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The Effects of Cultural Competency Training on Providers Knowledge, Skills and Attitudes
Towards the Latino Population

Submitted in Partial Fulfillment of the Requirements for the Degree of Doctor of Nursing
Practice at the University of Kentucky

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Lexington, Kentucky

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Abstract

Background: Providers in the United States (U.S.) healthcare system need to understand the cultural values, beliefs, and traditions of the growing Latino population. As a result, academic institutions are incorporating cultural competency training in their curricula. However, a noticeable knowledge gap exists for those currently practicing in the healthcare arena, impacting patient and provider satisfaction and healthcare outcomes.

Purpose: The purpose of the study was to obtain a baseline assessment of the cultural competence of a select group of Advanced Practice Providers (APPs) caring for the Latino population at the University of Kentucky and provide a targeted educational intervention, followed by a post-intervention assessment utilizing the same evidence-based tool.

Conceptual Framework: Schim and Miller's Cultural Competence Model (CCM) was utilized as the framework for this study.

Methodology: This study used a one-group pre-test post-test design to examine the effect of a cultural competency educational module for APPs on their knowledge related to cultural diversity, awareness, and sensitivity.

Results: Thirteen participants completed the pre-survey and 11 completed the post-survey. Seven participants completed both the pre and post-surveys. There was no change in the pre and post self-reported overall cultural competency assessment scores in relation to the educational intervention, which was expected with a small sample size. However, it is important to note that the cultural competence behavior (CCB) scores were higher after the educational intervention.

Conclusion: The implementation of cultural competency training for Advanced Practice Providers did result in increased CCB scores. However, this study needs to be replicated with a larger, more inclusive sample size.

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I genuinely appreciate all the faculty and staff within the College of Nursing who have supported me and provided such an excellent opportunity for professional growth and development. I have enjoyed hearing their personal stories and will take with me the pearls of wisdom they so graciously offered to everyone they encountered along the way. I am truly honored to be a part of the UK College of Nursing.

Dedication

First, I would like to thank my husband for his support, not only during this program but throughout my career. Most people do not know the joy of having a partner at work and home. We worked for many years side by side as a physician and a nurse with a true partnership and level of respect that I wish all nurses could know. Both he and my four children have sacrificed valuable time to allow me to pursue this dream. I hope my children will see the importance of education and the dedication needed to pursue and achieve a terminal degree and carry this lesson throughout life. I am thankful to my friends and family who have offered to carry the weight and be "my village" while I dedicated time to this program.

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The Effects of Cultural Competency Training on Providers Knowledge, Skills and Attitudes
Towards the Latino Population

Background and Significance

Culture is a broad term first seen in anthropology, that describes characteristics that humans attain from exposure to a particular environment or group of people with shared experiences and common values. Culture is not static, but instead is dynamic and ever-changing. Cultural competence is a general definition used to describe the ability to interact, understand and appreciate those who have a different belief system than one's own (Leininger, 1991). In the healthcare setting, cultural competency is the ability of systems to provide healthcare to patients with diverse beliefs, values, and behaviors, which may include tailoring the approach to meet their social, cultural, and linguistic needs (Betancourt et al., 2002). However, it is important to note that while individuals within the same cultural groups may share similar beliefs, attitudes, and behaviors, a patient's health beliefs concerning disease processes and treatments are influenced by a combination of cultural values, individual experiences, and perceptions. Therefore, if a provider lacks cultural sensitivity or fails to establish a basic level of cultural competence, the patient may receive suboptimal care.

According to Juckett (2013), Latinos are the fastest-growing, most diverse minority group in the United States (U.S.). From 2010 to 2020, Latinos/Hispanics comprised over half the total population growth in the U.S., and as of the 2020 Census, made up 18.5% of the total population (US Census Bureau, n.d.). Comparatively, the Latino population in rural states continues to rise. The 2015-2019 American Community Survey projects Kentucky growth has increased by 38.9% since 2010 (US Census Bureau, 2020).

The ethnic terms, *Latino or Hispanic*; refer to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture, regardless of race (Juckett, 2013). Each of the groups represents a subculture of the Latino population, which may share some commonalities or traditions but should be recognized for their distinct differences. Juckett (2013), notes that the three largest subcultures in the U.S. are Mexican American (65%), Puerto Rican (9%), and Cuban American (3.5%).

