	Design/ Method	Sample/ Setting	Intervention/ Variables	Outcomes/ Results	Level of Evidence, Worth To Practice
						compared to other immigrants' experiences.
<p>Steinfeldt, J.A., Clay, S.L., & Priester, P.E. (2020). Prevalence and perceived importance of racial matching in the psychotherapeutic dyad: A national survey of addictions treatment clinical practices. <i>Substance Abuse Treatment, Prevention, and Policy</i>, 15(76). https://doi.org/10.1186/s3011-020-00318-x</p>	<p>To examine the importance of racial matching in the psychotherapist-patient dyad, and to specifically examine the importance placed on culturally sensitive treatment based on the premise that racial matching is a component of culturally sensitive treatment.</p>	<p>Quantitative descriptive study using survey methodology</p> <p>Author-developed survey instrument with 4-part Likert type questions</p>	<p>N = 139 clinical supervisors at substance use disorder (SUD) centers from the Substance Abuse and Mental Health Services Administration (SAMHSA) representing all four (East, South, Midwest, and West) in the United States</p>	<p>N/A not an intervention study.</p> <p>In addition to demographic information, the survey asked clinical supervisors two questions:</p> <ol style="list-style-type: none"> 1. Is it important to match clients with racially/ethnically similar counselors? 2. Is it important to provide culturally sensitive treatment? <p>The researchers also gathered data on the existence of a potential to match a counselor with a racially similar client.</p>	<p>The majority (72%) of SUD clinical supervisors surveyed indicated that it was very important to provide culturally sensitive care and another 22% said it was “somewhat important” to provide culturally sensitive care.</p> <p>In an unexpected finding, given that racial matching is often recommended when feasible in general</p>	<p>Level III, Quality Level B</p> <p>The findings of this study confirm the importance of providing culturally sensitive care. However, the clinical supervisors in this study did not necessarily perceive racial matching as an important or necessary component of providing culturally sensitive care. The researchers</p>

Citation	Purpose	Design/ Method	Sample/ Setting	Intervention/ Variables	Outcomes/ Results	Level of Evidence, Worth To Practice
					<p>psychotherapy, the surveyed clinical supervisors were not as supportive of the importance of racial matching, even when there was a potential for match. Specifically, only 16% of respondents indicated that it was important to racially match, 26% said it was “somewhat important”, 36% said it was “slightly important”, 22% said it was “not important”.</p>	<p>suggested that this finding may be reflective of the need for multicultural and cultural sensitivity training for clinical supervisors.</p> <p>The study had a number of limitations, including a low response rate, the lack of power analysis, and the failure to break down racial matching in terms of its within-group variables.</p>
Suntai, Z.D., Lee, L.H., & Leeper, J.D. (2020). Racial disparities in substance use	To determine to what extent racial disparities, exist in substance use	Quantitative cross sectional	N = 6,653 older adults (age 65+ years) who	N/A not an intervention study	After controlling for predisposing,	Level III, Quality Level B

Citation	Purpose	Design/ Method	Sample/ Setting	Intervention/ Variables	Outcomes/ Results	Level of Evidence, Worth To Practice
<p>treatment completion among older adults. <i>Innovation in Aging</i>, 4(6), 1-9. https://doi.org/10.1093/geroni/iga051</p>	<p>treatment completion among adults aged 65 years and older.</p>	<p>descriptive study</p> <p>Data were drawn from the most recent Treatment Episode Data from the SAMHSA</p>	<p>reported to a substance use treatment program in 2017</p>	<p>The main independent variable was race. The main dependent (outcome) variable was substance use treatment completion</p> <p>Other variables considered included gender, marital status, employment, educational level, primary substance abused (coded as alcohol or other), and frequency of use (daily, some use or no use in the last month)</p>	<p>enabling, and need factors, race was a significant predictor of substance use treatment completion.</p> <p>Notably, Black/African American older adults were significantly ($p = .003$) <i>less</i> likely to complete SUD treatment than Whites. Overall, White adults were 60% more likely to complete treatment than Blacks. Hispanic older adults had a 26% higher</p>	<p>This study has worth to practice by providing additional evidence of the importance of culture and race in mental health treatment uptake and completion. In their conclusion, the authors noted that the evidence of continued racial disparities in substance abuse treatment indicates the need for an investigation of cultural factors in in practice, as well as a need</p>

Citation	Purpose	Design/ Method	Sample/ Setting	Intervention/ Variables	Outcomes/ Results	Level of Evidence, Worth To Practice
					completion rate than non-Hispanic whites.	to address aspects of the healthcare system that “create distrust of the healthcare system” among Blacks/African Americans.

