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Walden University

College of Health Sciences

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Althea M. Otuata

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Walden University
2019

Abstract

Cultural Competence of Public Health Nurses

Who Care for Diverse Populations

by

Althea M. Otuata

MS, College of New Rochelle, 1989

BS, College of New Rochelle, 1983

Proposal Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

May 2019

Abstract

Despite advances in health, science, and technology, U.S. healthcare lags in providing access to care and quality care to racial and ethnic minorities. Cultural competence has been noted as a strategy to improve access and quality. The purpose of this project was to assess public health nurses' cultural competence before and after participating in cultural competence informational modules. Two conceptual models were used in this project for theoretical guidance: Leininger's cultural care diversity and universality theory and Campinha-Bacote's process of cultural competence. To assess the nurses' cultural competence, the Cultural Competence Self-Assessment Checklist questionnaire was e-mailed to 57 public health nurses at a local health department. Survey participants remained anonymous. Data were collected on demographics. A paired *t* test was conducted to compare the statistical significance of the results. A quantitative software tool was used to analyze the data. Study results showed a confidence interval of 95% at $p = 0.15$, indicating that cultural competence informational modules made a significant difference between the pretest and the posttest of the Cultural Competence Self-Assessment Checklist. Thus, cultural competence informational modules make a difference in public health nurses' awareness, knowledge, and skills, which can enhance their ability to provide culturally competent care to racial and ethnic minorities. The implications of this project for social change include supporting health care professionals' ability to promote and implement cultural competence practices for all populations to decrease health disparities.

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Dedication

I humbly thank the One who has sustained, protected, provided, and made this possible. Thanks to my husband, my mother, and children, who have supported and encouraged me during the good and challenging times. I graciously thank you all for the support that you have provided while on this journey.

Acknowledgments

I would like to acknowledge my chair who has been an inspiration, guide, and my support during the production of this document. In addition, I would like to extend my thanks to Walden University for their academic resources and technical support. I would also like to mention my nurse manager, the administrative team, colleagues who frequently encouraged me, and the Department of Public Health for granting my request to engage in this research. A special thanks to all Public Health Nurses for the jobs they do daily. Thanks to those who participated in this research study.

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Section 1: Nature of the Project

Introduction

The U.S. population is becoming more diverse, with an array of racial and ethnic groups. Racial and ethnic minorities experience disparities in access to care, quality health care, and poor health outcomes. The Agency for Healthcare Research and Quality's *National Healthcare Disparities Report* noted that the quality of, and access to, care for minority groups continued to fall behind other groups (Phillips & Malone, 2014). Heintzman (2017) noted that over the years, only about 10% of health care disparities improved. According to Jackson and Gracia (2014), to address health disparities in the United States, cultural competency should be used to rectify issues associated with access, quality, and equity among racial and ethnic minorities.

There are 3 million nurses in the United States, the largest segment of the health care workforce (Melnyk et al., 2018). Assessing the cultural competence of public health nurses is a strategy to help eliminate health disparities among racial and ethnic groups (Phillips & Malone, 2014). Nurses in the 21st century need to be prepared to provide care that is culturally competent in a dynamic, innovative, and informational environment with diverse populations (Melnyk et al., 2018).

Problem Statement

Although there have been significant advances in science and technology during the last few decades, health care disparities persist. Racial and ethnic minorities experience less than optimal health outcomes than non-Hispanic Whites. Belonging to certain racial/ethnic groups puts one at risk for developing higher mortality risk-associated diseases, such as obesity (OB), diabetes (DM), chronic kidney disease (CKD),

and hypertension (HT). These diseases are not independent of each other; having one is predictive of having one or more of the other diseases. These comorbid conditions (OB, DM, CKD, and HT) have increased mortality risks for American Indians and Blacks compared to Whites (Daw, 2017).

Racial and ethnic minorities experience higher disease rates from treatable and preventable diseases, such as cardiovascular disease, DM, asthma, and cancer, compared to the general population (Jackson & Gracia, 2014). Data have shown that membership in minority groups have real health implications. Minorities' morbidity and mortality rates are less than optimal when compared to the overall health of the population (Douglas, Pacquiao, & Purnell, 2018).

In addition to minorities experiencing higher rates of treatable and preventable diseases, health disparities and inequity place an insurmountable financial burden on the U.S. economy. Health disparities and unequal access to health care are expected to increase. Nash (2017) noted that the financial burden of racial and ethnic minorities in the United States in 2009 was approximately $82 billion. The economic burden on health disparities is expected to increase by $44 billion in 2020 and to increase by $27 billion in 2050 if the issues associated with health disparities are not collectively addressed.

Purpose Statement

Former U.S. Health and Human Services Secretary Margret Heckler released the *Heckler Report* (as cited by Goodman, Gilbert, Hudson, Milam, & Colditz, 2017), which contained data on the health status of racial and ethnic minorities in the United States. According to the report, racial and ethnic minorities in the United States experience fewer years of quality life, higher morbidity and mortality rates, unequal treatment, and

disproportionately higher rates of preventable diseases compared to the general population (Peach State Health Plan, 2015). The *Heckler Report* provided the initial data on health disparities among racial and ethnic minorities in the United States (as cited by Goodman et al., 2017), and the backdrop needed to begin addressing the health gap between racial and ethnic minorities and the general population (Peach State Health Plan, 2015).

The purpose of this project was to assess the cultural competence of public health nurses at the community research partner. This study provided access to informational modules on cultural competency to public health nurses. Health disparities among racial and ethnic groups and the general population presented as an area of need that could be addressed through cultural competency. The practice-focused question for this project was the following: Does culturally competent nursing care decrease health disparities and improve health outcomes for racial and ethnic minorities?

Improving the health of the nation is a national priority (Centers for Disease Control and Prevention, 2014). An approach to reducing disparities is to promote cultural competence within health care organizations and among members of the healthcare? workforce (Jackson & Gracia, 2014). In the context of health care, providers must be aware of their own cultural beliefs and values; they must have a willingness to work with patients of various racial and ethnic backgrounds. They must also address communication barriers to provide safe, efficient, and effective care (Jackson & Gracia, 2014). According to research, providers promoting and supporting a culturally competent workforce are associated with quality health outcomes for racial and ethnic minorities (Jackson & Gracia, 2014).

According to Jackson and Gracia (2014), improving the health of the U.S. population is a national priority and addressing the social determinants associated with poor health outcomes may help improve the health outcomes of those at risk. Racial and ethnic minority groups are more likely to experience less than optimal health outcomes compared to the general population, such as in cardiovascular disease, cancer, asthma, and HIV/AIDS. Incorporating culturally competent care into the health system is a strategy to reduce the disparities among racial and ethnic groups.

Culturally competent nursing care: a cornerstone of care contains three modules online (Think Cultural Health, 2018). In each module, there is an introduction, a pretest, module content, a summary, and a posttest (see Appendix D).

The target population of this study was public health nurses in metropolitan Atlanta at the community research partner. There were 37 candidates (see Table 1). Their educational level ranges from licensed practical nurses to having a Master of Science degree in nursing. There were 302 years of experience among the 37 nurses.

Table 1

Community Research Partner of Health Nursing Workforce

Culture/ Ethnicity	G	Y	LPN	Di	RN	BSN	M	APRN	Do
Black	F	15.6			1				
Black	M	13.7	1						
Black	F	8.8			1	1	1		
Black	F	17.3			1	1			
Black	F	1.5	1						
Black	F	11.7			1	1	1	1	
Black	F	2.6						1	
Asian	F	1.5				1	1		
Bi-racial	F	0.9			1				
Black	F	2.6				1			
Black	F	9.8	1						
Black	F	3.9	1						
Black	F	10.6			1				
White	F	21.5			1				
Black	F				1				
Black	F	14			1				
Black	F	16.1			1				
Black	F	10.1			1				
Black	F	16				1			
Asian	F	6.7			1				
Black	F	21.6			1	1			
White	F	30.8			1				
Black	F	2			1				
White	F	4.5			1			1	
Black	F	3.6			1				
Black	F	1.8						1	
Black	F	1.8						1	
Black	F	15	1						
Black	F	19				1			
Black	F	9.5			1				
White	F	2.3						1	
Black	F	9.9			1				
Black	F	7.4			1				
Black	F	8.9	1						
Asian	F	2.1			1				
Hispanic	F	2.2			1				
Hispanic	F	1.5						1	
Black	F	1.5			1				
Black	F	6.9			1				
White	F	1.9						1	
Black	F	3.1			1				
Black	F	12.8	1						
Asian	F	1.3			1				
White	F	5						1	
White	F	6.3			1				
Total			7		27	8	3	9	

Note. G = Gender; Y = Years of experience; Di = Diploma; M = Masters; Do = Doctorate. Obtained from community research partner.