Twenty three percent of Latinos in the U.S. live in poverty and have difficulty accessing health care (Juckett, 2013). Hispanics have the highest uninsured rates of any racial or ethnic group (US Department of Health & Human Services, Office of Minority Health, 2021). Language is a huge barrier to care within the Latino population, which may help explain ethnic disparities in healthcare outcomes (Napoles et al., 2012). Communication challenges leave them feeling vulnerable, overlooked, and often dismissed. Many Latinos recognize the necessity of learning the English language to communicate but prefer living within their own communities and speaking their native language (Sobel & Sawin, 2014). Quality patient-provider communication and trust in physicians are associated with lower perceived emotional burden and higher patient satisfaction (Baig et al., 2014). Many medical schools are recommending that applicants take Spanish prior to applying and have begun to incorporate this offering in their curricula (Baig et al., 2014).

Prior to 1990, two-thirds of all the immigrants in the U.S. lived in six states, namely California, New York, New Jersey, Illinois, Texas, and Florida, in firmly rooted ethnic communities (Bagchi et al., 2012). Over the past twenty years, the immigrant population has spread to many other states, which has weakened community support and resulted in less successful integration of families. The decrease in community support further compounds racial

and ethnic disparities such as language barriers, lower education levels, and higher incidence of poverty (Bagchi et al., 2012).

Latinos are a collectivist culture, meaning group activities are dominant over individual functions and they believe in shared decision making which can affect health care planning and decision-making (Centers for Disease Control and Prevention, n.d). Providers should recognize the importance of the family role in the Latino culture and adjust their processes accordingly. "Providing culturally competent healthcare is congruent with providing high-quality health care and can contribute to reducing ethnic disparities and improving patient outcomes" (Napoles et al., 2010).

Quality indicators are implemented in healthcare systems to gauge performance; however, none are dedicated strictly to cultural factors. One attempt to address this was to create the "Culturally and Linguistically Appropriate Services (CLAS)" standards authored by the US Department of Health and Human Services, Office of Minority Health. CLAS standards are actionable steps to advance health equity, improve quality and help eliminate health care disparities by providing a roadmap to implementation for individuals and organizations (Office of Minority Health, 2021).

It is unreasonable to believe that systematic change can occur solely by improving individual providers' cultural competence. A systems perspective is comprised of interrelated pieces including patient care, professional staff, and ancillary services with necessary administrative support services including financial, informational, and physical (McCalman et al., 2017). Organizational cultural competency is a commitment from a strategic and business planning approach. Some aspects include human resource management, a diverse workforce, training,

interpretation services, and the creation of service level policies. In 2021, the American Hospital Association recommended adopting the following organizational standards:

1. Collecting race, ethnicity, and language preference (REAL) data
2. Identifying and reporting disparities
3. Providing culturally competent disease management programs
4. Increasing diversity and minority workforce pipelines
5. Involving the community
6. Incorporating cultural competency in institutional policy (including self-assessment checklists for hospital leaders)

Govere and Govere (2016) found that Latinos reported they felt as if they were receiving individualized care and experienced increased patient and family satisfaction when cultural competency training occurred. Latinos agreed that being offered an interpreter, or having the nurse or provider know a few Spanish words, helped build trust and illustrated a willingness to learn about their culture. Having the ability to receive patient education in their native language empowered them to participate in their care instead of being a bystander.

Purpose and Objectives

The purpose of the study was to obtain a baseline assessment of the cultural competence of a select group of Advanced Practice Providers (APPs) caring for the Latino population at the University of Kentucky and provide a targeted educational intervention, followed by a post-intervention assessment utilizing the same evidence-based tool. Advanced Practice Providers (APPs) are defined as Nurse Practitioners (NPs), Physician Assistants (PAs), and Certified Registered Nurse Anesthetists (CRNAs).

The specific aims of this study were:

1. Establish a baseline assessment of the cultural competency of advanced practice providers
2. Implement a cultural competency educational module focused on the Latino population and its three major subcultures
3. Examine changes in advanced practice providers awareness of the Latino culture
4. Assess changes in advanced practice providers sensitivity related to the Latino culture
5. Examine the change in advanced practice providers behaviors when providing care to the Latino population

Theoretical Framework

The cultural competence model (CCM), authored by Stephanie Myers Schim and June Miller (1999), aimed to establish a set of basic definitions paired with a simple stepwise framework of commonsense concepts (Schim et al., 2007). The initial visual representation was stair steps, with diversity as the bottom step and cultural competence as the top step; however, the revised 3-D model displays the interconnected components and illustrates the fact that they cannot exist independently (Fitzpatrick & McCarthy, 2014). In its current version, modified by Schim and colleagues in 2007, the visual representation of the model is a jigsaw puzzle of the four basic constructs that constitute the main pieces of the cultural competence puzzle (see Figure 1). These include (a) cultural diversity, (b) cultural awareness, (c) cultural sensitivity, and (d) cultural competence.

