2019

Cultivating Cultural Competence to Address Childhood Obesity in Ethnic Minority Youth

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This is to certify that the doctoral study by

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has been found to be complete and satisfactory in all respects,
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Walden University
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Abstract

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MS, Long Island University CW Post, 2014

BS, Stony Brook University, 2011

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

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Abstract

Obesity is an increasingly prevalent health issue, especially among children who live in high poverty, low income, and low education areas that lack needed resources and health care to promote quality of life. African American youth have a higher rate of obesity than other populations. The purpose of this project was to address an identified gap in practice by improving health care professionals' ability to provide culturally competent care to African American youth. An educational intervention framed by the Purnell model for cultural competence was developed to address if cultural competency staff education would improve knowledge to prevent and manage childhood obesity among African American youth ages 2 to 19. Health care professionals (n = 10) in 5 community clinics completed the 17-item, 5-point Likert response Cultural Competence Assessment before and after an online education module. The higher the sum of the scores on the items, the higher the self-assessed cultural competence. Using Cohen's d statistic to calculate effect size, a small effect size was found on 1 item, a medium effect size was found on 1 item, and a large effect size was found on 15 items, indicating an increase in self-assessment of cultural competency after the education intervention. The findings demonstrate that education can increase health care professionals' knowledge about how to provide culturally competent management of African American childhood obesity. Practicing culturally competent preventive care in ethnic communities can reduce the gap in practice, which may bring about positive social change in society by decreasing chronic health care comorbidities and disparities in ethnic populations. The project may be of particular interest to nurse providers in primary care and community settings.

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Dedication

This research project is dedicated to the continuation of social change and improvement of health disparities in America and abroad. As research continues to innovate, hopefully we can continue to close the health care gap transculturally.

Acknowledgments

I would like to acknowledge Walden University for its outstanding Doctor of Nursing program and unwavering effort to foster social change. Thank you to Dr. Sue Bell; you are an awesome professor! I was able to develop as a scholar through your direction. To my children Amira, Sydney, and Drew, you are my best accomplishment. Thank you for your patience and encouragement, which has kept me focused and given me the will to continue forward. Thank you, Dr. Terri Davis, for your support and direction. Lastly, to one of my mentors who transitioned a year ago: Dr. Edna P. Foster-Lewis, you are a woman of divinity and valor. Thank you for all the conversations, encouragement with my academic career, personal growth, and for your upstanding representation as an educator and a woman. I know you would have been at my graduation with that million-dollar smile. You will forever be missed; rest on, your living was not in vain. You have helped to develop this woman -- now a scholar -- to forge and lead fearlessly through greatness.

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Section 1: Nature of the Project

Introduction

Childhood obesity is a nationwide phenomenon in the United States. According to the Centers for Disease Control and Prevention (CDC) prevalence rating scale, the prevalence has tripled since 1980 (CDC, 2016b). One out of five school-aged children 6 to 19 years old in the United States is obese (CDC , 2016b). Not every child is affected to the same degree, however. The rate of childhood obesity among African American and Hispanic youth is higher than the rate in other populations, for example, and is an increasing epidemic, especially among children who live in high poverty, low income, and low educational areas that lack needed resources and health care to thrive and have a good quality of life (CDC, 2016b).

In this project, I developed a cultural competency education program addressing the challenges of childhood obesity among ethnic minority youth for nursing staff and health care providers. Cultural competence is knowledge of another person's culture; adapting interventions and approaches to health care to the specific culture of the patient, family, and social group (Cultural Competence, n.d). When caring for youth with obesity may promote potential positive social change in communication between healthcare professionals and individuals seeking care. As Yilmaz, Tokosoy, Direk, Bezirgan, and Boylu (2017) noted, understanding different health beliefs and attitudes of different ethnic groups allows nurses and health care professionals to facilitate communication, trust, and respect for cultural differences in their rendering of health care.

Problem Statement

The problem addressed by the project was the gap in culturally competent care for preventing childhood obesity among African American patients across five community clinic settings. Among African American youth, 21.4% of females and 18.4% of males are obese (CDC, 2016b). Poor nutrition, a sedentary lifestyle, and cultural behaviors can result in obesity, leading to long-term health care risks in adulthood such as diabetes and early death (CDC, 2016a, 2017). According to researchers, culturally sensitive nursing care can help to reduce the impact of such risk factors while addressing barriers and inequalities in health care, resulting in the improvement of patient care (Yilmaz et al., 2017, p. 160).

Culture is learned, shared, and transferred across generations (Marmo, Joyce, Jones, & Rabert, 2014). Furthermore, cultural family practices, values, and ways of life are critical factors in health care provider-patient relationships in all populations (Marmo et al., 2014) According to Jeffries (2006), cultural competence among providers is a factor that can make the greatest difference in promoting wellness, preventing illness, and restoring health.

