IMPROVING LEVELS OF CULTURAL COMPETENCE FOR HEALTHCARE STAFF CARING FOR LATINO PATIENTS

by

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GRADUATE COLLEGE

As members of the DNP Project Committee, we certify that we have read the DNP project prepared by Audrey Goh, titled Improving Levels of Cultural Competence for Healthcare Staff Caring for Latino Patients and recommend that it be accepted as fulfilling the DNP project requirement for the Degree of Doctor of Nursing Practice.

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DEDICATION

To God, everything I have accomplished and will accomplish is due to you. All honor goes to you; may you be glorified now and forever.

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ABSTRACT

Purpose: The purpose of this quality improvement project was to increase healthcare staff's cultural awareness, knowledge, skills, and desire pertinent to Latino populations.

Background: Increasing diversity of the United States population places critical importance on healthcare providers to provide culturally competent care. Patient-provider barriers, including language, nonverbal and verbal communication, and basic cultural knowledge, can diminish the efficiency and efficacy of patient treatment. Establishing cultural competence in healthcare clinic staff can improve patient interaction and outcomes; specifically, cultural competence has been noted to improve patient treatment adherence and reduce health disparities.

Framework and Methods: This educational quality improvement project employed a pre-post-test design. The project design and process were informed by the Plan-Do-Study-Act cycle and involved healthcare providers at an outpatient pediatric clinic in Gilbert, AZ. Voluntary participation in a synchronous educational session was delivered by PowerPoint training during a monthly staff meeting. Project outcomes were measured with a Likert-based pre- and post-survey incorporating components from Seeleman's framework for cultural competency. Survey data was collected and analyzed to determine changes in staff cultural competence.

Results: Aggregate comparative and descriptive analysis of pretest and posttest scores found increases in minimum, maximum, and mean overall cultural competency scores of participants (n=6). All measured components had increased comparative scores.

Conclusion: Educational training for healthcare providers can increase levels of basic cultural competency. Increasing overall cultural competence of healthcare staff may require more intermittent education sessions. Recommendations for maintaining culturally relevant care by

staff may include policies for initial and continued clinic-informed cultural competency. Data collection was limited to collection from the single clinic site. However, project findings can improve the quality of care delivered at the clinic and provide implications for future research. As healthcare providers and staff gain a foundation of cultural competence through education, they may be empowered to provide culturally informed quality patient care regionally, nationally, and globally.

INTRODUCTION

The population in the United States (US) is increasingly becoming diverse. Since 2010, 96% of all US counties registered declines in their white population shares (Frey, 2017). The increasing diversity of the national population places particular importance on healthcare providers to provide culturally competent care. Patient-provider barriers, including language, nonverbal and verbal communication, and basic cultural knowledge, can diminish the efficiency and efficacy of patient treatment (Brooks et al., 2019). Establishing cultural competence in healthcare clinic staff and providers, can improve the quality of patient interaction and patient outcomes; expressly, cultural competence has improved patient treatment adherence and reduces health disparities (Henderson et al., 2018).

Background Knowledge and Significance

Within an organization, cultural competence integrates knowledge about individuals and groups of people transformed into specific standards, policies, practices, and attitudes (Centers for Disease Control and Prevention [CDC], 2020). These standards are then applied in appropriate cultural settings to increase the quality of services. Cultural competence can be classified into six components: cultural awareness, cultural knowledge, cultural skills, cultural encounters, cultural desire, and cultural empathy (CDC, 2020). Although encounters are learned based on face-to-face interaction and cannot be taught, an educational implementation can target the other five components (Henderson et al., 2018).

Healthcare providers have implicit biases towards ethnic minority patients, regardless of intent; these implicit biases can negatively impact patient outcomes and sustain health disparities (Wheeler & Bryant, 2017). A health disparity is identified as a higher burden of an adverse

health determinant or outcome (Wheeler & Bryant, 2017). Patients subject to provider bias experience more shame and embarrassment that leads to avoidance of medical care and therefore promotes health disparities (Flynn et al., 2020).

As part of the goal to improve health in the US, government objectives highlight the importance of addressing social determinants of health and providing culturally and linguistically appropriate services (CLAS) standards within the community, local, and national organizations (Office of Disease Prevention and Health Promotion [ODPHP], n.d.). The social determinants of health and CLAS standards identified a need to promote health equity with objectives that can be addressed by improving cultural competence for healthcare professionals (ODPHP, n.d.; United States Department of Health and Human Services [USDHHS], n.d.). Cultural competence training aims to improve the quality of health care and reduce health disparities by improving communication and trust between patients and healthcare providers, thereby enhancing provider knowledge about socio-cultural factors linked to health beliefs, practices, and utilization of services (Henderson et al., 2018). Providers who completed cultural competence training reported improvements in cultural skills, attitudes, awareness, and knowledge (Govere & Govere, 2016).

Although cultural competence is presently taught in healthcare professional education programs, the formal integration of cultural competence teaching only began in the 1990s (Thackrah & Thompson, 2013). As a result, a considerable number of experienced and actively practicing healthcare providers were not provided formal education on cultural competence. Additionally, cultural competence is a lifelong process, so efforts to initiate or bolster learning are essential to the process of developing cultural competence (Watt et al., 2016).

Local Problem

Large metropolitan areas have historically been the nexus of minority settlement in the US, serving as destinations for immigrants, black migration to urban areas, and, more recently, for Latino and Asian Americans. In Arizona, the Latino ethnic population was 31.7% in 2019 (United States Census Bureau, n.d.). Latino populations in the US are disproportionately affected by the social determinants of health, resulting in high incidences of cardiovascular disease, diabetes, cancer, and liver disease (Velasco-Mondragon et al., 2016). Educational background, English proficiency, and cultural background lead to further health inequities (Velasco-Mondrago et al., 2016). Cultural and linguistic differences are also highlighted as significant contributors to health disparities (Alizadeh & Chavan, 2016). Therefore, given the prominence of the Latino population in Arizona, focusing on the cultural competence of primary care providers (PCPs) and staff is necessary to improve health equity and reduce the prevalence of health disparities for Latino patients.

Intended Improvement

Project Purpose

This project aims to improve cultural competency levels, specific to Latino populations, of healthcare providers and staff. Improved cultural competency of healthcare professionals who encounter Latino patients aims to improve patient outcomes and the patient-centered nature of care that reduces health disparities (Watt et al., 2016).

Project Question

In an outpatient clinic setting caring for Latino patients (P), do providers and staff who undergo cultural competency training (I) improve cultural competency scores (O) compared to no training (C)?

Project Objectives

The projected implementation method utilizes an in-person synchronous educational training adapted from national CLAS standards completed over the course of two weeks. Evaluation was determined by participant completion of a pre-/post-peer-reviewed cultural assessment survey. The survey instrument consisted of 20 questions, including five demographic questions and 20 questions assessing four components of cultural competency. Responses to the cultural competency questions were presented on a five-point Likert scale, ranging from strongly disagree =1 to strongly agree=5). Assessment of cultural competency scores and future implications were based on survey results. The first objective was to improve cultural competency scores of healthcare providers and staff in the outpatient clinic setting from baseline (pre-training) to post-training. A second objective was to increase healthcare staff intent to integrate culturally congruent practices into care from baseline to post-training. Lastly, the third objective was to utilize participant feedback to improve training modules for future application by outpatient clinics.

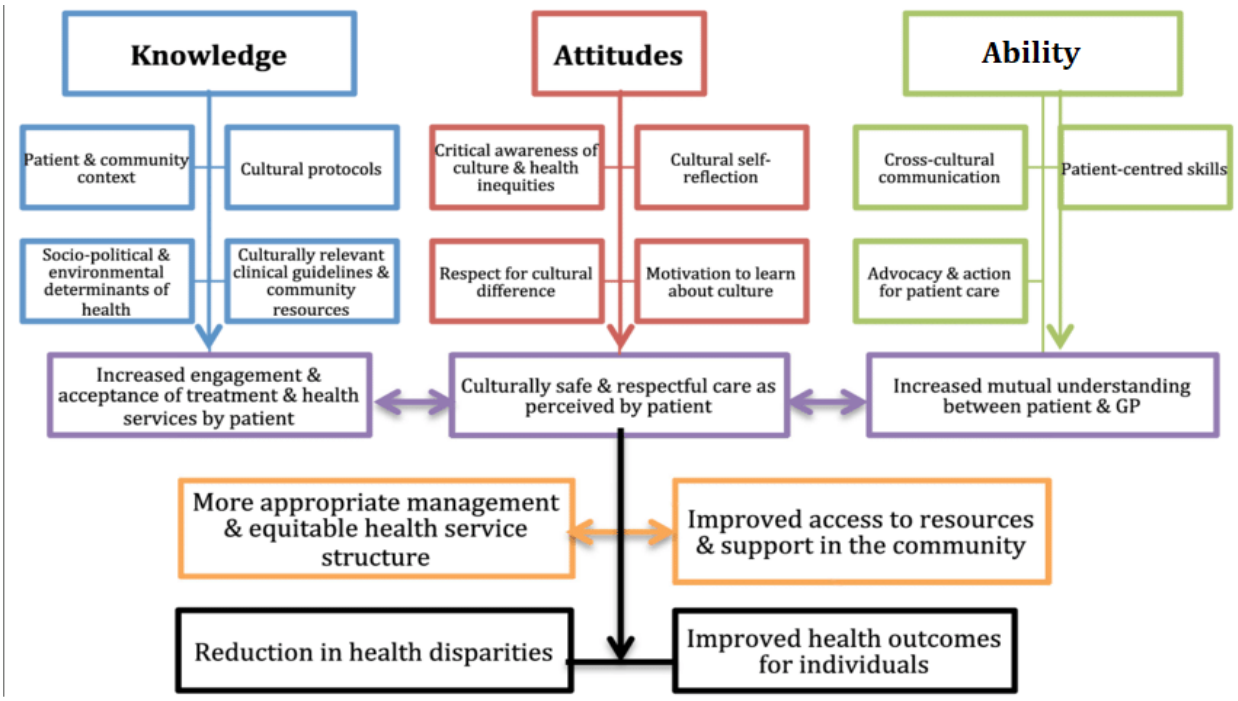
Theoretical Framework

Seeleman's Framework of Cultural Competence

The guiding theoretical framework for this project was Seeleman's framework of cultural competence (Figure 1). The framework, in general, identifies cultural competence as an essential practice in medicine and regards "culture" beyond just ethnicity (Seeleman et al., 2009).