Cultural diversity encompasses a human being's unique experience and exposure to individuals from diverse groups. This includes race, ethnicity, gender, religion, socioeconomic status, sexual orientation, and language differences. Cultural awareness can be defined as the knowledge surrounding the differences and the provider's ability to understand the importance of

cultural beliefs, values, and traditions to assess the patient appropriately. Cultural sensitivity is the ability to identify one's own beliefs and attitudes towards other cultures and recognize the importance of learning about other cultures. Finally, cultural competence is a set of behaviors demonstrated in response to cultural diversity, awareness, and sensitivity, allowing the provider to accurately assess the patient and adapt their services to meet their needs (Fitzpatrick & McCarthy, 2014).

Literature Review

A comprehensive literature search was performed using the CINAHL, PubMed and MEDLINE databases. Keywords included in the search were “cultural competency” and “Latino” which produced 26 full-text, peer-reviewed articles dating from 2011 to 2021. Introducing terms such as “healthcare” reduced the number of articles to 14. CINAHL with the exact wording, displayed six articles. The search was filtered to include articles for adults aged 18 and over.

Research has shown that an effective strategy to improve cultural competency is to provide training to healthcare providers (Baig et al., 2014; Cersosimo & Musi 2011; Chiauzzi et al., 2011; Cuevas et al., 2017; Napoles et al, 2012; Parrish & Farrada,2014; Juckett, 2013; Sobel & Sawin, 2016). The evidence is divided in relation to the type of training to include: educational training as it relates to Latino comorbidities or cultural competency training regarding values, beliefs, and traditions while incorporating folk medicine. Cersosimo and Musi (2011) discuss the importance of including the family in the plan of care and assessing the level of acculturation to gauge medication compliance.

The literature lends support to the value of addressing language barriers and utilizing trained interpreters if available. Strong evidence exists that Latinos prefer providers who are bilingual as

opposed to interpreters (Baig et al., 2014; Cersosimo & Musi, 2011; Chiauzzi et al., 2011; Napoles et al., 2012; Sobel & Sawin, 2016). Parrish & Farrada (2014) presented compelling evidence related to training medical students in emergency settings. The medical students participated in a General Surgery Grand Rounds highlighting the importance of communication in an emergency. Following the lecture, the students received a Spanish lesson with a pocket-sized handout card with English/Spanish translation emergency questions needed in a trauma setting. All participants' comfort levels increased after the lesson.

One systematic review of literature conducted by McCalman et al. (2017) offered the most compelling research to demonstrate the impact of improving cultural competence through an organizational systems approach. Three main themes emerged among the twelve interventions and three measurement studies. The first element was user engagement, which included activities such as community involvement, senior leadership commitment, and integration of cultural competency activities in daily operations (Chong et al., 2011; Wiley, 2009; Freeman, 2014; Liaw, 2015; O'Brien, 2007; Riebel, 2010). Chong et al. (2011) described building a quality improvement framework collaboratively with the community citizens.

The second element identified was organizational readiness (Noe, 2014). This was addressed by utilizing surveys and readiness assessments within the Department of Veterans Affairs to implement American Indian and Alaskan Native programming and services. Several articles noted the importance of management commitment as an enabler to implementation (Weech-Maldonado, 2012, Chong et al., 2011; Freeman, 2014; Lieu, 2004; Whitman & Davis, 2008). The final theme was focused on multiple sites of delivery, rather than a single healthcare site. The numbers ranged from two healthcare sites (Freeman et al., 2014) to sixty-six hospitals (Weech-Maldonado, 2012).

Specific publications reported the use of service level policies (Lieu, 2004; Weech-Maldonado, 2012) or implementing audit processes, including examples such as creating bicultural audit tools to measure the achievement of mental health nursing practice standards against standards of expected health care (O'Brien, 2007; O'Brien, 2008). Liaw (2015) documented full quality improvement cycles with 10 general practices with outstanding results. Some researchers focused their studies on policies and audit tools including cultural respect (Whitman & Davis, 2008; Freeman et al, 2014; Whelan, 2008).

