Increasing the Cultural Competence & Responsiveness of Family Nurse Practitioners

Preparing to Work with Children with Behavioral Challenges from High-Minority Low-Income Communities

Tyrone Robinson & Christine Clark

Introduction

While discussions involving multicultural education have typically concerned advocating for equity and social justice within the K-12 public schools and higher education institutions across the United States, similar advocacy and initiatives can and should be applied to the preparation of other professionals who serve the needs of the American public. This article focuses on the role of family nurse practitioners (FNPs) and describes the application of multicultural education theory in a program developed to prepare FNPs to better serve children in high-minority and low-income communities.

The article is presented from the perspective of the first author, a nurse consultant and developer of the program described here.

Goals

The HealthyPeople.gov (2013) website is a federal government undertaking, managed by the U.S. Department of Health and Human Services. The goals of the site are to increase the quality of life and decrease health disparities among, various segments of the U.S. population. These goals have been pursued within identified health focus areas dating back to 1979. Under *Healthy People 2020*, the fifth major initiative of the overall Healthy People undertaking, there are 13 new focus areas, one of which is "social determinants of health."

The goal of the social determinants of health focus area is to "create social and physical environments that promote good health for all" (para., 1). Further, because "heath starts in our homes, schools, workplaces, neighborhoods, and communities, the conditions in which we live explain in part why some Americans are healthier than others and why Americans more generally are not as healthy as they could be" (para., 2).

Through the development and implementation of a quality assurance (QA) program entitled, *The Wrap Around Service Model as an Effective Culturally Competent and Responsive Approach for FNPs in Pediatric Practice*, FNPs who work with children with behavioral challenges in families from high-minority, low-income communities can build increased cultural competence and responsiveness for serving this client population.

The Wrap Around Services Model is focused on keeping children and families together and in their homes, neighborhoods, and communities. Accordingly, the model focuses on meeting clients—children with behavioral challenges and their families—where they "are" as the starting point for healthcare practice, and then "wrapping around" them the healthcare services needed to facilitate their growth and development (holistic care) in a more positive direction (Burchard, Bruns, & Burchard, 2002).

By keeping these pediatric clients in community-based (non-institutional) settings (ideally their homes) and bringing services to them (via home visits, personalized transportation, etc.)—rather than hospitalizing them, restabilizing them in the in-patient setting, and then sending them back home—they (along with their families) will learn to make better health-related decisions over time in the contexts of their everyday lives. Removing these pediatric clients from their home environs would tend to lead to revolving-door inpatient visits, because it does not support clients in learning to manage their health status in their "real world" settings.

By highlighting healthcare solutions as community-tethered, *The Wrap Around Services Model* also challenges deficit perspectives often associated with high-minority and low-income people and neighborhoods. Moll, Amanti, Neff, and González (1992) describe working class, racial, ethnic, and linguistic minority groups as having "funds of knowledge" that are often unrecognized or, worse, unacknowledged by, for example, FNPs in pediatric practice or the healthcare establishment, as well as society at large.

Building on the idea of funds of knowledge, Yosso (2005) argues that low-income people of color also hold "community cultural wealth" characterized by various forms of capital that enable them to cope with the discrimination and oppression they experience, including in healthcare contexts, as a result of their system-imposed minoritized status. Through *The Wrap Around Services Model* lens, low-income, high-minority communities are seen as client assets when considering healthcare improvement and maintenance.

As the first author of this article, I was interested in developing the QA program, *The Wrap Around Service Model* for four reasons: (1) due to my experiences as a person and nurse of color; (2) because it dovetailed with my area of expertise as an advanced practice community health nurse; (3) a pediatric MD colleague indicated that it would potentially help to improve the quality of FNP pediatric healthcare service provision in the community in which her pediatric clinical agency is located; and (4) a growing body of evidence-based research literature, including the Social Determinants of Health policy initiative focus area of *Healthy People 2020*, has documented that such a program would enhance the teaching health promotion and disease prevention functions of the FNP (Alegría, Vallas, & Pumariega, 2010; Atkins, et al., 2006; Bernal &

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Scharrón-del-Río, 2001; Brody, et al., 2004; Cauce, et al., 2002; Coatsworth, Duncan, Pantin, & Szapocznik, 2006; deArellano, et al., 2005; Harrison, McKay, & Bannon, 2004; McNeil, Capage, & Bennett, 2002; Tolan & Dodge, 2005).