Figure 1

Model of Seeleman's Framework of Cultural Competence



(Adapted from Abbott, P., n.d.)

This framework establishes three subsets of cultural competency: knowledge, awareness, and ability (Seeleman et al., 2009). *Knowledge* refers to a healthcare clinician's factual comprehension of differences and nuances in epidemiology and treatment for ethnic groups (Seeleman et al., 2009). *Awareness* and *Ability* incorporate both external and internal

considerations; *Awareness* refers to clinicians' self-awareness of their prejudices and bias in addition to the acknowledgment of the social contexts of ethnic groups and how culture affects thinking and behavior in the groups (Seeleman et al., 2009). *Ability* refers to a clinician's ability to adapt and respond appropriately to diverse situations and effectively communicate information to and with the patient—using an interpreter as needed (Seeleman et al., 2009). Seeleman's framework maintains that cultural competency in these three areas can provide more timely, effective, and culturally appropriate care (2009).

Clinical judgment plays a significant role in the effectiveness of patient care. Poor competency in one or all these areas can lead to inadequate provision of care or an inappropriate diagnosis (Seeleman et al., 2009). Decreased knowledge or bias can lead to a clinician's lack of regard or clinical uncertainty, diminishing the overall standard of care (Seeleman et al., 2009). In contrast, knowledgeable clinicians understand different disease incidences in ethnic groups, resulting in a more timely and appropriate diagnosis (Seeleman et al., 2009). Paternotte et al. (2016) explored the impact of cultural competence on healthcare provider communication and found that a standard healthcare clinician at baseline can utilize generalized skills of adaptation and communication. Therefore, individual clinician behaviors that promote effective patient-centered care can improve by increasing cultural competence. However, lack of awareness can be a barrier to providing patient-centered communication (Derrington et al., 2018). An inability or unwillingness to achieve patient-centered communication can also result in a lack of depth in information transfer and collaboration between clinicians and patients (Rothlind et al., 2018). These studies, in addition to others incorporating Seeleman's framework of cultural competence, found evidence supporting the need to incorporate cultural competence training for healthcare

clinicians to not only increase cultural competence scores but an intent to become culturally competent (Paternotte et al., 2016; Sorensen et al., 2019).

For this project, application of Seeleman's framework of cultural competence and findings from previous studies were incorporated to focus the educational training on increasing Latino culture knowledge, awareness, and clinician ability. Information relevant to the Latino population, such as epidemiology and cultural effects on behavior, was presented with the intent to strengthen healthcare clinicians' foundational clinical skills and judgment. Incorporating self-reflection within the educational training was expected to allow clinicians to establish awareness and confront prejudice and bias, which can impede effective communication. An educational training was used for clinicians to equip them with the ability to adapt and respond to diverse situations—a trait expected to strengthen through continued practice. Thus, the use of a cultural competence educational training guided by Seeleman's cultural competence framework was expected to promote effective patient care for Latino patients and other diverse populations.

Literature Synthesis

Evidence Search

A literature search for peer-reviewed articles on cultural competence in the outpatient clinic was conducted in the following search databases: PubMed, EndNote, Medline, Google Scholar, and Cochrane. MeSH search terms used to locate articles included: "cultural competence," "cultural competency training," "Latino Americans," and "diversity," combined with keywords "outpatient" and "online." Inclusion criteria for articles included publication date within five years (2016-2021), English language, human subjects, and full-text availability. The initial search yielded 186 articles (Figure 2). Research completed in non-Western countries was

excluded due to differences in relevance and applicability of cultural competence training. Further inclusion criteria including applicability to the outpatient clinic or healthcare setting and focus on ethnic cultural diversity. A total of 17 articles were selected for final appraisal (Figure 2).

Comprehensive Appraisal of Evidence

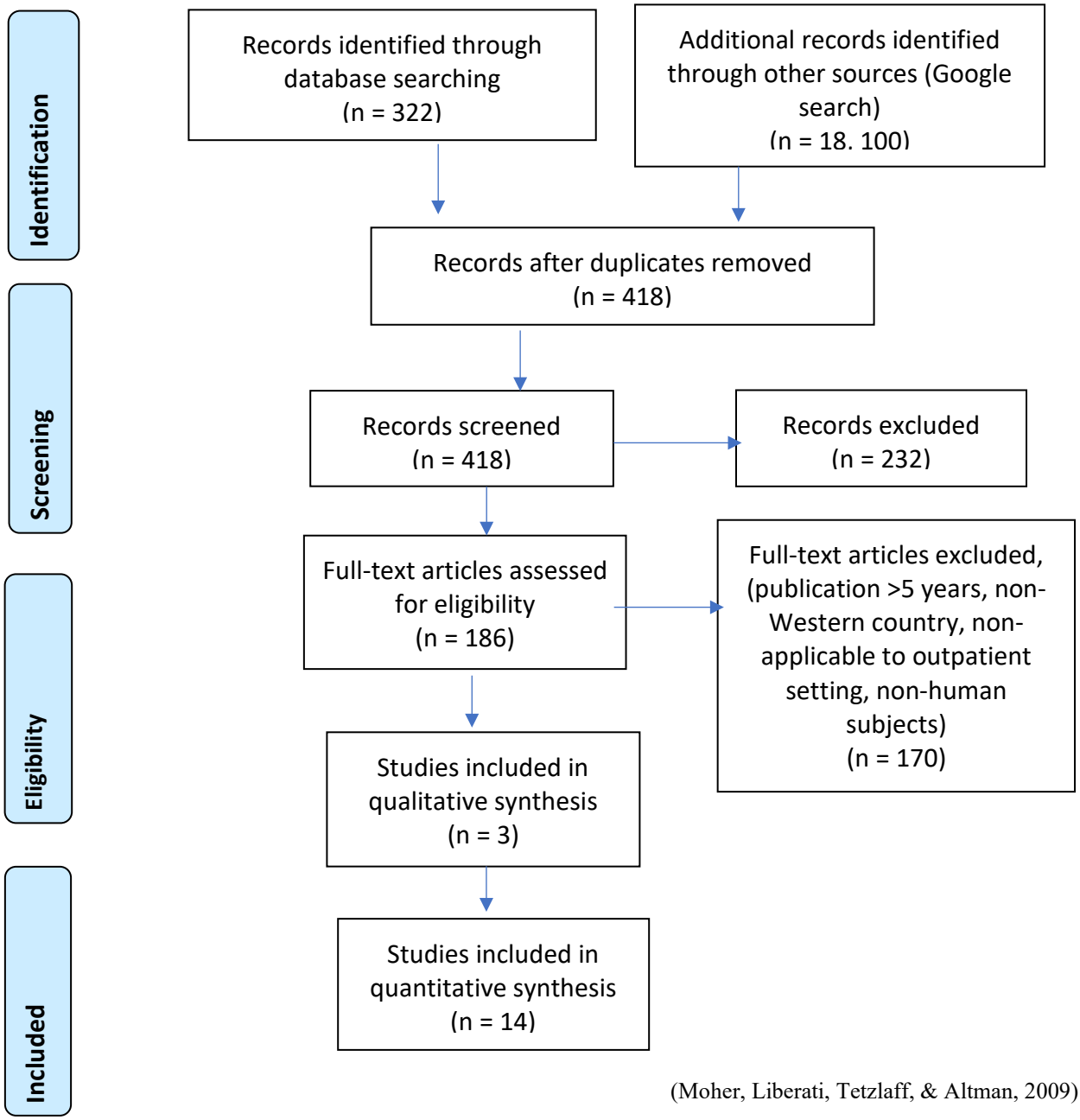
Most of the articles acknowledged the increasing globalization and diverse patient population in Western countries, particularly in the US (Abrishami, 2018; Ahmed et al., 2019; Drevdahl, 2018; Govere & Govere, 2018; Hemberg & Vilander, 2017; Henderson et al., 2018; Kessler et al., 2017; Lin et al., 2017; Sharifi et al., 2019; Watt et al., 2016). As a result of diverse patient encounters, a theme among many of the articles was addressing cultural competency to reduce health disparities for the culturally diverse patient population (Abrishami, 2018; Ahmed et al., 2019, Hemberg & Vilander, 2017; Jongen et al., 2018; Mcelfish et al., 2018; Shepherd, 2019; Sharifi et al., 2019; Watt et al., 2016). Greater adverse health outcomes, lower quality of care, and poor delivery of care were identified by Ahmed et al. (2019) as secondary issues that exacerbate health disparities in culturally diverse patients.

