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Cultural Competence and Practice Readiness of Filipino Internationally Educated Nurses in the U.S. Healthcare System: A Descriptive Comparative-Correlational Study

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Abstract *— The study contributes quantitative evidence on the interaction between cultural competence and practice readiness among Filipino IENs in the U.S. healthcare system in transition to practice. Filipino IENs are recognized for their solid clinical foundation, compassionate nature, and flexibility, but the literature has described challenges Filipino IENs may encounter during transition to U.S. practice. The aim of this study was to determine their level of cultural competence, readiness for independent practice, and to investigate the significant differences between demographic and professional characteristics and the relationship between cultural competence and readiness for practice. This study employed a descriptive comparative-correlational design. Data were collected using two validated instruments: the Cultural Competence Assessment Instrument (CCAI) and the Casey-Fink Readiness to Practice Survey. Proportional stratified sampling was used, and 101 Filipino Internationally Educated Nurses (IENs) participated. Descriptive statistics, Mann-Whitney U and Kruskal-Wallis H tests with Dunn's post hoc comparisons, and Spearman's rank-order correlation were used to analyze the data. Findings showed that participants had moderate levels of cultural competence in awareness, knowledge, skills, and organizational support domains. Most respondents scored within the Competent/Emerging Adaptation range for practice readiness, suggesting a relatively stable level of preparedness for U.S. clinical practice. Cultural competence differed only by support system, and practice readiness differed only by Philippine language group, current position, and years in current position; all other profile variables showed no significant differences. Correlation results indicated a statistically significant, albeit weak, positive relationship between Cultural Awareness and Knowledge and clinical problem solving, learning activities, and overall practice readiness, but no relationship with confidence and skill performance. Conversely, Cultural Skills and Organizational Support were not significantly associated with any of the readiness domains. The study findings suggest that Filipino IENs enter U.S. practice with solid clinical foundations and developing cultural competence. They require structured support to enhance cultural awareness, system familiarity, and early confidence. Results indicate that readiness was weak but significantly associated with cultural awareness/knowledge, and not with cultural skills or organizational support. Based on these findings, a 12-week transition program was proposed to support cultural competence and transition to U.S. practice. This program offers a structured, literature-aligned approach that may support Filipino IENs during transition to U.S. practice.*

Keywords *— **Cultural Competence, Practice Readiness, U.S. Healthcare System, Transition Experience, Clinical Problem-Solving, Learning Engagement, Professional Integration, Cultural***

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Awareness and Knowledge, Workforce Adaptation, Transcultural Nursing, Migration and Nursing Workforce

I. INTRODUCTION

The Philippines has long been acknowledged as one of the major producers of internationally educated nurses (IENs) globally. Filipino nurses who earned their BSN degrees in the Philippines relocate to high-income countries such as the United States, the United Kingdom, or Canada, hoping for better opportunities. The healthcare systems of these wealthy nations welcome Filipino IENs to address persistent labor shortages. The nursing skills they use in their daily routine help ease the current nursing issues, particularly understaffing. These nurses are allowed to practice their nursing skills anywhere around the world. Almost 20% of the world's nursing workforce is in the United States (World Health Organization, State of the World's Nursing Report: United States of America, 2020). Of the 4.3 million U.S.-registered nurses (RN) (American Nurses Association, Nurses in Workforce, accessed July 2023), 6–8% are IENs and more than half are Philippine-educated nurses (PENs) (Smiley et al., 2018). Registered Nurses trained in the Philippines make up 1 out of 20 RNs in the U.S. and continue to be the largest group of foreign-trained nurses today. (Yoshioka et al., 2021) They are among the most established healthcare workers across the United States and are recognized as some of the most skilled and caring nurses in most of the facilities where they work. These nurses have been recognized for their work ethic, competent nursing skills, and caring attitude. Their didactic training from their home country, both in the academe and real work settings, gave them the knowledge, skills, and overall experience that they need to provide high-quality patient care. Filipino IENs are excellent health care workers, possessing a bachelor's degree and honed nursing skills that they have acquired back in their home country.

Internationally Educated Nurses (IENs) have the potential to alleviate labor shortages, but they remain underutilized (Harun & Walton-Roberts, 2022). Despite a multitude of recognitions, Filipino IEN's continue to encounter challenges regarding their integration into the U.S. healthcare system, which potentially affects their overall performance as trusted healthcare workers.

From 2002–2021, only 45.8% of 177,730 Philippine-educated nurses passed the NCLEX-RN. Initial nursing licensure and the nursing workplace were significantly associated with passing. PENs comprise more than half of IENs in the U.S. workforce. (Montegrico et. al 2025). In the state-level statistical analysis, such as Texas, 32,623 foreign-educated nurses are employed, and 56% of them are Filipino, making the Philippines the leading source of internationally educated nursing workers in the state (Texas Board of Nursing, 2021). Some sources point out that rural hospitals are hiring Filipino nurses from the Philippines to fill ongoing staffing gaps. PBS NewsHour reports that Filipino IENs make up a large portion of the long-term staff in many North Dakota hospitals, highlighting their vital role in sustaining rural healthcare services (Nawaz, 2022).

Cultural competence is an essential factor in the successful adaptation of Filipino IENs into the U.S. healthcare system, and it has implications for how they interact with diverse patient populations and work in multidisciplinary teams. Also, closely related to readiness for practice is their ability to adapt to U.S. cultural norms and clinical practice and to provide safe and effective care in a new clinical setting. The lack of adequate support for these two constructs may be a potential threat to the job performance of Filipino IENs, which may ultimately affect patient outcomes. Although Filipino nurses are internationally trained and widely recognized for their professionalism and compassionate care, these strengths do not eliminate the challenges of transitioning into a different healthcare system. Lin (2014) and Xu (2020) noted that limited familiarity with U.S. hospital protocols, communication styles, and organizational expectations may affect Filipino IENs' confidence and clinical performance during the early days, weeks, and months of employment. While the experiences of Filipino IENs have been explored in several qualitative studies, most existing research relies on interviews and narrative accounts to describe their

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transition into the U.S. healthcare system. These studies provide valuable insights, but only a limited number of studies measure each variable cohesively. The relationship between cultural competence and practice readiness, which is useful to bridge the gaps in Filipino IENs' integration into the U.S. workforce, is a defining gap in most of the quantitative studies. Quantitative studies using validated and structured instruments to measure these variables are limited but are still emerging these days.

This study will evaluate their cultural competence when interacting with diverse populations and their readiness to work as nurses in the U.S. healthcare system. Studying the relationship and differences among Filipino IENS in terms of their cultural competence and practice readiness using a descriptive correlational-comparative design, specifically descriptive comparative and descriptive correlational designs, will pave the way for employers, stakeholders, administrators, nursing leaders, and interdisciplinary teams to acquire useful information and structured guidance to support the needs of their employees. The production of a Transcultural Transition Programs Guide will help Filipino Internationally Educated Nurses (IENs) adjust to their new jobs more easily.

Objectives of the Study

This study aimed to determine the cultural competence and practice readiness of Filipino Internationally Educated Nurses in the U.S. healthcare system. Specifically, the study sought to determine if there is a significant difference in the levels of cultural competence of Filipino Internationally Educated Nurses in Hospital A when grouped according to socio-demographic profile. It also aimed to determine whether there is a significant difference in the levels of practice readiness of Filipino Internationally Educated Nurses in Hospital A when grouped according to socio-demographic profile. Furthermore, it aimed to determine if there is a significant relationship between the levels of cultural competence and the level of practice readiness of Filipino Internationally Educated Nurses in Hospital A.

II. METHODOLOGY

The study used a descriptive-quantitative design that is aligned with examining the cultural competence and practice readiness of the Filipino Internationally Educated Nurses. Specifically, the design used correlational and comparative components and involved collecting numerical data to describe and explore relationships between these two variables. A descriptive-quantitative design with correlational and comparative elements is appropriate for this study because it allows for the measurement and analysis of the relationship between these key factors: cultural competence and practice readiness, which are associated with Filipino IENs' adaptation to the U.S. healthcare system (Grove, Gray, & Burns, 2019). The combination of these designs allows the researcher to compare and correlate the occurrences of the variables when grouped according to the respondents' demographic profile, and also investigate relationships and differences between the Filipino IENs' cultural competence and practice readiness (Polit & Beck, 2021).

The study was conducted in a selected hospital in the United States, specifically in the Midwest region (hereafter referred to as "Hospital A"). Hospital A is a facility scattered across different parts of the state of North Dakota and other neighboring states. It is composed of various facilities, whether tertiary or secondary hospitals, clinics, hospices, assisted-living facilities, or nursing homes. Hospital A in Fargo, North Dakota, is composed of 3 divided campuses.

The study used a stratification strategy based on service characteristics that differentiated the three campuses of the participating hospital system. Campus A is a specialist acute care campus providing specific clinical services within the system overall. Campus B is a secondary care campus, providing general inpatient treatment and secondary-level services. Campus C is classified as a referral site of Hospital A at the tertiary level, where advanced specialized care and high-complexity services are provided. Stratified random sampling was purposely used in Campuses A, B, and C because of these compelling reasons, which reflected their heterogeneity in terms of structure and function.

The target population for this study includes all Filipino internationally educated nurses currently employed as registered nurses across the three campuses of Hospital A at the time of data collection. The sampling frame was developed using the most

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recent de-identified roster of Filipino nurses provided by Hospital A's Human Resources department and verified by Nursing Administration. Only nurses who met the inclusion criteria, such as those who were Filipino-educated and trained, currently employed as a registered nurse, and with at least three months of clinical experience at Hospital A, were included. The study excluded nurses on long-term leave or those in administrative positions only, as they would not be providing direct patient care; therefore, the sample was representative of those in clinical practice. The complete population consisted of 136 Filipino nurses distributed across the three campuses: Campus A (38), Campus B (22), and Campus C (76). The sample size of 101 was obtained with the Raosoft calculator for a finite population of 136 at a 95% confidence level, 5% margin of error, and 50% response distribution, and was divided proportionally among the three campuses with a stratified sampling calculator.

This study employs a basic IV-DV model (Independent Variable-Dependent Variable Model), which links the two key variables, cultural competence and practice readiness. The Cultural Competence Conceptual Model of Balcazar et al. (2009) was determined as the guiding framework for this study because it provides an empirically grounded, behavior-based understanding of cultural competence that directly corresponds to the realities of Filipino internationally educated nurses (IENs) transitioning into the U.S. healthcare system. The study utilizes an integrated practice-centered paradigm that corresponds to the lived experiences of the Filipino IENs and realities in U.S. healthcare. It uses the Cultural Competency Conceptual Model developed by Balcazar et. al. (2009) in three domains: Awareness/Knowledge, Organizational Support, and Skills. This development was made to explore the cultural competency of various healthcare workers among their diverse patients. Benner's Novice to Expert Model highlights the Filipino IENs' practice readiness in transitioning to the U.S. healthcare workforce. Based on her framework, nursing competence is a developmental process influenced by experience and circumstance (Benner,1984). The approach sets out five levels: novice, advanced beginner, competent, proficient, and expert. Nurses move through these phases as they gain clinical experience and comprehension of the problem. Both models are anchored to Balcazar et al. (2009) Cultural Competence Assessment Instrument (CCAI) and Casey Fink's (2024) Readiness to Practice Survey. The Cultural Competence Assessment Instrument (CCAI) (Balcázar et al., 2009) is relevant to this study because it assesses cognitive (awareness/knowledge), behavioral (skills), and organizational support aspects of cultural competence that Filipino IENs should demonstrate in U.S. clinical environments. On the other hand, the Casey-Fink Readiness for Practice Survey (Casey-Fink, 2024) takes a similar developmental approach to the subject. The questionnaire evaluates clinical judgment, confidence, communication, and role transition, which are all significant indicators of growth of healthcare professionals from the novice to expert continuum.

The ethical clearance was processed by the Institutional Review Board of Wesleyan University after submission of essential documents. The study was approved by the WU-P University Research Ethics Committee on July 3, 2026. No data, including pilot data, were collected before this approval; the pilot test was conducted on July 6, 2026, and the main data collection ran from July 22 to August 28, 2026. The next process was the actual distribution of the research questionnaires to the Filipino IENs. Surveys from these research instruments were circulated electronically among Filipino IENs in Hospital A by means of personal or work emails, social media accounts, and professional connections for the participants' convenience. Technology was of great importance in distributing the Google Form survey electronically, and it was more accessible for Filipino IENs to respond using their mobile phones.

The collected data were stored on a password-protected computer and in an encrypted cloud storage service only accessible to the principal investigator. The data were securely stored according to ethical research guidelines for possible follow-up studies or audits. The data destruction software protected sensitive information, and to protect the privacy of respondents, all data will be permanently deleted and destroyed five years after data collection is completed.

All results were obtained from the targeted respondents from each stratum of Hospital A, and the data were encoded in SPSS. Because the sample exceeded 50, the one-sample Kolmogorov–Smirnov (K-S) test was used to check the distribution of the scale scores only; the categorical sociodemographic variables were not tested for normality, because normality does not apply to categorical data.

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Data were presented as frequency and percentage distributions by the sociodemographic profile of Filipino IENs, including age, sex, marital status, U.S. experience, education, work status, migration history, language competence, cultural background, continuing education, and support systems. To assess levels of cultural competence and preparation for practice, means and standard deviations were calculated for each dimension. Although Likert scales are ordinal, means and standard deviations are widely accepted in nursing research to summarize multi-item scales. The constructs were measured by a multi-item Likert scale that consists of the CCAI domains of cultural awareness/knowledge, cultural skill, and organizational support. These allowed the study to present a clear and interpretable picture of the cultural competence and practice readiness of Filipino IENs. This also includes consistency and differences detection within the group. Spearman's rank-order correlation was used to examine the relationships between the cultural competence domains and the readiness subscales. The Mann–Whitney U test was used for profile variables with two groups and the Kruskal–Wallis H test for those with three or more groups; results are reported with their degrees of freedom (number of groups minus one). When a Kruskal–Wallis test was significant, Dunn's rank-based post hoc test with Bonferroni adjustment was used to identify which groups differed. All tests used the .05 level of significance. These analytic procedures were chosen to fit the level of measurement and the distribution of the data. After measuring, correlating, and comparing the two variables as per the respondents' socio-demographic data, the study aims to create a 12-Week Transition Program that the institution may utilize that will support Filipino Internationally Educated Nurses in their adaptation to the U.S. healthcare system.