Needs

In 2004, the Sullivan Commission released its groundbreaking report, *Missing Persons: Minorities in the Health Professions, A Report on Diversity in the Healthcare Workforce*. The most striking finding in this report was that, especially in underserved communities, having a healthcare provider of the same race was more a factor in positive healthcare outcomes than having health insurance. This finding was attributed to a lack of attention to diversity in healthcare practitioner recruitment and preparation.

Not only are healthcare practitioners at all levels overwhelmingly White, but in addition their academic and professional training does little to build their capacity (knowledge, skills, and attitudes) to effectively treat patients who are culturally different from themselves. For example, "… an incomplete medical history truncated by a language barrier may lead a physician to compensate for possible deficiencies in the patient interview by obtaining more laboratory tests and other diagnostic evaluations" (p. 26).

As a Black American male raised in a low-income, inner-city housing project, working with children with behavioral challenges in families from high-minority, low-income communities comes fairly naturally to me because these families are very much like my family, and because I was labeled a behaviorally challenging child at a very young age. However, when I entered nursing school, I recognized quickly that not only were the majority of my nursing classmates (almost all of whom were White and middle class) uncomfortable working with this and similar client populations, my nursing school professors (all of whom were White and middle class), were ill prepared to facilitate their nursing students in developing such comfort.

After graduating with my BSN degree, I began working as a nurse and found that the majority of my nursing colleagues and nurse supervisors (again almost all of whom were White and middle class) were also woefully inadequately trained to provide quality healthcare to people, in essence, like me. While in my MSN program I wrote several articles on this topic in an effort to effect change, especially in nurse education programs. Accordingly, the *Wrap Around Service Model* program appeals to me as a mechanism to bring about needed change in FNP QA program offerings.

Objectives

The overall objective of this project was to develop and implement a QA program for FNPs (and other healthcare providers) in pediatric practice in the community in which my MD colleague's pediatric clinical agency is located. Toward this end, I developed and implemented in November of 2014 the 50-minute QA program entitled *The Wrap Around Service Model*.

According to Bannister (2002) and Bloom, et al. (1956), learning objectives should be stated in terms of the learner. With this directive in mind, the program was designed and implemented so that QA program participants were able to meet the following knowledge, attitude, and skill objectives:

A. *Describe* the *Wrap Around Service Model* and how it can be used by FNPs in pediatric practice with children with behavioral challenges in families from high-minority, low-income communities (cognitive domain);

B. *Explain* how the *Wrap Around Service Model* operates as an effective culturally competent and responsive approach to healthcare and can aid in achieving the Healthy People 2020 Social Determinants of Health focus area goal (affective domain); and,

C. *Apply* three elements of the *Wrap Around Service Model* to her/his own FNP pediatric practice (psychomotor domain).

I acknowledge that the objectives for this program were ambitious. Typically, a QA program should have a maximum of two objectives per hour of instruction so that content corresponding to each objective can be covered in detail to ensure the objectives can, in fact, be met (Bannister, 2002; Bloom et al., 1956).

However, as delineated in the next section of this article, because a key part of the learning in this program occurred at a meta level (not just learning this content, but learning how to learn it while learning it), this program was intentionally designed to be more intensive in order to bring about a paradigmatic shift in FNP pediatric practice orientation—moving from an unacknowledged/unexamined Eurocentric orientation to a consciously culturally responsive one (Nieto & Bode, 2012).