The evidence stated that cultural knowledge and cultural awareness were key factors identified in the progression towards providing culturally competent care (Ahmed et al., 2018; Henderson, 2018; Shepherd, 2019; Shepherd et al., 2019). Furthermore, lack of these key factors resulted in poorer outcomes, quality of care, and delivery of care (Ahmed et al., 2019; Henderson et al., 2018). However, increasing cultural awareness and knowledge are initial steps in developing cultural competence; translating those aspects into cultural safety, awareness,

experience, and clinical practice is necessary to become culturally competent (Jongen et al., 2018; Shepherd, 2019).

Figure 2

PRISMA Flow Diagram



(Moher, Liberati, Tetzlaff, & Altman, 2009)

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Another key theme noted in multiple articles was the responsibility of self; this is reflected as a healthcare provider's own ability to become culturally competent (Hemberg & Vilander 2017). To become more culturally competent, a healthcare provider needs to take the initiative to address both negative and positive aspects of their innate self (Hemberg & Vilander 2017. Positive aspects such as compassion and integrity were noted to promote cultural understanding in the absence of cultural knowledge (Hemberg & Vilander 2017). Watt et al., (2016) stated the supplementary need for healthcare providers to participate in critical and cultural self-reflection to decrease negative assumptions and biases when interacting with culturally diverse patients. Lack of self-reflection can manifest as the preservation of social constructs such as stereotypes, which affect rapport with the patient and lead to poor treatment adherence, poor communication, and ineffective delivery of care (Shepherd, 2019; Watt et al., 2016).

In clinical application, online educational training was found to improve engagement and promote self-reflection and external recognition of stereotypes and bias (Crocker et al., 2018).

The online educational method consisted of four 5 to 15-minute self-paced modules and provided heightened utility due to convenience, flexibility, and standardization (Crocker et al., 2018). In-person educational sessions and simulations were also found to be effective in improving aspects of cultural competence through application and discussion of self-reflection and cultural knowledge (Mcelfish et al., 2018; Paroz et al., 2016). These interventional methods ranged from 4.5 to 36 hours of contact time, with a majority totaling less than 24 hours (Govere & Govere, 2016). However, research by Drevdahl (2018) demonstrated that though online and in-person educational simulations can promote cultural humility, developers of the simulation must avoid one-dimensional scenarios that can strengthen stereotypes. Cultural competence workshops were stated to be ineffective in progressing cultural competence as they commonly address cultural awareness in a superficial and generalized manner (Shepherd, 2019). Instead of a technical approach to cultural competence education, effective cultural competence teaching emphasizes the complexity of culture and enhances the ability of a healthcare provider to adapt to individual qualities of a patient (Paroz et al., 2016).

Strengths of Evidence

A strength of the evidence w the unified acknowledgment of the growing diversity of patients and the need for cultural competence and cultural competence education. The evidence was also strengthened by increased external validity as the evidence draws from numerous geographical locations and healthcare disciplines. Additionally, research has been performed on and provides insight on various educational methods increasing inter-rater reliability.

Weaknesses of Evidence

Reliability was weakened in the evidence due to lack of longitudinal and standardized evidence. Additionally, a singular method has not been tested multiple times nor in different settings. Desirability bias was a pertinent weakness to the evidence. In many of the studies, participants are aware of the intended outcome and no blinding was noted.

Gaps and Limitations

Evidence for cultural competence overall requires further standardized research. Current research consists of supportive material for the development of cultural competence, but methodologies often vary. Variances in current research occur in settings, method of training, and key concepts highlighted in educational training. The most significant limitation to the measurement of cultural competence was the established notion that cultural competence is a continuous progression without a measurable end; thus, the evidence was limited by time considerations.

METHODS

Project Design

The purpose of this project was to implement an educational session on cultural competency, pertinent to Latino populations, at an outpatient clinic and assess for improvements in cultural competence of healthcare providers. A pretest/posttest design was utilized to evaluate the progression of cultural competence. The training was delivered through an online synchronous PowerPoint presentation focused on providing culturally competent care for Latino patients. The training was delivered during a scheduled providers' meeting although participation and completion of surveys was voluntary. Dessert was provided during the meeting. Aggregate

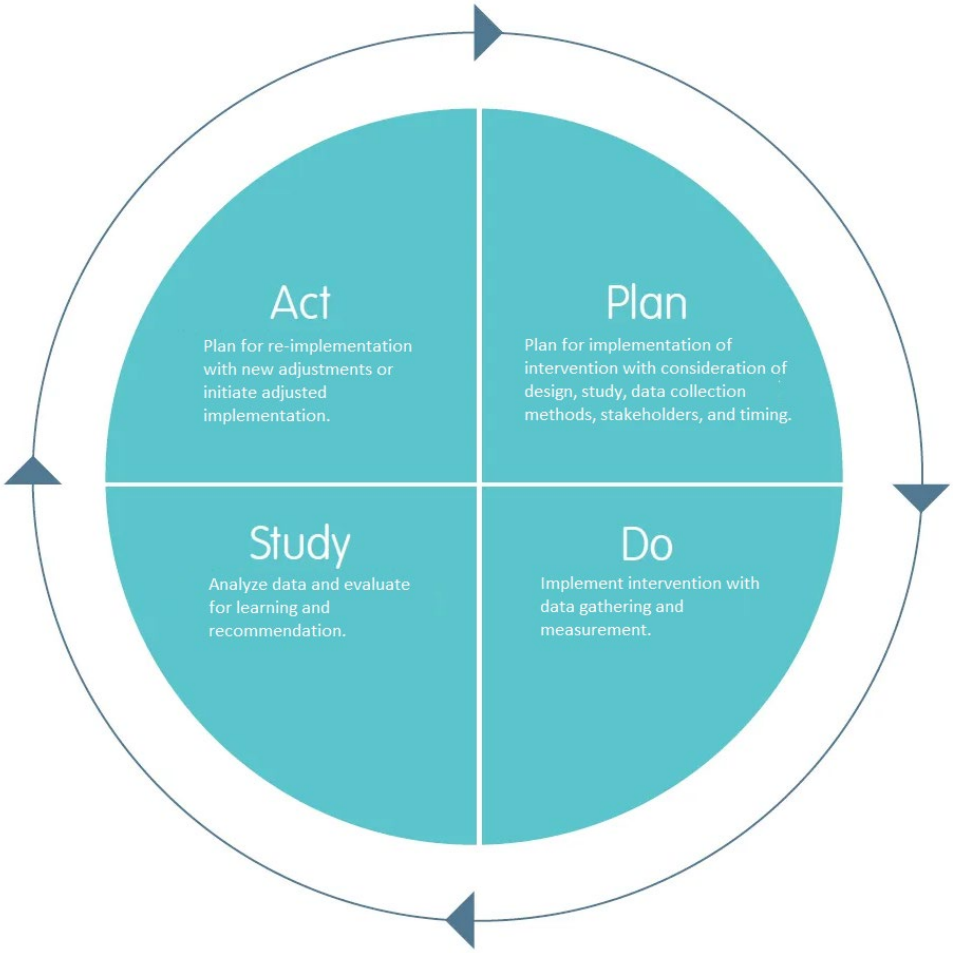
data from the design was evaluated for recommendations in improving quality of care for Latino patients at the project implementation site.

Model for Implementation

The model of improvement guiding this project was the Plan-Do-Study-Act (PDSA) model (Figure 3) by the Institute for Healthcare Improvement (IHI) (IHI, n.d.). Planning for the intervention included assessing for the need for healthcare provider cultural competence clinically and locally. The assessment guided data collection considerations, including stakeholders, participants, settings, and timing of the cultural competence training. This process determined the feasibility and appropriateness of different methodologies such as online versus in-person and written versus electronic material. Following the planning, the intervention was implemented in the designated setting and parameters of data collection. Aggregate data gathered during the implementation was analyzed and evaluated for learning, comparison, and future recommendations of culturally competent clinical care. These recommendations will be utilized for amendments of the initial implementation for future implementation and to guide future practice for the site and generalized use.

Figure 3

Model of Improvement (Plan-Do-Study-Act)



(Adapted from West of England Academic Health Science Network (n.d.)

Setting and Stakeholders

This project was implemented at an outpatient pediatric clinic in Gilbert, Arizona. The clinic currently serves patients in an area with an increasing Latino population. Healthcare staff at the clinic provide care Latino patients and had no pre-existing cultural competency training. Childhood obesity and its risk factors are more prevalent in Latino people compared to white people (Ochoa & Berge, 2017). The prevalence of childhood obesity in Latino people is

significantly associated with food and diet impacted by cultural food rituals, cultural family roles, and social influences (Coe et al., 2018; Ochoa & Berge, 2017). Presence of childhood obesity increases risk for development of chronic diseases such as diabetes and cardiovascular disease (Ochoa & Berge, 2017). As this clinic manages primary care for a diverse population including Latino patients, cultural competence can be beneficial in communicating and achieving positive outcomes with patients.