The study was conducted in accordance with the ethical standards for the protection of the dignity and rights of Filipino internationally educated nurses (IENs) who migrated to the U.S. in the Midwest and were working in a certain hospital system. Because the group of respondents was 101 healthcare professionals at most and was identifiable, further safeguards were taken to maintain strict anonymity. Before data collection, Institutional Review Board (IRB) permission was provided by the Wesleyan University ethical review board to ensure that all methods were in accordance with ethical guidelines for research involving human subjects. The respondents' involvement in the study was entirely voluntary, and they were asked to sign an informed consent form. Given the enhanced identifiability of the sample, all responses were anonymized, de-identified, and aggregated. No individual-level data, such as unit assignment, shift, or employment, were disclosed. Data were stored in encrypted, password-protected files accessible only to the principal investigator, so as to maintain confidentiality and to prevent unauthorized access. There were also explicit safeguards to protect participants and eliminate any possibility of coercion or retaliation. The respondents' involvement in the study did not affect their job, their annual performance reviews, or their relationships with colleagues at work when designing the study. The researcher maintained transparency throughout the study to avoid conflicts of interest. Permission was obtained for the intellectual property rights of the original authors of the selected adopted research instruments. The procedures used in the study guaranteed that throughout the entire research process, all of the participants were respected, protected, and appreciated collectively. This included voluntary participation, anonymity of the small target population of Filipino IENs, secure data handling, mitigation of conflicts of interest, and assurance of non-retaliation.

III. RESULTS AND DISCUSSION

This section presents, analyzes, and interprets findings on the cultural competence and practice readiness of Filipino Internationally Educated Nurses working in Hospital A. These findings include assessing the differences between both variables and the Filipino IENs' sociodemographic profile, correlating both variables to determine relationships, and the production of the 12-week Transition Program to aid Filipino IENs in their transition to the U.S. healthcare system.

Table 1.A: Socio-demographic variables of Filipino IENs: Personal profile (n=101)

Frequency and percentage distribution of Filipino IENs' personal demographic profile

Variable	Category	Frequency	Percentage

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Gender	Male	28	27.72
	Female	71	70.30
	Non-binary or Gender Fluid	0	0.00
	Prefer not to disclose	2	1.98
Age	Early adulthood (18–29 years)	6	5.94
	Early middle adulthood (30–39 years)	76	75.25
	Middle adulthood (40–49 years)	13	12.87
	Late adulthood (50 years and above)	6	5.94
Marital status	Single	40	39.60
	Married	59	58.42
	Separated	2	1.98
	Widowed	0	0.00
Languages spoken other than English	Yes	86	85.15
	No	15	14.85
Specific Philippine language groups	Northern Philippine / Luzon	45	44.55
	Central Philippine / Visayas	34	33.66
	Southern Philippine / Mindanao	10	9.90
	Prefer not to disclose	12	11.88
Race/Ethnicity	Luzon ethnic group	42	41.58
	Visayas ethnic group	48	47.52
	Mindanao ethnic group	10	9.90
	Prefer not to disclose	1	0.99
Support systems in the U.S.	Immediate family in the U.S.	54	53.47
	Friends and co-workers	40	39.60
	Faith-based or community groups	0	0.00
	No available support systems	7	6.93

Gender was chosen as part of the socio-demographic profile because of its cultural and identity factor that affects how Filipino IENs communicate and interact culturally in the US healthcare setting. Gender describes how people see themselves and how they express themselves in social and cultural contexts. This strongly influences professional behavior and perceptions of readiness in clinical practice. It is more appropriate for a study about cultural competence, since it is part of the broader understanding that cultural identity is shaped not only by ethnicity and region, but also by the way in which individuals experience and express their gender in social contexts.

Most Filipino IENs in this survey were female, a reflection of the long-standing reality of Philippine nursing, where women have historically comprised much of the nursing workforce. Although this demographic pattern shaped the composition of the sample, the statistical analysis showed no significant difference in cultural competence by gender ($p = 0.136$). Gender therefore serves as meaningful background context, but it did not influence cultural competence or practice readiness in this study. None of the respondents identified as non-binary, which simply reflects the responses provided in this sample, while some were not prepared to reveal their gender. This emphasized the individual nature of identity and the need to safeguard their privacy and personal boundaries in research, especially in cross-culturally diverse populations. The high number of female respondents is consistent with the statement of Nazareno et al. (2021) that "the majority of nurses in the United States are women and one out of every twenty registered nurses in this nation are trained in the Philippines". A limitation was the absence of other

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gender identities; hence, experiences beyond traditional gender categories were not represented in the dataset.

The age groups in this study are based on Jean Piaget's definitions of adulthood. She talks about the ongoing development of cognition and social-emotional functioning during adulthood. Early adulthood between ages 18-29 years is a time for exploration at work. Early middle adulthood, between ages 30-39 years, is a time of greater stability. Middle adulthood, ages 40-49 years, is a period of greater mastery, and Late adulthood, ages 50 and up, is characterized by accumulated experience. The study can apply Piaget's adult developmental brackets to place respondents' insights within meaningful transitions in life stages. The majority of respondents were 30–39 years old, a distribution frequently noted in literature on Filipino nurse migration. However, age did not significantly relate to cultural competence ($p = 0.873$) or practice readiness ($p = 0.676$). Age therefore describes the demographic profile of the group but does not explain differences in competence or readiness. This age pattern is consistent with findings from studies that find Filipino nurses generally migrate after a few years of professional experience, often during the mid-career stage. The lower number of young respondents is a reflection of the demographics of this sample. The reasons behind the age-related migration trends were not studied in this research. Similarly, the relative minority of the late-adulthood respondents reflects the age distribution and does not indicate underlying factors affecting migration at older ages. The overall sample was mostly mid-career nurses, in line with Bieski's (2022) comment that "IENs are often mid-career movers, often after having gained considerable clinical experience in their home country." This age distribution is consistent with general descriptions of Filipino nurses who tend to migrate in mid-career phases.

Married respondents were slightly more common, but marital status was not significantly associated with cultural competence ($p = 0.128$) or practice readiness ($p = 0.982$). In the current study, marital status was used as a descriptive variable and not as a variable influencing readiness or competence. The proportion of married and single respondents reflects the diverse personal backgrounds of Filipino IENs entering U.S. practice, and does not suggest differences in cultural competence or readiness outcomes. A small proportion of respondents reported being separated, which simply forms part of the demographic profile captured in this sample.

Filipino IENs in this study joined the U.S. workforce either married or single. Married nurses were slightly overrepresented. These personal profiles of the respondents illustrate the diversified life contexts of Filipino IENs since they migrated to the United States. Some balance family responsibilities and their marriage, while others pursue individual career advancement as single individuals. Masselink and Lee (2020) noted in their study that "many Filipino nurses base their decisions to migrate to improve family economic mobility." In this study, marital status provided background context but was not directly related to cultural competence or practice readiness. For example, some of the Filipino IENs know another language or dialect such as Tagalog, Bisaya, Ilonggo, or Kapampangan while providing care. This is a reflection of the multilingual character commonly described among Filipino IENs. Alvarez (2020) noted that a large number of nurses are multilingual or multi-dialectal, a feature that has been linked in the literature with more communication between different patient groups. In contrast, a smaller group of respondents did not use other languages in care, which simply reflects variation in linguistic backgrounds within the sample. Overall, the trend showed that Filipino IENs were highly multilingual, consistent with the linguistic diversity widely noted in the literature.

Most Filipino IENs in this study who spoke languages from the Northern Philippine language group (e.g., Tagalog or Ilocano) were dominant language speakers, since many originated from Luzon, the country's most populous region and a common starting point for nursing graduates. Some participants described themselves as bilingual and reported that their second-language English proficiency supported more comfortable communication with the diverse patient population they served in the United States. Only a small portion of the sample spoke languages from the Mindanao group (e.g., Maranao or Maguindanao), a trend that aligns with broader migration patterns described in the literature.

Nevertheless, the data showed the diversity of linguistic backgrounds despite these variations, as more than 85 percent of Filipino IENs spoke at least

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one Philippine language or dialect. Multilingual IENs were commonly described as prepared to communicate effectively, more trusted by patients, and having fewer misunderstandings (Xu & He, 2019). Most respondents spoke at least one Philippine language in addition to English, reflecting the multilingual nature of Filipino nursing. However, language use ($p = 0.453$) and language group ($p = 0.462$) showed no significant relationship with cultural competence. Multilingualism remains an important descriptive characteristic, but it was not associated with differences in cultural competence. Practice readiness, however, differed by Philippine language group (Table 8.A).

The race/ethnicity categories in this study are based on the three major ethnolinguistic regions of the Philippines: Luzon, Visayas, and Mindanao. Filipino nurses' understanding of community, communication, and interpersonal relationships is shaped by these regional identities, which have deep cultural histories, languages, and social norms. Although Filipino IENs share a common strong national cultural identity, their regional backgrounds often influence subtle factors of their worldview, caregiving values, and interaction styles. The inclusion of such categories enables the study to recognize the cultural richness and diversity within the Filipino nursing workforce and also acknowledges that ethnicity can be personal and sensitive, as indicated by the option Prefer not to answer. This bracketing allows the researchers to place the respondents' experiences within the larger cultural landscape that shapes their competence and preparedness for practice in U.S. healthcare settings. The ethnic group composition in this sample was consistent with wider migration patterns from Luzon, Visayas, and Mindanao. However, ethnicity was not significantly associated with cultural competence ($p = 0.583$). Thus, ethnic background enriches the demographic profile but does not indicate disparities in cultural competence.

This coincides with the long-term tendencies for the Philippine nursing workforce, where the Visayas region has traditionally been a source of many migrant nurses and is home to many nursing schools. Mindanao respondents made up the smallest ethnolinguistic group in the sample. This was consistent with national migration patterns, where there were fewer nurses from Mindanao, a region with fewer respondents represented in this sample. Masselink and Lee (2020) stated that "regional variation is observed in the migratory tendencies of Filipino nurses, with the majority from Luzon and the Visayas and a sizable but lesser population from Mindanao."

The Luzon, Visayas, and Mindanao groups together illustrated the range of cultural backgrounds represented among Filipino IENs entering U.S. employment. This variety offered a contextual foundation to appreciate the diverse cultural origins of Filipino IENs entering U.S. practice.

The only personal component that emerged significantly associated with cultural competence was support systems ($p = 0.015$). Those respondents who relied on friends or co-workers were rated to have higher cultural competence scores than those without support systems. This means that respondents with interpersonal support had better levels of cultural competence scores, which aligns with literature describing strong family interdependence in Filipino culture. Masselink and Lee (2020) noted in their study that most of the Filipino nurses are more likely to seek migration to Western countries, such as the United States, if they have a support system through family networks, finances, and emotional support from their friends abroad.

Interestingly, although Filipino society is strongly religious, none of the respondents mentioned church-based or community organizations as their major support system. The absence of church-based or community organizations as support systems simply reflects the responses in this sample. A modest but significant proportion of respondents said that they had no support system. Support systems were significantly associated with cultural competence, but not with readiness.

Overall, Filipino IENs in this research depended largely on interpersonal sources of support, notably family and colleagues. These patterns offered background, but the research found no clear relationship between the kind of support system and cultural competency or preparation for practice.

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Table 1.B: Professional Profile of Filipino IENs (n=101)

Frequency and percentage distribution of Filipino IENs' professional demographic profile

Variable	Category	Frequency	Percentage
Highest level of education	Diploma/Nursing vocational certificate	0	0.00
	Bachelor of Science in Nursing (BSN)	94	93.07
	Master's in Nursing (MSN, MS, MN)	7	6.93
	PhD	0	0.00
Current position/employment status	Volunteer/Student nurse/Nurse resident	0	0.00
	LPN/ADN (Licensed Practical Nurse/Associate Degree Nurse/Certified RN)	0	0.00
	BSN (Professional RN)	98	97.03
	Prefer not to disclose	3	2.97
Previous non-nursing degree or health care experience	Yes	13	12.87
	No	88	87.13
Years in current position	< 2 years	15	14.85
	3–5 years	16	15.84
	6–10 years	23	22.77
	> 10 years	47	46.53
Work-related hours earned	1–200 hours	10	9.90
	201–300 hours	13	12.87
	301–400 hours	7	6.93
	400 hours	71	70.30
Current area/unit of practice	Adult medical–surgical	38	37.62
	Adult ICU	8	7.92
	Step-down	0	0.00
	Behavioral health (adult/adolescent)	3	2.97
	Float pool	2	1.98
	Labor & delivery	0	0.00
	Mom/Baby/Post-partum	4	3.96
	Pediatric medical–surgical	8	7.92
	Pediatric ICU	4	3.96
	NICU	6	5.94
	OR–Perioperative	9	8.91
	PACU	8	7.92

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	Pre-operative	0	0.00
	Emergency department	8	7.92
	Urgent care	1	0.99
	Outpatient/Ambulatory clinic	2	1.98
	Home care agency	0	0.00
	Skilled nursing facility	0	0.00
	Rehabilitation	0	0.00
	School nurse	0	0.00
Continuing education/training	Self-directed learning	19	18.81
	Workplace-based training or mentorship	62	61.39
	Confident based on past work experience	9	8.91
	No training received/Open to training	11	10.89
Cultural competency training received	Self-directed learning	14	13.86
	Workplace-based training or mentorship	58	57.43
	Certified in cultural competency	4	3.96
	No training received	25	24.75
Type of cultural competency training	Learned during fieldwork	29	28.71
	Self-reading	4	3.96
	Learned through interdisciplinary interaction	46	45.54
	No formal training	22	21.78
Top 3 populations seen most often *(multiple response)*	White	88	Rank 1
	African American/Black	87	Rank 2
	Asian	83	Rank 3
	Hispanic/Latino	23	Rank 4
	Native American/Alaska Native	18	Rank 5
	Hawaiian/Pacific Islander	6	Rank 6

Although most respondents held a BSN, educational level did not significantly relate to cultural competence ($p = 0.789$) or practice readiness ($p = 0.883$). Education level therefore describes the academic background of the group but does not explain differences in competence or readiness. BSN preparation is the national standard in the Philippines, providing the academic background common among Filipino IENs. Dahl et al. (2021) noted that "Filipino-trained nurses reported that their BSN programs are rigorous, but the standards of proficiencies that were taught do not always meet those of the host nation." The U.S. healthcare system was becoming more demanding of BSN-prepared nurses, which correlates with the need for international migration. The high BSN rate is reflective of the typical educational background of Filipino IENs who enter U.S. practice. All respondents qualified for the national standard for BSN common to Filipino nursing graduates. Some Filipino nurses who migrated to the U.S. did not have a doctoral-level degree in nursing, but some pursued it after

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establishing stable professions abroad. The Filipino IEN labor trend is often highly BSN-prepared, with less graduate education and good academic foundational preparation. This reflects the educational background of the respondents being BSN-dominant.