Nature of the Doctoral Project

For several decades, the U.S. population has been growing in racial and ethnic diversity. There are approximately 300 million people who live in the United States, of whom 100 million are members of racial and ethnic minority groups (Douglas et al., 2018). Racial and ethnic minority groups need health care services that address their medical needs and accommodate their health beliefs and values. In addition, health care providers need to be knowledgeable about their patient's culture and health beliefs. Thus, there was a need to address services delivered to racial and ethnic minorities.

Demographic changes among health care professionals has not kept pace with the changing ethnic and racial landscape of the United States, known as the *disparity divide* (Englund, 2018). The increase in racial and ethnic minorities indicates an underrepresentation of racial and ethnic minority licensed registered nurses: 80% of RNs are non-Hispanic White (Englund, 2018).

Nurses have opportunities to improve access to care and the quality of care that is delivered. Nurses spend more time providing direct care than any other type of health care professional. Based on their role as direct care providers, nurses are uniquely positioned to deliver culturally and linguistically competent care (U.S. Department of Health and Human Services [HHS], Office of Minority Health [OMH], 2013). Nurses should develop cultural competence and use it when delivering care to racial and ethnic minorities.

This project was designed to assess public health nurses' cultural competence and provide informational modules to enhance it. The online course, culturally competent nursing care: a cornerstone of caring, included informational modules that were used to

assess public health nurses' cultural competence. The Health Resources and Service Administration's (HRSA) mission is to improve the health of the U.S. population. The HRSA (as cited by Kovner et al., 2018) found that a diverse, culturally competent health care workforce would improve health outcomes, improve access, and eliminate health disparities among racial and ethnic minorities. Furthermore, the online course, culturally competent nursing care: a cornerstone of caring, contained specific content on delivering culturally and linguistically competent nursing care, providing effective communication and language assistance, and supporting culturally and linguistically competent organizations.

Cultural diversity in the United States is increasing, and registered nurses provide care to individuals of various races, cultures, and ethnicity. There are more than 3 million registered nurses in the United States. They represent the largest segment of the health care workforce (AACN, 2016). In addition, the U.S. population has become more diverse. Colby and Ortman's (2015) population projection indicated that the number of non-Hispanic Whites would decrease from 198 million in 2014 to 181million? in 2060. During the same period, (a) the Hispanic population would increase from 55 to 119 million (Colby & Ortman, 2015). (b) The Black population would increase slightly from 42 to 60 million in 2060 (Colby & Ortman, 2015). (c) Asians would increase from 17 to 38 million, and (d) American Indians and Alaska Natives would experience an increase from 4 million in 2014 to 6 million in 2060 (Colby & Ortman, 2015). With the projection of increases in racial and ethnic groups, nurses must provide culturally competent care to the changing population demographics of the United States.

This project was designed to assess public health nurses' cultural competence and to provide informational modules to increase nurses' awareness, knowledge, and skills about racial and ethnic groups, and thus enable them to provide culturally competent care. Assessing and informational modules for nurses on cultural competence was an implication for social change by addressing health disparities among racial and ethnic groups.

Significance

The stakeholders that are influenced by public health nurses' cultural competence include nurses; other health care providers; patients; nursing professionals; public health workers; community partners, such as educational institutions; health care organizations; and policy makers and enforcers. This doctoral project provided data for further nursing research, evaluation, and recommendations used as a basis from which to plan and implement training, recommendations, and policy developments.

The World Health Organization (WHO) noted that one of the ways to help close the gap in health inequity is to address the health care needs of racial and ethnic groups (Browne, 2017). This project's contribution to nursing practice may improve racial and ethnic groups' access to quality care, improve their health outcomes, and decrease their health disparities. This project was also expected to influence the field of nursing by raising nurses' awareness, in all areas of practice, of their own cultural competence and it served as a basis for improving nurses' journey to becoming culturally competent. Culturally competent care reduces health care disparities among racial and ethnic minorities, thus improving the health of the nation.

Leaders of organizations, such as the WHO, have supported universal access, equity, and social justice (Browne, 2017). Since racial and ethnic minorities seek care throughout the health care system, healthcare providers from multiple disciplines have opportunities to engage with racial and ethnic individuals in many different settings. There, nurses and other culturally competent providers could provide an enriched environment, where racial and ethnic minorities would receive culturally appropriate care and improve the health outcomes of racial and ethnic groups.

Summary

More than 30 years ago, the *Heckler Report* set the stage and examined the status of minority health. Moreover, the report brought this issue to the forefront by indicating the disparities experienced by racial and ethnic minorities when compared to the general U.S. population. Disparities in health are influenced by many factors. Researchers have suggested that health disparities derive from poverty and limited access to quality healthcare, employment, and education. Disparities in health are also influenced by factors, such as socioeconomics, disabilities, demographics, and geographic location. Moreover, these disparities are concentrated in certain groups, such as minorities and the disadvantages.

Minority populations disproportionately experience greater morbidity and mortality rates from preventable diseases, such as cardiovascular diseases, cancer, DM, and asthma. Improving the health and health outcomes of racial and ethnic minorities will decrease morbidity and mortality rates from preventable and treatable diseases. Therefore, the health of the U.S. population will improve.

Section 2: Background and Context

Introduction

Racial and ethnic minorities are at greater risk of experiencing health and health care disparities compared to the general population. Racial and ethnic minorities experience greater incidences of preventable and treatable diseases, such as cardiovascular disease, DM, asthma, and cancer (Jackson & Gracia, 2014). The purpose of this project was to assess the cultural competence of public health nurses. The practice-focused question was the following: Does culturally competent nursing care improve racial and ethnic minorities' health outcomes and reduce health disparities?

Conceptual Framework

Two theorists were applicable to cultural competence in the health care setting. The first was Leininger (2012), who developed the theory of cultural care diversity and universality to focus on two key concepts: caring and culture. Care providers, such as nurses who assess, plan, and implement components of culture into their care, may lead to culturally congruent nursing care (Singleton, 2017).

Leininger (2012) used her theory to emphasize that caring was the central aspect essential for human growth, development, and survival. Caring goes beyond time, culture, and environment. Leininger differentiated between curing and caring. Curing is usually associated with medical practices, whereas acts of caring are intertwined in curing. Practitioners may overlook their coexistence when providing care to individuals (Leininger, 2012).

Nursing is a profession that provides care for individuals with diverse social, cultural, and environmental needs. Health care providers should be aware of both caring

and curing when providing health care services to anyone, including racial and ethnic minorities (Leininger, 2012). Racial and ethnic groups may benefit from nurses who provide culturally competent care (Leininger, 2012).

The second theorist, Campinha-Bacote (2017), developed a theory on the process of cultural competence. Cultural competence involves health care providers seeking, at every encounter, opportunities to provide culturally sensitive nursing care to individuals, families, and communities (Halabi & de Beer, 2018). The process of cultural competence contains five model constructs: (a) cultural awareness, (b) cultural knowledge, (c) cultural skill, (d) cultural encounter, and (e) cultural desire. Of the constructs, cultural encounter is central to the process of cultural competence. Cultural encounter provides the impetus for one's journey toward becoming culturally competent (Halabi & de Beer, 2018).

Individuals with diverse racial and ethnic backgrounds tend to need health care that is diverse. Campinha-Bacote (2017) used the process of cultural competence to emphasize that health professionals should persistently attempt to understand diverse racial and ethnic groups' customs, traditions, and values. The process of cultural competence can be a framework used by health care professionals because they provide culturally competent care (Chen et al., 2018).