A key stakeholder was the medical director who expressed a significant amount of interest in project participation. Other stakeholders in the clinic included patients, physicians, the office manager, physician assistants, medical assistants, nurses, and front desk personnel. The physicians and medical director played a role in promoting participation, completion, and clinical benefits of the training. Additionally, the medical director assisted with the decision-making of financial considerations in relation to time spent on the training. All personnel fulfilled roles in scheduling and timing of the project. Physicians and the medical director benefitted from projected improvements in patient satisfaction. Medical assistants and front desk personnel benefit from projected increased primary and secondary efficiency of care with decreased probability of working overtime. Risks to the stakeholders were minimal due to the verbal presentation of data and combination of the education with the scheduled monthly meeting.

Intervention

The project was an online synchronous education training presented through a 30-minute PowerPoint and one pre- and one post-survey focused on providing culturally competent care to Latino patients. Content in the PowerPoint was presented in the English language and was adapted from peer-reviewed studies and the national CLAS educational program. Content was

also reviewed for cultural congruency and relevancy by content expert Dr. Audrey Russell-Kibble. The content addressed the key themes of cultural competence: (1) awareness, (2) knowledge, (3) skills, and (4) desire—with a prompted self-reflection at the end of the training.

The pre-/post-survey assessed for participant demographic in addition to progress in cultural competency; survey questions were peer reviewed and adapted from the Cultural and Linguistic Competence Health Practitioner Assessment (CLCHPA) developed by the National Center for Cultural Competence. The PowerPoint and surveys were completed voluntarily and presented online and synchronously. Surveys were completed directly after completion of the PowerPoint training. Upon completion of the PowerPoint and surveys, completed surveys were sent to and reviewed by the project director for data collection and evaluation.

Participants and Recruitment

Participants were eligible for inclusion if they were healthcare staff who regularly interaction with patients at the clinic. This was required as minimal to no clinical benefit would be predicted with staff who undergo the training and do not interact with patients regularly. Duration of interaction was not included in this requirement because establishing high quality of conversation content was considered feasible within a shorter period. Participant exclusion criteria included infrequent interaction with patients or seasonal staff. Seasonal staff were not included as the benefits to their future practice are variable depending on patient population and geographic location. Staff were scheduled to attend the training as part of their monthly educational meetings; participation in the training and completion of the surveys was voluntary.

Recruitment of the participants was through email and verbal promotion. General email announcement with a meeting agenda was sent out by the medical director two weeks prior to the

training. Information regarding the training was included in the agenda. The training was also promoted verbally by the medical director and stakeholders.

Consent and Ethical Considerations

Participants received a disclosure (Appendix B) prior to initiation of the training stating that continuation implies consent. Participant confidentiality was maintained by having the training and survey link emailed by a third-party individual not involved with the project. Participant privacy was maintained by sharing post-analyzed data and recommendations with only staff or the medical director. Information shared has no key identifiers. The project review and approval was received by the University of Arizona Institutional Review Board (IRB) prior to implementation (Appendix A).

Data Collection

Prior to initiation of project implementation, participants were informed of the pretest and posttest design and the use of data for academic and clinical improvement purposes. Data was collected for this project directly after completion of the educational training, beginning with the administration of a voluntary 5-10-minute pretest survey. The pretest was used to determine baseline levels of the four pre-stated key themes of cultural competence: *awareness*, *knowledge*, *skills*, and *desire*. Socio-demographics were also assessed in the pretest survey for descriptive and demographic comparison of study participants' age, ethnicity, race, educational level, and clinical experience. Following the pretest, participants were presented with a PowerPoint presentation of a 30-minute educational training on improving cultural competence for Latino patients.

At the completion of the training, participants voluntarily completed a 5-10-minute posttest used to re-assess the key themes, but also assess effectiveness and satisfaction of the presentations. The posttest consisted of 20 Likert-scale questions (1—strongly disagree or not comfortable and 5—strongly agree or very comfortable); both pretest and posttest were scored out of 100, with no points assigned to demographic questions. Expert and peer review was utilized to establish the appropriateness of the data collection tools and all survey questions.

Data Analysis

Data from the pretests and posttests were collected onto an Excel spreadsheet and aggregated for analysis. Comparative and descriptive analysis were completed on the data to depict differences in pretest and posttest results and, thus, any improvements in cultural competency of the healthcare staff. Rigor in the data analysis was demonstrated by use of measurement tools that have been utilized in previous research and peer-reviewed articles. Additionally, expert review of the measurement tool increased the rigor of the analysis. Rigor was also demonstrated in results through upholding neutrality of the principal investigator by utilizing the medical director as a point of contact and ensuring anonymity of participants.

RESULTS

Findings from the implementation were used to assess the effectiveness of an educational training session to improve levels of cultural competency in healthcare providers. Out of a total of nine healthcare providers scheduled, six healthcare providers at the clinic participated in the educational training sessions and pretest and posttest surveys. The pretest and posttest surveys were scored out of 100 and comparison analysis utilized to assess improvement. Demographics were utilized for descriptive analysis and not scored.

Outcomes

Participant Demographics

Six healthcare providers participated in the training and completed the pretest and posttest surveys. Out of the six participants, four were doctorly prepared providers and two were master's level providers. All six providers were Caucasian ethnicity, and two providers reported the ability to speak Spanish proficiently. All the providers had at least five years of clinical practice experience with four providers having greater than 20 years of experience.

Level of Cultural Competency

The pretest and posttests were divided into the four components of cultural competency: awareness, knowledge, skills, and desire. In conjunction with the five-point Likert scale and relative question count, each section was scored with its respective points. The total points for each section were as follows: awareness 30 points, knowledge 20 points, skills 20 points, desire 30 points. The grand total score for overall test was thus scored out of 100 points.

As depicted in Table 2, score comparison between the pretest and posttest showed an increase in all aggregate scores. The largest increase in aggregate scores was the *Knowledge* section which increased by 20% (24 points). Overall increases were also noted in comparison of minimum scores. The largest minimum score increase was in the *Knowledge* section with an increase of 25 % (five points). The small minimum scores increase was in the *Awareness* section with an increase of 6% (two points).

Table 1

Participant Demographics (n=6)

Characteristic	n
Ethnicity	
Caucasian	6
Languages Spoken	
Spanish	2
Clinical Practice Experience	
0-5 years	
5-10 years	2
15-20 years	0
20-25 years	1
25-30 years	3
Specialty	
MD/DO	4
PA	1
-	1

Table 2

Pretest and Posttest Survey Category Analysis

	Aggregate Score	Minimum	Maximum	Mean	Standard Deviation
Awareness (30 points)					
Pretest	127	18	26	21.2	2.927
Posttest	142	20	26	23.7	1.967
Knowledge (20 points)					
Pretest	62	7	12	10.3	1.751
Posttest	86	12	18	14.3	2.658
Skills (20 points)					
Pretest	59	8	12	9.8	1.602
Posttest	77	12	16	12.8	1.602
Desire (30 points)					
Pretest	121	18	23	20.2	2.137
Posttest	135	21	24	22.5	1.049
Overall (100 points)					
Pretest	369	58	65	61.5	2.739
Posttest	440	67	80	73.3	4.457

The largest maximum score increase was also in the *Knowledge* section, increasing by 30% (six points) (Table 2). All maximum scores except the *Awareness* section had an increase in scores as well. The maximum score for the *Awareness* section had no change. The highest reported scores were in the *Awareness* and *Desire* section with the maximum in *Awareness* being 26 points and the highest in *Desire* being 24 points. Table 2 also depicts the increase of 11.3% (11.3 points) when comparing overall aggregate pretest and posttest scores. The overall posttest score's standard deviation of 4.457 was the highest of all the sections followed by notable standard deviations of 2.927 and 2.739 in the *Knowledge* pretest and overall pretest sections, respectively.

Comparison of mean pretest and posttest scores showed an increase from pretest to posttest in every section (Table 2). The greatest increase was noted in the *Knowledge* section with an increase of 20% (four points). The smallest increase was noted in the *Desire* section with an increase of 7.7% (2.3 points).

Individual participant scores shown in Figure 4 depict an overall increase in posttest scores compared to pretest scores. These scores were reflective of all combined sections. Calculations for specific individual scores were not completed due to methodology to preserve participant confidentiality. Aggregate cultural competency scores graphed in Figure 5 below also depict an increase in overall scores.