Educational preparation is necessary to provide culturally competent care. Researchers have examined barriers to proper care for patients and found evidence of the need for ongoing cultural sensitivity courses for nursing professionals in order to promote optimal health outcomes (Allen, Brown, Duff, Nesbitt, & Hepner, 2013). Allen (2010) concluded that “cross-cultural education focused on both cultural competence and antiracism is necessary to promote effective cultural care in nursing education” (p. 314).

These research findings support the need for nurses and other health care professionals to acquire needed skills and knowledge in cultural competence to ensure better patient health and satisfaction outcomes. As Yilmaz et al. (2017) observed, an understanding of various ethnic health beliefs, individual patient needs, resource deficits, and unhealthy behaviors can foster improved communication, assessment, verbal and nonverbal cues, and therapeutic relationships that may lead to optimal health care outcomes.

Purpose

The purpose of this project was to develop cultural competency among clinic staff through an education intervention. When they understand cultural differences and needs, health care professionals are able to communicate effectively, change unhealthy eating behavioral patterns, discourage sedentary lifestyles, and promote methods of communication and implementation of care (Kanchana & Sangamesh, 2016). Information may be accepted more positively and trust developed more easily when care encompasses cultural competence, thereby enabling a better patient-provider partnership and patient commitment to change health status over time (Kanchana & Sangamesh, 2016). This doctoral project has the potential to address barriers related to cultural competence in health care, which may reduce health-related gaps in care. The question I sought to answer was, Will cultural competency staff education improve knowledge to prevent and manage childhood obesity among African American youth ages 2 to 19?

Nature of the Doctoral Project

I conducted the doctoral project at five community health centers in a low income, high poverty suburban area in a metropolitan area in the northeast United States; the

centers have 40 primary health care providers and nursing staff combined. I collected deidentified data from staff on their knowledge about different cultures and cultural health beliefs and their approach to caring for patients with different cultural backgrounds. The staff completed the self-assessment Cultural Competence Assessment (CCA) questionnaire developed by Schim, Doorenbos, Miller, and Benkert (2003) who determined that cultural competence training improved culturally competent care. (The questionnaire is included in Appendix A.) I then created an educational program based on Purnell's (2010) cultural competence model and provided it to the staff in an online format. The program encompassed culturally competent methods to address identified challenges and promote cultural competent health coaching for best patient outcomes related to primary and secondary prevention of childhood obesity. This education also promoted effective communication among the health care providers, nurses, and patients in order to change unhealthy eating behavioral patterns and discourage sedentary lifestyles for better quality of health.

Significance

Cultural competence when caring for youth with obesity may promote better communication between health care professionals and the individual seeking care which may result in positive social change. When approaching care from a cultural context with patients from different cultural ethnicities, health care professionals are able to communicate effectively by understanding different health beliefs and nutritional preferences (Kachana & Sangamesh, 2016).This knowledge allows providers to assist in changing unhealthy eating behavioral patterns, discouraging sedentary lifestyles, and

promoting methods of communication and implementation of care (Kanchana & Sangamesh, 2016). I sought to improve the quality of health care given to ethnic minorities facing childhood obesity by addressing children's weight as it relates to their cultural health beliefs. In doing so, I implemented an education intervention for nursing staff and health care providers to develop their preparedness for addressing the challenges of childhood obesity in a culturally competent manner. Araiza, Valenzuela, and Gance-Cleveland (2012) initially argued that less acculturated individuals maintain their connection to their own original cultural beliefs, which may include less utilization of health care services; however, the researchers discovered that culturally appropriate interventions and tailored nutrition programs are effective in promoting improved obesity prevention health outcomes among ethnic minorities. This project was aimed at cultivating a culturally competency staff education program on childhood obesity. However, findings might be transferable to address other comorbidities in healthcare practices (e.g., diabetes, hypertension, and depression), which also occur at a high rate in the African American community and represent a primary care gap (CDC, 2016a).

Summary

Evidence supports the need for nurses and other health care professionals to acquire the requisite skills and knowledge in cultural competency to ensure better patient health and satisfaction outcomes. The provision of culturally competent care encompasses improved communication, assessment, verbal and nonverbal cues, and therapeutic relationships (Purnell, 2002). Staff education on childhood obesity prevention can open communication about and understanding of various ethnic health beliefs,

individual patient needs, resource deficits, and unhealthy behaviors to produce optimal health care outcomes (Yilmaz et al., 2017). In Section 2, I will provide more information on the project's background and context and relevance to nursing practice.