In the **"current position/employment status,"** most of the Filipino IENs in this study were licensed Registered Professional Nurses. This finding is consistent with the long-standing trend that most Filipino nurses migrated to the U.S. to work as professional RNs. Masselink & Lee (2020) noted, "Filipino nurses rarely enter U.S. employment in lower-tier nursing occupations; instead, their migration has typically been aimed at RN positions. This aligns with migration patterns that typically have Filipino nurses entering the U.S. workforce as RNs. In contrast, none of the respondents worked as LPNs, ADNs, or in trainee positions. This was consistent with migration patterns that suggest Filipino nurses rarely enter the U.S. workforce in non-RN positions. This is consistent with literature on migration of Filipino nurses into RN roles.

Some respondents had non-nursing degrees in the past, but this variable was not significantly associated with cultural competence ($p = 0.689$) or readiness ($p = 0.308$). Previous education gives more depth to the demographic profile but does not address differences in competence. "Many Filipino nurses pursue nursing immediately after secondary education, and this forms a single-track professional identity shaped entirely by nursing training," asserted Ortiga (2018). This reflects long-standing Philippine educational patterns where nursing is pursued immediately after high school, and families encourage nursing as a stable global career. On the other hand, a small number of respondents reported possessing non-nursing degrees or health care experience in the past, indicating diverse educational backgrounds among a minority of respondents. The overall migration trend of Filipino IENs in the U.S. workforce indicates that most Filipino IENs are single-career individuals, and the minority of the group have other professional backgrounds. This pattern results in the prevalence of single-track nursing careers among Filipino IENs, some of whom had other professional backgrounds.

Years in current position were not significantly related to cultural competence ($p = .383$), and nurses with less than two years in their current position reported lower practice readiness than those with more than 10 years (Table 8.B). This implies that readiness develops meaningfully within the framework of sustained exposure to U.S. practice. This is reflective of the longer tenure of many respondents, consistent with longer employment in U.S. practice settings. "The Filipino nurses have long been a steady part of the U.S. nursing workforce, often staying in their jobs for long stretches of time, due to strong professional commitment and integration in the workplace" (Nazareno et al., 2021). By contrast, the shorter tenure of some respondents merely reflects the early stage of employment in U.S. practice. Overall, the spread showed a gradual increase in tenure, with the majority of respondents working in positions for 6+ years. This suggested good retention and alignment with the practice expectations, with continuing exposure to the US healthcare system.

The work-related hours of Filipino IENs were not significantly associated with their cultural competency ratings ($p=0.480$), nor with their readiness scores ($p=0.217$). Hours were reflective of clinical exposure, but did not predict competence or preparedness in this sample. The data set of Area/Unit of Current Practice revealed distinct patterns of concentration, diversity of specialty, and migration-related placement among Filipino IENs.

Adult medical–surgical was the most common work setting for Filipino IENs (close to one-third of Filipino nurses in Hospital A). This finding was consistent with international migration trends, where Med–Surg units represented the entry point for internationally educated nurses.

A broad clinical environment is linked to the current clinical skill set of internationally educated nurses. Internationally educated nurses often enter a broad clinical environment. Filipino IENs are typically placed in medical-surgical units to start their US clinical transition, as these units offer wide patient exposure, allow a gradual cultural transition, and help establish practice readiness.

Xu et al. (2019). In contrast, special areas, such as Step-Down, Labor & Delivery, Pre-operative, Home Care, Skilled Nursing Facility, and Rehabilitation, have 0% representation. This absence simply reflects the distribution of units represented in this dataset and Filipino nurses' preference for acute care environments that match their training. Across the dataset, Filipino IENs were widely distributed across

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high-acuity and procedural units, including Adult and Pediatric ICU, NICU, OR/ PACU, and Emergency Department. This reflects the distribution of respondents across high-acuity units.

Many respondents participated in workplace-based training, but training type did not significantly relate to cultural competence ($p = 0.058$; $p = 0.499$; $p = 0.548$). Training patterns describe how Filipino IENs engage with professional development, but they did not explain differences in cultural competence. Xu, Y., & He, Z. (2019) stated that "IENs' cultural competence, communication skills, and practice readiness are commonly supported through mentoring and organized workplace training." This only reflected the emphasis placed by U.S. healthcare organizations on standardized onboarding, competency-based practices, and ongoing professional development—areas in which Filipino IENs are actively engaged. In contrast, a small group relied solely on previous experience, while most engaged in workplace-based training. In addition, a few Filipino IENs relied solely on their previous work experience without any training, but they were willing to engage in such programs. The overall pattern showed that Filipino IENs rely primarily on workplace-based training, supplemented by self-directed learning, with very few depending solely on experience. This reflected a workforce that participated in workplace-based training among most respondents.

The "Cultural competency trainings/education" data showed that over half of Filipino IENs take advantage of workplace-based cultural competency training, which includes diversity and inclusion modules, cultural sensitivity workshops, mentorship from senior nurses, unit-based cultural communication coaching, and organizational competency requirements. "Structured workplace training is consistent with cultural competency, communication skills, and practice preparedness of globally trained nurses, as per Xu et al. (2019). This reflects the types of cultural competency training reported by respondents, yearly competencies, and team-based learning in U.S. healthcare.

The lowest-ranked category of Filipino IENs was the cultural competence certification. This shows that although certification programs may not be easily available, organizations may be unwilling to pay for formal credentials, and cultural competence is mostly learned informally, not through standardized certification. This indicates that a formal certification in cultural competence was rare in this sample.

The results for the variable "Type of cultural competency training" showed that Filipino IENs developed cultural competency through interactions with coworkers at work. Gaining cultural awareness through everyday contact with diverse colleagues, exposure to alternative clinical viewpoints, informal mentoring and peer learning, and workplace interactions learned through real interaction, and impacted by workplace culture rather than formal teaching in terms of multidisciplinary cooperation was frequently mentioned by respondents.

Most of the respondents answered that they had not received any formal training in cultural competence. "Cultural competency is often learned in the daily contacts with colleagues and patients, not in formal training" (Xu & He, 2019). This is consistent with the training patterns reported in this dataset and the reliance on informal learning reported in this sample. A minority engaged in self-directed learning about culture (e.g., reading cultural competence literature, online programs, independent study). Thus, Filipino IENs were more interested in experiential learning, as opposed to formal or self-directed cultural learning. In general, the trend showed that Filipino IENs mainly acquired cultural competence through involvement in the workplace, clinical fieldwork, experiential learning, and multidisciplinary cooperation. Formal certification and formal training are still not widely recognized.

For the diverse population that Filipino nurses work with, the data showed that Filipino IENs most frequently care for White, African American/Black, and Asian patients, dominating the clinical exposure profile, indicating frequent care for racially diverse patient groups: "Filipino nurses' cultural competence is shaped by their frequent interactions with racially diverse patient populations, including White, African American, and Asian communities." According to Yoshioka et al. (2021). This aligns with literature describing Filipino nurses' exposure to diverse patient groups. In contrast, Hawaiian/Pacific Islander and Native American/Alaska Native populations appear far less frequently, which means limited representation is cared for by the Filipino IENs. The general trend meant that the data showed Filipino IENs consistently care for racially diverse groups, especially White, African American/Black, and Asian

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patients, which reflects the diversity of patient populations encountered in this sample.

Table 2: Level of cultural competence of Filipino IENs based on CCAI domains (n = 101)

Mean and standard deviation of Filipino IENs' cultural awareness/knowledge, cultural skills, and organizational support

Variable	Category	Frequency	Percentage	Mean	Standard deviation
Cultural awareness/knowledge	—	—	—	31.81	6.22
	8–23 (Low awareness/knowledge)	1	0.99	—	—
	24–37 (Developing awareness/knowledge)	59	58.42	—	—
	38–48 (High awareness/knowledge)	41	40.59	—	—
Cultural skills	—	—	—	31.06	6.27
	8–23 (Low skill)	10	9.90	—	—
	24–37 (Developing skill)	56	55.45	—	—
	38–48 (High skill)	35	34.65	—	—
Organizational support	—	—	—	30.31	5.99
	8–23 (Low support)	7	6.93	—	—
	24–37 (Developing support)	84	83.17	—	—
	38–48 (High support)	10	9.90	—	—
Overall cultural competence	—	—	—	93.20	16.86
	24–71 (Culturally incompetent/high risk)	6	5.94	—	—
	72–111 (Culturally aware/developing)	83	82.18	—	—
	112–144 (Culturally competent/proficient)	12	11.88	—	—

Cultural Awareness and Knowledge

The only domain of cultural competence that **was statistically significantly associated with the practice readiness variables was Cultural Awareness/Knowledge (ρ =.242–.229, p < .05)**. This trend indicated that, compared to skills and organizational structures, the awareness/knowledge category was the only cultural dimension that was somewhat related to readiness among Filipino IENs. Most of the Filipino IENs in the sample reported intermediate levels of cultural awareness, showing that they are aware of cultural differences and are learning U.S. cultural norms, but have not yet achieved advanced understanding. This developmental stage is an initial step in the trajectory of Filipino IENs' adaptation to U.S. healthcare practice that involves a process of cultural differences detection, learning about patient needs, and reflection on their own cross-cultural communication and relational skills. These findings are consistent with literature on Filipino IENs developing cultural awareness over time as they are immersed in new clinical environments with changing communication styles and changing patient expectations. Their scores

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also reflected curiosity and willingness to learn, qualities often reported in studies of Filipino IENs who are moving into new health care systems. The only low score in this domain is a consequence of individual variation and shows that a lack of familiarity with U.S. culture is not common within this group, although it is present.

With a mean score of 31.81, the interpretation that Filipino IENs are currently working on the acquisition of cultural awareness during their transitional experience in the U.S. workforce is supported. The moderate mean and relatively low standard deviation suggested that the construct of cultural awareness/knowledge is relatively stable in this sample, and that most of the Filipino nurses cluster around similar levels of awareness. The variability, however, shows that cultural awareness is defined by individual differences such as background, prior experience with other cultures, and personal learning trajectories. Overall, these findings characterize Filipino IENs as culturally competent practitioners who are developing their cultural competence in practice in U.S. practice settings.

Cultural Skills

The majority of Filipino IENs at Hospital A had acquired cultural skills to effectively communicate and adapt to the U.S. workforce, but they were still undergoing the process of learning culturally responsive behaviors. It showed that Filipino IENs are engaged in the development of practical skills for culturally sensitive care. The scores are indicators of Filipino IENs' development of cultural skills. However, not all Filipino IENs in Hospital A can utilize cultural skills. In the sample, there is a variation in the level of cultural skills. This pointed to the need for more support for some Filipino IENs, particularly for people who are new to the US healthcare system or who have minimal expertise with culturally diverse environments.

The Filipino IENs in this sample had a moderate level of cultural competency with an average score of 31.06, which suggested that Filipino IENs were learning cultural skills with low levels of awareness. There was a large range and a standard deviation of 6.27, which indicated that although many nurses had similar levels of cultural competence, the patterns of cultural skill development were associated with individual background and experience. Overall, the data indicate that Filipino IENs came to U.S. health care practice with a foundation of cultural sensitivity. These emergent skills mirror the moderate cultural skill scores in this dataset.

Organizational Support

Most Filipino IENs in Hospital A reported having moderate organizational support in most of the U.S. institutions, through the availability of some cultural resources some Filipino IENs described it as sporadic and informal. Most of them have peer support available; some considered having training, while others are lucky to have supportive nursing leadership. However, they reported that organizational processes such as onboarding programs, cultural competence training, or transition paths did not meet their needs. The variation in the sample is reflected in the low organizational support reported by some respondents. Although they state that they may not have institutional backing, systems of documentation, norms of communication, or cultural subtleties, this mean score of 30.31 was still within the Developing Support range. This is consistent with the assumption that generally Filipino IENs saw the workplace as somewhat helpful, although in the emerging stage. Organizational support had an average variability of 5.99 standard deviations. There was a significant variance in the organizational assistance provided among institutions overall.

Overall Cultural Competence of Filipino IENs

Findings indicated that Filipino IENs' cultural competence was generally developing in the CCAI domains. The Cultural Awareness and Knowledge (M = 31.81, SD = 6.22) measure also revealed that Filipino IENs had a strong basis of cultural sensitivity and were working to enhance their ability to apply this awareness/knowledge in clinical practice. Both showed majority clustering in developing categories for Cultural Skills (M = 31.06, SD = 6.27), suggesting moderate but emerging cultural capability. This domain relates to self-reported cultural skill levels of respondents, such as developing culturally sensitive care plans, communicating effectively in cross-cultural situations, and practicing cultural humility.

However, a few Filipino IENs expressed that there is a need for more support for some Filipino IENs, especially those who are new to the U.S. healthcare system or have limited exposure to culturally diverse environments. Organizational Support (M = 30.31, SD

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= 5.99) was most heavily concentrated in one category, suggesting the presence of institutional cultural resources that are not evenly distributed.

Overall Cultural Competence (M = 93.20, SD = 16.86) suggested that most of the Filipino IENs were in the culturally aware/developing range, and only 11.88% reached proficient levels. This suggested that Filipino IENs who entered the U.S. healthcare system and work in this new healthcare environment possessed adequate cultural awareness and developing skills for culturally competent practice. These developmental skills correspond to working in multicultural clinical settings and demonstrate the levels of cultural competence displayed in this population. Ongoing mentoring, formal education, and favorable workplace cultures may support their cultural competency and readiness for safe and successful practice. Findings of this study on the cultural competency levels of Filipino IENs across the CCAI areas were supported by recent studies.