Figure 4

Individual Participant Score Comparison (n=6)

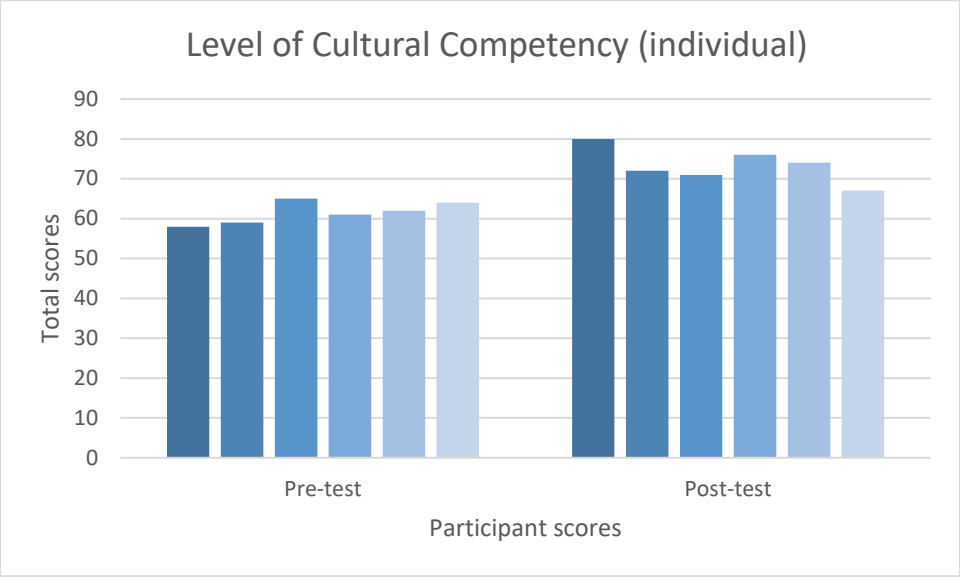
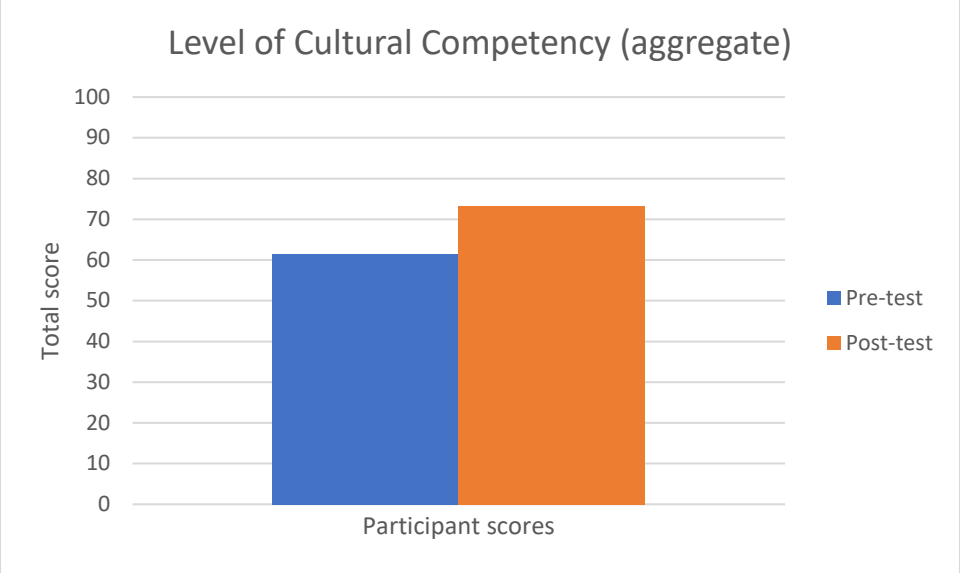


Figure 5

Aggregate Participant Score Comparison (n=6)



DISCUSSION

Summary

67% (4 out of 6) of the participants were doctorly prepared and 67% (4 out of 6) of the participants had been practicing for >20 years. Aggregate increases in section-specific and overall scores were noted in the data gathered. The largest increases in scores were in the *Knowledge* section—noted in the minimum, maximum, and mean scores. The small score increases were found in *Awareness* and *Desire* section. Overall, aggregate scores increased by a mean of 11.3%. Variability was noted among the scores with the overall posttest score having the largest standard deviation.

Interpretation

Higher increases in the *Knowledge* section were expected due to the nature of the cultural competency process. The educational training section was designed to initiate the cultural competency process as this was a "first" training session for the participants. Thus, the educational training included stronger elements focused on improving knowledge of the participants. The smallest increases were noted in the *Awareness* and *Desire* section. This was assumed due to the subjective nature of the two concepts as compared to *Knowledge* and *Skills*. Additionally, due to the complexity of enacting change and the desire to learn, large increases in the *Desire* section were not expected. Furthermore, *Desire* is identified as a later component in the cultural competency process and was not feasibly expected to significantly increase because of a single training session.

An increase in the aggregate overall score reflects an improvement in the level of cultural competency of the participants. Increases noted in minimum and maximum scores further

support this as improvement was noted in participants who initially scored lower and participants who initially scored higher. Additionally, increases were noted in all mean scores demonstrating an average improvement of levels of cultural competency in all participants.

Implications (Practice, Education, Research and Policy)

Information gained from this study can help guide and shape clinician practice at this clinic. Healthcare providers who undergo an educational session such as the one included in this implementation can use recommendations and recommended interviewing tools to guide their skills in patient interviewing. Although some healthcare providers may have a large amount of experience, focusing interviewing skills to be culturally competent may be novel for some and necessary for all.

As this educational session was a single session, future education could build on the initial session and move forwards from the introductory stage of cultural competency. As noted in the national CLAS standards, a multi-part educational training can help further improve cultural competency. Healthcare providers could even refer to the national CLAS standards as a means for further education as the educational training utilized in this implementation was based on the standards.

Within an organization, stakeholders and organizational leaders can utilize the information gained from this implementation by re-assessing currently utilized policies regarding care for ethnically diverse patients. Establishing cultural competence of the stakeholders, leaders, and healthcare staff can help the organization develop or re-shape policies to more specifically, safely, and satisfactorily care for ethnically diverse patients. Future quality improvement (QI)

initiatives with multiple educational sessions would allow for focused learning on either the components of cultural competence or specific areas of the desired culture.

The clinic had in place formal and informal methods to support Latino patient interaction including use of Spanish-speaking medical assistants (MAs). Recommendations based on the educational training session include requiring and enacting more application of culturally competent techniques from the providers beyond simply the use of Spanish interpreters. Post-presentation discussion revealed a hesitancy by staff to apply culturally competent care beyond the use of Spanish language interpreters. Considering the complex nature of the desire to change or accept change, eliciting the desire to change in individuals through a single educational session was not expected outcome. The project was not designed with sole focus on persuasion—instead including aspects of persuasion, information, and reflection. Thus, future quality improvement initiatives could consider increasing the quantity of education trainings and include a more techniques to enact change or the desire to change.

The implications from this implementation could guide future research into how to specifically overcome and approach Latino patients with cultural beliefs that may hinder their healthcare. Furthermore, this could guide or promote research on other prevalent minor ethnicities in the US and potentially, less prominent ethnicities. Research on culturally competent care for more ethnically diverse patients will help promote health equity not only in the US, but for healthcare providers caring for patients on a global aspect.

Limitations

A strength of the intervention was the synchronous presentation that allowed both delivery and discourse within the session. This allowed for the insight of multiple providers as

opposed to simply information delivery. The information presented was also generalizable enough to utilize for providers of different specialties and experience levels.

Limitations of the project included time and longitudinal constraints, individual desire and motivation, specificity to the clinic, and participation bias. Although the desired time allotment was granted, the synchronous educational session was scheduled during a workday lunchtime meeting; this scheduling meant providers were upwards to 15 minutes late to the meeting depending on the timing of their patient visits. This led to decreased time for information presentation or decreased information intake from providers were late. Additionally, due to the nature of the cultural competency process, a single educational session limited the degree of improvement healthcare providers could have. Multiple educational sessions would have bolstered the improvement process but were not feasible at this time.

Professional and personal desire and motivation to learn or improve was a limitation to the project. Post-education discussion revealed hesitancy in to incorporate the training content into personal clinical practice. As 67% of the participants have been practicing for >20 years, formal education regarding cultural competence may have been novel to them. Participants may have been satisfied or confident in the clinical practice skills they honed over years resulting in hesitation to change. Thus, those who maintained a lack of desire or motivation to improve were expected and accounted for as a limitation to the project.

Lastly, participation bias was a limitation to the study. Participants and the medical director were likely able to infer the desired outcome of the study due to the pre-post-test design. As 6 out of 9 scheduled providers completed the training and both surveys, any preexisting willingness and bias could have skewed the data.

DNP Essentials Addressed

DNP Essentials addressed in this quality improvement project are:

DNP Essential I: Scientific Underpinnings for Practice

A foundational understanding of scientific, physiological, and clinical knowledge was utilized to guide the basis of this project. This foundational understanding was practiced in the conceptualization of the project in determining the importance of health care delivery and identifying new practice approaches (American Associations of Colleges of Nursing [AACN], 2006). Furthermore, aspects of nursing science were applied to shape the approach in a manner reflecting of nursing care.

DNP Essential II: Organizational and Systems Leadership for Quality Improvement and Systems Thinking

Methods and implementation design utilized the DNP essential through organizational understanding in conjunction with a desire to eliminate health disparities and improve health outcomes. The synchronous and online nature of the quality improvement implementation was decided upon through collaboration with the organizational leader; this further improved on skills in cost-effective and practice-effective methods to improve healthcare.

DNP Essentials III: Clinical Scholarship and Analytical Methods for Evidence-Based Practice

Clinical scholarship and analytical methods were thoroughly addressed throughout the process of this quality improvement project. The process of initiating with gathering and evaluating information to establishing an intervention to data analysis embodied scholarly

nursing practice. Furthermore, technological advances were utilized to implement the intervention with hopes of future dissemination.

DNP Essential VII: Clinical Prevention and Population Health for Improving the Nation's Health

The nature of addressing cultural competency in this quality improvement project addressed this essential in identifying a prevalent population and community locally and globally with health disparities. The underlying nature of this project was to better address disease prevention and health promotion in the Latino population engaging clinical leaders to become more culturally competent.