Section 2: Background and Context

Introduction

The childhood obesity rate for African American youth is one of the highest in the United States, particularly for those who live in high poverty, low income, and low education areas where there is a lack of needed resources and health care (CDC, 2016b). Information may be accepted more positively, and trust developed more easily, when health care is provided with cultural competence, researchers have found; such care helps to create a better patient-provider partnership and obtain commitment by patients to change their health status over time (Kanchana & Sangamesh, 2016). I designed this project to determine if cultural competency staff and provider education improved knowledge of prevention and management of childhood obesity among African American youth.

Concepts, Models, and Theories

To provide a foundation for this project, I explored key theorists, philosophers, and foundational scholars who have addressed issues of cultural competency within health care. Key contributers to the literature include Madeleine Leininger, Collins Airhihenbuwa, Larry Purnell, and James Allen. Leininger's (1985) cultural care theory posits that culturally tailored nursing care results in beneficial outcomes for an individual or group of persons with similar or different backgrounds.

Airhihenbuwa (1989) developed the PEN-3 model to support the centrality of culture in health promotion projects. The premise of the theoretical model is that cultural beliefs and practices influence behaviors through three conceptual areas: (a) cultural

identity (person, family, neighborhood); (b) relationships and expectations (perceptions, enablers, nurturers); and (c) cultural empowerment (existential, positive, and negative behaviors; Airhihenbuwa, 1989). Lofton, Julion, McNaughton, Bergren, and Keim (2016) applied the PEN-3 model in their review of the strengths and weaknesses of culturally adapted obesity prevention trials in the U.S. published between 2003 and 2013. The review documented the importance of joint parent–child interventions, building a relationship between AA mentors and children, and emphasizing participation in preferred healthful activities. The authors stressed the need to understand cultural adaptation in order to create culturally congruent strategies and interventions in health promotion programs (Lofton et al., 2016).

Another contributor to the cultural competency approach to health care delivery was Allen (2013) who contended that "cross-cultural care is vital to ethical effective health care systems" (p. 1592). Purnell (2002) first used the cultural competence model as a clinical assessment tool for student nurses. This model can be used to foster culturally competent methods in health care delivery to minority youth and their caregivers by incorporating current evidence-based prevention measures and management interventions (Purnell, 2002). The additional schematic and metaparadigm concepts are applicable to all health care disciplines and practice settings, research findings show (Purnell, 2002). Major assumptions of Purnell's models are

- all health professionals need information about cultural diversity,
- understanding differences in an individual or group culture is imperative,
- culture has a powerful influence on responses to health care,

- cultural adaptations to standard interventions are necessary,
- a culturally competent health care provider must be aware of his or her own biases without affecting the care provided to patients, and
- cultural awareness improves self-awareness (Purnell, 2002).

Appendix B includes permission from Purnell to use this model in my project.

Nurses require educational preparation in cultural care. Allen et al. (2013) found a gap in nursing preparation, which resulted in the development and implementation of a cultural care community context in nursing education and within the social model of health. This knowledge allowed them to guide learning outcomes in creating health promoting interventions for populations, individuals, and families from culturally diverse backgrounds. They reasoned that health and medical treatment required healthy social, cultural, and physical environments. These social determinants played a vital role in health outcomes (Allen et al., 2013). Transcultural nursing care predicted the care needs of individuals and promoted culturally tailored care for best outcomes (Allen et al., 2013).

Social determinants of health for various ethnic populations affect a wide range of health risks and outcomes, such as low-income unstable housing, substandard education, and no access to quality nutrition (CDC, 2017). Promoting good health and social and physical environments requires an ongoing commitment by nurses to closing the gap to produce quality health outcomes for all (CDC, 2018). Past researchers found that learning transcultural care interventions was effective and gave nurses confidence in practicing cross-cultural care (Allen, 2013). Allen (2013) found that developing and implementing

an evidenced-based teaching approach to cross-cultural care, evaluating self-reported attitudes of biases by analyzing pretest and posttest education self-efficacy, and providing evidence-based recommendations supported nurses in providing cross-cultural care nursing. I undertook this doctoral project to help fill the gap in care observed among nurses and other health care professionals in clinic settings. Facilitating appropriate communication and respect for cultural differences can ultimately improve health care outcomes (Kanchana & Sangamesh, 2016). An expected outcome of project implementation is that nurses and other health care professionals will be better prepared to provide care applicable to all culturally diverse cases.

Relevance to Nursing Practice

This doctoral project advanced cultural competence in the clinical setting where it was implemented and filled a gap in care for nurses and other health care professionals. It did so by facilitating appropriate communication and respect for cultural differences among participants; incorporating such elements in patient care can ultimately improve health care outcomes, according to researchers (Purnell, 2002). Continuing to offer culturally competent education with nurses and health care professionals should allow them to hone their skills in implementing cultural adaptations for best health outcomes. Because innovation of nursing practice occurs through evidence-based research (Debiasi & Selleck, 2017), cultural competency education is pivotal to address the increasing demographic changes within U.S. society.