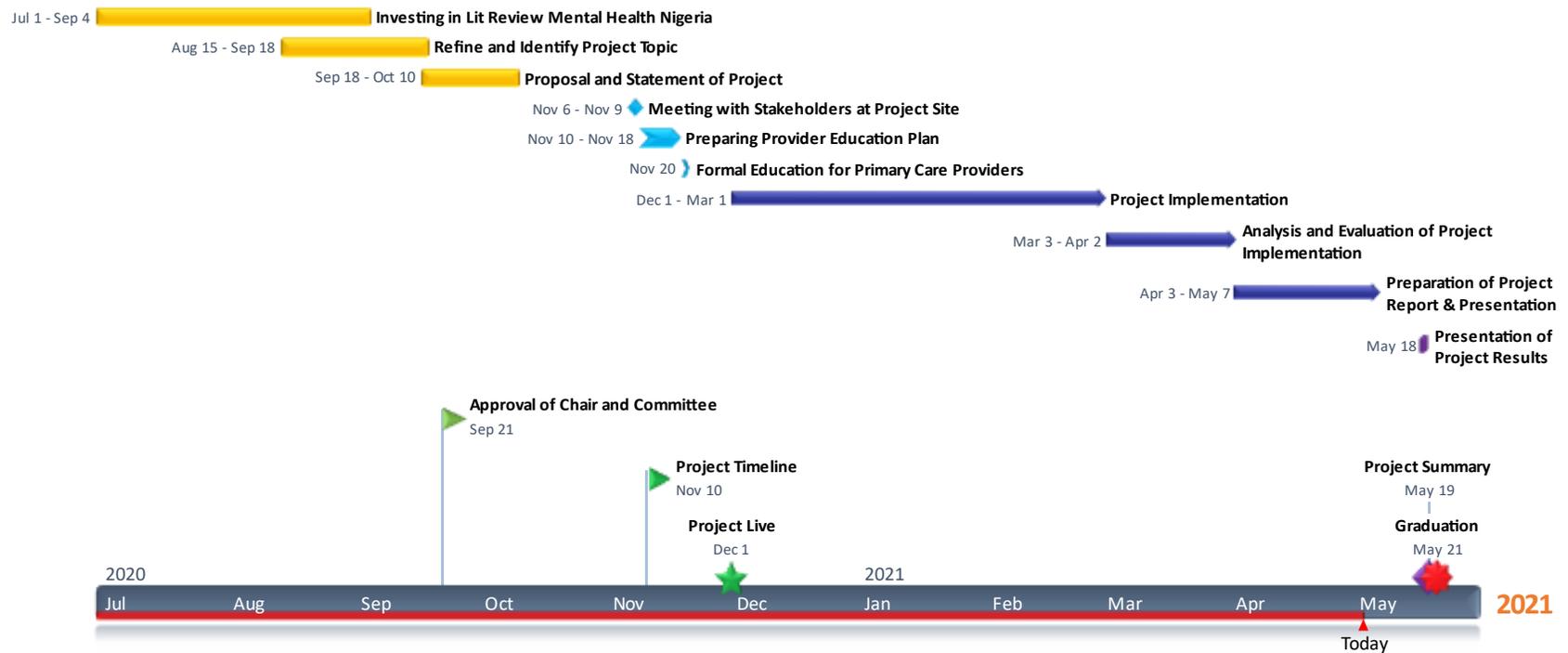
Appendix B

Gap Analysis

A needs assessment of the site facility ranked need for culturally competent integrated care as the primary need for patients of African descent. Assessment of the allocation of mental health care by geographic divisions revealed that minority communities, including populations of African descent, receive less mental health care than non-minority communities (Kim et al., 2017). This finding matches the evidence from the literature review that demonstrated deficiencies in access to mental health care as well as disparities in mental health care among non-white populations, especially communities of African descent (Eylem et al., 2020; Lee-Tauler et al., 2018; Olukotun et al., 2019; Wrenn et al., 2017). Cultural factors, including stigma related to mental illness and seeking mental health care, lack of same-culture providers, and the lack of culturally sensitive communication and care contribute to the problem and to the perpetuation of health disparities (Wrenn et al., 2017; Woods-Giscombe et al., 2016). A lack of mental health professionals to work within primary care centers in disadvantaged communities adds to the problem, as it is challenging to provide appropriate treatment when providers are not available. Although the organization emphasizes the importance of culturally sensitive care in its mission, the clinics currently do not utilize culturally-sensitive methods for assessing patients with mental health needs. Such a system is essential for expanding mental health care and ensuring that all patients in need of mental health services are able to obtain them. This project seeks to fill this gap by developing a culturally tailored, integrated mental health assessment for individuals of African descent and training the clinic nurse practitioners in the implementation of this assessment.