Some research results on the cultural evolution of Filipino IENs are similar to the findings characterized by Xu and He (2019), as they continuously enhance their cultural awareness. These studies revealed how immersion in the work context and everyday interaction with a varied patient group boosted nurses' cultural awareness. These experiences taught them how to discern cultural subtleties, how to adapt to diverse ways of communication, and how to be attentive to the needs of patients from other cultures. The results showed that cultural competencies are not quickly acquired but developed through experience, collaborative partnerships with peers, and structured mentoring consistent with the studies of Dahl et al. (2021).

Finally, the perception of developing organizational support mirrors findings by Masselink and Lee (2020), Primeau et al. (2022), and Casey-Fink (2024), which highlight that institutional support for IENs is often present but inconsistent; this highlights that organizational support for IENs can vary across settings. Collectively, these recent studies are consistent with the present findings, which align with literature describing Filipino IENs as having developing cultural competence shaped by workplace experiences and evolving cultural competence shaped by lived experiences, workplace interactions, and organizational environments."

Table 3: Levels of practice readiness based on Casey-Fink readiness subgroups (n = 101)

Mean and standard deviation of Filipino IENs' readiness for professional nursing practice

Variable	Category	Frequency	Percentage	Mean	Standard deviation
Clinical problem-solving	—	—	—	18.06	2.60
	5–11 (Advance Beginner/ High transition risk)	1	0.99	—	—
	12–19 (Competent/Emerging adaptation)	45	44.55	—	—
	20–25 (Proficient/Globally ready)	55	54.46	—	—
Learning activities	—	—	—	18.50	2.11
	5–11 (Advance Beginner /High transition risk)	1	0.99	—	—
	12–19 (Competent/Emerging adaptation)	48	47.52	—	—
	20–25 (Proficient/Globally ready)	52	51.49	—	—
Practice readiness	—	—	—	18.20	2.43
	5–11 (Advance Beginner /High transition risk)	3	2.97	—	—

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	12–19 (Competent/Emerging adaptation)	46	45.54	—	—
	20–25 (Proficient/Globally ready)	52	51.49	—	—
Confidence and skill performance	—	—	—	19.32	3.53
	5–11 (Advanced Beginner /High transition risk)	4	3.96	—	—
	12–19 (Competent/Emerging adaptation)	44	43.56	—	—
	20–25 (Proficient/Globally ready)	53	52.48	—	—
Overall readiness for professional nursing practice	—	—	—	74.10	8.70
	20–47 (Advance Beginner /High transition risk)	1	0.99	—	—
	48–79 (Competent/Emerging adaptation)	64	63.37	—	—
	80–100 (Proficient/Globally ready)	36	35.64	—	—

Clinical Problem-Solving

Most of the Filipino IENs had the capacity to solve challenges in the workplace, indicating high clinical reasoning and decision-making abilities. This was reflected in the category Proficient/Globally Ready at 54.46%. This was in accordance with the findings of Nazareno et al. (2021), who discovered that Filipino nurses had good clinical judgment related to years of experience in high-acuity settings in hospitals in the Philippines and the Middle East.

Several Filipino IENs demonstrated strong clinical judgment consistent with literature relating to Filipino nurses' significant clinical backgrounds. These nurses felt confident in their ability to assess the patient's health, anticipate possible problems, and coordinate care. These clinical skills were consistent with norms of nursing practice worldwide and facilitated a seamless transition to practice in the U.S. In contrast, there was only one different response recorded, which suggested that some Filipino IENs may require particular assistance throughout the transition phase to the U.S. This low score pertains to individual variance in the dataset. This highlighted the need to provide a systematic onboarding process and mentoring that targets essential clinical skills for Filipino IENs when they begin working in the United States.

The mean score for the Competent/Emerging Adaptation category was 18.06, which implied that Filipino IENs scored at a moderate to high level. This means that Filipino nurses are able to overcome the challenges at work even with early integration into the U.S. workforce. The lower variation of standard deviation of 2.60 showed that Filipino IENs had similar skills in clinical reasoning and decision-making in their work as health care providers. This is consistent with the findings of Primeau et al. (2022) that immigrant nurses have clinical reasoning skills because of their standardized training in their countries of origin and similar cultural norms that may indicate hard work and competence.

The results in this data meant that Filipino IENs were equipped to employ clinical judgment and problem-solving abilities while they work in the U.S. healthcare system. The ratings showed that the Filipino respondents were capable of clinical problem-solving so long as they continue to receive structured training and mentorship while they work.

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Learning Activities

In the data, almost half of the Filipino IENs working at Hospital A were utilizing continuous learning practices through positive learning, flexibility, and engagement. It showed that many respondents were engaged in the learning activities available to them, and these scores reflected both positive learning and consistent learning engagement within the sample, showing that nurses learned freely and used new experiences across a broad spectrum of clinical conditions. This context was supported by the findings of Dahl et al. (2021). Their study found that Filipino nurses are motivated learners and seek mentorship, are open to self-directed learning and reflective practice to adapt to the U.S. healthcare system.

The low variance of learning engagement (SD = 2.11) was consistent with the findings of Xu & He (2019) that IENs have stable learning motivation when they transition to new practice settings. There were still some groups of Filipino IENs who needed some coaching to improve opportunities for learning engagement. This low score reflected the variability within the sample. The existence of this minority only proves that there is a need for training programs that are readily accessible, supportive mentorship from the nursing leadership, and culturally appropriate onboarding training. The mean score in the category of Competent/Emerging Adaptation suggested that Filipino IENs are engaged in learning and are ready for ongoing progression as a group. The standard deviation shows the least variety; most of the respondents had similar levels of learning desire and adaptability.

The data set generally suggested that Filipino IENs enter the U.S. healthcare system with sufficient levels of learning engagement. Filipino IENs' continued engagement in learning activities and their ability to work within complex multicultural clinical environments were reflected in the learning engagement scores. The ongoing teachings, structured training, and positive corporate cultures were consistent with better engagement and overall readiness for safe, effective practice. This was consistent with Casey Fink (2024); their study emphasized that readiness of healthcare professionals improves with time in their role, their familiarization with U.S. documentation standards, and interdisciplinary collaboration.

Practice Readiness

Recent empirical evidence suggested that more than 50% of Filipino IENs were ready to practice independently with good clinical judgment, flexibility, and communication skills. Nazareno et al. (2021) revealed that Filipino nurses consistently demonstrate high-acuity clinical judgment because of their vast experience in Philippine and Middle Eastern hospitals. Alvarez (2020) stated that nurses' culturally based patient-centered care helps them develop excellent assessment and decision-making skills. These findings align with literature describing Filipino nurses' clinical backgrounds and addressing the various requirements of patients in U.S. clinical settings. Global IEN research supported the presence of a small subgroup that required additional transition assistance. This is aligned with the idea that "Newly immigrated nurses with limited recent clinical experience may face some initial challenges and may benefit from structured onboarding, coaching, and culturally responsive mentoring", based on the findings of Primeau et al. (2022). **The average score of 18.20 was also in the Competent/Emerging Adaptation range. This was consistent with the proposition that Filipino IENs, as a group, were well positioned for successful integration into U.S. practice**. The small SD = 2.43 indicated that the respondents' preparedness and confidence levels were fairly consistent. These findings were consistent with the literature at large, suggesting Filipino IENs brought to the U.S. healthcare system strong clinical skills, flexibility, and cultural sensitivity (Masselink & Lee, 2020; Casey-Fink, 2024).

The majority of Filipino IENs were in the Competent/Emerging-Adaptation range of practice preparedness. A smaller group of Filipino IENs were in the Proficient/Globally Ready range of practice preparedness. This group of nurses was considered well-prepared healthcare professionals from the start of their employment and is continually growing through experience. Continuous mentorship, organizational support, and professional development will be crucial for their readiness to provide quality patient care, and this reflects their readiness in the long run.

Confidence & Skill Performance

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The Filipino IENs rated their confidence and ability in performing skills as "high", reflecting high confidence scores among respondents. This tendency was strongly supported by recent studies. Most participants reported high levels of confidence in their ability to perform skills related to assessment, intervention, patient management, and interdisciplinary communication. This corresponded to the findings of Nazareno et al. (2021), who found that Filipino nurses were often recruited for complex clinical roles in U.S. hospitals due to their strong technical skills and adaptability. Filipino nurses' culturally based patient-centered care and long-standing experience at the bedside were associated with high confidence in clinical decision-making and communication, similar to Alvarez (2020), according to the study. Competency in this domain reflects respondents' self-reported confidence in skill performance and commitment to providing safe, effective, and culturally appropriate care.

A small group of Filipino IENs in the dataset showed that they still need to acquire more skills training to be more inclined toward the nature of the work environment in the U.S. This is in line with the findings of Primeau et al. (2022), who stated that for immigrant nurses with limited recent clinical exposure, immersion in structured onboarding, supportive preceptorship, and culturally responsive training programs will be immensely beneficial.

Filipino IENs were generally confident and competent, as indicated by their mean score of 19.32 in the results, which is below the Competent/Emerging Adaptation level. The scores had moderate dispersion (SD=3.53), which showed that the individual working environment and previous experiences of the nurses still played a role in the development of confidence. This is consistent with the study of Omeri et al. (2019), who showed that migrant nurses' confidence was related to experience, learning, and a supportive team atmosphere. Overall, results showed Filipino IENs are entering the U.S. health care system with well-developed clinical abilities and rising confidence, as shown by high confidence and skill performance levels in this group.

As Casey-Fink et al. (2024) found in their study, there are factors that contribute to the nurses' preparedness to practice, such as continuous mentoring and support from the organization even after the orientation phase. This boosted the trust of Filipino IENs and aligned with high-quality patient treatment. This created confidence in the Filipino IENs and was in line with high-quality patient care.

Readiness for Professional Nursing Practice

The Competent/Emerging Adaptation was considered to be the most prominent category in this data at 63.37%. It showed that most Filipino IENs possessed competence to practice in the United States. As Dahl et al. (2021) stated, they described Filipino immigrant nurses as having strong baseline competencies and a high motivation to learn; their competent clinical judgment, growing independence, and comfort with U.S. standards of documentation and communication indicate a similar adjustment. Likewise, Masselink and Lee (2020) showed that Filipino nurses' previous overseas experience and cultural adaptability were consistent with literature describing Filipino nurses' diverse clinical backgrounds.

The capacity of nurses to adapt to various patient groups and multidisciplinary teams is aligned with the work of Nazareno et al. (2021), who highlighted the flexibility and excellent clinical work of Filipino nurses working in U.S. hospitals.

The Advance Beginner /High Transition Risk category had a small number of respondents at 0.99%. This result was consistent with other literature on Filipino nurses' clinical experience, which suggests that Filipino IENs tend to have a low transition risk. This is the same as Xu and He (2019), who noted that internationally trained nurses who migrated to the U.S. with high baseline abilities or had little and recent clinical experience still needed specific assistance when they started working in a new system. The results highlight the continued need for culturally appropriate onboarding, mentoring, and transition programs for Filipino IENs. These supports are not optional; they are important mechanisms within the workplace that allow nurses to increase their competencies while ensuring that their learning environment is representative of cultural appropriateness. In line with this, higher practice preparedness was connected with knowledge of the U.S. system, namely documentation requirements and team-based care procedures (Casey-Fink, 2024).

The Filipino IENs' mean scores in the research were high in the Competent/Emerging Adaptation category, suggesting a fairly consistent level of preparation and a strong pattern of global practice

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competence. The standard deviation of 8.70 is moderate and shows that there is a meaningful variance in the group. This meant that the Filipino IENs came from different demographic and vocational backgrounds.

This conclusion is similar to Primeau et al. (2022), which revealed that the confidence and preparation of an immigrant nurse during transition is significantly affected by their work environment and personal life experiences. Therefore, training is not the only influence on preparedness, but also the situation in which the nurses work and the support received. Results highlighted strengths of the Filipino IEN workforce, including strong clinical judgment, adaptability, and cultural sensitivity to the U.S. health care system. Readiness scores fell in the Competent/Emerging Adaptation group.

Table 4.A: Significant Difference in the Cultural Competence of Filipino IENs According to Personal Demographic Profile (n = 101)

Variable	Category	n	Mean Rank	H (df) / U	p (Asymp. Sig.)
Gender	Male	28	60.16	3.99 (2)	0.136
	Female	71	47.23		
	Prefer not to disclose	2	56.50		
Age	Early adulthood (18–29)	6	47.75	0.699 (3)	0.873
	Early middle adulthood (30–39)	76	51.36		
	Middle adulthood (40–49)	13	47.04		
	Late adulthood (50+)	6	58.33		
Marital Status	Single	40	44.43	4.115 (2)	0.128
	Married	59	54.70		
	Separated	2	73.25		
Speaks language(s)/dialects other than English	Yes	86	50.09	566.50	0.453
	No	15	56.23		
Type of Philippine language/dialect spoken	Northern/Luzon	45	49.68	2.57 (3)	0.462
	Central/Visayas	34	54.12		
	Southern/Mindanao	10	39.25		
	Prefer not to disclose	12	56.92		
Race/Ethnicity	Luzon Ethnic Group	42	49.77	1.95 (3)	0.583
	Visayas Ethnic Group	48	53.45		
	Mindanao Ethnic Group	10	42.1		

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	Prefer not to disclose	1	74		
Do you have any support systems while working in the U.S.?	Immediate family in the U.S.	54	49.92	8.443 (2)	0.015
	Friends and Co-workers	40	57.39		
	No available Support Systems	7	22.86		
Post hoc: Dunn's test (Bonferroni-adjusted) Friends and co-workers vs. No support systems z = 2.88, adj. p = .012*					

The Kruskal–Wallis and Mann–Whitney U tests showed no statistically significant differences in the cultural competence of Filipino IENs across the personal profile variables (gender: p = 0.136; age: p = 0.873; marital status: p = 0.128; speaking other languages other than English: p = 0.453; Philippine language group: p = 0.462; and ethnolinguistic background: p = 0.583). Cultural competence remained stable across demographic groups, considering that mean rankings were different across categories, but these variances were not sufficiently large to reach statistical significance. This showed that demographic determinants were not strongly related to differences in cultural competence. **The only personal characteristic that showed a statistically significant difference in cultural competence scores was the presence of support systems, H(2) = 8.443, p = .015.** Dunn's post hoc test showed that Filipino IENs whose support system was friends and co-workers had significantly higher mean ranks (57.39) than those without support systems (22.86; z = 2.88, Bonferroni-adjusted p = .012). The difference between those with immediate family and those without support systems was not significant after adjustment (z = 2.30, adj. p = .065), and only seven respondents reported no support system. This highlighted peer support and social integration as situational and relational factors associated with higher cultural competence scores in this sample.