Local Background and Context

A high poverty, high obesity prevalence suburban area in a metropolitan city in the northeast United States was the site of the project. The population was approximately 63.1% African American, 34.1% Hispanic, 2% Caucasian non-Hispanic, 4.5% two or more races, 0.6% Asian, 0.8% American Indian, and 0.6% other races, according to the 2010 Census (United States Census Bureau, 2010). Thirteen percent (12.7%) of the population had a bachelor's degree, and 76% had a high school diploma (United States Census Bureau, 2010). The poverty rate was 13.3%, the per capita income was $21,818, and the median household income was $65,469 (United States Census Bureau, 2010).

According to the local health centers within the communities in the area, there were over 1,200 obese youth in the communities' health center registries. Five community health centers serviced the majority of the families within the population area by providing primary care to children, adolescents, adults, and older adults; women's health care; dental care; nutritional counseling; behavioral health services; and a Women's, Infants, and Children (WIC) program. The staff consisted of clerical personnel, nurses, medical assistants, physicians, nurse practitioners, a dentist, a nutritionist, social workers, and psychiatrists.

Among African American youth, 21.4% of females and 18.4% of males are obese (CDC, 2016b). Risk factors for obesity include poor nutrition, sedentary lifestyle, and cultural behaviors, which have been found ultimately result in physiological and psychosocial long-term health care risks in adulthood, which could lead to early death (CDC, 2015). The five health care centers within the low income, high poverty

neighborhoods in this project were staffed by multidisciplinary professionals from diverse cultural backgrounds. Clinic administrators felt that training the clinics' providers and staff members about African American culture and health practices would reduce cultural biases and lack of understanding cultural health beliefs that might be impeding best care outcomes for the African American patient population experiencing obesity comorbidities and increasing numbers of children with obesity (Marmo et al., 2014).

Role of the DNP Student

According to the AACN (2006), the doctoral-level nurse role enhances knowledge to improve nursing practice and outcomes, enhances leadership skills to strengthen practice and delivery of health care, and educates the next generation of nurses. As a primary care provider who delivers care to an underserved ethnically diverse population, I see a lack of support, trust, rapport, and communication between health care professionals and the individuals receiving care that affects patient outcomes. For this project, I implemented an education program for nursing staff and health care providers to address these challenges in a culturally sensitive manner; a goal was to assist providers with the delivery of care in childhood obesity prevention and management. This approach may be adapted by providers in other settings to address other health care comorbidities and disparities affecting ethnic minority populations.

Summary

Cultural competency education and research with nurses and other health care professionals may help to address the ongoing need and importance of culturally competent care for ethnic populations and may help to improve health outcomes and

reduce health disparities (Allen et al., 2013). The findings of this project are expected to help to implement culturally competent care and improve health outcomes by using established evidence-based prevention measures and management interventions to decrease childhood obesity. In section 3, I will provide more information on the analysis of evidence collected, which provided a context and relevance of cultural competence to nursing practice.

Section 3: Collection and Analysis of Evidence

Introduction

Cultural competency in caring for an individual or group's health is an ongoing issue in nursing and health care practice. Past researchers have discussed barriers to proper care for ethnically, racially, and linguistically diverse patients (Allen, 2010). The need for ongoing cultural competence courses for nurses and other U.S. health care professionals for optimal health outcomes has been reported consistently since the 1960s (Allen et al., 2013). The lack of adequate support in high poverty, low-income, underserved communities has led to the high rate of health care disparities today (CDC, 2016b).Childhood obesity is high among African American youth and is increasing in prevalence nationwide according to the CDC, resulting in long-term health care risks (CDC, 2016b).

Practice-Focused Question

The question addressed by this project was, Will cultural competency staff education improve knowledge to prevent and manage childhood obesity among African American youth ages 2 to 19? When the project was undertaken, there were over 1,200 obese youth in the registry at the local community health center in the project area. If health care professionals are inclined to understand different cultural health beliefs, presumably they will be able to improve health outcomes in this population.

Sources of Evidence

I used two sources of evidence to develop, implement, and evaluate this project: a literature review and the pretest/posttest CCA questionnaire. Kanchana and Sangamesh

(2016) noted that culturally competent nursing care is important in health care. Nurses and other health care professionals must acquire the skills and knowledge to improve outcomes of patient health and satisfaction through improved communication, assessment, verbal and nonverbal cues, and therapeutic relationships in their encounters with patients of diverse cultures. Marmo et al. (2014) reported that culturally competent care is "critical so each individual understands nutrition, physical activity, and cultural history shape who they are" (p. 5). In all populations, cultural family practices, values, and ways of life are important factors when considering healthcare provider-patient relationships (Purnell, 2002), which can be developed over time with an open mind toward the importance of cultural sensitivity Marmo et al., 2014). Araiza et al. (2012) affirmed that less acculturated individuals maintain their connection to their own original cultural beliefs, which may include lower utilization of healthcare services; however, the researchers discovered that culturally appropriate interventions and tailored nutrition programs are effective in promoting improved obesity prevention health outcomes among ethnic minorities.