Appendix C

Gantt Chart



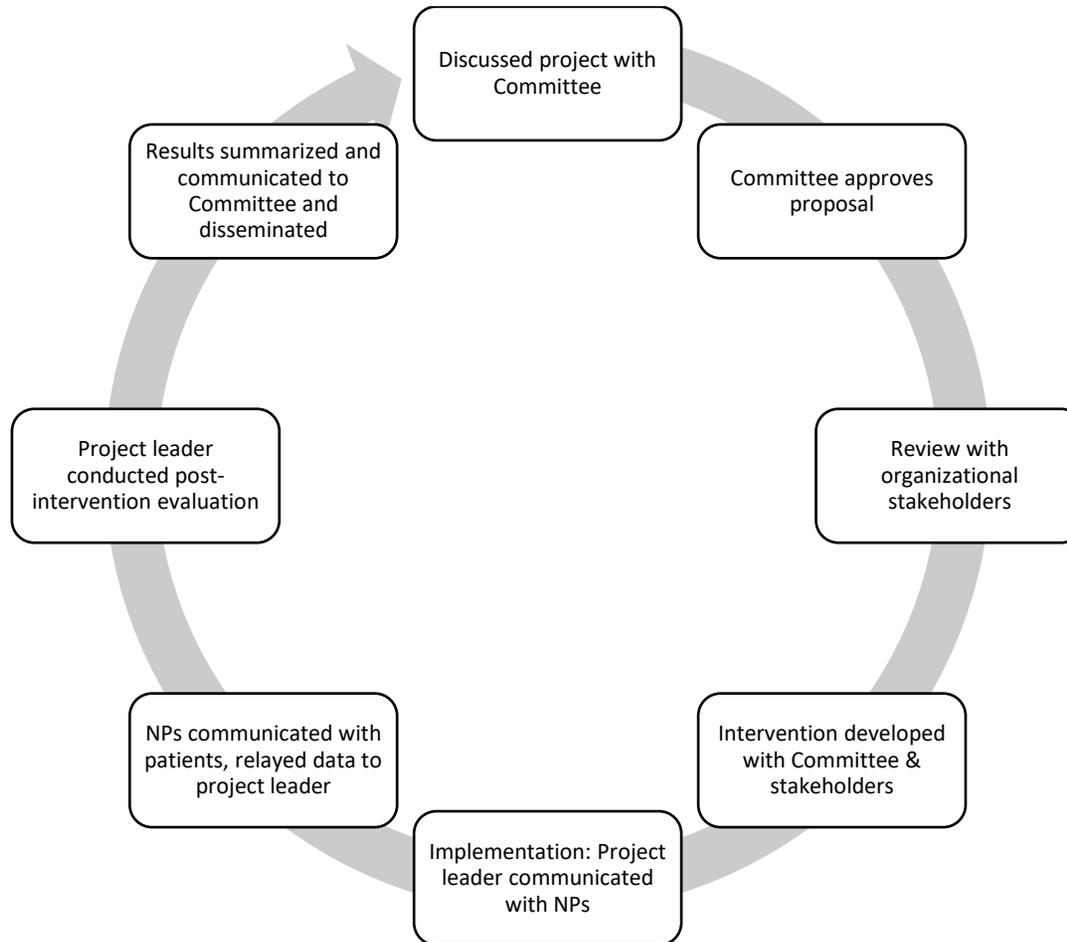
Appendix D

Work Breakdown Structure



Appendix E

Communication Matrix



Appendix F

SWOT Analysis

<p>STRENGTHS</p> <ul style="list-style-type: none"> ● High level of viability ● Can be realistically implemented to enhance cultural competence ● Enhance skill and knowledge of primary providers ● Decrease hospitalization & ED ● Strengthen patient- provider trust and relationship 	<p>WEAKNESSES</p> <ul style="list-style-type: none"> ● Lack of trust in providers ● Lack of data documentation for tracking ● Lack of immediate result can lead to discouragement ● Poor staff motivation ● Busy schedules prevent proper assessment
<p>OPPORTUNITIES</p> <ul style="list-style-type: none"> ● Improve mental health awareness ● It can be used for other cultures ● Improve readiness for management of mental health in the primary care setting ● Decrease mental health treatment