Gaps in the Literature

Gaps were noted in the literature in relation to cultural competency education. Much of the existing literature focused on patient satisfaction as opposed to provider comfort level. Only one study, from the University of Kentucky (Bernard et al., 2006) cited the anxiety and stress felt by physicians and nurses when they were unable to communicate with patients and families. Another limitation of the literature is the minimal number of Latino men included in research studies. This could be attributed to them being the breadwinners for their families and working outside the home. Alternately, women in the Latino culture are the primary caregivers of the children and the elderly and were participants in most studies. Finally, studies evaluating the cost-effectiveness of cultural competency training are needed to continue tackling the minority healthcare disparities. "Seventy percent of the growth in the US population between now and 2050 is predicted to be due to immigration; research strategies and interventions that meet the needs and circumstances of these newly arrived populations will be crucial to public health" (Martinez, 2012).

Methods

Design

This study employed a one-group pre-test post-test design.

Setting

The setting for the study was the University of Kentucky, a 977-bed academic medical center in the southeastern United States, which holds designations as a level I adult and pediatric trauma center and is a designated Magnet facility. The hospital employs approximately 580 APPs. This study aligns with the values of the medical center (DIReCT), fostering diversity in a people-centered environment that is inclusive while embracing innovation, continual learning, and driving positive change. One value is that the university will respect patients and families, show compassion, and cultivate teamwork to create positive outcomes (UK Healthcare, 2022).

Sample

APPs were recruited from various settings, including one outpatient primary care clinic, the emergency department, and four inpatient services staffing the intensive care units, medical units, and the perioperative areas. Inclusion criteria were providers, 24-70 years of age, of several races and ethnic backgrounds. The providers had varied job titles, including NPs, PAs, and CRNAs. Exclusion criteria included those not employed by the academic medical center for at least six months and those not seeing patients independently.

Procedures

The University of Kentucky's Institutional Review Board (IRB) approved this study. Approval was granted by the university's nursing research council and the advanced practice provider Professional Development Coordinator. Participants were sent a cover letter describing the study with an embedded link to take the pre-survey. Informed consent was implied if the APP chose to participate in the pre-survey. The participants were instructed to review the PowerPoint educational module. A post-survey link was embedded at the end of the educational

module. Participants were given two weeks from the date of receiving the email notification to complete the education and survey.

Intervention

The educational module was provided to APPs in various settings, including Primary Care, Emergency Department, Hospital Medicine, Medical Intensive Care Unit, CRNAs, Trauma-Surgical Services, and Critical Care Medicine. The educational module consisted of a 20-minute comprehensive overview of the history of the Latino population in the U.S., the origin of the Hispanic terminology, identification of the three main subcultures, their similarities, and differences. Medical comorbidities for the Latino population and cultural normative values were discussed in depth to provide context to the APPs. Broad social and political concepts were discussed and a short video clip on minority health disparities was made available. Additional resources were provided at the end of the presentation for continued learning. The goal of the intervention was to enhance provider knowledge and understanding of acculturation and its impact on healthcare outcomes. A post-assessment survey was completed following the intervention to identify if there was a change in self-reported competency, personal diversity experiences, awareness, sensitivity, or cultural competency behaviors.

Measures and Instruments

The Cultural Competence Assessment (CCA) Tool, created by Drs Schim et al. in 2003, was utilized for pre and post-surveys. The tool was adapted by eliminating two questions, and it included four components: demographics, cultural diversity experience, two subscales including cultural awareness and sensitivity, (CAS) cultural competency behaviors (CCB).

Demographic items included age, current role, years of experience, and prior diversity training. The cultural diversity question is a single item that asked the participant if they had

encountered certain racial/ethnic groups in the past 12 months. A higher number indicated a greater diversity of experience. The CAS subscale, measuring awareness and sensitivity, and the CCB subscale, measuring cultural competence behaviors both had scores ranging from 1 (strongly disagree) to 7 (strongly agree), with 8 labeled (no opinion). An average of the items within each of the CAS and CCB domains were computed, yielding a potential range of 1 to 7. Higher scores indicated greater knowledge, more positive attitudes and greater frequency of competency behaviors (Doorenbos et al. 2005). Mean scores of 4-5 indicate moderately high levels of cultural responsiveness while scores of 6-7 indicate high levels of cultural responsiveness.

Cultural competence behaviors are the observable outcomes of diversity experience, increased awareness, and sensitivity. Consistent demonstration of behaviors such as focusing on cultural assessment and discussing expectations for care are hallmarks of cultural competence (Doorenbos et al. 2005). Changes in the pre-and post-survey scores determined the effectiveness of the intervention.