Lofton et al. (2016) developed the PEN-3 model based on the premise that cultural beliefs and practices influence health behaviors related to obesity of African American ethnic minority youth. Researchers studying childhood obesity have focused primarily on low socioeconomic status ethnic minorities whose needs are unmet -- for example, the National Health and Nutrition Examination Survey, which has been used to collect data on the issue (CDC, 2017). Staff education of childhood obesity prevention can open communication about the issues and increase understanding of various ethnic

health beliefs, individual patient needs, resource deficits, and unhealthy behaviors to produce optimal health care outcomes (Yilmaz et al., 2017).

Analysis and Synthesis

I collected two sources of evidence for the project. Methods to complete the project included

1. I conducted a search of online databases including CINAHL, ProQuest, Medline, and Google Scholar to find current evidence related to best practices in obesity prevention and culturally sensitive approaches to obesity care of minority patients.
2. The clinics collected deidentified data over a 1-month period using the Schim et al. (2003) CCA questionnaire; the data were collected anonymously from staff who completed the pretest, education, and posttest on cultural competency online during clinic hours using Survey Monkey. The education was designed to improve the staff and health care professionals' knowledge of culturally competent provisions of obesity care to African American youth ages 2 to 19. Pretest and posttest knowledge data were collected from participants at the beginning of the education intervention and at the end of the education intervention. A staff member who did not participate in the project entered the pretest and posttest questionnaire data into SPSS. I analyzed the data using SPSS to generate descriptive data for determining if there was a self-reported increase in cultural competency knowledge and

approaches to care using culturally competent methods of health coaching to improve prevention and management of childhood obesity.

Summary

For this doctoral project, I reviewed staff perceptions, biases, and educational needs before and after implementation of a cultural competency educational intervention designed to improve and manage childhood obesity health outcomes in community clinic settings. This educational intervention was expected to promote positive social change through improved communication between health care professionals and the individuals seeking care. These changes may foster a patient-provider partnership and patients' commitment to health care change over time.

Section 4: Findings and Recommendations

Introduction

Childhood obesity in ethnic minority youth in suburban low-income metropolitan areas in the United States continues to increase (CDC, 2016b). Across the five community health centers where the project took place, the gap in practice was the health care professionals' lack of knowledge to implement culturally competent care. The question answered by the project was, Will cultural competency staff education improve knowledge to prevent and manage childhood obesity among African American youth ages 2 to 19? At the time of the project, the registry of patients with childhood obesity within the health centers' population numbered over 1,200.

The implementation of the project proceeded as follows. After obtaining approval from the Walden University Institutional Review Board (approval number 08-15-18-0671378), I wrote an invitation letter, which was sent to all staff and providers by the practice managers. The letter covered the amount of time it would take to complete the educational intervention module and the pretest and posttest questionnaires. The anonymous pretest and posttest questionnaires were administered by e-mail through Survey Monkey over a 1-month period with 2-week reminders after the initial e-mail invitation to participate. This section of the paper presents the findings, implications, and recommendations related to the outcomes of the project.

Findings and Implications

I analyzed the CCA data from the pretest and posttest questionnaires for health care providers and nurses using IBM SPSS Statistics software. Descriptive statistics,

which included percentages, means, and standard deviations, were used to determine if cultural competence education improved health care providers' knowledge of ways to prevent and manage childhood obesity among African American youth. To be entered into the analysis, the returned pretests and posttests had to include an answer to each of the 17 questions. The findings demonstrated an increase in the Likert rating scale sum from pretest to posttest results. The Likert rating scale sum from the pretest of the 17 questions was 627, and the posttest sum after the educational module intervention was 808, an increase of 181 points. The pretest mean score was 3.4 (3 = *not sure*) while the posttest mean score was 4.75 (4 = *often*; see Table C1 in Appendix C). Assessments were compared in SPSS for effect size estimation. Effect size estimation is the probability of finding statistical significance of the effect given the number of data points in the sample, the research design, and the population being tested (Cohen, 1988).