There is a caveat to providing culturally competent health care to racial and ethnic groups: health literacy. Racial and ethnic groups must be provided with resources to read, communicate, and understand information that will assist them with their health care needs—and they must be able to read it (Chen et al., 2018). Health care providers must

make every effort to ensure that appropriate resources are available for racial and ethnic groups to assist them? with communicating their health needs (Chen et al., 2018).

Relevance to Nursing Practice

Historically, nurses and other health professionals have worked with racial and ethnic minorities by addressing human rights and health disparities issues. In 2015, over 300 registered nurses gathered and collaborated on evaluating the newly revised *Code of Ethics for Nurses with Interpretive Statements* (hereafter, "*Code*"). The *Code* contains eight provisions (Lachman, O'Connor Swanson, & Winland-Brown, 2015).

Provision 8 included nurses collaborating with other health professionals and the public to protect human rights. The newly revised *Code of Ethics for Nurses* supports their moral and ethical duty to the population's right to health as a human right and may reduce disparities among those who experience it (Lachman et al., 2015).

As the cultural landscape of the United States continues to change and expand, nurses are more likely to encounter patients who are of different races, ethnicities, and cultures. Imbedded in nursing practice are one's attitudes, which influence the nursing care one delivers to patients (Debs-Ivall, 2018). Nurses and other health professionals may unintentionally transfer attitudes, which are deeply embedded in a society that marginalizes and racializes the very populations nurses provide care. Nurses must remain conscious of their attitudes toward their patients when engaging in care (Debs-Ivall, 2018).

Nurses' attitudes can hinder them from delivering and engaging in patient's cultural needs. Incorporating cultural competence (awareness, knowledge, and skills) during each patient and family encounter must include the patient's culture and views of

health, wellness, and disease. This knowledge will assist in improving the health of racial and ethnic groups (Debs-Ivall, 2018).

Improving the health of the nation is priority for the Division of Community Health (DCH; Centers for Disease Control and Prevention, 2016). This issue involves the social determinants of health, such as a person's residence, school, work, income, education, and access to health care. All of these can influence his or her ability to live a healthy life (Centers for Disease Control and Prevention, 2016).

Healthy People 2020 is the federal government's prevention program for building a healthier United States. The leaders of Healthy People 2020 envision that people will be free of preventable diseases, disabilities, and injury. Leaders believe people can live in environments to promote healthier lifestyles (Centers for Disease Control and Prevention, 2014).

In addition to DCH and Healthy People2020, Congress requested that the Institute of Medicine (IOM) would conduct a study to assess the depth and breadth of disparities in the type and quality of health services provided to racial and ethnic minorities and non-minorities in 1999 (Wheeler & Bryant, 2017). The result of the IOM's report was that the U.S. racial and ethnic minorities were less likely to receive routine medical procedures, and when they did, it was of lesser quality than non-minorities (Smedley et al., 2017).

The IOM's committee recommended that to reduce racial and ethnic disparities, awareness should increase among stakeholders, such as the public, health care providers and organizations, insurance companies, and policy makers. In addition, care should be evidence-based, consistent, and equitable, as seen on the website (http://www.nationalacademic.org). Additional recommendations from the IOM included

one increasing the racial and ethnic diversity of health care workers and using interpreters in settings where there was a need for individuals with limited English proficiency (http://www.nationalacademic.org). Furthermore, the IOM showed that disparities existed among racial and ethnic groups (Lewis, Fraze, Fisher, Shortell, & Colla, 2017). The IOM's recommendation was to diversify the health care workforce, incorporate cultural training into health care curriculums, and advance research efforts to identify sources of disparities (Jackson & Gracia, 2014).

The current state cultural competence in nursing involves one promoting competence in academics, research, and practice. Promoting cultural competence in nursing is crucial to reducing health disparities (Diaz, Clarke, & Gatua, 2015). The American Association of Colleges of Nursing (AACN, 2016) recognized an association between nurses who were culturally diverse and their abilities to provide quality culturally competent patient care (Diaz et al., 2015). In addition, leaders of the National League for Nursing (NLN) have supported expanding diversity beyond the borders of ethnicity to include nursing education that would result in equitable, evidence-based quality outcomes (Diaz et al., 2015). Furthermore, leaders of The Sullivan Commission have recommended promoting diversity for health professionals, including students, faculty, and health care providers (Diaz et al., 2015).

Strategies to address cultural competence include incorporating cultural competence training into nursing curriculums and health care delivery systems. The Patient Protection and Affordable Care Act supports projects to increase the training of health care professionals in cultural competence. In addition, the U.S. HHS, OMH (2018)

developed and published the National Standards for Cultural and Linguistically Appropriate Services (CLAS).

The OMH developed Think Cultural Health (2018), an interactive, online informational module for users to earn continuing education units. Think Cultural Health is a repository of resources to improve the delivery of cultural and linguistic care that will improve the health outcomes of racial and ethnic groups. The CLAS standards support culturally and linguistically appropriate care that is effective, equitable, and understandable. Such learning activities may diminish health disparities among racial and ethnic groups (Adopoju, Preston, & Gonzales, 2015).

Public health nurses provide care to a large segment of the U.S. population. Assessing public health nurses' cultural competence provided a baseline from which to address their cultural competence. The culturally competent nursing care: a cornerstone of care online module provided an opportunity for public health nurses to become more aware of their own cultural competence and the culture of other individuals.

Public health nurses should provide care that is culturally congruent to their patient populations. As a result, racial and ethnic minorities who receive culturally competent care will have improved access to care, care quality, equity, and improved health outcomes (Jackson & Gracia, 2014). Therefore, the results of this project supported incorporating cultural competence informational modules into the community research partner's training of new and existing public health nurses. This project could be used to create a culturally competent workforce, which researchers found necessary in the pursuit to eliminate health disparities (Adopoju et al., 2015).

Local Background and Context

Among developed nations, the United States is behind its counterparts in terms of health care access and health equity. Inequities in access and health equity continue to persist. Eliminating health disparities involves strategic planning with multiple layers, which must be addressed for elimination of barriers to care (Rust, 2017). A purposeful collaboration among entities should be undertaken with full participation from entities, such as those in medical care, public health, community leadership, income equity, public and private sectors, and law, as well as policy makers. They should work closely to eliminate inequities in health care (Rust, 2017).

The Code of Ethics for Nurses, Provision 8 indicated the importance of nurses collaborating with other health professionals to protect human rights and eliminate health disparities (Lachman et al., 2015). Cultural competence is an integral part of nursing and delivering care to individuals, families, and communities of diverse racial and ethnic backgrounds. Delivering culturally competent nursing care assists in addressing and eliminating disparities in health and health care.

The community research partner was founded in 1921 and was in suburban Atlanta, Georgia. At the time of this study, the population of the community research partner was ethnically and racially diverse (see Table 2).

Table 2

Population of Community Research Partner

Description	Measure
Population	
2015 Population Estimate (as of July 1, 2015)	734,871
Race and Hispanic Origin	
White alone	251,754
Black or African American alone	384,831
American Indian and Alaska Native alone	2,911
Asian alone	41,121
Native Hawaiian and Other Pacific Islander alone	327
Some Other Races alone	19,596
Two or More Races	15,791
Hispanic or Latino (of any race)	64,968
White alone, Not Hispanic or Latino	212,598

Note. Adopted from community research partner.

The mission of this organization was to protect, promote, and improve the lives of the residents of community research partner. The vision of the Board of Health was to be the leader in creating a healthier community research partner by

- informing and educating the community about public health issues through diverse communication channels;
- mobilizing the community through partnerships to address public health problems;
- developing policies and plans to support community health efforts;
- linking people to public health services and resources; and
- demonstrating quality and excellence.

Protecting and serving the public also includes providing care that is culturally and linguistically appropriate.

The community research partner had four centers with the headquarters located in Georgia. At each health center, the populations being served were diverse in race, ethnicity, religion, education, sexual preference, and socioeconomic level. In addition, the

community research partner stated one of the clinic sites provided services for refugee patients.