The finding was consistent with the studies of Nazareno et al. (2021), who found that Filipino nurses' cultural competency was more closely related to workplace realities and systemic variables, rather than demographic characteristics, thus consistent with this trend. Likewise, Alvarez (2020) noted that cultural competency among Filipino nurses has been associated with workplace experiences rather than demographic characteristics. These studies were consistent with the finding that Filipino IENs' cultural competency did not differ substantially by demographic factors.

The finding was in line with previous studies which have highlighted the relevance of peer support and social integration in cultural adaptation. Xu & He (2019) described peer interactions as an important context for cultural learning among internationally educated nurses. Likewise, Dahl et al. (2021) found that teamwork and collegiality were observed among Filipino nurses in foreign healthcare settings. In a more recent study, Primeau et al. (2022) noted that peer support is associated with positive cultural experiences among immigrant health care workers.

Table 4.B: *Significant Difference in the Cultural Competence of Filipino IENs According to Professional Demographic Profile (n = 101)*

Professional Profile Variable	Category	n	Mean Rank	H (df) / U	Asymp. Sig.
Highest Level of Education	Bachelor of Science in Nursing (BSN)	94	50.79	309	0.789

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	Master of Science in Nursing (MSN)	7	53.86		
Current Position / Employment Status	BSN (Professional RN)	98	50.09	57.5	0.073
	Prefer not to disclose	3	80.83		
Previous Non-Nursing Degree or Healthcare Experience	Yes	13	53.50	0.16 (1)	0.689
	No	88	50.05		
Years in Current Position	< 2 years	15	57.30	3.054 (3)	0.383
	3–5 years	16	40.78		
	6–10 years	23	54.87		
	>10 years	47	50.57		
Work-Related Hours (Recent Experience)	1–200 hours	10	59.55	2.471 (3)	0.48
	201–300 hours	13	40.81		
	301–400 hours	7	50.50		
	400 hours	71	51.71		
Continuing Education / Training	Self-directed learning	19	55.05	7.482 (3)	0.058
	Workplace-based training or mentorship	62	49.19		
	Feels confident with past work experiences	9	33.89		
	No training / open to training	11	68.23		
Cultural Competency-Related Training	Self-directed learning	14	51.50	2.369 (3)	0.499
	Workplace-based training or mentorship	58	50.07		
	Certified in cultural competency	4	32.38		
	No training received	25	55.86		
Type of Cultural Competency Training Received	Fieldwork experience in school	29	46.60	2.12 (3)	0.548
	Self-reading	4	68.25		
	Interdisciplinary workplace interactions	46	52.21		
	No formal training	22	51.14		

Also, none of the professional profile variables showed any statistically significant differences in cultural competence. There were no significant differences between the groups for highest educational attainment ($p = 0.789$), current employment status ($p = 0.073$), prior non-nursing or health care experience ($p = 0.689$), years in current position ($p = 0.383$), work-related hours ($p = 0.480$),

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continuing education or training (p = 0.058), cultural competency-related training (p = 0.499), and types of cultural competency training received (p = 0.548) with p-values greater than 0.05. Though the mean ranks were higher in some categories (e.g., MSN-prepared nurses, > 10 years of experience, self-directed learning), these differences were not statistically significant. Thus, professional background, level of education, work experience, and exposure to training were not strongly related to differences in cultural competence of Filipino IENs. The non-significance of all professional variables implied that cultural competence did not vary according to professional credentials or work history but rather aligns with literature suggesting that cultural competence is shaped by contextual and relational factors. The Filipino IENs generally had a stable cultural competence across their professional profiles, which aligns with literature indicating that cultural competence is often associated with contextual experiences rather than professional qualifications. This mirrored the findings of Xu and He (2019), who found that cultural competence among internationally educated nurses is more closely related to contextual and relational factors, such as workplace integration and social support, than to formal education or years of experience. Similarly, Dahl et al. (2021) reported that Filipino immigrant nurses gained cultural competence through lived experience, personal relationships, and workplace immersion rather than from formal professional training. The study by Masselink and Lee (2020) found that Filipino nurses' cultural adaptation did not differ according to prior degrees or clinical tenure, but rather by their migration experiences and organizational culture. These studies suggested that professional background alone did not show a significant relationship with cultural competence but rather was consistent with studies suggesting that cultural competence is influenced by contextual and experiential factors. The non-significant p-values for all professional variables suggested that Filipino IENs have a stable cultural competence regardless of their professional profile. This was consistent with the relevance of workplace support and cultural exposure compared with formal qualifications.

Table 5.A: Significant Difference in the Practice Readiness of Filipino IENs According to Personal Profile (n = 101)

Personal Profile Variable	Category	n	Mean Rank	H (df) / U	Asymp. Sig.
Gender	Male	28	44.54	1.979 (2)	0.372
	Female	71	53.64		
	Prefer not to disclose	2	47.75		
Age	Early adulthood (18–29)	6	62.08	1.529 (3)	0.676
	Early middle adulthood (30–39)	76	50.64		
	Middle adulthood (40–49)	13	52.35		
	Late adulthood (50+)	6	41.58		
Marital Status	Single	40	51.59	0.035 (2)	0.982
	Married	59	50.55		
	Separated	2	52.50		
Language Use	Yes	86	50.09	566.5	0.453
	No	15	53.23		
Philippine Language Group	Northern/Luzon	45	50.43	8.616 (3)	0.035*
	Central/Visayas	34	56.60		
	Southern/Mindanao	10	26.95		
	Prefer not to disclose	12	57.29		
Race/Ethnicity	Luzon	42	48.02	6.343 (3)	0.096
	Visayas	48	57.33		

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	Mindanao	10	33.40		
	Prefer not to disclose	1	48.00		
Support Systems	Immediate family in the U.S.	54	50.19	0.358 (2)	0.836
	Friends and co-workers	40	51.00		
	No support systems	7	57.21		

Note. H = Kruskal-Wallis statistic with degrees of freedom in brackets; two-group variables report the Mann-Whitney U statistic. Post hoc for Philippine language group (Dunn's test, Bonferroni-adjusted): Central/Visayas vs. Southern/Mindanao, z = 2.81, adj. p =.030; all other pairings non-significant; Groups with extremely few members (e.g., "Prefer not to disclose", n = 1–2) make the comparisons less stable.

The statistical analysis showed no significant difference in the practice readiness of Filipino IENs by gender, H(2) = 1.979, p = .372; age, H(3) = 1.529, p = .676; marital status, H(2) = 0.035, p = .982; speaking languages other than English, U = 566.5, p = .453; ethnolinguistic background, H(3) = 6.343, p = .096; or support systems, H(2) = 0.358, p = .836. Practice readiness differed significantly by Philippine language group, H(3) = 8.616, p = .035. Dunn's post hoc test showed that respondents who spoke Central Philippine (Visayas) languages had higher readiness mean ranks (56.60) than those who spoke Southern Philippine (Mindanao) languages (26.95; z = 2.81, Bonferroni-adjusted p = .030); no other pair differed significantly after adjustment. Because only 10 respondents spoke Mindanao languages, this result should be interpreted with caution.

Apart from the language-group difference, the mean ranks varied only slightly across categories (e.g., early adulthood scoring higher), and these variations did not reach statistical significance.

These findings were consistent with Dahl et al. (2021), who found that Filipino immigrant nurses' preparedness for practice was described in the literature as being associated with workplace experiences rather than demographic characteristics than to demographic characteristics. Similarly, Primeau et al. (2022) observed that contextual and organizational variables were noted in connection with practice preparedness among immigrant healthcare personnel, although age, gender, or ethnicity did not.

Therefore, apart from the Philippine language group, the personal profile variables did not show significant differences in the practice readiness of Filipino IENs.

Table 5.B: Significant Difference in the Practice Readiness of Filipino IENs According to Professional Profile (n = 101)

Professional Profile Variable	Category	n	Mean Rank	H (df) / U	Asymp. Sig.
Highest Level of Education	BSN	94	50.88	318	0.883
	MSN	7	52.27		
Current Position / Employment Status	**BSN (Professional RN)**	**98**	**52.38**	**11.5**	**0.007***
	Prefer not to disclose	3	5.83		
Previous Non-Nursing Degree or Healthcare Experience	Yes	13	42.88	466.5	0.308
	No	88	52.20		
Years in Current Position	**< 2 years**	**15**	**31.57**	**8.898 (3)**	**0.031***
	3–5 years	16	55.00		
	6–10 years	23	49.07		
	>10 years	47	56.79		

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Post hoc: Dunn's test (Bonferroni-adjusted)	< 2 years vs. 6–10 years	—	z = 1.80	—	adj. p = .432
	< 2 years vs. >10 years	—	z = 2.90	—	adj. p = .022*
	3–5 years vs. >10 years	—	z = 0.21	—	adj. p = 1.000
Work-Related Hours	1–200 hours	10	33.55	4.447 (3)	0.217
	201–300 hours	13	47.73		
	301–400 hours	7	53.43		
	400 hours	71	53.82		
Continuing Education / Training	Self-directed learning	19	46.58	3.762 (3)	0.288
	Workplace-based training or mentorship	62	55.04		
	Confident with past work experiences	9	47.83		
	No training / open to training	11	38.45		
Cultural Competency-Related Training	Self-directed learning	14	55.96	5.906 (3)	0.116
	Workplace-based training or mentorship	58	48.30		
	Certified in cultural competency	4	83.38		
	No training received	25	49.30		
Type of Cultural Competency Training	Fieldwork experience in school	29	48.34	0.451 (3)	0.930
	Self-reading	4	49.25		
	Interdisciplinary workplace interactions	46	51.57		
	No formal training	22	53.64		

In contrast, the analysis revealed that two professional profile variables were statistically significantly different in practice readiness. **A Mann-Whitney U test revealed a significant difference between those who identified as BSN (Professional RN) and those who preferred not to disclose their employment status, U = 11.50, z = –2.71, p =.007, with professional RNs having a dramatically higher mean rank (52.38) than those who did not disclose (5.83)**. The study did not measure professional identity or involvement in RN roles. It only measured employment status categories. **A Kruskal-Wallis H test also indicated a significant difference between tenure groups, H(3) = 8.898, p = .031. Dunn's post hoc test with Bonferroni adjustment showed that nurses with less than 2 years in their current position had lower readiness mean ranks (31.57) than those with more than 10 years (56.79; z = 2.90, adj. p = .022). No other pair differed significantly after adjustment, including < 2 years vs. 6–10 years (adj. p = .432) and 3–5 years vs.**

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> 10 years (adj. p = 1.000). Only three respondents preferred not to disclose their position, so the position result rests on a very small group and should be interpreted with caution.

These results are strongly supported by Casey-Fink (2024), Omeri et al. (2019), and Xu & He (2019), who listed clinical tenure, familiarity with unit workflow, and sustained immersion in the host healthcare system as factors described in the literature as relevant to practice readiness. Together, these results indicated that while demographic factors did not influence readiness, employment status and tenure in their current position were associated with higher readiness scores among Filipino IENs.

Across all demographic and professional variables, only four showed significant differences:

- Support systems → cultural competence (p = 0.015)
- Current RN position → readiness (p = 0.007)
- Years in current position → readiness (p = 0.031)
- Philippine language group → readiness (p = 0.035)

All other variables showed no significant differences.

Table 6: Relationship Between Cultural Competence and Practice Readiness Among Filipino IENs (n = 101)

Cultural Competence Dimension	Practice Readiness Component	Spearman's ρ	p-value (2-tailed)
CAKnow	PRClinical	.242*	.015
	PRLearning	.229*	.021
	PRPractice	.222*	.026
	PRConfidence	.015	.880
CASkill	PRClinical	.093	.355
	PRLearning	.086	.392
	PRPractice	.032	.749
	PRConfidence	.000	.999
CAOrgSupp	PRClinical	.116	.249
	PRLearning	.110	.274
	PRPractice	.050	.618
	PRConfidence	.027	.791

Using Spearman Rank-Order Correlation analysis, this study found that Cultural Awareness/Knowledge showed weak but significant correlations with readiness components. Some literature suggested that this relationship may vary across settings, indicating that awareness contributes to readiness but is not sufficient on its own. There was a small but statistically significant positive association between Cultural Awareness and Knowledge (CAKnow) and Clinical Problem-Solving, Learning Activities, and Practice Readiness.

Findings showed that Filipino IENs with high ratings in cultural awareness/knowledge also scored highest in clinical reasoning, learning engagement, and readiness in various components of readiness in this sample. This is consistent with the study results of Xu and He (2019) that foreign nurses who learned cultural awareness early in the transition had greater cognitive flexibility and clinical judgment.

Moreover, Dahl et al. (2021) found a significant association between cultural learning (e.g., communication norms, patient expectations, confidence in clinical decision-making). The results confirmed that cultural awareness is somehow connected to components of preparation in this sample and to what they need to know to perform in the U.S. system.

Based on the findings, CAKnow was not correlated with Confidence and Skill Performance. Some literature states that "confidence has been described in

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prior literature as more closely associated with clinical experience than cultural knowledge. Filipino IENs are known to have a perceived clinical foundation, and Nazareno et al. (2021) found that Filipino nurses often enter U.S. hospitals with high technical competence and strong self-assurance. Cultural awareness may be related to how the respondents think and adapt, but the confidence comes from the hands-on work they have mastered.