Data Collection

Participants completed the pre and post-survey on Research Electronic Data Capture (REDCap). Surveys were numbered automatically using the sequential numbering format within REDCap. Participants were asked to provide their year of birth and the first name of their street as identifiers. The participant data was not associated with any email addresses. The pre and post-survey results were available in electronic format.

Descriptive analysis, including means, standard deviations, or frequency distributions, were used to summarize demographic data such as age, current role, years of experience, and prior diversity training. Outcome variables for the CCA were analyzed using paired sampled T-test to

assess differences in the APPs knowledge before and after completing the cultural competency educational module. To examine differences in baseline CCA outcomes by previous formal training in APP programs, the two-sample t-test was used. SPSS version 28 was used to perform statistical analyses, and statistical significance was considered a p-value less than or equal to .05.

Results

A total of 18 participants accessed either the pre or post-survey. Thirteen completed the pre-survey and 11 completed the post-survey. Seven participants completed both the pre and post-surveys. The average age of participants was 39.2 years of age (SD=3.9; see Table 1) with the average years of experience being 6.8 years (SD= 4.1). The majority were NPs (85.7%) while 14.3% were PAs and none were CRNAs.

The majority of APPs (71.4%) had formal cultural awareness training within their academic programs. All participants answered “yes” regarding having encountered patients from the Hispanic/Latino, White and Asian populations. The majority had encountered Black (85.7%) and Arab American (85.7%) individuals, with fewer having encountered Native Hawaiians (14.3%). On the self-reported CCA, the majority rated themselves as somewhat competent (57.1%) or competent (28.6%).

For the 7 providers, pre-education and post-education mean scores for cultural competency did not change. Based on a scale of 1) incompetent to 5) competent, participants rated themselves exactly the same and relatively competent prior to and following completion of the education (M=3.71, SD=.76; see Table 2). The cultural awareness and sensitivity subscale scores were similar between the pre and post-education surveys ($p = .60$). Based on a potential range of 1-7 with higher scores reflecting more cultural awareness, the scores were relatively high at both

time points ($M = 6.57$, $SD = 0.31$ pre and $M = 6.52$, $SD = 0.33$ post). There was a slight, but non-significant ($p = .17$) increase in the cultural competence behavior subscale scores following education ($M = 5.17$, $SD = 0.65$ pre and $M = 5.39$, $SD = 0.65$ post).

Five providers reported having formal cultural competency training in their APP program whereas two providers reported no formal training. While there was no significant difference in the baseline self-reported cultural competency, and the cultural competence behavior subscale scores between the two groups, there was a marginal increase ($p = .058$) in the baseline cultural awareness and sensitivity subscale scores ($M = 3.92$, $SD = 0.55$ vs. $M = 3.42$, $SD = 0.12$; see Table 3).

Discussion

This study sought to determine if a virtual educational intervention could result in an increase in cultural competency in caring for the Latino population for a group of APPs. Overall cultural competence scores did not change significantly following an educational intervention, but there was a slight increase in the CCB scale score. Upon reflection, an improvement in both subscales and overall self-reported cultural competency scores would have been ideal. However, perhaps the educational intervention did not align with the CCA tool. As previously stated, the hallmark of cultural competence is the presence of culturally competent behaviors reflected in the provider's daily practice as evidenced by seeking additional resources, noting cultural aspects in the provider's documentation, and eliciting information from the patient to address cultural aspects of care. The lack of difference in pre and post overall cultural competency scores may have occurred because the post-survey was done immediately after the intervention. However, the possibility exists that participants could have reported what they believed to be the most socially acceptable but perhaps not the most accurate answer, as noted in a study by Loftin et al (2013). Utilizing a tool that observes behavior instead of self-reporting would minimize this limitation in the future.

Of the seven APPs in this study, five (71.4%) previously had cultural competency training in their educational program and reported higher cultural awareness and sensitivity scores pre-intervention compared to those who did not have formal cultural competency training. Chiauzzi et al. (2010) stated “healthcare providers report minimal training regarding cultural competence which isn’t surprising given that only 26% of US and Canadian medical schools teach their students about the aspects of Latino culture that can potentially affect health care.”