resistant ● Reduce healthcare cost 	<p>THREATS</p> <ul style="list-style-type: none"> ● Facility staffs not including cultural part of assessment ● Lack of sustainable process ● Lack of efficient tool for monitor progress ● Threats of patient- provider mistrust ● Lack of patient education

Appendix G

Budget, Proposed

Expenses	Cost (\$)
Labor: 50 hours of student labor @ \$65/hour (Includes education of NP Providers on use of screening tool)	3,250
NP Provider labor, administering the assessment (no cost) - Incorporating the assessment does not add materially to the NPs' routine assessment protocol in either time or effort	0
Office Materials	40
Snacks	30
Gas expense estimate	60
Facility Use (no cost)	0
Total Projected Cost of Project	\$3,380

Appendix H

Cost-Benefit Analysis

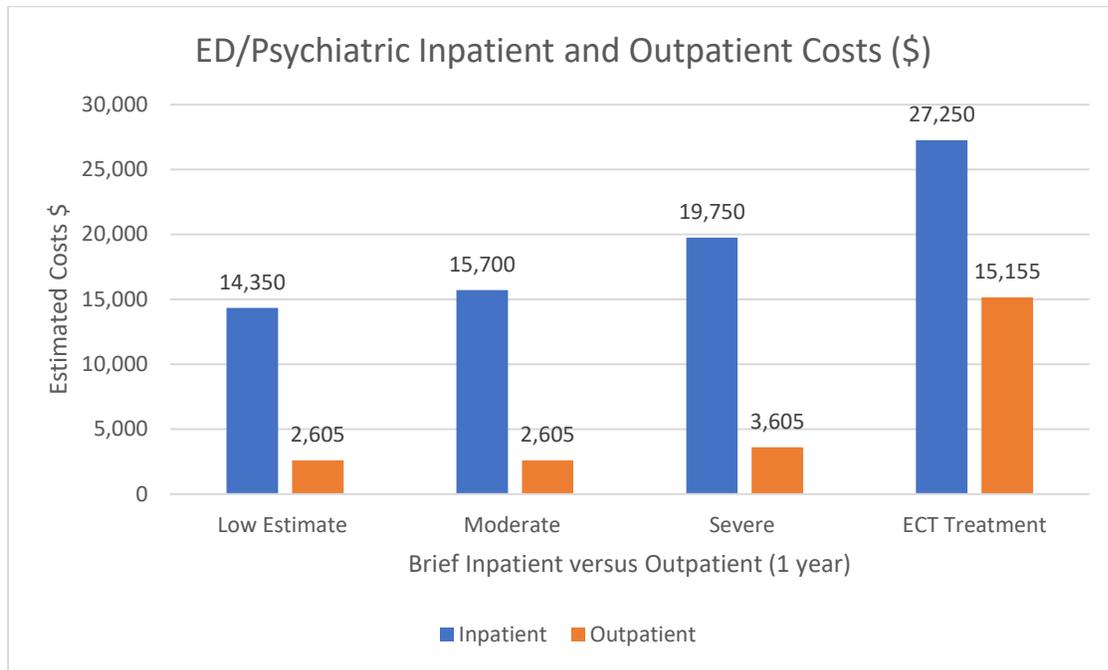
**Referral to Outpatient Mental Health Services versus Psychiatric Inpatient Crisis Care
(Cost in \$, per Patient)**