Cohen's *d* values of 0 to 0.2 indicate a small effect size, 0.5 indicates a medium effect size, and greater than 0.8 indicates a large effect size (Cohen, 1988). Using these cut-off values for the Cohen's *d* value, I found that one question had a small effect size, one question had a medium effect size, and 15 questions had a large effect size, indicating that the educational intervention had a positive impact on the 17 items (see Table C2 in Appendix C). The conclusion can be made that there was an increase in cultural competency knowledge after the education among the health care professionals who participated in the project. This outcome is needed to improve health care outcomes for patients presenting with different ethnic backgrounds, different levels of health care literacy, and differing cultural needs related to nutrition, traditions, and behaviors

(Purnell, 2002). When health care professionals understand the needs and preferences of patients, a care plan suitable for the patient and the provider can be implemented (Debiasi & Selleck, 2017). With evidence-based health care resources, improved health outcomes for individual patients can be expected (Lofton et al., 2016). Practicing preventive care with cultural competence in ethnic communities can also reduce the gap in practice, which may lead to a decrease in chronic health care comorbidities and disparities in ethnic populations to bring about a positive social change in society (CDC, 2016a).

I conducted this project over a 4-week period. The limitations for this project were twofold. First, the study had a small sample size. Only 10 of the 40 participants asked to participate in the study actually did. Second, the anonymity of the participants limited my ability to personally know how much time participants spent reviewing the educational module and comprehending the CCA questions. Even with these limitations, I believe that this project furthers existing research and can potentially serve as a pilot for a larger scale project.

Recommendations

For future studies, I offer three recommendations. First, I recommend that a quality control measurement be incorporated within the education module to ensure that the educational intervention content is reviewed and understood by the participants prior to taking the posttest. This assessment could potentially eliminate misleading posttest data. Second, onsite educational training with the pretest and posttest questionnaires taken at the time of the education is recommended. Doing so could enable quality control measurement to ensure that content is understood by the participants prior to distributing

the questionnaires. It also would likely improve the sample size (Debiasi & Selleck, 2017). Third, future studies should be conducted that assess the effectiveness of the culturally competent educational implementation in changing health care professionals' behavior and approach in encounters with patients from ethnic groups other than their own (Debiasi & Selleck, 2017). Researchers conducting such assessments might measure health care outcomes attributable to increased provider and staff provision of culturally competent care. They might measure changes in BMI of the patient registry, decreased prevalence of obesity among the children in the registry, and increased patient and family satisfaction with care within the ethnic populations served.

Strengths and Limitations of the Project

A limitation of this project was the number of participants. In addition, not having a control test to see if the participants were reviewing the educational material and understanding the pretest and posttest questions may have resulted in inaccurate data. A strength of this project was the validity and reliability of the instrument, the CCA (Schim et al., 2003), which made it possible to discuss the impact of the intervention. Another strength was that the data provided statistically detailed information related to the intervention implemented. Recommendations for future projects addressing a similar topic and using the same methods are to include a quality control measure added to the online module and/or conduct face-to-face educational sessions to reduce the effect of possibly misleading data results from lack of understanding the education, its purpose, and data collection expectations. In a face-to-face education setting, questions can be answered related to content and data collection processes.

Section 5: Dissemination Plan

Dissemination Plan

I plan to disseminate the findings of this project to the organization where the project took place through meetings with target stakeholder audiences at the five clinical sites and by communicating with stakeholders in policymaking and decision-making meetings. I also hope to present the project at health care conferences such as the annual national and/or regional Nurse Practitioner Association and the American Academy of Pediatricians conference. I will write abstracts for poster and podium presentations over the next year to exchange knowledge and raise awareness of the continuing gap that lack of cultural competence in clinical practice creates for ethnic minorities.

Analysis of Self

As a nurse practitioner who provides care to various ethnic groups in a family medicine setting, I see cultural competence as a professional priority. During this project, I gained a greater understanding of how to approach my care delivery and improved my awareness of cultural needs. Conducting the project also reaffirmed my belief that culturally competent care can assist patients as they strive to achieve the best possible health outcomes. Strategies are important to gain knowledge concerning a particular phenomenon in health care (Debiasi & Selleck, 2017). This project has taught me to be very organized and to adhere to time lines and goals in order to have a successful outcome. Furthermore, I have increased my knowledge and abilities as a scholar, which has also increased my desire to continue research that can assist different organizations, locally and possibly on a national level.

This scholarly journey has been exciting and required much sacrifice and determination. Its completion was not without its challenges as I tried to stay focused and finish the doctoral program at my pace. As I discussed in the previous paragraph, strategies are important in gaining the required information and data for successful interventions. In the future, I suggest that researchers educate and survey participants face-to-face and/or offer an incentive for participation. Continued research for innovation to health care is also important because knowing what works and what does not can offer solutions to critical health care issues.