One possible cause for not seeing an increase in CCA or CAS scores after the intervention could be related to a common misconception or generalization by the providers being familiar with the Latino culture. The educational module provided in-depth knowledge regarding the three Latino subcultures. Baig et al. (2014) concurred that there is insufficient comprehension regarding various cultural subgroups, which is of no surprise since most studies are focused on Mexican Americans and little is known of other subcultures. Even Latino providers do not always score high in cultural awareness scores as they may not be aware of differences in subgroups, and how their beliefs affect health behavior (Baig et al., 2014).

Implications for Practice, Policy, and Research

Cultural competency remains a broad topic with many facets; however, there is substantial evidence of its impact on the patient-provider relationship, and patient satisfaction. While many valid and reliable tools exist to measure cultural competency, the educational methodologies vary in format and length. Some allow for retesting after a standard period while others do not. Standardization would strengthen the evidence. The purpose of this study was to obtain a baseline assessment of the cultural competency of a select group of Advanced Practice Providers (APPs) caring for the Latino population and provide an educational intervention to improve their knowledge, skills, and attitudes related to this population. The goal of the intervention was to

improve the APPs' cultural competency levels and provide compelling evidence to support the intervention. The approach to addressing cultural competency education should be comprehensive, incorporating a robust curriculum throughout the undergraduate and graduate settings in both nursing and medical schools. Systems and organizations should prioritize these efforts, specifically when implementing culture-specific quality indicators that impact minorities. Policymakers should explore incentivizing healthcare organizations and academic institutions that generate cultural competency best practices that are associated with quality metrics (i.e., healthcare organizations- increased medication compliance related to diabetes; academic institutions-% of students qualified as certified interpreters). We too have a personal responsibility to be open to learning about other cultures, not only from our patients but our peers, while remembering that cultural competency is a lifelong journey.

Limitations

This study had several limitations, the most obvious being the small sample size of 7 participants who completed all three study components. The second limitation was that only some participants completed the pre-survey and the intervention while others completed the intervention and the post-survey only. An unavoidable challenge was the need to do virtual versus in-person education due to COVID-19 social distancing guidelines, which may have stifled participation. Another limitation was collecting self-reported behavior of providers as opposed to observing behavior. The final challenge encountered was the REDCap software, which went down several times throughout the study, specifically on the initial day the study opened.

Conclusion

The intent of the study was to capture a baseline cultural competency assessment of a specific group of APPs at the University of Kentucky and provide an educational intervention to see if there was any improvement in cultural competency scores. The study results did show improvement in CCB Subscale scores, however only minor improvements. One theory is that the Latino population is a diverse population with many subcultures that is often generalized and providers may feel overly confident regarding their knowledge, specifically when it is self-reported. Healthcare providers need to focus their efforts not only on unique aspects of each subculture but also on the differences that exist between immigrants and those born in the U.S. Healthcare leadership and its correlated system must be prepared to manage not only their population-specific illnesses but tackle cultural challenges, language barriers, inherent lack of trust in our system, and poor patient satisfaction (Baig et al., 2014). While the academic curricula are changing for medical and nursing schools to address this transforming landscape, there is still a glaring knowledge gap that exists for many providers currently delivering care to those who are vulnerable and facing challenges to access quality healthcare within our country.

References

- American Hospital Association. (2021). Becoming a Culturally Competent Health Care Organization. Retrieved from <https://aha.org/system/files/hpoe/Reports-HPOE/becoming-culturally-competent-health-care-organziation.PDF>
- Baig, Benitez, A., Locklin, C. A., Campbell, A., Schaefer, C. T., Heuer, L. J., Lee, S. M., Solomon, M. C., Quinn, M. T., Burnet, D. L., & Chin, M. H. (2014). Community Health Center Provider and Staff's Spanish Language Ability and Cultural Awareness. *Journal of Health Care for the Poor and Underserved*, 25(2), 527–545.
<https://doi.org/10.1353/hpu.2014.0086>
- Betancourt, Green, A. R., Carrillo, J. E., & Park, E. R. (2005). Cultural Competence and Health Care Disparities: Key Perspectives and Trends. *Health Affairs*, 24(2), 499–505.
<https://doi.org/10.1377/hlthaff.24.2.499>
- Centers for Disease Control and Prevention. Cultural Insights: Communicating with Hispanics/Latinos. Retrieved on March 20th, 2022 from [Cultural Insights: Communicating with Hispanics/Latinos \(cdc.gov\)](https://www.cdc.gov/culturalinsights/communicating-with-hispanics-latinos)
- Centers for Disease Control and Prevention (2021). Minority Health and Health Equity.
<https://www.cdc.gov/minorityhealth/index.html>
- Cersosimo, & Musi, N. (2011). Improving Treatment in Hispanic/Latino Patients: Challenges and Opportunities in the Management of the Hispanic/Latino Patient with Type 2 Diabetes Mellitus. *The American Journal of Medicine*, 124(10A)