It must be noted that working with children with behavioral challenges in families from high-minority, low-income communities is very high stress work in which time is a constant enemy. Accordingly, culturally responsive practice requires the ability to thoughtfully adapt to constant change in challenging situations in which communication is continuously negotiated in seeking to arrive at culturally affirming healthcare outcomes. The intensive nature of this program was designed to simulate these practice realities.

Methods

To identify participants for *The Wrap Around Service Model* QA program, I used a combination of convenience and snowball sampling—starting with two pediatric FNPs that I know who work in the immediate community surrounding the clinic run by my pediatric MD colleague, and then asking these two FNPs to help me find ten pediatric FNPs willing to participate in the QA program.

I took advantage of the fact that November 11, 2014, was Veteran's Day and, thus that many of the medical offices in the area closed early that day, making their staff available in the afternoon. I was fortunate that I was able to find 10 willing participants with relative ease (I had them all confirmed by the first week in November and, thankfully, everyone who confirmed showed up).

According to the *Graduate-level Quality and Safety Education for Nurses (QSEN) competencies: Knowledge, Skills and Attitudes* (AACN, 2012), teamwork and collaboration are important competencies for FNPs to develop through graduate nursing education, including QA program offerings. Teamwork and collaboration are also key pedagogical tools used in education for building student dispositions for diversity (Nieto & Bode, 2012). Building on this intersection between competencies and diversity, *teamwork* and *collaboration* were employed as the overarching methods to facilitate the QA program participants in achieving the program's afore-referenced measurable objectives.

In addition to the intensive program design discussed above relative to its ambitious objectives, program enrollment was limited to 10 to further enable these methods to work. Some of the more specific instructional delivery methods utilized in the program included:

1. Pre-program reading and writing assignments and corresponding needs assessment

Three reading assignments, two writing assignments, and one needs assessment, five hours total.

Prior to the program, participants were asked to read:

a. "The Wraparound Approach" (Burchard, Bruns, & Burchard, 2002);

b. *Missing Persons: Minorities in the Health Professions* (Sullivan, 2004); and,

c. "Overview" from the Social Determinants of Health focus area (HealthyPeople.gov, 2013).

After the reading assignments were completed, participants were asked to complete two writing assignments:

1. A one-page, informally typewritten essay, in which participants described, in their own words, the *Wrap Around Service Model* as it is used in pediatric practice with children with behavioral challenges in families from high-minority, low-income communities; and,

2. A three-to-five page, informally typewritten philosophy of pediatric practice, in which participants applied three elements of the *Wrap Around Service Model* to their own pediatric practice with children with behavioral challenges in families from high-minority, low-income communities.

After the essay and philosophy assignments were completed, participants were asked to complete a brief needs assessment (one page, informally typewritten responses to the three question areas delineated below):

1. How knowledgeable do you think you are about the pediatric practice-related community health nursing needs of children with behavioral challenges in families from high-minority, low-income communities? What criteria do you use to assess your knowledge here?

2. How culturally responsive do you think you are as an FNP in pediatric practice? What criteria do you use to assess your adeptness here?

3. What, if any, is your prior experience with the *Wrap Around Service Model*?

Participants were asked to e-mail the completed writing assignments and needs assessment to me in my role as the program lead facilitator one week prior to the program. I used the writing assignments and needs assessment data to differentiate instruction (e.g., structure program activity groups) to ensure that all participants would get equitable levels of support and be challenged in engaging the program content.

2. Brief didactic introduction to the program with program agenda handout

Three-minute introduction, one handout (see Appendix A).

An agenda was handed out at the beginning of the program and then briefly reviewed by the program lead facilitator to provide a roadmap for participants about how the program curriculum would be sequenced and to queue participants to the pace of that sequencing (i.e., the intensive nature of the program).

Relevant details from the pre-program writing assignments and needs assessment were shared to convey to participants that this pre-work did, in fact, relate to and drive program implementation.

3. Co-facilitation of program content activities

Involving transition from one activity to the next; two co-facilitators, three activities (37 minutes total).