The county board was governed by the Georgia Department of Public Health (DPH). An administrative team was led by the district health director. In addition, there were three functional divisions:

1. Administration,
2. Community Health and Prevention services, and
3. Marketing and Business Development.

The community research partner provided services across the life span. These services included children services, immunization, family planning, hearing and vision screening pregnancy testing and counseling, physical exams, HIV screening and counseling, dental services, refugee services, infectious disease testing and treatment, vital records services, and environmental health services.

Definition of Terms

The following terms are used throughout this study:

Culture: Culture refers to the integrated pattern of thoughts, communications, actions customs, beliefs, values, and instructions associated with racial; ethnic; or linguistic groups, including religious, spiritual, biological, geographical, or sociological characteristics (Think Cultural Health, 2018).

Cultural competence: Cultural competence consists of the ability of health-care providers to function effectively in different cultural contexts (Jackson & Gracia, 2014).

Culturally and Linguistically Appropriate Services (CLAS): The U.S. HHS, OMH (2018) goals are to promote the health and wellbeing of racial and ethnic populations. In

addition, the leaders develop policies and programs to support health equity and eliminate health disparities. The OMH has developed the national standards for CLAS. The OMH's goal is to improve health care quality and equity to result in improved health outcomes for diverse populations, as stated on the website (http://www.minorityhealth.hhs.gov).

Community research partner: The local government agency, the community research partner, supports the goals of HHS and OMH. The leaders of the community research partner provide health care services to all races and ethnicities. They also provide linguistically appropriate services and access to care. In addition, their health care providers are of diverse cultures, ethnicity, and backgrounds.

Health disparity: Health disparity refers to a particular type of health difference that is closely linked with social, economics, and or environmental disadvantages (Think Cultural Health, 2018).

Health care disparity: Health care disparity refers to differences in the receipt of, experiences with, and quality of health care that are not due to access-related factors or clinical needs, preferences, or appropriateness of intervention (Think Cultural Health, 2018).

Role of the DNP Student

At the time of this study, I worked at the community research partner, and participants were coworkers. I informed and educated the agency's administrators, managers, and clinical staff about cultural competence and its importance in providing care to the public that was of good quality, equitable, evidence-based, and accessible. In addition, I provided instructions for nurses who participated in the online Cultural

Competence Self-Assessment Survey (CCSC) and cultural competence informational modules.

A segment of my practicum hours was spent in the community research partner's refugee clinic. There, I observed a nurse practitioner and other diverse staff providing care and interacting with clients with limited English proficiency. There was concern for how efficient and effective other health board providers would be at incorporating culturally competent care at the other locations.

My potential biases included being aware that I might not be familiar with some cultures and not knowing what acceptable behavior was in clinical settings. Steps to address this matter was to continue to increase my awareness, knowledge, and skills in cultural competence. Furthermore, I provided an environment where patients would feel comfortable enough to discuss their health concerns. I listened and shared information that might safely include patient's cultural beliefs and values.

Summary

Health disparities persistently exist in the United States among racial and ethnic populations despite advances in science, research, and technology. Nurses and other healthcare professionals are in a prime position as they engage in patient care to incorporate patient's cultural beliefs and values. Leininger (2012) used her theory on cultural care diversity and universality to emphasize caring and culture which nurses can incorporate as they provide culturally competent care. Furthermore, Campinha-Bacote (2017) developed the process of cultural competence to provide the opportunity for providers to engage with patients by opening the door to developing cultural competence.

During each patient encounter, nurses and other health professionals could engage in caring and being open to racial and ethnic minority population's health beliefs and values. To evaluate the cultural competence of public health nurses, data were researched from the literature. Internal review board (IRB) approval was obtained on 12-13-17-0349969. The data were collected from voluntary participants, and these collected data were analyzed.

Section 3: Collection and Analysis of Evidence

Introduction

Although there have been significant advances in science and technology during the last few decades, health care disparities persist. According to Gwede et al. (2016), disparities in health status are linked with variations in rates of diseases and are associated with socioeconomics, ethnicity, gender, age, race, and the underserved population groups. Racial and ethnic minorities experience less than optimal health outcomes compared to non-Hispanic Whites. Racial and ethnic minorities experience higher disease rates from treatable and preventable diseases, such as cardiovascular disease, DM, asthma, and cancer, compared to the general population (Jackson & Gracia, 2014).

The purpose of this project was to assess the cultural competence of public health nurses at the community research partner. Cultural competence was assessed through an online survey, the CCSC, which was used as both a pretest and posttest. An online informational module, culturally competent nursing care: a cornerstone of caring, was used as an intervention.

The community research partner was founded in 1921. Located in a suburban community, its mission is to protect, promote, and improve the health of the residence of the community research partner. In doing so, services included screening, preventive services, educating the public, and engaging with the community and other stakeholders in health-related topics.

Practice-Focused Questions

The U.S. population is becoming increasingly racially and ethnically diverse. Researchers have predicted that by 2043, the population will become a majority-minority (Phillips & Malone, 2014). Racial and ethnic minorities experience decreased years of quality life, greater incidences of morbidity and mortality rates from preventable diseases, and unequal treatment compared to the majority population (Peach State Health Plan, 2015). In short, there is a disproportion in health outcomes between racial and ethnic minorities and the majority population. The shift in demographics will present a challenge for the nursing workforce, because does not mirror the emerging population in race and ethnicity (Phillips & Malone, 2014).

At the time of this study, there were an estimated 3 million registered nurses in the United States. The U.S. population consisted of 65.6% non-Hispanic White. Approximately 84.8% of registered nurses were employed and 83.2% of RNs were non-Hispanic White (Phillip & Malone, 2014). There was a disproportion of health care providers (nurses) in race and culture who provided care to racial and ethnic minorities. As a result, care that was being delivered might not be culturally congruent and could lead to challenges in access and quality in health care delivery services. The practice-focused questions were as follows:

- Will the cultural competence informational module improve nurses' cultural awareness, knowledge, and skills?
- Will culturally competent nurses improve the health outcomes for racial and ethnically diverse populations?

- Will culturally competent nursing care improve care quality, equity, and access for racial and ethnically diverse populations?
- Will culturally competent nurses improve health disparities among racial and ethnic minorities?

The purpose of this project was to assess cultural competence of public health nurses. In addition, there was a pretest administered, followed by and online learning intervention, culturally competent nursing care: a cornerstone of caring, which was then followed by a posttest. This process should provide answers to the focus question of whether public health nurses were providing culturally competent care. This project's steps were as follows:

1. Determined the cultural competence of the community research partner's (2018) public health nurses on their journey to becoming culturally competent through an online survey entitled CCSC (http://www.coloradoedinitiative.org; see Appendices A and B; http://www.cvims.org).
2. Obtained IRB permission before proceeding with data collection.
3. Provided informed consent. Participation was voluntary. Participants' confidentially and security were maintained through the survey online tool, and the information was stored on a flash drive under lock and key in the human resources department.
4. The online survey tool could be assessed at http://www.coloradoedinitiative.org/wp-content/uploads/2015/10/cultural-competence-self-assessment-checklist.pdf.

5. The questionnaire was used for both pretest and posttest. There were 30 questions, which took approximately 10 minutes to complete.
6. Once permission was granted by the community research partner, Walden University's IRB, and the Department of Public Health's IRB, the questionnaire survey was posted online, where participants had 24/7 access during the survey period.
7. Once the pretest was completed, participants were asked to proceed to the informational modules entitled culturally competent nursing care: a cornerstone of caring (see Appendices C, D, and E).
8. The informational modules were accessed at http://www.https://www.thinkculturalhealth.hhs.gov/education/nurses.
9. After completion of the modules, participants completed the posttest: CCSC.
10. After completion of the modules, participants were eligible to receive nine continuing educational units.
11. Results of the findings were shared with participants.
12. Through the online survey tool, data were stored, and the results were analyzed.
13. A report was written explaining the data results. The data provided information on public health nurses' awareness, knowledge, and skills regarding cultural competence (http://www.smartsrvey.com).