In terms of Cultural Skills and Organizational Support, these two were not significantly correlated with any readiness domain. This means that neither directly predicted readiness scores in this sample. These scores reflect variation in cultural skills and perceived organizational support within the sample, but these did not correspond directly with higher readiness scores. This is congruent with the findings of Primeau et al. (2022), who stated that immigrant nurses often displayed their readiness to work and their individual resilience, with clinical experience before practice.

Also, Masselink and Lee (2020) spoke on Filipino nurses' flexibility even in the absence of official support mechanisms. Collectively, these findings provided compelling insight that the cultural competence domain most associated with practice readiness was cultural awareness, rather than cultural skills or organizational support. The data presented show that higher cultural awareness scores are more strongly associated with higher scores on readiness components such as problem solving, learning engagement, and adaptation of Filipino IENs in U.S. practice.

These associations align with literature describing the value of cultural orientation in supporting IENs. To summarize, the data supported the notion that these findings align with literature describing Filipino IENs as having strong clinical backgrounds and that higher readiness scores were observed alongside higher cultural awareness. This was a hopeful and empowering finding that aligns with literature describing Filipino nurses' strong engagement in learning and adaptation.

Although the presented study revealed a weak but statistically significant relationship between CAKnow and Clinical Problem-Solving, Learning Activities, and Practice Readiness, recent literature suggests that this relationship may not always be valid and may be overshadowed by other factors. Most studies stated that cultural awareness is not significantly associated with nurses' preparation or overall work performance. This is particularly true with the globally trained nurses who have just started working in the most complex U.S. institutions.

In the study conducted by Primeau et al. (2022), they found that immigrant nurses' practice preparedness and confidence were more correlated with organizational support, workload conditions, and team dynamics than with cultural awareness. Even nurses with a high level of cultural awareness are challenged in unsupportive conditions. This implied that awareness is necessary but not sufficient.

Filipino nurses often had a high level of cultural knowledge (Masselink and Lee, 2020); however, they had difficulty in practice preparation due to systemic issues such as paperwork, communication, and institutional expectations. Their findings from scholars challenge the assumption that cultural awareness leads to preparedness and emphasize the significance of structural and organizational factors.

Some studies, like those by Nazareno et al. (2021), have suggested that cultural awareness might be related to increased sensitivity in the structure of workplace dynamics. Findings indicated that cultural understanding may be a resource for emotional work rather than a prerequisite and that awareness does not always align with the readiness outcomes across studies. Moreover, cultural awareness was not a predictor of confidence, but rather confidence was more closely associated with clinical experience, mentoring, and knowledge of U.S. (Dahl et al., 2021). The processes, similar to the result that CAKnow was not correlated with Confidence and Skill Performance.

Statement of the Problem # 7

Development of a Transition Program for Filipino IENs

Summary of the Program Contents

The Enhanced 12-Week Transition Program for Filipino Internationally Educated Nurses (IENs) is an evidence-informed proposal developed from the patterns identified in the study of 101 Filipino IENs in the U.S. healthcare system. It is intended for newly hired Filipino IENs or those in the first 12 months of practice in the U.S. The program is designed to foster safe, culturally responsive clinical practice, professional integration, confidence, well-being, and

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retention through a strengths-based, competency-based approach.

1. Program Rationale and Evidence Base

The program responds to the findings that indicated that cultural awareness, cultural skills, and organizational support were generally developing and that overall practice readiness was largely in the Competent/Emerging Adaptation range. Cultural Awareness/Knowledge correlated weakly but significantly with readiness. Cultural orientation was introduced as an early program focus. It is a contributing factor, not a predictor. The findings do not suggest clinical deficiencies of Filipino IENs. Rather, the findings support the need to assist nurses in localizing their current competence to U.S. health care systems, communication patterns, documentation, safety expectations, and workplace culture.

The program further integrates cultural competence with experiential learning, as cultural awareness had weak positive associations with clinical problem-solving, learning activities, and overall practice readiness, but was not significantly associated with confidence/skill performance

2. Program Goal and Objectives

The overall goal is to prepare Filipino IENs to practice safely, competently, confidently, and culturally responsively while supporting their integration into the U.S. nursing workforce. Specific objectives include improving cultural awareness, achieving at least 80% U.S.-specific knowledge proficiency, applying U.S. standards, completing 80 hours of supervised preceptorship, improving confidence and well-being, developing a Personal Professional Integration Plan (PPIP), and maintaining mentor/peer support through six months.

3. Three-Module Program Framework

The 12-week program is organized into three major modules:

- **Module 1 – Cultural Awareness and U.S. Healthcare Orientation (Weeks 1–3):** cultural humility, self-awareness, communication, autonomy, patient-centered care, bias awareness, and U.S. healthcare workflow.
- **Module 2 – Clinical Practice Readiness and Integration (Weeks 4–8):** EHR, documentation, patient safety, clinical reasoning, medication safety, scope of practice, legal/ethical practice, interprofessional communication, simulation, and supervised clinical practice.
- **Module 3 – Professional Integration and Wellbeing (Weeks 9–12):** self-confidence, assertiveness, professional identity, resilience, employment rights, discrimination awareness, career development, mentoring, ongoing support.

4. 12-Week Implementation

The weekly program progresses with baseline evaluation and cultural basis, clinical localization, and simulation. Confidence and resilience building continue with supervised clinical integration. The curriculum ends with professional integration and transition planning. Specific learning activities, clinical applications, outputs/assessments, and persons accountable for each week.

5. Preceptorship and Mentoring

Week 6-8 Preceptorship and Mentoring Weeks. A minimum of 80 hours of organized, supervised clinical/preceptorship experience. Preceptorship involves increasing patient assignments, direct observation, record review, drug safety observation, communication and clinical reasoning feedback, and documentation of competence. At completion, mentors are expected to give professional, relational, confidence-building, career and transition assistance for up to six months.

6. Personnel and Resources

Implementation Program Coordinator, Unit Leader/Supervisor, Clinical Educator or Preceptors, Mentored Pharmacist, Informatics Team, HR/Employee Support, Wellbeing Staff, Simulation Staff, Evaluation. Resources needed: Classrooms; simulation facilities; EHR training facilities; clinical units LMS; Clinical/simulation materials; Assessment tools; mentoring and wellbeing resources.

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7. Monitoring and Evaluation

The program is assessed by an integrated assessment matrix which includes cultural competence, practice readiness, clinical/system knowledge, clinical competency, EHR competency, drug safety, communication, confidence, wellness, professional integration, and retention. Assessments are at baseline, implementation, 12 weeks, and 6 months. Program Requirements: ≥80% knowledge competence; ≥90% medication safety performance with no significant errors; completion of critical safety skills; 80 hours of supervised practice; ≥85% retention at 6 months; results of the study are not program requirements.

8. Remediation and Organizational Support

Those participants who do not initially meet competency criteria are offered targeted remediation rather than being automatically labeled as unsuccessful. Interventions included: additional instruction, simulation, supervised practice, EHR coaching, medication-safety practice, communication coaching, mentoring, wellbeing referral, and PPIP revision. Program Responsibility: Organizational Support. Aspects of organizational support include structured onboarding, assignment of mentors and preceptors, regular feedback, workplace integration, communication support, workplace-rights orientation, wellbeing resources, escalation pathways, career support, and post-program mentoring.

9. Completion and Six-Month Follow-Up

The 12-week requirements completed: supervised clinical hours obtained; documentation of skills; critical safety competencies; US-specific knowledge assessment; cultural awareness portfolio; PPIP post-assessment; exit evaluation; Continuing Mentor/Peer support established.

Follow-up for 6 months will be performed on retention, professional integration, mentoring, wellness, career development, organizational support, and overall program effectiveness.

10. Expected Outputs and Outcomes

Cultural Awareness Portfolio includes expected CCAI and Casey-Fink Profile outputs: Demonstration of Clinical Competence, Evaluation of U.S. Specific Knowledge, EHR Competency, Evidence for Medication Safety, PPIP Wellbeing Assessment, Six-Month Follow-Up, Preceptor Review Report. They are designed to result in increased cultural awareness, practice preparation, U.S. specific knowledge, documentation and medication safety, clinical performance, professional development, transition aid, and retention.

11. Budget and Sustainability

The estimated budget is $ 29,920 for a batch of 10 participants or around $ 2,992 per participant (including 10% contingency). Sustainability is embedded within the program through integration into the institution's routine IEN onboarding and professional development program that includes a cadre of trained mentors/preceptors, annual review of the curriculum, updated simulation and LMS resources, annual budgeting, outcome tracking, support for alumni, and continuous quality improvement.

ENHANCED 12-WEEK TRANSITION PROGRAM FOR FILIPINO INTERNATIONALLY EDUCATED NURSES (IENs)

Enhancing Cultural Competence, U.S.-Specific Practice Readiness, Professional Integration, and Retention

Evidence-Informed Program Output based on the findings from the Study:

Cultural Competence and Practice Readiness of Filipino Internationally Educated Nurses in the U.S. Healthcare System: A Descriptive Comparative-Correlational Study

PROGRAM OVERVIEW

The Enhanced 12-Week Transition Program for Filipino Internationally Educated Nurses (IENs) is a planned transition program for newly employed Filipino IENs, or those who are within their first 12 months of practice in the United States. The program seeks to foster safe, culturally sensitive, U.S.-specific clinical practice and professional integration via a strengths-based, competency-based, experiential, mentored, and organization-supported approach.

It will be executed over 12 weeks, with a follow-up of professional integration and retention over 6 months. The curriculum has five primary components: cultural orientation, U.S.-specific clinical practice, and professional integration via a strengths-based, competency-based, experiential, mentored, and organization-supported approach. The program is 12 weeks and is followed by a six-month professional

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integration and retention follow-up. The program consists of five major components: cultural orientation, U.S.-specific clinical practice readiness, supervised preceptorship, professional integration, and wellbeing and retention support. A key requirement is the completion of at least 80 hours of organized supervised clinical/preceptorship experience during Weeks 6 – 8. The program progress is assessed by baseline assessment, formative and weekly monitoring, mid-program competence assessment, and Week 12 post-program assessment, with ongoing evaluation at six months. The expected deliverables are documented competence records, Cultural Awareness Portfolio, preceptor evaluation, Personal Professional Integration Plan (PPIP), post-program assessment findings, and a six-month follow-up report.

PROGRAM RATIONALE AND EVIDENCE BASE

The program was designed based on the research results of 101 globally trained Filipino nurses. Results showed cultural competence was typically emerging, and practice readiness was largely in the Competent/Emerging Adaptation category. Importantly, the data do not support clinical characterization of Filipino IENs as inadequate. The curriculum is not designed to train nurses in new competence, but to adapt current competence to U.S. systems, communication patterns, documentation practices, safety requirements, and workplace culture.

Table 7: Evidence-to-Program Alignment

Study Finding	Program Need	Program Response
Cultural Awareness and Knowledge was developing (M=31.81, SD=6.22); 58.42% were developing and 40.59% high	Early transition requires deliberate cultural orientation	Cultural humility, bias awareness, autonomy, U.S. communication, patient-centered care, and reflective activities
Cultural Skills were developing (M=31.06, SD=6.27)	Cultural knowledge needs to be translated into observable practice	Role-play, simulation, clinical application, feedback, and interprofessional communication
Organizational Support was developing (M=30.31, SD=5.99), with variability in perceived support	Transition support should be structured rather than dependent on informal workplace learning.	Formal mentor/preceptor assignment, onboarding pathway, feedback schedule, referral and escalation mechanisms
Overall Practice Readiness was M=74.10 (SD=8.70); 63.37% were Competent/Emerging Adaptation	Most participants require refinement and integration rather than basic nursing remediation.	U.S.-specific EHR, safety, clinical reasoning, medication, legal/ethical, and workflow training
Clinical Problem-Solving was M=18.06; 54.46% were Proficient/Globally Ready.	Existing clinical strengths should be retained while decision-making is localized	Case-based reasoning, simulation, prioritization, escalation, and supervised practice
Years in current position and current position/employment status were associated with readiness.	Experience within the U.S. system contributes to readiness	Protected preceptorship, progressive responsibility, mentor contact, and structured feedback
CAKnow had weak positive associations with Clinical Problem-Solving (ρ=.242), Learning Activities (ρ=.229), and Practice Readiness (ρ=.222)	Cultural awareness should be integrated with experiential learning	Early cultural orientation followed by simulation, preceptorship, reflection, and feedback
CAKnow was not significantly associated with Confidence/Skill Performance (ρ=.015)	Cultural orientation alone is insufficient for confidence and skill development.	Experiential learning, supervised practice, mentoring, assertiveness training, and organizational support

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Transition stress and workplace/social connection are important integration concerns.	Retention requires more than clinical competence.	Wellbeing support, resilience, workplace-rights orientation, peer support, career planning, and alumni linkage

Statistically, CAKnow was favorably linked with Clinical Problem-Solving, Learning Activities, and overall Practice Readiness, but not with Confidence/Skill Performance at a weak but significant level. The program thus deliberately blends cultural orientation, hands-on experience, and organizational support, rather than relying on cultural competency as the main predictor of preparation.

PROGRAM GOAL AND OBJECTIVES

General Goal

The program's aim is to prepare Filipino IENs to practice in a safe, competent, confident, and culturally responsive manner, enabling them to successfully integrate into the U.S. nursing workforce.

Specific Objectives

By the end of the 12-week program, participants will be able to:

[1]. Demonstrate improved cultural awareness and knowledge through pre- and post-program assessment.
[2]. Demonstrate at least 80% proficiency on a U.S.-specific clinical and healthcare-systems knowledge assessment.
[3]. Apply U.S.-specific standards in documentation, medication safety, patient autonomy, communication, scope of practice, and safety reporting.
[4]. Complete at least 80 hours of supervised clinical/preceptorship experience with documented competency feedback.
[5]. Demonstrate improvement in confidence related to clinical role performance and patient assignment management.
[6]. Develop a Personal Professional Integration Plan (PPIP) covering career goals, mentoring, professional development, support systems, and self-care.
[7]. Demonstrate measurable improvement in transition wellbeing using an institution-approved validated measure.
[8]. Maintain connection with a mentor or peer-support mechanism after program completion and participate in six-month retention monitoring.

These objectives retain the original program's measurable outcomes while avoiding claims that are unsupported by the study.