ED Visit & Transfer to Inpatient Psychiatric Hospital (\$)		Referral to Outpatient Mental Health Treatment (\$)		Outpatient Cost Savings
Emergency Department Presentation, 2 days @ \$3,800/d	7,600	Referral, comprehensive psych. Evaluation	205	
Psychiatric Inpatient Care, 5 days @ \$1,350/day	6,750	Crisis therapy – 7 days 20 visits @ \$85/each	700 1,700	
Total Low Estimate (1 week)	\$14,350	Total Low Est. (1 year)	\$2,605	\$11,745
Additional day of hospitalization	1,350	No change		
Total Moderate Estimate (8/d)	\$15,700	Total Moderate Est (1yr)	\$2,605	\$13,095
+ 3 days increased severity	4,050	Add'l crisis/med mgt	1,000	
High Estimate (11 days)	\$19,700	Total high estimate	\$3,605	\$16,145
ECT for Severe Depression	7,500	High estimate	3,605	
High severity hospitalization	19,700	ECT for Depression	7,500	
		3 days inpatient	4,050	
Total for ECT/hosp. (11 days)	\$27,250	Total for ECT/hosp.	\$15,155	\$13,095

Notes on Table Assumptions: For the inpatient scenario, it is assumed that the patient presents in mental health crisis at an Emergency Department (ED) and has a two-day wait (standard in the area) for transfer to an available room at an inpatient psychiatric facility. Nationally, the average low-moderate severity inpatient hospitalization is 5-6 days (Owens et al., 2019). Per diem rates for inpatient psychiatric hospitalization are based on an April 2021 telephone survey of Northern California facilities. Costs for electroconvulsive therapy (ECT) treatment are based on published data of national averages and the assumption of 5-6 inpatient sessions, with three days allowed for treatment and recovery (Owens et al., 2019). Outpatient cost estimates are based on 2021 Medi-Cal reimbursement rates for outpatient mental health treatment. Twenty (20) combination medication management/psychotherapy outpatient visits are allocated per year, not including crisis management and evaluation visits.

Appendix I

Cost Savings Analysis: Psychiatric Inpatient versus Outpatient Treatment



Low Estimate

Inpatient: ED admission, 2 day stay, 5 days psychiatric inpatient

Outpatient: Comprehensive Evaluation, 7 days crisis therapy, 20 outpatient visits (1 year)

Moderate Estimate

Inpatient: ED admission, 2 day stay, 6 days psychiatric inpatient

Outpatient: Comprehensive Evaluation, 7 days crisis therapy, 20 outpatient visits (1 year)

Severe Estimate

Inpatient: ED admission, 2 day stay, 9 days psychiatric inpatient

Outpatient: Comprehensive Evaluation, 7 days crisis therapy 20 visits, \$1000 allowance for crisis management/additional consultation

ECT Treatment

Inpatient: ED + 9-day inpatient, \$7,500 in ECT treatments for severe depression

Outpatient: Severe level + 3 days hospitalization + \$7,500 for inpatient ECT

Appendix J

BATHE Assessment QuestionnaireThe BATHE Technique as a Method for Teaching Patient-Centered Medical Interviewing

<u>B=</u> <u>Background</u>	<u>“What is going on in your life?” “Tell me what has been happening since I saw you last.”</u>
<u>A = Affect</u>	<u>“How do you feel about what is going on?”</u>
<u>T = Trouble</u>	<u>“What troubles you about this?”</u>
<u>H = Handling</u>	<u>“How are you handling that?”</u>
<u>E = Empathy</u>	<u>“Sounds like things are difficult for you.” “Let’s schedule you to see one of our behavioral staff.”</u>