As indicated above, I served as the lead facilitator for the entire program. However, in facilitating the following program activities, I worked with a co-facilitator (the second author) who is observably culturally different from me (e.g., in terms of race, gender/gender identity or expression, first language, dis/ability, age, etc.) in order to role model cultural responsiveness in the delivery of the program content on cultural responsiveness—in essence, to "walk the talk" of culturally responsive FNP pediatric practice.

My co-facilitator and I "turn-took" in directing the process of each activity. We also both mingled among/eavesdropped on the groups as they undertook the activities. To ensure that we were "on the same page" and/or uniformly well-prepared to respond to questions that arose during these activities, three "Facilitator Notes" (see Appendix B) were developed to support our co-facilitative process.

Activity 1: Groups of three for discussion and report out (12 minutes).

In assigned groups of three, participants were asked to briefly describe *The Wrap Around Service Model* to each other as they delineated it in the pre-writing assignment essay. While listening to each other's delineations, participants were asked to inscribe, on easel paper, three keywords used in the delineation.

After all three members of the group described once and inscribed twice, trios were asked to briefly discuss all 18 keywords (or fewer if there was duplication) relative to the model. Each participant was then asked to briefly share one of her/his trio member's model delineation in a report out to the whole class using the keywords identified to succinctly structure the description.

Activity 2: Groups of five in discussion and report out (10 minutes).

In assigned groups of five, participants were asked to briefly discuss the readings. Based on their discussion, each group was asked to develop a graphic, drawn on easel paper, explaining their understanding of the culturally responsive nature of *The Wrap Around Service Model*.

The graphic had to include at least one element contributed by each group member. Each group was asked to elect one member of their group to briefly explain the group's graphic to the whole class.

Activity 3: Whole group discussion (15 minutes).

In advance of this activity, the co-facilitators wrote out on easel paper and then posted on the walls around the QA program classroom space the 10 essential elements and the 10 requirements for practice of *The Wrap Around Service Model*.

Each participant was asked to briefly delineate to the whole program cohort the culturally responsive nature of her/his pediatric practice with children with behavioral challenges in families from high-minority, low-income communities, and the three *Wrap Around Service Model* elements she/he chose (and the rationale for the elements chosen) to apply to her/his practice delineated in the pre-writing assignment philosophy.

Evaluation

The Center for Teaching and Learning at the University of North Carolina, Charlotte, has adapted assessment tools appropriate to objectives written for each level of *Bloom's Taxonomy* (N.A., 2014). A five-minute test of learning (see Appendix C) for this program was developed following the Center's approach.

Accordingly, on the test participants were required to: (A) correctly *identify*; (B) accurately *describe*; and (C) correctly *list* key details from the pre-program readings that were reviewed and discussed in the program.

A five-minute program evaluation (see Appendix D) for this program was also

developed to assess the participants' experiences of the program, especially their perception of its effectiveness in achieving stated objectives, and the role of the instructional methods (including facilitator approach and skill) in supporting and/or inhibiting realization of these objectives.

While program participants completed their program evaluations, their tests of learning were reviewed, and participants who passed the test of learning with a score of 85% or higher received certificates of program completion. Those who received less than 85% were given an opportunity to immediately retake the test. Everyone passed the test on either the first or second attempt.

The feedback on the overall program evaluations was overwhelmingly positive, although everyone asked for more time (I discuss this issue of time further below). In sum, I chose the 50-minute time period to align this program with "typical" QA program time commitments. I was thinking that I might pursue having the program approved for CEUs and, thus, the time alignment would be an important element because of that. But I also wanted to capture an audience and I was not sure I could do that if I required a longer time commitment. Once I had the interest of the 10 participants who participated, I do believe I could have engaged them in a longer session, but I'm just not sure I could have done that initially.

Conclusion

Table 1 provides an overview of how all of the components of *The Wrap Around Service Model* program were interrelated and came together. Of note, all of the objectives related to all of the instructional and evaluation methods, and the evaluation methods themselves were included in the overall time frame for the program (Gronlund, 2009).