PROGRAM FRAMEWORK

The program integrates the study's cultural competence dimensions—Awareness/Knowledge, Skills, and Organizational Support—with a developmental view of competence and the Casey-Fink practice-readiness domains used in the study. The progression is:

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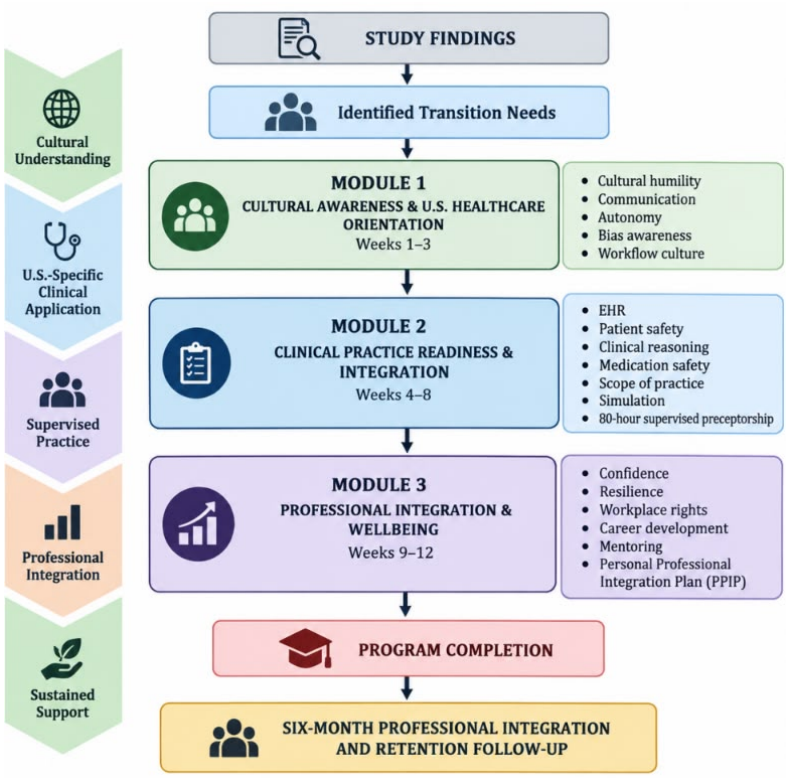

Figure 1.

The three-module framework is directly consistent with the original program structure.

12-WEEK PROGRAM IMPLEMENTATION PLAN

This table should replace the separate detailed weekly sections in the original document. It contains the information needed for implementation without repeating the same information in several places.

Table 8: 12-Week Program Implementation Plan

Week	Learning Focus	Key Activities	Clinical/Application	Output/Assessment	Lead
1	Program Orientation & Baseline Assessment	Program briefing; CCAI; Casey-Fink; transition expectations	Individual transition-needs mapping	Baseline cultural competence/readiness profile	Program Coordinator, Cultural Educator
2	Cultural Humility & Self-Awareness	Bias-awareness activities; reflective journaling; guided discussion	Culture-related communication cases	Reflection journal; bias-awareness worksheet	Cultural Educator, Mentor
3	U.S. Communication, Autonomy & Workflow Culture	Communication micro-lectures; Filipino–U.S. scenarios; autonomy cases	Handoff, patient teaching, assertive communication	Cultural Awareness Portfolio	Educator, Preceptor

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4	U.S. Clinical Systems & Patient Safety	EHR orientation; documentation; safety reporting; delegation	EHR/documentation simulation	Documentation competency checklist	Clinical Educator, Informatics Staff
5	Clinical Reasoning Under U.S. Standards	Case-based reasoning; simulation; debriefing	Prioritization, escalation, clinical judgment	Simulation performance rubric	Clinical Educator, Simulation Team
6	Medication Safety & Scope of Practice	Medication reconciliation; error prevention; legal/ethical practice	Medication administration and safety simulation	Medication Safety Checklist	Pharmacist, Educator, Preceptor
7	Interprofessional Communication	SBAR; closed-loop communication; conflict/feedback practice	Interprofessional simulation	Communication rubric	Interprofessional Team, Preceptor
8	Supervised Preceptorship Consolidation	Guided clinical practice; reflection	Progressive patient assignments under supervision	Preceptor evaluation; competency checklist	Preceptor, Unit Leader
9	Confidence, Assertiveness & Professional Identity	Assertiveness workshop; role-play; feedback	Workplace communication scenarios	Confidence assessment	Mentor, Educator
10	Transition Stress, Resilience & Workplace Rights	Wellness; resilience; discrimination awareness	Support and escalation pathway mapping	Wellbeing assessment; personal support map	HR, Wellbeing Staff, Mentor
11	Career Development & Professional Integration	Career planning; continuing education; leadership opportunities	Mentor conference	Draft PPIP	Mentor, Nurse Leader
12	Program Consolidation & Sustained Support	Post-tests; portfolio presentation; peer debrief; alumni linkage	Final competency review and transition planning	Final PPIP; post-assessment; exit evaluation	Program Coordinator, Evaluator

The weekly content, activities, facilitators, and outputs are based on the original program's 12-week plan.

Module 1: Cultural Awareness and U.S. Healthcare Orientation

Weeks 1–3

This module establishes the cultural and professional foundation of the program. It addresses cultural humility, self-awareness, communication, patient

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autonomy, patient-centered care, bias awareness, and U.S. healthcare workflow.

The emphasis is not on replacing Filipino professional identity but on helping participants recognize differences in expectations and adapt appropriately to the U.S. healthcare environment.

Major outputs:

- Baseline CCAI and Casey-Fink profile
- Individual transition-needs map
- Reflection journal
- Cultural Awareness Portfolio

The need for this module is supported by the study's finding that CAKnow was developing and showed weak positive relationships with several readiness-related domains.

Module 2: Clinical Practice Readiness and Integration

Weeks 4–8

This module translates existing nursing competence into U.S.-specific practice. It focuses on EHR use, documentation, safety reporting, clinical reasoning, medication safety, scope of practice, legal/ethical practice, interprofessional communication, and supervised clinical practice.

The program intentionally adopts a **strengths-based approach** because overall readiness was relatively strong and many participants were already in the Competent/Emerging Adaptation range.

Major outputs:

- EHR competency checklist
- Clinical reasoning/simulation assessment
- Medication safety checklist
- Communication rubric
- Clinical Competency Checklist
- Preceptor evaluation

Module 3: Professional Integration and Wellbeing

Weeks 9–12

This module extends transition beyond technical competence. It addresses confidence, assertiveness, professional identity, transition stress, resilience, workplace rights, discrimination awareness, career development, mentoring, and long-term professional support.

This component is especially noteworthy given that this study discovered a significant association between CAKnow and Confidence/Skill Performance. Therefore, Confidence and integration into the profession have to be cultivated not just by cultural education but also by experiential learning, mentorship, organizational support, and continual workplace participation.

Major outputs:

- Confidence assessment
- Personal support map
- Personal Professional Integration Plan
- Mentor continuity plan
- Final program assessment

PRECEPTORSHIP AND MENTORING SYSTEM

A. Supervised Preceptorship

Participants will complete a minimum of 80 hours of structured supervised clinical/preceptorship experience in Weeks 6-8.

The 80 hours should not be construed to mean that they occur only in Week 8. These are the total minimum supervised clinical hours required during the specified preceptorship period.

Preceptorship includes:

- Progressive patient assignments
- Direct observation and supervision
- U.S.-specific workflow application
- Documentation review
- Medication-safety observation
- Communication feedback
- Clinical reasoning feedback
- Daily/regular competency documentation
- Final preceptor evaluation

The 80-hour requirement is a program implementation standard, not a statistical finding of the thesis.

B. Mentoring

Mentors provide:

- Weekly professional support
- Confidence-building

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- Reflection and transition conversations and discussions
- Support with workplace communication
- Career-development guidance
- PPIP development
- Assistance during transition difficulties
- Continuity for up to six months after completion

The mentor and preceptor roles should be separate. The preceptor is primarily responsible for assessing clinical performance and the mentor for providing professional, relational, and transition support.

PROGRAM PERSONNEL AND RESOURCES

Table 9: Personnel Responsibilities

Personnel	Primary Responsibility
Program Coordinator	Overall coordination, scheduling, documentation, communication, evaluation
Cultural Educator	Cultural humility, communication, autonomy, bias-awareness training
Clinical Educator	Simulation, clinical skills, competency assessment, remediation
Preceptor	Supervised clinical practice, feedback, competency documentation
Mentor	Professional and psychosocial support, confidence-building, PPIP
Unit Leader/Supervisor	Performance review, unit integration, escalation
Pharmacist	Medication safety and medication-related education
Informatics Staff	EHR training and documentation competency
Simulation Team	Simulation setup, facilitation, and debriefing
HR/Employee Support	Workplace rights, discrimination concerns, retention, and organizational support
Wellbeing Staff	Wellbeing assessment, resilience, stress-management support
Evaluator	Program-level evaluation and reporting

These roles are based on the personnel structure in the original program.

Table 10: Required Resources

Category	Required Resources
Facilities	Classroom, simulation laboratory, EHR training environment, clinical unit, LMS
Clinical Materials	Simulation supplies, mock medications, PPE, IV supplies
Learning Materials	Manuals, case studies, worksheets, communication scripts
Assessment	CCAI, Casey-Fink, knowledge assessment, competency checklists, wellbeing measure
Documentation	Reflection journals, Cultural Awareness Portfolio, PPIP
Support	Mentor/preceptor system, HR resources, wellbeing resources
Technology	EHR sandbox/training environment, LMS

The original program identifies these facilities and materials as necessary for implementation.

MONITORING AND EVALUATION (Target Outcomes)

The evaluation should be presented in **one consolidated matrix**, rather than having separate lengthy sections for baseline, formative, mid-program, post-test, feedback, and follow-up.

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Table 11: Program Monitoring and Evaluation Matrix

Outcome	Indicator/Instrument	Timing	Target/Success Criterion	Response if Not Met
Cultural competence	CCAI	Weeks 1 & 12	Improvement from baseline	Cultural coaching; targeted reflection; mentoring
Practice readiness	Casey-Fink Readiness Survey	Weeks 1 & 12	Improvement/no decline in critical domains	Additional supervised practice; simulation
Clinical/system knowledge	U.S.-specific knowledge assessment	Weeks 4 & 12	≥80%	Remediation and retesting
Clinical competency	Clinical Competency Checklist	Weeks 5–8	100% of critical safety items completed	Additional supervision/simulation
EHR competency	EHR Documentation Checklist	Week 4	100% accuracy on critical items	Repeat EHR simulation/coaching
Medication safety	Medication Safety Checklist	Week 6	≥90%; no critical errors	Repeat simulation and supervised medication practice
Communication	SBAR/closed-loop rubric	Week 7	Meets competency level	Communication drills/coaching
Confidence	Confidence/Skill Performance Scale	Weeks 1, 8 & 12	Improvement from baseline	Additional simulation/assertiveness coaching
Wellbeing	Validated wellbeing measure	Weeks 1 & 12	Measurable improvement; ≥20% reduction only where instrument/scoring supports this interpretation	Wellbeing referral and resilience coaching
Professional integration	PPIP review	Weeks 11–12	100% completed PPIP	Additional mentoring/revision
Retention	HR retention follow-up	6 months	≥85% program benchmark	Follow-up support/alumni mentoring

The measures and timings of the original program form the basis of the evaluation matrix.

Important distinction

The following are **program standards,** not findings of the thesis:

- ≥80% knowledge proficiency
- ≥90% medication-safety performance
- 100% completion of critical safety competencies
- ≥80 supervised preceptorship hours
- ≥20% stress reduction where the instrument permits such interpretation
- ≥85% six-month retention

The original program calls these thresholds evidence-informed program standards, not study findings.

Key Performance Indicators

<u>KPI Category 1 – Development of cultural competency</u>

- Improvement in Cultural Awareness : ≥20% increase in CCAI Cultural Awareness scores from baseline to Week 12.
- Cultural Skills Application: ≥ 80% demonstration of culturally responsive

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communication in simulation and supervised practice.
- Cultural Humility Engagement: 100% completion of Cultural Awareness Portfolio with reflective entries.

KPI Category 2 – U.S. Specific Practice Readiness

- Knowledge proficiency: ≥80% on assessment of US-specific knowledge (documentation, workflow, safety, communication).
- EHR Competency: 100% completion of EHR training modules and ≥90% accuracy on EHR competency check.
- Medication safety performance: ≥90% medication safety performance – zero critical errors
- Critical Safety Competencies: 100% completion of required safety competencies (falls, infection control, high alert meds).

KPI Category 3: Clinical Integration & Performance

- Supervised Clinical Hours – Minimum of 80 Hours to be completed during Weeks 6-8.
- Clinical Reasoning Performance: ≥80% competency on case-based reasoning and simulation scenarios.
- Communication & Interprofessional Collaboration: ≥80% rating on preceptor evaluation of communication clarity, SBAR utilization, and teamwork.

KPI Category 4: Professional Integration & Wellbeing

- Confidence Improvement >15% increase in Casey-Fink confidence measures from baseline to Week 12.
- Professional Identity Development: 100% PPIP (Personal Professional Integration Plan) completed.
- Wellbeing & Resilience: Week 12 evaluation: ≥80% positive wellbeing rating.

KPI Category 5: Program Retention/Completion

- Completion Rate: 95% or more of Week 12 requirements.
- Six-Month Retention: ≥85% of Filipino IENs retained at 6-month follow-up
- Mentoring Engagement:>90% participation in mentor check-ins for 6 months post-program period.
- KPI Category 6: Organizational Support & Sustainability
- Quality of Preceptor/Mentor Feedback — ≥80% satisfaction rating from preceptors and mentors on program structure and support.
- Participant Satisfaction: Satisfaction rate of exit evaluation ≥85%.
- Program Sustainability: Completed annual curriculum review, maintained mentor pool at 90%+ staffing

IMPLEMENTATION AND SUPPORT FLOW

The detailed procedure parts of the original program can be summarized in the following figure.