The operational definitions of the doctoral project included the following: *Culture* refers to the integrated pattern of thoughts, communications, actions, customs, beliefs, values, and instruction associated with racial; ethnic; or linguistic groups, including

religious, spiritual, biological, geographical, or sociological characteristics (Think Cultural Health, 2018). *Cultural competence* is the ability of health-care providers to function effectively in different cultural context (Jackson & Gracia, 2014). *Health disparities* refer to a particular type of health difference closely linked with social, economic, and or environmental disadvantages (Think Cultural Health, 2018). *Health care disparities* consist of differences in the receipt of experiences with and quality of health care that are not due to access-related factors or clinical needs, preferences, or appropriateness of intervention (Think Cultural Health, 2018).

Sources of Evidence

The databases used to obtain relevant information related to the practice problem in this doctoral project included CINAHL with Full Text, Thoreau Advance, and Medline with Full Text. The key search terms and combination of search terms used for this doctoral project were as follows:

- *Cultural, competence*
- *Cultural, competency*
- *Cultural, competence, theorist*
- *Cultural competence, health, disparity*
- *Diversity in, health care, cultural competence*
- *Health disparities*
- *Health, care, disparities*
- *Health, equity*
- *Health, disparities, cultural competence*
- *Racial and, ethnic, minorities*

- *Rates of diabetes in Blacks*
- *United States cost, of, health disparity*

The scope of this review spanned 2012 to 2018. The types of literature included editorials, public health journals, educational journals, social sciences journals, and research journals. The search provided information on cultural competence and its relevance to nurses and other healthcare providers as they delivered care to racial and ethnic groups. The resources indicated that addressing cultural competence was a multi-level concept and becoming culturally competent was a process people underwent as they became self-aware and recognized other cultures, races, ethnicities, socioeconomic groups, and environmental differences in the patients and families they served. Becoming culturally competent is a journey where many encounter engagements that may lead to competence in becoming culturally aware, knowledgeable, and skilled (Halabi & de Beer, 2018).

Literature Review

The demographics of the U.S. population have been changing. In the 1900s, the population consisted of 88% Whites. The 2010 U.S. Census Bureau reported approximately 72% Whites. Thus, more that 100 million people are minorities (Keenan, 2013). One of Healthy People 2020 goal is to have a healthy U.S. population, which includes all races and ethnicity (Centers for Disease Control and Prevention, 2014). Mirowsky (2017) noted that eliminating health disparities was an important goal for many health care organizations.

Improving the health of the nation will involve addressing the health and health care disparities of racial and ethnic groups (Dickerson et al., 2017; Kovner et al., 2018).

To improve the health of the nation, the federal government has invested in and implemented programs to eliminate racial and ethnic health disparities (Anderson, 2018). Furthermore, changes to the U.S. health care system to reduce health and health care disparities involve leaders focusing on increasing the diversity and cultural competence of health care workers (Jackson & Gracia, 2014; Phillips & Malone, 2014).

According to Jackson and Gracia (2014), racial and ethnic groups, when compared to the general population, experience disproportionate poorer health outcome measures for preventable and treatable diseases, such as cardiovascular disease, asthma, cancer, and HIV/AIDS. Cultural competency is viewed as a strategy that will make influence providers improving the health outcomes of minority groups by empowering patients to participate in the care they receive and be a part of the decision-making process (Cuevas, O'Brien, & Saha, 2017).

Leaders of the U.S. HHS, OMH have promoted cultural competence as an avenue to improve health outcomes for all citizens (Jackson & Garcia, 2014). In addition, the AACN (2016) promoted a culturally competent nursing workforce by financially supporting cultural competence for baccalaureate education programs. Furthermore, leaders of both the American Medical Association and the American Nurses Association have developed standards and position statements about cultural competence to make it relevant to clinical practice (Holland, 2017). Leaders of the American Public Health Association have also targeted health care disparities for elimination (Adopoju et al., 2015).

To achieve a healthier population per the goals of Healthy People 2020 (Centers for Disease Control and Prevention, 2014), disparities in health and health care must be

addressed. Addressing the cultural competence of health care providers, such as nurses, is one way to address health disparities among racial and ethnic populations. In the United States, racial/ethnic minorities are at disproportionate risk, in comparison to the general population for experiencing poor health outcomes regarding access, quality, and outcomes from preventable and treatable health conditions (Adopoju et al., 2015).

According to Douglas et al. (2018), racial and ethnic minorities experience barriers to care along with receiving poor quality care. Addressing the health needs of racial/ethnic minorities presents challenges to care providers (nurses) who are not of the same race/ethnicity and or culture as their patients. As the growing U.S. demographics change, the health care workforce will need diversity to address the needs of the changing racial and ethnic population. The growing diversity in the health care environment prompts the need for solutions to address cultural diversity in the work environment. Steps should be taken to consider care that is culturally supportive of racial and ethnic minorities (Phillips & Malone, 2014).

To reduce health care disparities, leaders implemented the Patient Protection Affordable Care Act (ACA) to improve health care access, quality, and outcomes (Adopoju et al., 2015). As a result, several state leaders require cultural competency informational modules for medicine, nursing, and other health care professionals (Mirowsky, 2017). Researchers have discussed leadership implementing cultural competency into health care organizations, educational institutions, research, and practice arenas as the bridge to close the gap to eliminate disparities in the health and health care (Cuevas et al., 2017).

According to Adopoju et al. (2015), leaders of the ACA have provided opportunity for health professionals to train in cultural competency. Creating a culturally competent workforce is an important and necessary step to eliminating health disparities. To address the cultural disproportion further between health care providers and patients who are of diverse cultures and races, the HHS, OMH (2018) published the CLAS standards. The national CLAS standards are intended to advance health equity, improve quality, and eliminate health care disparities by establishing a blueprint for health and health care organizations (Think Cultural Health, 2018). The CLAS standards promote leadership, language assistance, and continuous evaluation of health care organizations (Adopoju et al., 2015). In developing CLAS, the U.S. HHS, OMH (2018) recognized the importance health care providers played in improving access to care quality and reducing health care disparities. Furthermore, CLAS standards are designed to address improving the cultural and linguistic encounters between providers and patient and to improve access and quality of care (Heintzman, 2017).

Approximately 9% of the U.S. population has limited English proficiency (LEP). Providing language assistance to LEP patients is required by the Civil Rights Act of 1964. Furthermore, providing care in a culturally and linguistically appropriate manner may result in improved patient understanding, satisfaction, provider-patient encounter, and health outcomes, as well as reduced health disparities (Adopoju et al., 2015).

Obtaining and assessing data on public health nurses’ cultural competence provided information on whether nursing care provided to racial and ethnic populations at the health department was culturally competent. Collection and analysis of this evidence provided data on the cultural competence status of public health nurses at the community

research partner. The data indicated whether racial and ethnic patients received culturally care from nurse care providers. Racial and ethnic patients who experienced culturally competent health care services would have improved access and provider-patient engagement, as well as decreased disparities in patient experiences.

Participants

Potential individuals who participated as study subjects in this doctoral project were public health nurses. The nurses were employed and delivering nursing care to individuals, families, and communities. The nurse's degrees ranged from licensed practical nurse to master's degree nurse. Areas of clinical practice included immunization, sexually transmitted disease, refugee program, family planning, maternal and child health program, tuberculosis program, epidemiology, and community outreach screening programs.

Selecting participants was in collaboration with the human resources department. The human resources department had an accurate count of all nurses employed at the community research partner and provided a current list of nurses. Nurses were selected through simple random sampling. A computer-generated program provided the randomly selected sample (Terry, 2015). I used the randomly selected numbers to contact participants requesting their volunteer participation in the study. Public health nurses were selected as study participants because they were directly involved in providing care daily to racial and ethnic individuals, families, and communities.