The definition of service-learning guiding this project is "a form of experiential education in which [participants] engage in activities that address human and community needs together with structured opportunities intentionally designed to promote learning and development" (Jacoby, 1996, p. 5). Accordingly, this project contributed to the principles of service learning in two ways. First, it used a low-income, high minority community as the site of learning for the QA program. Second, the QA program sought to develop and augment the cultural competence and responsiveness of FNPs in pediatric practice in the community where the program was implemented.

Self Reflection

The greatest lesson I learned in developing this 50-minute QA program curriculum had to do with its instructional time limit. To make the most of the time, I allotted a specific amount of time to each program activity. However, in so doing, I encountered some anxiety. In all of my nursing educational experiences, cultural responsiveness is almost always deemed an important attribute for nurses, but it is never centered in nursing education or QA program education; rather, it is marginalized in "optional readings" or limited to a discrete portion of an educational offering. Everyone says it vital, but no one actually makes it essential by integrating into the fabric of all nursing learning.

Accordingly, a major implication of this QA program for the FNP role and the future of healthcare must be that the development of culturally responsive practitioners and practices becomes a priority through the widespread development and implementation of a comprehensive multicultural nursing educational and professional development curricula. The Social Determinants of Health *Healthy-People2020* focus area provides the best guidance to FNPs for developing the competencies necessary to realize this priority (NONPF, 2013a, 2013b, 2012, 2006).

Among the various competencies, the leadership competency is most critical here. That competency requires FNPs to: "(1) assume complex and advanced leadership roles to initiate and guide change; …(5) advance practice through the development and implementation of innovations incorporating principles of change; [and], …(7) participate in professional organizations and activities that influence advanced practice nursing and/or health outcomes of a population focus" (NONPF, 2013b, p. 56).

Further, FNPs must have curriculum content that supports the development of these competencies in learning about "the relationship between community/public health issues and social problems (poverty, literacy, violence, etc.) as they impact the health of patients" (p. 12), especially "vulnerable children in non-traditional settings" (p. 56).

Because of my own inadequate culturally responsive nursing educational experiences, and because of related life experiences I have had prior to, concurrent with, and outside of my educational activities with various healthcare providers who are not only not culturally responsive, but culturally unresponsive and otherwise hostile, I am passionate about helping all

Table 1
The Wrap Around Service Model as an Effective Culturally Competent and Responsive Approach in Pediatric Practice: Overview of Interrelationship of Program Components

Objectives *By the end of this QA program, the participant was able to:*	**Instructional Methods** Teamwork and Collaboration	**Time**	**Facilitator(s)** (Content Expert)	**Evaluation** Adapted to Objectives
Describe the *Wrap Around Service Model* as…(cognitive domain); Explain how the *Wrap Around Service Model* operates…	*Pre-program assignments:* • Three pre-program reading assignments • Two pre-program writing assignments • Pre-program needs assessment	5 Hours Total	Lead Facilitator	Test of Learning Program Evaluation
(affective domain);	*Didactic introduction and handout*	3 Minutes	Lead Facilitator	
Apply three elements of the *Wrap Around Service Model* to… (psychomotor domain).	*Co-facilitated activities*	37 Minutes	Lead Facilitator & "Diverse" Co-Facilitator, TBD	
	Evaluation Methods			
	Test of learning	5 Minutes	Lead Facilitator	
	Program evaluation	5 Minutes	Lead Facilitator	

FNPs, especially those in pediatric practice, to develop cultural responsiveness. I am also adamant that to do this effectively, academic airtime dedicated to this topic must be substantially augmented.

So, while more time is always needed, I did not want to give up any opportunity, no matter how short, to expose FNPs in pediatric practice to this topic, especially given that this opportunity was wholly dedicated to this topic. With this conundrum of sorts in mind, I chose to make use of pre-program readings and writing assignments to add substance to this program without adding instructional time that would preclude it from being able to be implemented in the "typical" 50-minute QA time-frame. In sum then, this program represents a compromise between hunger for much more to be done and resolve to do at least something of substance.