Conclusions

With increases in the Latino population and concurrently, health disparities, addressing and improving healthcare provider cultural competency is imperative to address underlying cultural and social health issues. Enacting healthcare providers is essential as they have the ability and duty to exercise leadership roles in organizations and institutions. Additionally, health promotion and prevention can make a significant difference as the Latino population is disproportionately affected by preventable diseases such as obesity, diabetes non-alcoholic fatty liver disease (NAFLD), and cardiovascular disease (CVD) (Velasco-Mondragon et al., 2016). As demonstrated by this quality improvement project, improvement in levels of cultural competency is feasible and achievable with education. However, initiating the process of cultural competence needs to be done now and not later so that healthcare providers can achieve national and globally equitable care during the continual process of becoming competence (Watt et al., 2016).

Plan for Sustainability

The implementation utilized consisted of one educational training session to a pediatric primary care clinic. As discussed previously, the cultural competency process is a lifelong process. Additionally, objective, and subjective components of cultural competency require continuing education to bolster the process. Therefore, following PDSA cycles to improve the initial educational training session, further sessions focused on each specific component of cultural competency should be implemented and trialed. Additional PDSA cycles could also trial the implementation of a greater number of trainings to help address the numerous components. The continued use and trialing of these educational methods will help initiate cultural competency in some and fortify the established cultural competency process in others. Furthermore, once education for the components is improved on, the generalizability of the material will allow for adaption and use by organizations other than pediatric clinics or for education on ethnic cultures other than Latino.

Plan for Dissemination

Aggregate data analysis was sent in an executive summary to the medical director of the clinic. The information presented to medical director can be utilized as desired for presentation to healthcare providers or staff members at the clinic. Further presentation of material to committee members was completed at the final defense.

APPENDIX A:

SITE APPROVAL/THE UNIVERSITY OF ARIZONA INSTITUTIONAL REVIEW BOARD AUTHORIZATION LETTER

Desert Shores Pediatrics, PC
6285 S. Higley Rd, Gilbert, AZ 85298

7/27/2021

University of Arizona Institutional Review Board
c/o Office of Human Subjects
1618 E Helen St
Tucson, AZ 85721

Please note that Ms. Audrey Goh, UA Doctor of Nursing Practice student, has permission of Desert Shores Pediatrics, PC to conduct a quality improvement project at our facility for her project, Improving Levels of Cultural Competence in Staff Caring for Latino Patients.

Ms. Goh will conduct a survey of health care providers and staff at Desert Shores Pediatrics, PC. She will promote to participants through email. Participants will be provided with a description of the project, what they will be asked to do, and the time involved. Ms. Goh's activities will be completed by *(date of monthly meeting)*

Ms. Goh has agreed to provide to my office a copy of the University of Arizona Determination before she recruits participants. She will also present aggregate results to the medical director and providers at their monthly staff meeting.

If there are any questions, please contact my office.

Signed,

Christine P. Holmes, MD, FAAP

President, Desert Shores Pediatrics

THE UNIVERSITY OF ARIZONA
Research, Discovery & Innovation

Human Subjects Protection Program

1618 E. Helen St.
P.O.Box 245137
Tucson, AZ 85724-5137
Tel: (520) 626-6721
http://rgw.arizona.edu/compliance/home

Date:	August 13, 2021
Principal Investigator:	Audrey Goh
Protocol Number:	2108122155
Protocol Title:	Improving Levels of Cultural Competence in Staff Caring for Latino Patients at Desert Shores Pediatrics, PC
Determination:	Human Subjects Review not Required

Documents Reviewed Concurrently:

Data Collection Tools: *Goh_DNP project pre-and post-survey.docx*
HSPP Forms/Correspondence: *Goh_IRB determination.pdf*
Informed Consent/PHI Forms: *Goh_disclosure form.docx*
Other Approvals and Authorizations: *Advisor Confirmation Email.pdf*
Other Approvals and Authorizations: *Goh_DSP Approval Letter.pdf*
Participant Material: *Goh_Culture Competence Training Synchronous.pptx*
Recruitment Material: *Goh_meeting agenda announcement.docx*

Regulatory Determinations/Comments:

- Not Human Subjects Research as defined by 45 CFR 46.102(f): as presented, the activities described above do not meet the definition of research involving human subjects as cited in the regulations issued by the U.S. Department of Health and Human Services which state that "human subject means a living individual about whom an investigator (whether professional or student) conducting research obtains data through intervention or interaction with the individual, or identifiable private information."

The project listed above does not require oversight by the University of Arizona.

If the nature of the project changes, submit a new determination form to the Human Subjects Protection Program (HSPP) for reassessment. Changes include addition of research with children, specimen collection, participant observation, prospective collection of data when the study was previously retrospective in nature, and broadening the scope or nature of the study activity. Please contact the HSPP to consult on whether the proposed changes need further review.

The University of Arizona maintains a Federalwide Assurance with the Office for Human Research Protections (FWA #00004218).

APPENDIX B:

CONSENT DOCUMENT (DISCLOSURE AND CONSENT FORM)

Project Director's Name: Audrey Goh, RN, FNP-DNP student

Institution: University of Arizona, College of Nursing

Title: Improving Levels of Cultural Competence in Staff Caring for Latino Patients

INTRODUCTION

You are being asked to participate in a quality improvement project studying the improvement of cultural competence in healthcare staff caring for Latino patients. This project is being conducted as part of the doctoral requirement at the University of Arizona. The project consists of three steps to be completed by you, the participant:

1. Pre-test survey (5-10 minutes)
2. One educational PowerPoint (30 minutes)
3. Post-test survey (5-10 minutes)

Upon completion of this study, analyzed information and recommendations will be presented to the medical director and staff in an executive summary. No identifying or personal information will be recorded, and participants' integrity will be upheld throughout the project.

Participation in this project is voluntary and you may choose to stop participating at any time without penalty or risk of loss of benefits to which you are otherwise entitled. As your participation is voluntary, there will be no monetary or non-monetary incentives provided for completion of this project. This project is for academic purposes as a non-profit endeavor and is not funded by any agency.

For concerns and questions regarding this project, please contact the following:

1. Ms. Audrey Goh (investigator) at audreyg@email.arizona.edu
2. Dr. Timian Godfrey (committee chair) at timiangodfrey@email.arizona.edu

By viewing the PowerPoint and completing the surveys, you are consenting to participate in the project.

APPENDIX C:

RECRUITMENT MATERIAL (RECRUITMENT EMAIL)

Recruitment Email

As an academic requirement, DNP-FNP student Audrey Goh will be completing a quality improvement project at our clinic. She will present a 30-minute educational PowerPoint training with one pre- and one post-survey (5-10 minutes) to staff at the monthly meeting. The information presented will be regarding improving levels of cultural competence for healthcare staff caring for Latino patients.

APPENDIX D:

EVALUATION INSTRUMENTS (PRE-SURVEY AND POST-SURVEY)

PRE-SURVEY

Race/Ethnicity (please select all that apply)

African American/Black
American Indian/Alaska Native
Asian American
Caucasian
Latino/Hispanic
Native Hawaiian/Other Pacific Islander
Other

Do you speak any languages other than English? Yes _____ No _____ If Yes, please specify _____

Years of Clinical Practice___ (<1, 1, 2, 3… ,)

Specialty of Practice___ (MD/DO, NP, PA, RN, Other, N/A)

Awareness Questions: How much awareness do you have of the following:

	1—strongly disagree	2—disagree	3—neither agree nor disagree	4—agree	5—strongly agree
My own cultural values, beliefs, bias and opinions of other cultures					
Possible barriers or biases in my beliefs, values, and perceptions on others that may create disparities or negative outcomes for Latino patients					
Possible barriers or biases in organizational standards or policies that may create disparities or negative outcomes for Latino patients					
Gender, family, and life values are essential considerations when caring for Latino patients (e.g., regard for religion or family carry high importance when making decisions)					
Religion and faith are a major determinant on how Latino patients perceive and respond to healthcare practices, diseases, and death					
The importance of learning how to care for Latino patients with different cultures from my own					

Knowledge and Education Questions: How knowledgeable do you think you are about:

	1—not knowledgeable	2—a little knowledgeable	3—somewhat knowledgeable	4—knowledgeable	5—highly knowledgeable
The process of becoming culturally competent					
Health barriers and disparities faced by Latino patients					
Health management or communication strategies with Latino patients					
Variations in traditional or folk Latino health practices					

Skills and Practice Questions: How skillful do you think you are in:

	1—not skilled	2—a little skilled	3—somewhat skilled	4—skilled	5—highly skilled
Determining how patients or families from Latino cultures want to be treated					
Effectively communicating and greeting Latino patients in a culturally sensitive manner					
Interviewing a Latino patient in a culturally appropriate manner					
Identifying a Latino patient's personally important cultural beliefs and values					

Desire & Encounters Questions: How comfortable are you in:

	1—very uncomfortable	2—uncomfortable	3—neither comfortable nor uncomfortable	4—comfortable	5—very comfortable
Communicating with Latino patients					
Caring for ethnic groups who prefer to use or seek folk healers or alternative therapies					
Identifying beliefs that are not expressed by Latinos but might interfere with the treatment regimen					
Providing culturally competent care for Latino patients					
A schedule that includes culturally diverse patients					
Utilizing your time to professionally enhance your knowledge, skills, and competence in caring for culturally and linguistically diverse group like Latino patients					

POST-SURVEY:

Awareness Questions: How much awareness do you have of the following:

	1—strongly disagree	2—disagree	3—neither agree nor disagree	4—agree	5—strongly agree
My own cultural values, beliefs, bias and opinions of other cultures					
Possible barriers or biases in my beliefs, values, and perceptions on others that may create disparities or negative outcomes for Latino patients					
Possible barriers or biases in organizational standards or policies that may create disparities or negative outcomes for Latino patients					
Gender, family, and life values are essential considerations when caring for Latino patients (e.g., regard for religion or family carry high importance when making decisions)					
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The importance of learning how to care for Latino patients with different cultures from my own					

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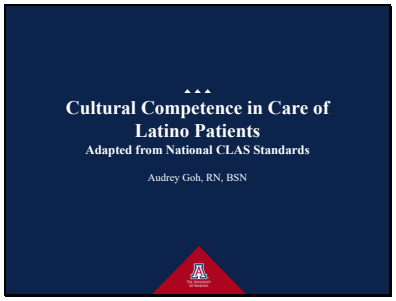
Providing culturally competent care for Latino patients					
A schedule that includes culturally diverse patients					
Utilizing your time to professionally enhance your knowledge, skills, and competence in caring for culturally and linguistically diverse group like Latino patients					

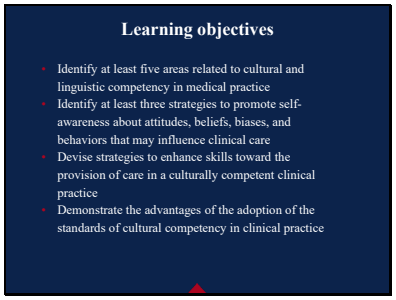
APPENDIX E:

PARTICIPANT MATERIAL (POWERPOINT PRESENTATION)

Slide 1



Slide 2



Slide 3

Slide 4

Importance of cultural competency

- Cultural competency is a national priority
- Many government organizations recognize existence of health disparities
- Barriers involve economic, geographic, social, and cultural factors
- Sources of disparities and barriers include patients, providers, the healthcare system, and patients' responses.

Slide 5

Present issue

- Burden of health disparities affects racial and ethnic minority populations disproportionately
- Within the next 50 years, 48% of United States (U.S.) predicted population from cultures other than White, non-Hispanic (U.S. Census Bureau, 2012)

Slide 6

Key factors:

- **Knowledge**: comprehension gained through research and study
- **Awareness:** self-reflection and acknowledgement of biases and social context of culture
- **Skills**: ability to adapt, communicate, and respond in diverse situations
- **Desire**: motivation to engage in cultural competence

(CDC, 2020; Henderson et al., 2018; Seeleman, et al., 2009)

Slide 7

Cultural competency process

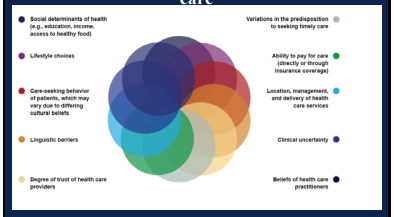
- Cultural *knowledge* can help healthcare providers and staff adapt to diverse situations
- Practice of *awareness* and *skills* will strengthen cultural competency
- ***Cultural competency is a lifelong process driven by *desire*, but continued education and practice can initiate and improve competence**

Slide 8

Cultural Competency Process

Slide 9

Factors related to difference in health care



(OMH, n.d.).

Slide 10

Barriers in healthcare

Racial/ethnic minority patients:

- ***Less likely*** to comply with treatment if they do not understand it
- ***More likely*** to refuse or delay care (IOM, 2002).
- Perceive ***higher*** levels of discrimination in healthcare (IOM, 2002)

Time pressures placed on providers hamper their ability to assess symptoms and increase shortcuts

(Haskard-Zolnierek & DiMatteo, 2010; IOM, 2002)

Slide 11

Regional and National problem

- In 2019, 31.7% of population identified as Latino ethnicity (United States Census Bureau, 2019)
- Latino populations in the U.S. disproportionately affected by the social determinants of health, resulting in high incidences of
  - cardiovascular disease
  - diabetes
  - cancer
  - liver disease

(Nunez et al., 2016; (Velasco-Mondragon et al., 2016)

Slide 12

Latino traditional and folk remedies

- Spiritual and religious folk healing belief systems include:
  - *Curanderismo* (Mexico, most of Latin America)
  - *Santeria* (Brazil and Cuba)
  - *Espiritismo* (Puerto Rico) (Jackett, 2013)

Slide 13

Latino traditional and folk remedies

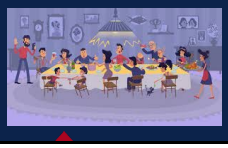
Also seek:

- *Curanderos* (traditional healers)
- *Brujos* or *brujas* (wizards or witches)
- *Yerberas* (herbalists)
- *Hueseros* (bone setters)
- *Parteras* (midwives)
- *Sobradores* (similar to physical therapists) (Jeckett, 2013)

Slide 14

Latino culture & healthcare beliefs

- In Latino culture, a concept known as *familismo* can impact a patient's decisions (Caballero, 2011)
  - *Familismo* is loyalty to family and extended family
  - Patient seeks counsel from large number of family (Caballero, 2011)



Slide 15

Latino culture & healthcare beliefs

- For Latino males, the concept of *machismo* can also impact personal disease management
  - *Machismo* encompasses positive qualities
  - Belief that pain should be endured and seeking care is a weakness
  - Seek care as a means to fulfill expectation to work and provide (Caballero, 2011)

Slide 16

Latino culture & healthcare beliefs

- For Latino females, the concept of *marianismo* can also impact personal disease management
  - *Marianismo* refers to the expected nurturing roles of females
  - Home-centered, submissive, virtuous, and spiritual leader
  - Increased psychological distress and poor coping

(Nunez, et al., 2016; Sanchez et al., 2019)

Slide 17

Latino culture & healthcare beliefs

- Two other concepts are *fatalismo* and *personalismo*
  - *Fatalismo* is belief the disease is destined
    - Decreased treatment adherence
  - *Personalismo* is belief in a personal patient and healthcare provider relationship
    - Patient preference for physical contact and genuine personal interest
    - If lacking, satisfaction and adherence are decreased

(Caballero, 2011; Sanders et al., 2018)

Slide 18

Latino spiritual belief

Mal de ojo

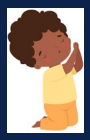
- Belief of "evil eye" in Latin America
  - Strong stare of jealousy, admiration, or envy causing disease or death
  - Can manifest as true physical symptoms
  - Women and children more vulnerable

(Martinez, 2012)

Slide 19

Latino culture & healthcare beliefs

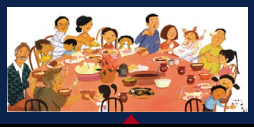
- Religion is a significant factor
  - Strong religious beliefs can lead to view that:
    - Disease is predestined
    - Only God can control the disease
      - May lead to lack of adherence to or initiation of treatment
  - Strong religious beliefs can also act as
    - Support system
    - Source of hope and positivity (Caballero, 2011)



Slide 20

Latino culture & healthcare beliefs

- Food & Diet
  - Cultural
    - Food rituals
    - Family roles
    - Social influences
  - Increased childhood obesity and risk factors



(Coe et al., 2018; Ochoa & Berge, 2017)

Slide 21

Patient-provider communication

U.S. Census reported

- Over 50% of Latinos are bilingual
- Speak English at a proficiency of "very well."

- Need to address improvements to prevent patient-provider miscommunication

(Concha, 2018)

Slide 22

Patient-provider communication

To improve communication:

- Avoid "false fluency," misinterpreting the meaning of a Spanish word
- BELIEF instrument or ETHNIC interviewing tool can help improve communication and engage the patient
  - Prompted questions to facilitate understanding of the cultural beliefs

(Concha, 2018)

Slide 23

Patient-provider communication

BELIEF instrument

B: Beliefs about health (What caused your illness?)

E: Explanation (Why did it happen?)

L: Learn (Help me understand your beliefs)

I: Impact (How is this illness impacting your life?)

E: Empathy (This must be very hard for you)

F: Feelings (How are you feeling about it?)

(Concha, 2018)

Slide 24

Patient-provider communication

ETHNIC interviewing tool

E: Explanation (How do you explain your illness?)

T: Treatment (What treatment(s) have you tried?)

H: Healers (Have you sought any advice from folk healers?)

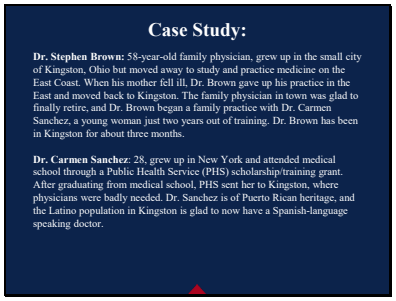
N: Negotiate (Mutually acceptable options)

I: Intervention (Consented to)

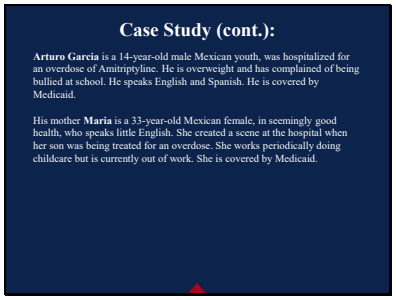
C: Collaboration (with patient, family, and healers)

(Concha, 2018).