Procedures

The tool that was used to collect evidence for the doctoral project was a questionnaire entitled CCSC. This tool was designed for participants to self-assess and

become cognoscente of their awareness, knowledge, and skills regarding their beliefs, interactions, and experiences when interacting with individuals, families, and communities of diverse cultures and backgrounds, as seen online (htttp://www.diversityteam.org). The CCSC was a 30-question tool accessed online. There were three sections that assessed a participant's awareness, knowledge, and skills in cultural competence. Rating scaled was presented in a 4-point Likert scale, ranging from 1 (*never*), 2 (*sometimes/occasionally*), 3 (*fairly often/pretty well*), and 4 (*always/very well*). The higher the points, the more likely one was becoming more culturally competent, as shown online (htttp://www.diversityteam.org)

Modifications made to the CCSC were to change the word *colour* to *color*. Moreover, a modification included changing aboriginal person to racial and ethnic individuals, Canadians to Americans, and *behaviour* to *behavior*. Furthermore, one omitted the Chinese Head Tax, the Komagata Maru, Indian Act, and Japanese internment.

Protections

The process of recruiting study participants began with sharing information on the purpose of this study with the district nurse manager, clinic nurse coordinators, and clinic nurse supervisors, and clinic nurses. Other leadership members included in information sharing were district director, district medical director, director of administration, director of human resources, and internal services.

Recruiting study participants began by verbally informing the clinic nurse coordinator of each health center at their monthly clinic nurse coordinator's meeting about this project. Once the clinic nurse managers received information about the study project and questions were addressed, the clinic nurse coordinators informed their staff

that the researcher would hold a meeting at their center to provide information on the project and answer any questions.

With the permission of the district nurse manager, I visited each clinic site to inform nurses of this project, requesting their participation, and answering any questions and concerns. I gave my contact information should anyone have further questions after the meeting. Potential study participants received information to make an informed consent, such as the safeguarding of their personal information, voluntary participation, and the ability to withdraw from the study at any time; no were consequences associated with withdrawing from the study.

In addition, participants were informed of the risks and benefits of participating in this study. The risk involved the time it took to take the online questionnaire and the self-study informational modules on cultural competency. The benefits included one becoming self-aware of their own biases, other cultures, races, ethnicities, and one's own cultural competence. Participants also developed skills in communicating with other people from other races and cultures. Furthermore, participants who completed the online cultural competence informational modules earned nine continuing education units with a certificate.

To protect the anonymity of the study subjects early in the study, participants' names/identities were replaced with numbers. The human resources department provided demographic data, such as age, race, gender, education, and years of experience on each participant. I did not have access to the names of the participants. Maintaining confidentiality of the participant's personal information was paramount to safeguarding personal information (Terry, 2015). Personal data were stored in the human resources

department under double lock with a locked door and individual file lock. Numbers were assigned to participants, and participants were randomly selected, which also increased the security and confidentiality of study subject's identity and personal data (Terry, 2015).

The IRB's role was as the guiding body that oversaw and ensured that study participants were ethically protected, and no harm came to anyone who participated in a pilot or actual research study. The IRB approval was required before data were collected and analyzed, as stated online (http://www.Waldenu.edu). The purpose of the IRB was to ensure that Walden University researchers conducted research in which the benefits outweighed the potential risks, and they were compliant with relevant U.S. federal regulations and guidelines, as seen online (http://www.Waldenu.edu).

Analysis and Synthesis

The Statistical Package for the Social Sciences (SPSS) was used to collect and analyze data. Specifically, data were collected on two groups of nurses with different practice degrees (licensed practical nurses and registered nurses). The nurses were analyzed preexposure and postexposure to informational modules (culturally competent nursing care: a cornerstone of caring).

The approaches used to maintain the integrity of the data, outliers, and missing information were as follows:

- Assigned numbers to the study participants,
- Selected participants through simple random sampling, and
- Utilized an online survey where everyone could create a user name and password.

Only the student researcher had access. Data were stored online, and hard copies were stored in human resources.

Summary

Cultural competence was a strategy to address health disparities among racial and ethnic populations who experienced less than optimal health compared to the general population. In this section, the practice focus questions were listed. The sources of evidence were presented. Approval was obtained from the IRB prior to contacting potential participants. The procedures were explained, and potential participants were protected ethically and confidentially. Moreover, their data were stored securely and safely. Data were analyzed according to the SPSS. Findings and recommendations will be presented in the next section.

Section 4: Findings and Recommendations

Introduction

In the United States, racial and ethnic groups have experienced disparities in health and health care, which have resulted in inadequate access to health care, quality care, and less than optimal health outcomes compared to the general population. Racial and ethnic groups have experienced higher rates of mediocre care than the general population. According to the *Heckler Report* (as cited by Goodman et al., 2017), racial and ethnic minorities' life expectancies are shorter; they experience higher morbidity and mortality rates, unequal treatment, and higher rates of preventable diseases.

Concerns have been raised about the state of health of ethnic and racial minority groups. Cultural competence training of healthcare workers is noted as a key component in addressing health disparities in minority groups. The practice-focused question for this project was the following: Does culturally competent nursing care decrease health disparities and improve health outcomes for racial and ethnic minorities? The purpose of this project was to assess the cultural competence of public health nurses, provide informational modules on cultural competence, and evaluate their postinformational modules' results. The sources of evidence were obtained through an online questionnaire. The data were analyzed with the SPSS.

Participants were instructed that participation was voluntary. Participants had access to the anonymous online survey through an email sent to their work e-mail addresses. The survey was sent to 57 public health nurses; 14 (24%) responded to the pretest and six (10%) responded to the posttest.

Demographics for the 14 respondents were as follows: 11 (78%) African Americans, one (7%) Asian, one (7%) Hispanic, and one (7%) White (see Table 3). The study participants were all female. There was one (7%) Associate Degree, one (7%) advanced practice registered nurse, and 12 (85%) registered nurses. The years of experience ranged from 6 months to 30 years, with a mean average of 11.2-years. Demographic questions on race, gender, license, and years of experience followed the Cultural Competence Self-Assessment Checklist questionnaire.

Table 3

Public Health Nurses' Demographics

Participants	Race	Gender	License	Years of Experience
1	White	F	Associate Degree	30
2	A-A	F	RN	23
3	Hispanic	F	RN	1
4	A-A	F	APRN	4
5	A-A	F	RN	20
6	A-A	F	RN	9
7	A-A	F	RN	20
8	A-A	F	RN	11
9	A-A	F	RN	12
10	Asian/Pacific Isl.	F	RN	5
11	A-A	F	RN	16
12	A-A	F	RN	5
13	A-A	F	RN	0.5
14	A-A	F	RN	1

Findings and Implications

To answer the practice-focused question, the CCSC informational modules were administered to public health nurses; a paired sample *t* test was conducted. The CCSC pretest questionnaire was e-mailed to a population of 57 public health nurses. Fourteen (24%) of the PHN responded to the pretest. Of the 14 who responded to the pretest, six (10%) responded to the posttest. The participants were all anonymous; six respondents from the pretest were randomly selected in SPSS, along with six posttest participants.

A paired sample *t* test was conducted in SPSS using six participants from the pretest group and six participants from the posttest group (see Table 4). The mean pretest CCSC (M = 93.33, SD = 6.28) and the posttest mean (M = 104.66, SD = 5.00) were not equal, a paired sample *t*-test was performed. The mean difference between the variables (pretest and posttest) is -11.33. The standard deviation between pretest and posttest is 7.65. The *t* result is -3.62 which indicates that the Sig or p value is < 0.05.

The difference between the pretest score and the posttest score is statistically different at 0.05. The Confidence Interval 95% between the pretest and posttest is between -13.37 and -3.30.

Table 4

Paired Samples t *Test Statistics*

		Mean	*N*	Std. Deviation	Std. Error Mean
Pair 1	Score on Test Before Informational Modules	93.33	6	6.29	2.56
	Score on Test After Informational Modules	104.67	6	5.01	2.04

Table 5

Paired Samples Test

		Paired Differences							
					95% Confidence Interval of the Difference				
		Mean	Std. Deviation	Std. Error Mean	Lower	Upper	*t*	*df*	Sig. (2-tailed)
Pair 1	Score on Test Before Info. Modules - Score on Test After Info. Modules	-11.33	7.66	3.13	-19.37	-3.30	-3.62	5	0.02

There was a 95% confidence interval at 0.02, which indicated that CCSC informational modules made a difference. The pretest standard deviation was 6.28. The posttest standard deviation was 5.01.