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Appendix A

Agenda Handout

The Wrap Around Service Model as an Effective Culturally Competent and Responsive Approach for FNPs in Pediatric Practice

1. Introduction: Welcome! Program Overview/Attention to Pre-Program Assignments (3 minutes)
2. Activity 1: Groups of 3 (12 minutes)
3. Activity 2: Groups of 5 (10 minutes)
4. Activity 3: Whole Group (15 minutes)
5. Conclusion: Thank You! Test of Learning/ Program Evaluation (10 minutes)
6. Certificates of Completion

Appendix B

Facilitator Notes

Facilitator Note 1*

Essential Elements of Wrap Around Service Model

1. Wrap around must be based in the community.
2. The wrap around approach must be a team-driven process involving the family, child, natural supports, agencies, and community services working together to develop, implement, and evaluate the individualized plan.
3. Families must be full and active partners in every level of the wrap around process.
4. Services and supports must be individualized, built on strengths, and meet the needs of children and families across life domains to promote success, safety, and permanence in home, school and community.
5. The process must be culturally competent, building on the unique values, preferences and strengths of children and families, and their communities.
6. Wrap around child and family teams must have flexible approaches and adequate and flexible funding.
7. Wrap around plans must include a balance of formal services and informal community and family supports.
8. There must be an unconditional commitment to serve children and their families.
9. The plans should be developed and implemented based on an interagency, community-based collaborative process.
10. Outcomes must be determined and measured for the system, for the program, and for the individual child and family.

Requirements for Practice of the Wrap Around Service Model

1. The community collaborative structure, with broad representation, manages the overall wrap around process and establishes the vision and mission.
2. A lead organization is designated to function under the community collaborative structure and manages the implementation of the wrap around process.
3. A referral mechanism is established to determine the children and families to be included in the wrap around process.
4. Resource coordinators are hired as specialists to facilitate the wrap around process, conducting strengths/needs assessments; facilitating the team planning process; and managing the implementation of the services/support plan.
5. With the referred child and family, the resource coordinator conducts strengths and needs assessment.
6. The resource coordinator works with the child and family to form a child and family team.
7. The child and family team functions as a team with the child and family engaged in an interactive process to develop a collective vision, related goals, and an individualized plan that is family centered and team based.
8. The child and family team develops a crisis plan.
9. Within the service/support plan, each goal must have outcomes stated in measurable terms, and the progress on each monitored on a regular basis.
10. The community collaborative structure reviews the plans.

*Excerpted from: Burchard, J., Bruns, E., & Burchard, S. (2002). The wrap around approach. In B. Burns, K. Hoagwood, & M. English (Eds.), *Community treatment for youth: Evidence-based interventions for severe emotional and behavioral disorders*. New York, NY: Oxford University Press.

Facilitator Note 2*

Rationale for Increasing Diversity in the Healthcare Workforce (relative to diversity-related health disparities)

Understanding diversity as the:

(1) representation of all racial and ethnic groups from the community served within a given health care agency, institution, or system;
(2) system-wide incorporation of diverse skills, talents, and ideas from those racial and ethnic groups; and,
(3) sharing of professional-development opportunities and resources, as well as responsibilities and power among all racial and ethnic groups and at all levels of a given agency, institution, or system.

Diversity improves the cultural competence in health care delivery

Diversity improves cultural competence at the system level

Diversity improves cultural competence at the organizational level

Diversity improves cultural competence at the provider level

Increasing patient satisfaction and access to health care requires increased diversity in the healthcare workforce

Diversity is good business

Diversity facilitates achievement of social justice

*Excerpted from: Sullivan, L. (Chair). (2004). *Missing persons: Minorities in the health professions: A report on diversity in the healthcare workforce*. Battle Creek, MI: W.K. Kellogg Foundation.