- Chiauszi, Black, R. A., Frayjo, K., Reznikova, M., Grimes Serrano, J. M., Zacharoff, K., & Wood, M. (2011). Health Care Provider Perceptions of Pain Treatment in Hispanic Patients. *Pain Practice, 11*(3), 267–277. <https://doi.org/10.1111/j.1533-2500.2010.00421.x>
- Cuevas, O'Brien, K., & Saha, S. (2017). What is the key to culturally competent care: Reducing bias or cultural tailoring? *Psychology & Health, 32*(4), 493–507. <https://doi.org/10.1080/08870446.2017.1284221>
- Cypress. (2015). Theories guiding nursing research and practice: making nursing knowledge development explicit By Joyce J. Fitzpatrick and Geraldine McCarthy. Springer Publishing Co., 2014, \$70.00, 361 pages. ISBN 978-0-8261-6404-9 [Review of *Theories guiding nursing research and practice: making nursing knowledge development explicit* By Joyce J. Fitzpatrick and Geraldine McCarthy. Springer Publishing Co., 2014, \$70.00, 361 pages. ISBN 978-0-8261-6404-9]. *Nursing Philosophy, 16*(3), 167–169. <https://doi.org/10.1111/nup.12084>
- Doorenbos, Schim, S. M., Benkert, R., & Borse, N. N. (2005). Psychometric Evaluation of the Cultural Competence Assessment Instrument Among Healthcare Providers. *Nursing Research (New York), 54*(5), 324–331. <https://doi.org/10.1097/00006199-200509000-00006>
- Govere, & Govere, E. M. (2016). How Effective is Cultural Competence Training of Healthcare Providers on Improving Patient Satisfaction of Minority Groups? A Systematic Review of Literature. *Worldviews on Evidence-Based Nursing, 13*(6), 402–410. <https://doi.org/10.1111/wvn.12176>

- Juckett (2013). Caring for Latino Patients. *American Family Physician*, 87(1), 48–54. Retrieved from <https://www.aafp.org/afp>
- Leininger, M. M. (1991). Culture care diversity and universality: A theory of nursing. New York: National League for Nursing.
- Loftin, C., Hartin, V., Branson, M., & Reyes, H. (2013). Measures of cultural competence in nurses: an integrative review. *The Scientific World Journal*, 2013, 289101. <https://doi.org/10.1155/2013/289101>
- McCalman, Jongen, C., & Bainbridge, R. (2017). Organizational systems' approaches to improving cultural competence in healthcare: a systematic scoping review of the literature. *International Journal for Equity in Health*, 16(1), 78–78. <https://doi.org/10.1186/s12939-017-0571-5>
- Martinez, McClure, H. H., Eddy, J. M., Ruth, B., & Hyers, M. J. (2011). Recruitment and Retention of Latino Immigrant Families in Prevention Research. *Prevention Science*, 13(1), 15–26. <https://doi.org/10.1007/s11121-011-0239-0>
- Nápoles, Santoyo-Olsson, J., Farren, G., Olmstead, J., Cabral, R., Ross, B., Gregorich, S. E., & Stewart, A. L. (2012). The patient-reported Clinicians' Cultural Sensitivity Survey: a field test among older Latino primary care patients: Clinicians' cultural sensitivity survey. *Health Expectations: An International Journal of Public Participation in Health Care and Health Policy*, 15(1), 63–77. <https://doi.org/10.1111/j.1369-7625.2010.00654.x>
- Parrish, & Ferrada, P. (2014). Understanding our patient's disparities and needs: a brief report in the use of a Spanish lesson to increase the comfort level during trauma situations. *The American Surgeon*, 80(11), E287–289. <https://doi.org/10.1177/000313481408001104>