Summary

The findings of this project support that culturally competent care with ethnic minority youth is a useful approach to preventive health care in childhood obesity and other health-related comorbidities in ethnic minority populations. There was an increase in knowledge among the participants after the education intervention. I believe if institutions continue to educate health care professionals in a succinct manner with cultural competency training, the current gap in practice can be reduced. This project adds to the evidence showing that education can improve cultural competence among health care providers and nurses (Jeffries, 2006). Implementation of the educational program developed for this project is expected to increase awareness, participation, practice change, and health care competency in the future. Nursing theorist Madeline Leininger stated, “Culturally based care and maintenance sets forth beneficial health outcomes, which are essential to human’s health, wellbeing, and survival” (Leininger, 1988 p. 154). As cultural groups continue to be integrated into U.S. society, health care

professionals must endeavor to learn, share, and transmit cultural competence into applications and policies for practice that will reduce health risks and disparities and increase quality health outcomes (Debiasi & Selleck, 2017). Ultimately, I hope that this project will make a significant contribution in the reduction of childhood obesity and other chronic comorbidities within ethnic populations.

References

Airhihenbuwa, C. O. (1989). Perspectives on AIDS in Africa: Strategies for prevention and control. *AIDS Education and Prevention, 1*(1), 57–69.

Allen, J. (2010). Improving cross-cultural care and antiracism in nursing education: A literature review. *Nurse Education Today, 30*(4), 314-320. Retrieved from https://ezp.waldenulibrary.org/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=edsgea&AN=edsgcl.221213128&site=eds-live&scope=site

Allen, J., Brown, L., Duff, C., Nesbitt, P., & Hepner, A. (2013). Development and evaluation of a teaching and learning approach in cross-cultural care and antidiscrimination in university nursing students. *Nurse Education Today*, *33,* 1592-1598. doi:10.1016/j.nedt.2012.12.006

American Association of Colleges of Nursing. (2006). *The essentials of doctoral education for advanced nursing practice*. Retrieved from http://www.aacn.nche.edu/publications/ position/DNPEssentials.pdf

Araiza, C., Valenzuela, M., & Gance-Cleveland, B. (2012). Salud con sabor Latino: A culturally sensitive obesity prevention curriculum in an underserved Latino community. *International Journal of Health Promotion & Education*, *50*(2), 51-60. doi:10.1080/14635240.2012.661963

Centers for Disease Control and Prevention. (2016a. Childhood obesity causes & consequences. Retrieved from https://www.cdc.gov/obesity/childhood/ causes.html

Centers for Disease Control and Prevention. (2016b). Childhood obesity facts. Retrieved from https://www.cdc.gov/obesity/data/childhood.html

Centers for Disease Control and Prevention. (2017). National Health and Nutrition Examination Survey (NHANES). Retrieved from https://www.cdc.gov/nchs/nhanes/index.htm

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Hillsdale, NJ: Erlbaum.

Cultural Competence. (n.d.) *Medical Dictionary for the Health Professions and Nursing*. (2012). Retrieved from https://medicaldictionary.thefreedictionary.com/cultural+competence.

Debiasi, L. B., & Selleck, C. S. (2017). Cultural competence training for primary care nurse practitioners: An intervention to increase culturally competent care. *Journal of Cultural Diversity*, *24*(2), 39-45.

Jeffries, M. (2006). *Teaching cultural competence in nursing and health care*. New York, NY: Springer.

Kanchana, M. N., & Sangamesh, N. (2016). Transcultural nursing: Importance in nursing practice. *International Journal of Nursing Education*, *8*(1), 135-138. doi:10.5958/0974-9357.2016.00024.6

Leininger, M. M. (1988). Leininger's theory of nursing: Cultural care diversity and universality. *Nursing Science Quarterly*, *1*(4), 152–160. doi:10.1177/089431848800100408

Lofton, S., McNaughton, D. B., Julion, W. A., Bergren, M. D., & Keim, K. S. (2016). A systematic review of literature on culturally adapted obesity prevention

interventions for African American youth. *Journal of School Nursing*, *32*(1), 32-46. doi:10.1177/1059840515605508

Marmo, L., Joyce, C. D., Jones, D., & Rabert, A. (2014). Right sizing care. *Pennsylvania Nurse*, *69*(2), 4-11.

Purnell, L. (2002). The Purnell model for cultural competence. *Journal of Transcultural Nursing: Official Journal of the Transcultural Nursing Society*, *13*(3), 193-196. doi:10.1177.10459602013003006

Schim, S. M., Doorenbos, A. Z., Miller, J., & Benkert, R. (2003). Development of a cultural competence assessment instrument. *Journal of Nursing Measurement*, *11*(1), 29-40.