Facilitator Note 3*

Five Key Social Determinants of Health

1. Economic Stability (e.g., poverty, employment status, access to employment, housing stability (e.g., homelessness, foreclosure, etc.)
2. Education (e.g., high school graduation rates, school policies that support health promotion, school environments that are safe and conducive to learning, enrollment in higher education), etc.)
3. Social and Community Context (e.g., family structure, social cohesion, perceptions of discrimination an equity, civic participation, incarceration/institutionalization, etc.)
4. Health and Health Care (e.g., access to health services (including clinical and preventive care), access to primary care (including community-based health promotion and wellness programs), health technology, etc.)
5. Neighborhood and Built Environment (e.g., quality of housing, crime and violence, environmental conditions, access to healthy foods, etc.)

*Excerpted from: HealthyPeople.gov (2013). *2020 topics and objectives: Social determinants of health* (“Overview” [tab]). Retrieved from: http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39

Appendix C

Test of Learning

The *Wrap Around Service Model* as an Effective Culturally Competent and Responsive Approach for FNPs in Pediatric Practice

(A) Identify the 10 essential elements and the 10 requirements for practice of the wrap around approach
(Hints: Look at the easel paper posted around the classroom, and recall the Burchard, Bruns, & Burchard [2002] reading).

Essential Elements	Requirements for Practice
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.
7.	7.
8.	8.
9.	9.
10.	10.

(B) Briefly, but accurately, describe the rationale for increasing diversity in the healthcare workforce relative to diversity-related health disparities (Hint: Recall the Sullivan [2004] reading).

(C) List the five key social determinants of health (Hint: Recall the HealthPeople.gov reading).
1.
2.
3.
4.
5.

Appendix D

Program Evaluation

The *Wrap Around Service Model* as an Effective Culturally Competent and Responsive Approach for FNPs in Pediatric Practice

November 11, 2014

Your feedback on this program will help to improve future iterations of it, and aid in the development of additional program offerings on related content.

I. PURPOSE OF THE PROGRAM

To provide FNPs in pediatric practice with children with behavioral challenges in families from high-minority, low-income communities a professional development opportunity through which they can build increased cultural competency for serving this client population.

Circle the option below that describes the extent to which you believe this program fulfilled its purpose?

Did Not Fulfill   Somewhat Fulfilled   Mostly Fulfilled   Completely Fulfilled

II. OBJECTIVES

For each objective below, circle the option below it that describes the extent to which you believe this program met that objective.

A. Describe the *Wrap Around Service Model* and how it can be used by FNPs in pediatric practice with children with behavioral challenges in families from high-minority, low-income communities (cognitive domain).

Did Not Meet   Somewhat Met   Mostly Met   Completely Met

B. Explain how the *Wrap Around Service Model* operates as an effective culturally competent and responsive approach to healthcare and can aid in achieving the Healthy People 2020 Social Determinants of Health focus area goal (affective domain).

Did Not Meet   Somewhat Met   Mostly Met   Completely Met

C. Apply three elements of the *Wrap Around Service Model* to her/his own FNP pediatric practice (psychomotor domain).

Did Not Meet   Somewhat Met   Mostly Met   Completely Met

III. INSTRUCTIONAL METHODS

For each program instructional method below, circle the option below it that describes the extent to which you believe it facilitated your learning in this program.

A. Pre-Reading Assignments (*Wrap Around Services Model*, Diversity-Related Health Disparities, Social Determinants of Health)

Not Helpful   Somewhat Helpful   Helpful   Very Helpful

B. Pre-Writing Assignments (Essay, Philosophy, Needs Assessment)

Not Helpful   Somewhat Helpful   Helpful   Very Helpful

C. Program Activities (Group of Three, Group of Five, Whole Group)

Not Helpful   Somewhat Helpful   Helpful   Very Helpful

D. Lead Facilitator (Approach and Skill)

Not Helpful   Somewhat Helpful   Helpful   Very Helpful

E. Co-Facilitator (Approach and Skill)

Not Helpful   Somewhat Helpful   Helpful   Very Helpful

IV. OPTIONAL ADDITIONAL REMARKS

(e.g., Something else you want to share? Better ways to structure or places to offer the program? Was something missing?, etc.)