- Schim, S. M., Doorenbos, A., Benkert, R. & Miller, J. (2003). Development of a Cultural Competence Development Instrument. *Journal of Nursing Measurement*, 11(1), 29-40.
PMID: 15132010
- Schim, S. M., Doorenbos, A., Benkert, R., & Miller, J. (2007). Culturally Congruent Care: Putting the Puzzle Together. *Journal of Transcultural Nursing*, 18(2), 103–110.
<https://doi.org/10.1177/1043659606298613>
- Schim, S.M., & Doorenbos, A.Z. (2010). A Three-Dimensional Model of Cultural Congruence: Framework for Intervention. *Journal of Social Work in End-of-Life & Palliative Care*, 6, 256 – 270. <https://doi.org/10.1080/15524256.2010.529023>
- Sobel, & Metzler Sawin, E. (2016). Guiding the Process of Culturally Competent Care with Hispanic Patients: A Grounded Theory Study. *Journal of Transcultural Nursing*, 27(3), 226–232. <https://doi.org/10.1177/1043659614558452>
- United States Census Bureau (2020). *Quick Facts; Kentucky*. Retrieved on March 19, 2022, from <https://www.census.gov/quickfacts/fact/dashboard/US,KY/PST040221>
- University of Kentucky Healthcare. (n.d.) *Mission/Vision*. Retrieved on March 19, 2022, from <https://ukhealthcare.uky.edu/subsite-test-daw/mission>

Table 1Table 1. *Descriptive Summary of Participant Characteristics (N=7)*

	Mean (SD) or n (%)
Age	39.2 (3.9)
Years of Experience	6.8 (4.1)
Role	
Nurse Practitioner	6 (85.7%)
Physician's Assistant	1 (14.3%)
Ever had cultural competency training	
Yes	5 (71.4%)
No	2 (28.6%)
Race/ethnicities encountered in practice, % yes	
Hispanic/Latino	100%
White	100%
Black	85.7%
Native American	28.6%
Asian	100%
Native Hawaiian	14.3%
Arab American	85.7%
Self-reported competency	
Neither competent nor incompetent	14.3%
Somewhat competent	57.1%
Competent	28.6%

Table 2Table 2. *Comparison of Cultural Competency Pre and Post-Intervention (N = 7)*

	Pre-education Mean (SD)	Post-education Mean (SD)	<i>p</i>
Cultural Competency (1-5)	3.71 (0.76)	3.71 (0.76)	---
Cultural Awareness & Sensitivity (CAS) Subscale (1-7)	6.57 (0.31)	6.52 (0.33)	.60
Cultural Competence Behavior (CCB) Subscale (1-7)	5.17 (0.76)	5.39 (0.65)	.17

Note: *p* value not available for changes in competency due to exact same scores for pre- and post-education

Table 3

Table 3. Comparison of Baseline Cultural Competence Scores in Providers based on whether they had Prior Cultural Competency Training in their APP Programs (N = 7)

	Prior Training/Yes (n = 5) Mean (SD)	Prior Training/No (n = 2) Mean (SD)	p
Cultural Competency (1-5)	3.56 (0.39)	3.50 (0.14)	.423
Cultural Awareness & Sensitivity (CAS) Subscale (1-7)	3.92 (0.55)	3.42 (0.12)	.058
Cultural Competence Behavior (CCB) Subscale (1-7)	5.57 (0.54)	5.81 (0.97)	.333

Figure 1

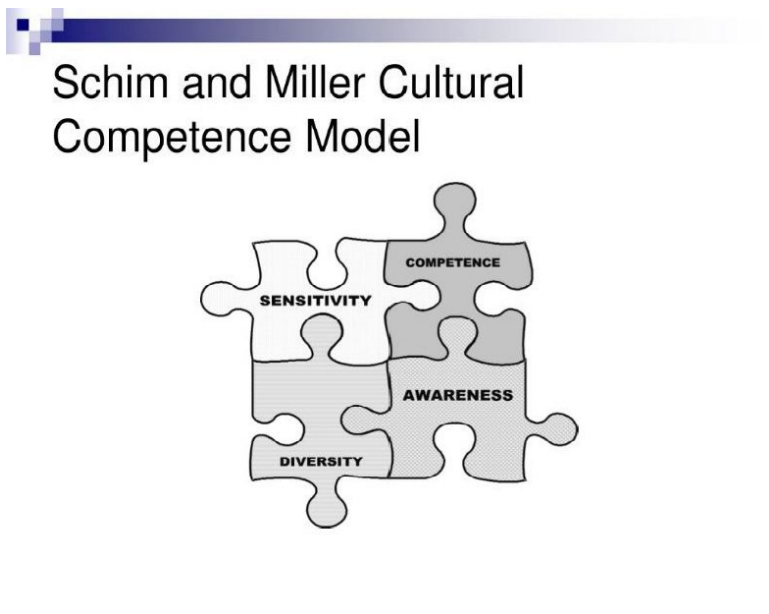


Figure 1. Cultural Competency Mode