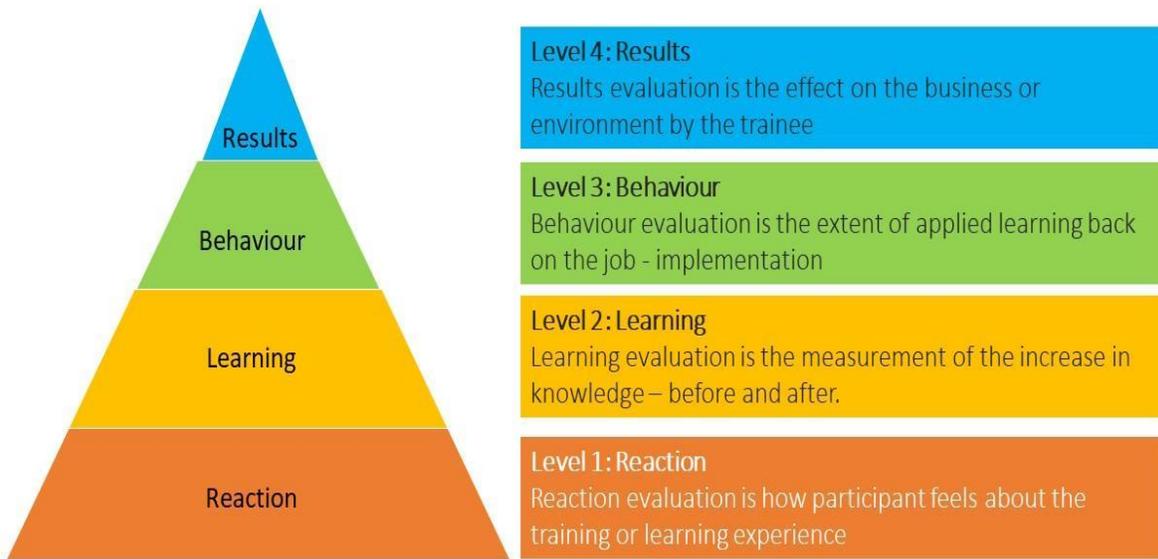
Source: Lieberman & Stuart, 1999, p. 37.

Appendix K

CQI Model

Kirkpatrick Levels of Training Evaluation

Evaluation Process – Kirkpatrick Levels of Training Evaluation



Appendix L

Data Collection Tool

INSTRUCTIONS: Please rate how strongly you agree or disagree with each of the following statements by placing a check mark in the appropriate box.

1. My culture has a perspective on mental health therapy or counseling.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

2. I am comfortable discussing my mental health with my care provider.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

3. My cultural or faith practices that I follow helps me deal with my sadness, anxiety, bad experiences, or other troubles.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

4. I am likely to seek treatment (and comfortable doing so) for any mental health issues I have.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

Scoring:

- Strongly Disagree = 1
- Somewhat Disagree = 2
- Neutral = 3
- Somewhat Agree = 4
- Strongly Agree = 5

Appendix M

Nurse Practitioner Post-Intervention Assessment

INSTRUCTIONS: Please rate how strongly you agree or disagree with each of the following statements by placing a check mark in the appropriate box.

1. Overall, I would rate the BATHE assessment form very highly.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

2. The assessment addressed my patients' mental health concerns.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

3. The assessment questions are culturally focused.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

4. The length of the assessment is too short.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

Scoring:

- Strongly Disagree = 1
- Somewhat Disagree = 2
- Neutral = 3
- Somewhat Agree = 4
- Strongly Agree = 5

Appendix N

Patient Post-Intervention Assessment

INSTRUCTIONS: Please rate how strongly you agree or disagree with each of the following statements by placing a check mark in the appropriate box.

1. Overall, I would rate the assessment form very highly.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

2. The assessment addressed my mental health concerns.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

3. The assessment questions were culturally focused (relevant to my culture).

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

4. The length of the assessment is too short.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

Scoring:

- Strongly Disagree = 1
- Somewhat Disagree = 2
- Neutral = 3
- Somewhat Agree = 4
- Strongly Agree = 5

Appendix O

Letter of Support from Organization

April 10, 2020

Dear Ms. Iyamu

Facility Agreement

Dr. Gregory Smith outpatient clinic specialized in emergency and internal medicine. This letter supports and approves Roberta Iyamu to implement her project in the clinic. Roberta Iyamu will not have contact with the patients; personal information and identity will not be share for the project.

Agnes Gitau will be in charge of performing the assessment and relates results to Roberta Iyamu for analysis. The clinical will not be responsible for any expenses acquired during this project.

Thanks



Agnes Gitau FNP-BC