Study participation was considerably low. Generalization to the larger population would be difficult regarding the participation level. A larger sample size might have been possible if the study was extended to the entire state, where there might have been additional opportunities for more study participants. The length of time for the informational modules might have been an obstacle regarding one completing the entire informational modules, followed by completing the posttest questionnaire.

Researchers have suggested cultural competence nursing care will improve care quality, access, and health outcomes of racial and ethnic minorities (Adegboyega & Hatcher, 2016). Nurses are in a primary role to provide care for clients by communicating and providing guidance throughout their care. Nurses and other health care providers have opportunities at each encounter when they communicate with individuals, families, and communities to improve access to care (Adegboyega & Hatcher, 2016). In addition, nurses and other health care providers can advocate for patients by assisting them with communication to navigate through the health care system, which will achieve better health outcomes for all patients (Adegboyega & Hatcher, 2016).

Increasing access to care through cultural competence and communication may help to improve health outcomes of racial and ethnic groups. Providing effective communication through interpreters will assist groups with language barriers to feel accepted and participate in their own care (Adegboyega & Hatcher, 2016). Culturally competent care will improve patients' abilities to communicate and have a better

understanding of the care they receive. Communication also helps to develop provider-patient relationship to foster trusting relationships.

Providers can assist patients in seeking care that is culturally and linguistically appropriate, which will improve the quality of care they receive. In addition, providers can assist patients in seeking care that is accessible and affordable. Providing access through culture, language, accessibility, and affordability can improve health outcomes and diminish health disparities of racial and ethnic groups (Adegboyega & Hatcher, 2016). Communication is an important aspect of receiving quality care. Providing culturally competent care that is communicated appropriately can improve health outcomes.

Nurses and other health care professionals can utilize the CLAS standards to eliminate health disparities for racial and ethnic minorities. The CLAS standards promote effective, equitable, understandable, and respectful quality services to diverse populations. Implementing CLAS standards throughout the healthcare system will improve patient access and quality to eliminate disparities and improve health for individuals, communities, institutions, and the nation (Adopoju et al., 2015).

Recommendations

The recommended solution to address the gap in practice is to address the cultural competence of public health nurses and provide informational modules on cultural competence. An informational module on cultural competence is not just for nurses, but for other health care providers, as well. Researchers have supported that training all members of an organization is crucial in helping to eliminate health disparities. Avila, Kamon, and Beatson (2016) reported that a recent systemic review on cultural

competence intervention made a positive difference in improving health provider's knowledge, attitudes, and skills. Anyone who contacted patients, such as clerical, nursing, social service, refugee services, dental, human resources, and administration should participate in the informational modules, thus encouraging an organizational culture of cultural competence.

The instructional modules on cultural competence were not just applicable to public health nurses. Other disciplines, care providers, and support staff were posed with the responsibilities of providing linguistic and culturally appropriate care. The Civil Rights Act of 1964 required that patients with limited English proficiency received interpretation services (Adopoju et al., 2015). Thus, leaders encouraged health care organizations to adapt an environment of cultural competence to promote decreasing health disparities among racial and ethnic groups.

Creating an organizational culture of cultural competence throughout healthcare organizations through policy development will support staff at all levels to demonstrate cultural competence to both their internal and external customers. Utilizing the informational modules on cultural competence will provide nurses and other healthcare providers with the awareness, knowledge, and skills needed to engage successfully in behaviors associated with cultural competence. Such engagements will improve the health of all patients, and thus improve the health of individuals, families, communities, and the nation. Culturally competent care will increase access to care, improve the quality of care, and decrease health disparities among racial and ethnic groups.

Strength and Limitations of the Project

This study provided an opportunity for the participants to become aware of their cultural competence in areas of self-awareness, knowledge, and skills. Numbers were not assigned to the questionnaire which was anonymous and allowed participants to respond freely. The informational modules provided scenarios depicting nurse-patient interaction and how one can or should respond in different situations when providing nursing care. The questionnaire was user friendly, easy to read, and took an average of 10 minutes.

One of the limitations was that staffs were not permitted to participate in the study during work hours. Time was also a factor. The informational modules took approximately 9 hours to complete. There were more staffs who began the study than completed the study. The study participants were from one health department.

It is recommended that further study be conducted on cultural competence and racial and ethnic minorities, as well as the relationship to health disparities. Furthermore, additional research is needed to address gains in implementing cultural competence, its benefits over time, and the benefits to patients (Avila et al., 2016). Expanding the study to other health departments in the surround regions may provide a larger study sample. In addition, extending the time to complete the informational modules may improve the completion rate of the entire study.

Section 5: Dissemination Plan

Assessing the cultural competence of public health nurses who care for racial and ethnically diverse populations was disseminated to the institution experiencing the gap through an e-mail presentation. A PowerPoint presentation was delivered to the district nurse director, medical director, administration, the human resources department, and the nursing staff. The data? and results of this study were presented at a monthly nurse leadership meeting through a PowerPoint presentation. In addition, the information was presented at the organization's quarterly staff training and development meeting. The results of the study were sent to study participants via work e-mail addresses. The results of this study were shared with the Department of Public Health IRB.

Analysis of Self

Embarking on this journey provided me with insight into the profession of nursing. The study broadened my knowledge and skills in leadership and management. The DNP project improved my communication skills. The project provided me with the sources of healthcare disparities, some of which I was not aware, and possible solutions to this issue. I was reminded that I chose what I enjoyed doing most in my profession, which was leadership and management, in addition to coaching and counseling. The DNP project allowed me to be a change agent in different quality assurance/quality improvement projects. The project reignited my desire to serve and continue to serve others by making a positive difference. I experienced more confidence that I could sit at the table and work collaboratively with others to make a difference in society.

My future goals are to continue to promote best practices in nursing by engaging in quality assurance and quality improvement projects. I aim to improve health outcomes

for all individuals, families, and the community through leadership and management. I will teach nursing students at a local or online university. I plan to assist one of the local politicians and advocate for nursing.

Challenges encountered with completing this project involved life events and navigating how to continue to work on this project and address other challenges. The solutions were to take a step back and reassess, regroup, and engage support as needed. I learned that I had he tenacity and willingness to see this project through to its completion.

The purpose of this DNP project was to assess public health nurses' cultural competence before and after the use of the cultural competence informational modules. This project was in support of the DNP Essential VII: Clinical Prevention and Population Health for Improving the Nation's Health (AACN, 2016). Clinical prevention involved activities that assessed and prevented health risks and disease. Population health addressed the health of communities, environments, and cultural/socioeconomic statuses, as these interplayed with health (AACN, 2016). Integrating cultural competence into the nursing profession would improve health outcomes of racial and ethnic minorities. Thus, cultural competence would decrease health disparities and improve the health of the nation.

Summary

Health care disparities in the United States have been targeted for elimination and supported by federal agencies and professional organizations, such as the American Public Health Association. Although the ACA has made important first strides, additional steps are needed to reduce healthcare disparities. A few aims of the ACA in reducing health disparities are to increase access to equitable care and make the care received more

efficient and affordable (Adopoju et al., 2015). However, a lag continues in areas of access, quality, and outcomes.

Creating a workforce that is culturally competent and rich in ethnicity is a necessary and immediate component to eliminating health care disparities. The HHS, OMH (2018) published the revised CLAS. The CLAS promotes leadership, language assistance, and continuous evaluation of health care organizations. More importantly, the CLAS provides a wealth of information on provider-patient engagement while care is being delivered to patients (Adopoju et al., 2015).

Language assistance, health literacy, and cultural competence are important aspects of care access, quality, and outcomes. Approximately 9% of the U.S. population has LEP. Patients with LEP need interpreters to understand the care they receive and to navigate the health care system. Adopoju et al. (2015) noted that because LEP patients who received interpretative assistance were better satisfied with the care they received, they had better quality and care outcomes.

Nurses, other health care providers, academia, and policy makers should continue to promote and support making cultural competence and the CLAS an integral part of the health care system in terms policy and daily practice. Patients are more satisfied with the care they receive when they can understand and incorporate their culture. Leininger (2012) developed her theory on cultural care diversity and universality to focus on the concept that caring was essential for the human growth, development, and survival. Incorporating cultural competence into nursing care will be in support of better access, care quality, and health outcomes for individuals, families, communities, and the nation.