Slide 25



Slide 26



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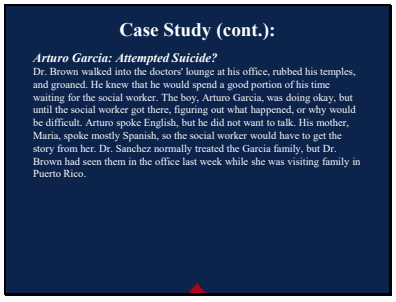

Slide 28

Case Study (cont.):

The irony of Arturo's attempted suicide was that he took a handful of Amitriptyline, the very prescription that Dr. Brown had recently renewed to combat the boy's depression and anxiety. Dr. Brown thought back to his review of Dr. Sanchez's notes, where he had learned that Arturo felt depressed and anxious about school. It seemed like usual "14-year-old stuff" to Dr. Brown: Arturo was overweight and Mexican, so the other kids teased and bullied him for being different. Dr. Brown thought that the kid just needed to exercise more and to learn to stand up for himself, but Dr. Sanchez had prescribed the Amitriptyline (as a less expensive alternative to Sertraline since Mrs. Garcia was currently out of work). Dr. Brown was not about to stop or change the treatment without consulting her.

Slide 29

Case Study (cont.):

What are your initial thoughts of this situation? What, if any, biases might have Dr. Brown have towards Arturo?

Slide 30

Case Study (cont.):

When Dr. Brown was finally able to talk with Arturo and Mrs. Garcia, he asked if Arturo was seeing a counselor and Arturo replied angrily, "I went a few times, but I hated it, so I stopped going." At the end of the session, Dr. Brown told Mrs. Garcia that he wanted to speak with Arturo alone for a few minutes. Dr. Brown told Arturo that counseling was important and asked why he stopped going. Arturo stared sullenly at him then replied, "The counselor thought we should talk about my sexual orientation." He used his fingers to make quotation marks as he said "sexual orientation." Arturo continued, very angrily, "She was so judgmental about me liking other guys. It's none of her business!" Dr. Brown started to follow up with a question, but Arturo exploded, "It's not your business either," then abruptly got up and left the office.

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Case Study (cont.):

What are some cultural barriers that could impact Arturo's disease management? What culturally relevant strategies could be used to improve Arturo's health outcomes?

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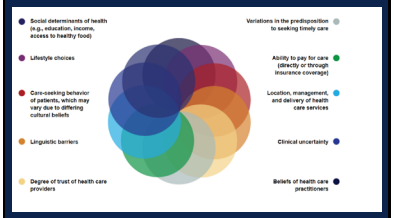

Slide 33

Case Study (cont.):

Dr. Brown knew that Arturo had neglected to take his medication for some days. From what Dr. Brown could understand from his conversation with Mrs. Garcia (Arturo, was not very cooperative), she would have Arturo take two or three pills at a time when she discovered that he'd missed a dose. That's what made Dr. Brown nervous. Did Arturo really attempt suicide, or did his mother think that he was supposed to take a handful of pills all at once? Dr. Brown was sure that he'd explained the dosing clearly--one a day, every day, in the morning. He may even have jotted it down on a note pad for her, but he could not remember. Now it seemed silly to even think about it; why did he think that she could read English better than she could speak it?

But it made him very nervous. He'd seen that "ER" episode in which a patient ended up in the hospital because of the doctor's written instruction, "once a day." In Spanish, "once" means "11."

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Self-reflection

Please take 5-10 minutes to reflect on these questions.

1. How do you feel about the situation? What is your attitude toward Arturo Garcia and Dr. Brown?

2. Would you have approached the initial medical encounter differently than Dr. Brown did? If so, how?

3. What is the patient's perspective? How might you feel if you received care from Dr. Brown?

4. Do you think you would be comfortable as the primary provider for Arturo in this situation? Why or why not?

5. What could you do to prepare for similar encounters?

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Conclusion

This concludes the educational training. Please proceed to fill out the post-test survey.

Thank you for your participation and time!

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Additional resources

Additional resources if further exploration is desired:

Think Cultural Health (resources and education sponsored by Office of Minority Health): https://thinkculturalhealth.hhs.gov/

Caring for Latino Patients article (further elaboration of disease beliefs): https://www.aafp.org/afp/2013/0101/p48.html

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APPENDIX F:

PROJECT TIMELINE

Completion Date	Planning	Pre-Implementation	Implementation	Evaluation
May 11, 2021	Review DNP proposal	Review implementation evidence and revised proposal	Complete DNP project presentation and defense	Apply revisions to DNP presentation
May 12, 2021	Prepare forms and content needed for implementation	Review application with committee	Submit revised project presentation and IRB determination application	Review and add revisions to recruitment forms and intervention forms
May 15, 2021	Prepare methods of implementation as applicable to site	Review applicability of implementation measures	Complete pre-implementation visit	Adjust implementation requirements as needed for site
July 4, 2021	Prepare presentation for educational training presentation	Review presentation for implementation	Initiate implementation of educational training intervention	Adjust implementation as needed or identified by process measures
July 26, 2021	Prepare forms for data collection	Review data collection methods	Complete data collection from educational training and calculate cultural competence scores	Organize scores and data for analysis
August 2, 2021	Identify method for organization and analysis of data	Review data analysis method	Complete descriptive and comparative data analysis	Prepare graphs or charts to accompany analyzed data
September 6, 2021	Review changes in current research practice of cultural competence	Identify validity and reliability of data based on analysis	Integrate data analysis into results, discussion, and implications for future practice	Prepare document for implementation site staff
October 1, 2021	Prepare and adjust project presentation	Schedule presentation date	Complete final project paper and presentation	Review feedback for future research

APPENDIX G:

LITERATURE REVIEW GRID

Project Question: *In an outpatient clinic setting caring for Latino patients (P), do providers and staff who undergo cultural competency training (I) improve cultural competency scores (O) compared to no training (C)?*

Pub. Year Author's Last Name	Title of Publication	Type of Study	Main Outcomes or Findings	Support for and or Link to Project
Ahmed, et al., 2018	How to measure cultural competence when evaluating patient-centred care: a scoping review	Scoping review	Standardized measures for cultural competence evaluation are lacking Most used structure and process indicators which are foundation for building process and outcome indicators—importance noted by Lewin group and patient-centered care framework Inclusion of cultural humility and safety perspective can prevent stereotyping of people from diverse backgrounds Indicators should reflect cultural humility and safety—need to collaborate with patients, families, and community members Lack of evidence on the evaluation and implementation of indicators in care settings; one source identified cultural competence with respect to cultural humility and cultural safety	Patient-centered care (PCC) needs to be culturally competent to serve diverse community—will reduce health disparities Lack of communication can lead to distrust between patient and provider and reduce intent to seek care
Alizadeh & Chavan, 2016	Cultural competence dimensions and outcomes: a systematic review of the literature	Systematic review	Cultural competence an ongoing process, no endpoint Cultural awareness, cultural knowledge and cultural skills/behavior found to be major elements agreed on in cultural competence frameworks Cultural desire and cultural encounter also included in some	Help to define elements of cultural competence that can be altered or improved

Pub. Year Author's Last Name	Title of Publication	Type of Study	Main Outcomes or Findings	Support for and or Link to Project
			Most measured outcome is patient satisfaction Few used impact of providers' cultural competence on patient trust and health status as outcome	
Darnell & Hickson, 2015	Cultural Competent Patient-Centered Nursing Care	Theoretic framework	National League for Nursing and the Association of Colleges of Nursing cultural diversity tool kit Cultural awareness, cultural knowledge, cultural skill, and cultural encounter needed for cultural competence Cultural competence achieves patient-centered cared, improves patient satisfaction and outcomes	Not a study; review of cultural competence with resources
Henderson, Horne, Hills, & Kendall, 2018	Cultural competence in healthcare in the community: A concept analysis	Concept analysis	Cultural openness, awareness, desire, knowledge and sensitivity and encounter noted as antecedents to cultural competence Antecedents represent a superficial level of understanding, driven by social desirability What is culturally appropriate for one may not be appropriate for another even if from the same culture—simply having cultural knowledge is not sufficient; lack of understanding of what cultural competence is and ensues	Rather than training, skills, and information for cultural competence, must attempt to develop a higher level of moral reasoning through exposure to authentic situations Mandatory cultural competence training

Pub. Year Author's Last Name	Title of Publication	Type of Study	Main Outcomes or Findings	Support for and or Link to Project
			Antecedents needed to achieve positive consequences of cultural competence Fairness and critical and moral self-reflection required to develop cultural competence	
Govere & Govere,	How Effective is Cultural Competence Training of Healthcare Providers on Improving Patient Satisfaction of Minority Groups? A Systematic Review of Literature	Systematic review	Cultural competence training intervention significantly increased the cultural competence level of healthcare provider and significantly associated with increased patient satisfaction	Quality and methodological rigor of individual studies were low Need to conduct high-quality studies to establish relationship between cultural competence training and patient satisfaction
Lin, Lee, & Huang, 2017	Cultural Competence of Healthcare Providers: A Systematic Review of Assessment Instruments	Systematic review	Six cultural dimensions addressed by instruments: attitudes, knowledge, skills, behaviors, desires, and encounters 10 instruments had content validated by expert panel Attitude-knowledge-skill model of cultural competence was the most frequently used	Help to decide which instruments to measure/developing questions for process and outcome measures
Paroz, et al., 2016	Cultural competence and simulated patients	Descriptive study	Two 90-minute case scenarios completed by students Students reported improvements in self-reflection and cultural sensitivity	No causative association Description of simulative teaching without formal measures

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