United States Census Bureau. (2010, April 1). *Quick facts*. Retrieved from https://www.census.gov/quickfacts/table/PST045215/3663506

Yilmaz, M., Toksoy, S., Direk, Z. D., Bezirgan, S., & Boylu, M. (2017). Cultural sensitivity among clinical nurses: A descriptive study. *Journal of Nursing Scholarship*, *49*(2), 153-161. doi:10.1111/jnu.1227

Appendix A: Cultural Competence Assessment Questionnaire

I used Schim et al.'s (2003) assessment questionnaire to gather data for the project. Cultural Competence Assessment Items
1. I find ways to adapt my services to client and family cultural preferences
2. I welcome feedback from coworkers about how I relate to others with different cultures
3. I avoid making generalizations about groups of people (stereotyping)
4. I act to remove obstacles for people of different cultures when clients and families identify them to me
5. I act to remove obstacles for people of different cultures when I identify them
6. I ask clients and families to tell me about their own expectations of explanation of health and illness
7. I ask clients and families to tell me about their own expectations of care
8. I welcome feedback from clients about how I relate to others with different cultures
9. I document the adaptations I make with clients and families
10. I document cultural assessments
11. I recognize potential barriers to service that might be encountered by different people
12. I use a variety of sources to learn about the cultural heritage of other people
13. I seek information on cultural needs when I identify new clients and families in my practice
14. I ask my coworkers not to make comments or jokes
15. I learn from my coworkers about people with different cultural heritages
16. I include cultural assessment when I do client or family evaluations
17. I have resource books and other materials available to help me learn about clients and families from different cultures

Appendix B: Permission to Use the Purnell Model for Cultural Competence

I received permission for use via e-mail from Dr. Larry Purnell to use his model in my project. “YOU absolutely can use the model and I wish you success in your program. It would be nice to see your final project.”

Appendix C: Tables

Table C1

Likert Scale Pretest and Posttest Results (n = 10)

Likert rating scale	Pretest response percentages	Posttest response percentages
5 = *Always*	30%	135%
4 = *Often*	87%	29%
3 = *Not sure*	23%	2%
2 = *At times*	9%	0%
1 = *Never*	10%	0%

Note. The sum of the pretest responses to the 17 questions was 627 while the posttest sum after the educational module intervention was 808, representing an increase of 181 points. The pretest mean score was 3.4181% while the posttest mean score was 4.75.

Table C2

Pretest and Posttest Cohen's *d* Results

CCA Item	Pretest mean scores (n = 10)	Posttest mean scores (n = 10)	Pooled standard deviation (n = 20)	Cohen's *d**
1. I find ways to adapt my services to client and family cultural preferences	4.0	4.8	0.544	1.43
2. I welcome feedback from coworkers about how I relate to others with different cultures	3.9	4.9	0.655	1.35
3. I avoid making generaliza-tions about groups of people (stereotyping)	4.5	4.7	0.505	0.395
4. I act to remove obstacles for people of different cultures when I identify them	4.4	4.9	0.416	1.16
5. I ask clients and families to tell me about their expectations or explanation of health and illness	3.9	4.9	0.527	1.76

CCA Item	Pretest mean scores (n = 10)	Posttest mean scores (n = 10)	Pooled standard deviation (n = 20)	Cohen's d*
6. I ask clients and families to tell me about their own expectations of care	3.4	4.9	0.745	1.74
7. I ask clients and families to tell me about their own explanations of health and illness	3.6	4.9	0.695	1.64
8. I welcome feedback from clients about how I relate to others with different cultures	4.2	4.8	0.527	1.11
9. I document the adaptations I make with clients and families	3.4	4.9	0.507	2.76
10. I document cultural assessments	3.4	4.8	0.797	1.58
11. I recognize potential barriers to service that might be encountered by different people	4.1	4.9	0.441	1.74

CCA Item	Pretest mean scores (n = 10)	Posttest mean scores (n = 10)	Pooled standard deviation (n = 20)	Cohen's d*
12. I use a variety of sources to learn about the cultural heritage of other people	3.6	4.3	0.957	0.731
13. I seek information on cultural needs when I identify new clients and families in my practice	3.2	4.6	0.872	1.48
14. I ask my coworkers not to make comments or jokes	3.2	4.8	1.086	1.25
15. I learn from my coworkers about people with different cultural heritages	3.8	4.8	0.869	1.02
16. I include cultural assessment when I do client or family evaluations	3.5	4.9	0.583	2.18

CCA Item	Pretest mean scores (n = 10)	Posttest mean scores (n = 10)	Pooled standard deviation (n = 20)	Cohen's d*
17. I have resource books and other materials available to help me learn about clients and families from different cultures	2.6	4.0	1.253	1.11
*An absolute value of 0 - 0.2 represents a small effect size; 0.5 represents a medium effect size; and > 0.8 represents a large effect size				