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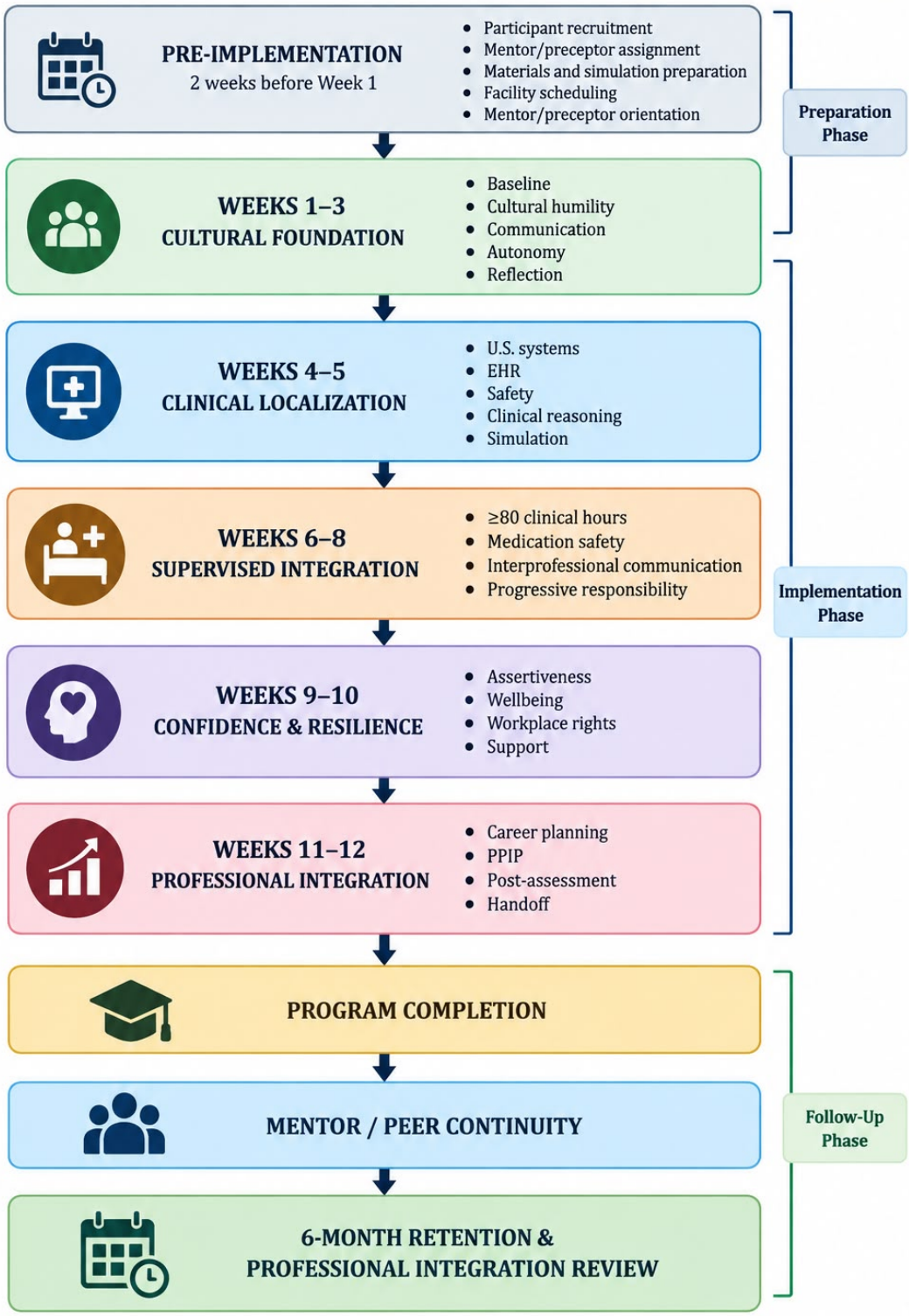

Fig.2: Program Implementation Flow

This summarizes the original implementation techniques and flow, but keeps all the important steps.

REMEDIATION AND SUPPORT MECHANISM

Participants who do not meet the required standards of competence should not be automatically marked as unsuccessful. The program should offer a systematic, structured path to remediation.

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Table 12: Remediation Pathway

Identified Concern	Initial Intervention	If Concern Persists
Knowledge deficit	Review module and retest	Additional U.S.-specific instruction
Clinical skill deficit	Repeat simulation	Additional supervised practice
EHR/documentation deficit	Repeat EHR simulation	One-to-one informatics coaching
Medication-safety concern	Repeat medication simulation	Additional supervised medication practice
Communication difficulty	Communication drills	Mentor/educator coaching
Confidence concern	Simulation and assertiveness coaching	Extended mentoring
Transition stress	Wellbeing consultation and resilience activities	Referral to appropriate support services
Professional integration concern	Mentor conference	PPIP revision and nurse-leader support

The original program includes additional simulation, 40–80 hours of extended preceptorship, one-to-one coaching, repeated evaluations, and referral to HR, wellness professionals, or nurse leaders when challenges arise.

ORGANIZATIONAL SUPPORT AND PROFESSIONAL INTEGRATION

A major improvement in the revised program is that support from the organization is viewed as a responsibility of the program rather than the individual participant. **The study reported Organizational Support development (M=30.31, SD=5.99)** with variability in perceived support. The program thus creates formalized mechanisms for onboarding, supervision, communication, and integration into the workplace.

Table 13: Organizational Support Mechanisms

Mechanism	Program Action
Structured onboarding	Standardized IEN onboarding checklist
Mentor assignment	Mentor assigned at program initiation
Preceptor assignment	Preceptor assigned before clinical integration
Feedback	Weekly mentor feedback and structured preceptor feedback
Workplace integration	Unit introduction, team participation, peer support
Communication support	SBAR, closed-loop communication, conflict-management coaching
Workplace rights	HR orientation and reporting pathways
Wellbeing	Access to wellbeing and stress-management resources
Escalation	Clearly defined clinical, safety, communication, and workplace pathways
Career integration	Nurse-leader and mentor support for career planning
Post-program support	Alumni/mentor linkage and six-month follow-up

The original model included particularly structured onboarding, mentor/preceptor referral, workplace integration, communication support, supervisor input assignment pathways, and organizational responsibility.

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PROGRAM COMPLETION CRITERIA

The following must be recorded before completion of the program: Completion of the 12-week program requirements.

[1]. Completion of criteria for the 12-week program.
[2]. Completion of a minimum of 80 hours of supervised clinical/preceptorship experience.
[3]. Completion of required U.S.-specific knowledge assessment.
[4]. Completion of critical safety competencies.
[5]. Completion of the Cultural Awareness Portfolio.
[6]. Completion of the PPIP.
[7]. Completion of Week 12 post-program assessments.
[8]. Participation in the exit evaluation.
[9]. Establishment of a continuing mentor/peer-support pathway.

Completion should not be interpreted as replacing state licensure, credentialing, institutional onboarding, scope-of-practice requirements, or other regulatory requirements.

SIX-MONTH FOLLOW-UP

The program does not end at Week 12. A six-month follow-up should determine whether transition gains are sustained.

Table 14: Six-Month Follow-Up

Area	Follow-Up Activity
Retention	Verify employment status
Professional integration	Assess workplace adjustment and role integration.
Mentoring	Mentor follow-up
Wellbeing	Reassess transition/wellbeing concerns
Career development	Review and update PPIP.
Organizational support	HR/supervisor review
Program effectiveness	Consolidate retention and integration findings.

The original program specifies retention checking, professional integration assessment, mentor follow-up, and HR review at six months.

EXPECTED PROGRAM OUTPUTS AND OUTCOMES

Table 15: Expected Outputs and Outcomes

Expected Outputs	Expected Short-/Intermediate Outcomes
Baseline and post-program CCAI profile	Improved cultural awareness
Baseline and post-program Casey-Fink profile	Improved practice readiness
Cultural Awareness Portfolio	Better understanding of U.S. healthcare expectations
Reflection records	Greater reflective practice
Clinical Competency Checklist	Documented clinical competency
U.S.-specific knowledge assessment	Improved U.S.-specific knowledge
EHR competency evidence	Safer documentation
Medication-safety evidence	Safer medication practice
Preceptor evaluation	Improved supervised clinical performance
PPIP	Clear professional development pathway
Wellbeing assessment	Improved transition support

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Six-month follow-up report	Evidence of retention and professional integration

The original program identifies these same outputs, including CCAI, Casey-Fink, portfolio, competency documentation, PPIP, wellbeing assessment, and six-month follow-up.

PROGRAM BUDGET

Assumption: The budget is presented for a 10-participant batch, consistent with the original budget document. Costs are estimates and should be replaced with actual institutional costs before implementation.

Program Budget

Budget Category	Estimated Cost
Facilitator/Educator Fees	$6,000
Preceptor/Mentor Support	$8,000
Simulation Laboratory Use	$4,500
Simulation Supplies	$2,000
EHR Training and Access	$1,200
Instructional Materials	$1,000
Printing and Documentation	$300
Assessment Materials	$500
Online Learning Platform	$1,500
Certificates and Recognition	$200
Administrative Costs	$2,000
Subtotal	**$27,200**
Contingency (10%)	**$2,720**

SUSTAINABILITY PLAN

The program should be integrated into the institution's regular IEN onboarding and professional-development system rather than implemented as a one-time project.

Table 16: Sustainability Strategies

Area	Sustainability Action
Institutional	Integrate program into standard IEN onboarding.
Human Resources	Maintain a trained mentor/preceptor pool.
Curriculum	Conduct annual curriculum review
Simulation	Update clinical scenarios regularly.
Technology	Maintain EHR training and LMS resources.
Financial	Establish an annual program budget.
Data	Track CCAI, readiness, competency, integration, and retention outcomes
Professional Support	Maintain alumni and peer-support networks
Quality Improvement	Use evaluation findings to revise the program annually.

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The original sustainability plan provides recommendations for institutional integration yearly.

PROGRAM GOVERNANCE

The Program Coordinator should serve as the primary point of both responsibility and accountability.

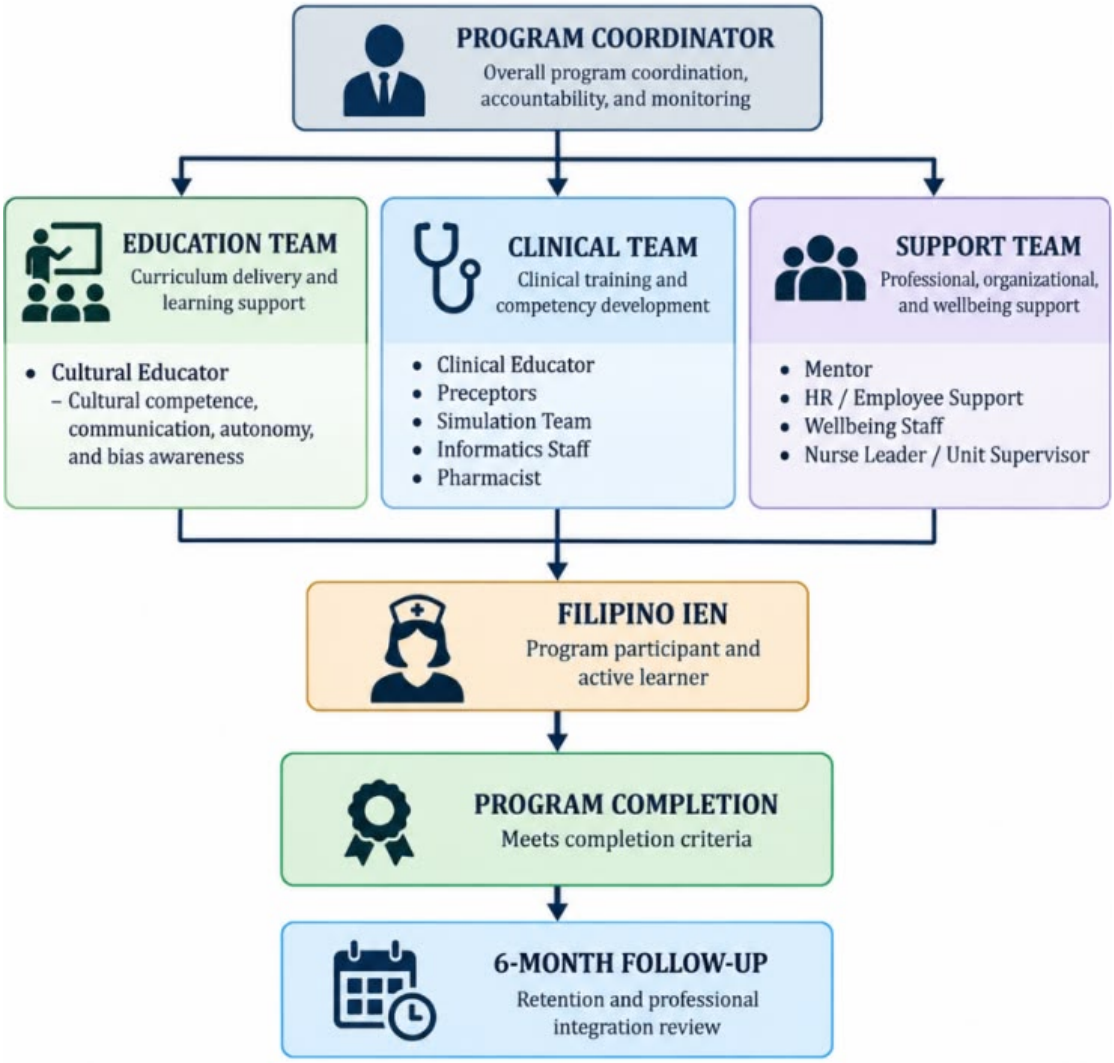

Fig.3: Program Governance Structure

This structure clarifies accountability without requiring separate lengthy sections for every personnel group.

PROGRAM IMPLEMENTATION CONDITIONS

This program is a proposal for implementation. It should be adapted to:

- relevant state nursing regulations;
- institutional policies;
- scope-of-practice requirements;
- certification and licensing standards;
- institutional EHR procedures;
- medication-administration policies;
- patient-safety procedures;
- approved assessment instruments;
- available simulation resources; and
- actual institutional staffing and budget.

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The original program explicitly states that its empirical findings come from the thesis while the program itself is an implementation proposal that must be adapted to applicable regulations, institutional policies, scope-of-practice requirements, and validated instruments.

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