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Appendix A: Cultural Competence Self-Assessment Checklist

Cultural Competence Self-Assessment Checklist is a questionnaire tool designed to assess one's cultural competence. The tool's goal is to help you establish where you are currently and where you might like to be as you become more culturally competent. There are three areas (awareness, knowledge, and skills) of assessments.

The awareness promotes an assessment of self-awareness of value diversity, how well one knows oneself; being aware of comfort and discomfort in regard to the culture of other groups. In addition, awareness assesses one's assumption of other people's cultural differences, stereotypes, and how culture has informed judgement and decisions (http://www.coloradoedinitiative.org).

The knowledge component assesses self-knowledge and the ability to learn one's own limitations; in addition, having the willingness to learn about other racial and ethnic groups. Acquiring knowledge enables one to not be stagnant but fosters growth and adapting to change based on multiple factors (http://www.coloradoedinitiative.org).

The skills aspect of the Cultural Competence Self-Assessment Checklist allows one to demonstrate behavior related to cultural competence. Cultural competence skill also involves adjusting communication style to fit the situation and context, being engaged, and acting respectfully towards individuals of diverse race, ethnicity, and culture (http://www.coloradoedinitiative.org).

The Cultural Competence Self-Assessment Checklist tool can be taken at any time to assess one's progress as one continue on his/her journey to becoming culturally competent. This tool contains a rating scale which will help identify areas of strengths

and other areas that may need enhancing as one progress on their journey to becoming culturally competent.

Appendix B: Permission to Use the Cultural Competence Self-Assessment Checklist

Otuata, Althea

To

althea.otuata

04/28/15 at 4:15 PM

From:

Sent: Monday, April 27, 2015 3:28 PM

To: Otuata, Althea

Subject: RE: Request for Cultural Competence Self-assessment Checklist

Hello Althea,

Well, you chose the right person. Permission granted. Thanks for making the request…

All the best,

Executive Director

Appendix C: Culturally Competent Nursing Care: A Cornerstone of Caring Course Outline

COURSE I *Deliv ering Culturally and Linguistically Competent Nursing Care*

Course Introduction

Course I Pretest

Course Content Outline

Module I.I: Overview of Cultural and Linguistic Competence

Learning Objectives

After completing this module, you should be able to:

- Define cultural and linguistic competency; and
- Describe factors that affect a nurse's ability to provide culturally and linguistically competent care.

Module 1.2: The importance of Self-Awareness

Learning Objectives

After completing this module, you should be able to:

- Explain the role of self-awareness in culturally and linguistically competent nursing;
- Articulate how assumptions, biases, and stereotypes can lead to differential care; and
- Complete a self-assessment to learn about your own assumptions, biases, and stereotypes.

Module 1.3: Models for Becoming Culturally Aware

Learning Objectives

After completing this module, you should be able to:

- Identify two research-based models for becoming culturally self-aware; and
- Articulate how to apply these models when working with diverse patients.

Module 1.4: Understanding Health Related Experiences

Learning Objectives

After completing this module, you should be able to:

- Articulate the distinction between disease and illness as it relates to patient care;
- List cultural and social factors that may have an impact on a patient's experience of illness; and
- Describe how to elicit a patient's understanding of illness to inform culturally appropriate treatment.

Module 1.5: Delivering Patient Centered Care

Learning Objectives

After completing this module, you should be able to:

- Describe patient-centered care;
- Identify patient-centered principles and resources; and
- Articulate the relationship between patient-centered care and cultural and linguistic competency.

Module 1.6: Balancing Knowledge-Centered and Skill-Centered Approaches

Learning Objectives

After completing this module, you should be able to:

- Define knowledge-centered and skill-centered approaches to learning and applying cultural knowledge;

- Explain the importance of balancing knowledge-centered and skill-centered approaches; and
- Apply knowledge-centered and skill-centered approaches to enhance your cultural and linguistic competency skills.

Course Summary

Course I Posttest (thinkculturalhealth.hhs.gov, 2013).

COURSE II ***Providing Effective Communication and Language Assistance***

Course Introduction

Course II Pretest

Module 2:1 Overview of Effective Communication

Learning Objectives

After completing this module, you should be able to:

- Articulate the importance of effective nurse-patient communication; and
- Use the patient explanatory model interview questions to elicit information about health beliefs.

Module 2.2: Models for Effective Communication

Learning Objectives

After completing this module, you should be able to:

- Articulate the importance of using communication tools in cross-cultural encounters; and
- Describe and apply three effective communication models

Module 2.3: Overview of Language Assistance Services

Learning Objectives

After completing this module, you should be able to:

- Articulate the importance of using communication tools in cross-cultural encounters; and
- Describe and apply three effective communication models

Module 2.4: When Interpreter Services Are Needed

Learning Objectives

After completing this module, you should be able to:

- Articulate the three main roles of an interpreter;
- Define the triadic interview process and its participants; and
- Identify best practices of working with interpreters.

Module 2.5: Role of Health Literacy in Effective Communication

Learning Objectives

After completing this module, you should be able to:

- Define health literacy;
- Understand strategies for helping patients with limited health literacy;
- Identify one or more health literacy assessment tools and how they are used.

Module 2.6: When Written of Translated Materials Are Needed

Learning Objectives

After completing this module, you should be able to:

- Describe types of written or translated materials to communicate with patients with LEP;
- Define plain language;
- Understand the distinction between interpretation and translation; and

- Identify the characteristics of qualified translators.

Course Summary

Course II Posttest (thinkculturalhealth.hhs.gov, 2013).

COURSE III ***Supporting Culturally and Linguistically Competent Organizations***

Course Introduction

Course III Pretest

Module 3.1: Culturally and Linguistically Competent Organizations

Learning Objectives

After completing this module, you should be able to:

- List characteristics of a culturally and linguistically competent organization; and
- Identify ways that nurses can support organizational cultural and linguistic competency.

Module 3.2: Nurses' Role as Advocate for Cultural and Linguistic Competency in Organizations

Learning Objectives

After completing this module, you should be able to:

- Describe how nurses can advocate for cultural and linguistic competency; and
- Identify the skills nurses need to effectively advocate for culturally and linguistically competent care in their organizations

Module 3.3: Organizational Assessment

Learning Objectives

After completing this module, you should be able to:

- Explain organizational assessments as a major organizational cultural and linguistic competency support;
- Identify critical domains of organizational assessments; and
- Use an organizational assessment checklist.

Module 3.4: Strategic Planning

Learning Objectives

After completing this module, you should be able to:

- Understand strategic planning and its relationship to developing culturally and linguistically competent organizations;
- Identify the ways that nurses can contribute to strategic planning process; and
- Identify the effective methods of data collection and the ways that data collection can contribute to the strategic planning process.

Module 3.5: Training and Education

Learning Objectives

After completing this module, you should be able to:

- Describe recommendations for cultural and linguistic competency training and education programs; and
- Identify the attitudes, knowledge, and skills necessary to develop cultural and linguistic competency.

Module 3.6: Building Community Partnerships

Learning Objectives

After completing this module, you should be able to:

- Understand the importance of developing partnerships to support organizational cultural and linguistic competency;
- Identify factors that contribute to successful partnerships;
- Identify the ways to contribute to developing and maintaining partnerships; and
- Describe the role of minority communities in partnerships for improving culturally and linguistically competent care

Course Summary

Course III Posttest (thinkculturalhealth.hhs.gov, 2013).

Appendix D: Permission to Use Culturally Competent Nursing Care: A Cornerstone of Caring

To
Althea Otuata
02/26/16 at 1:49 PM
Good afternoon,

Thank you for your interest in our Think Cultural Health eLearning program, entitled Culturally Competent Nursing Care: A Cornerstone of Caring! Think Cultural Health eLearning programs are federally funded; therefore, the content within these programs is in the public domain. The Office of Minority Health does require that any persons, agencies, or organizations who want to use this material properly cite the source. One request we also have is that you include the "Intention" statement that appears at the top of the Standards list on any printed documents as well. The intention statement is as follows: "The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:"
We thank you for checking with us. We would love to hear about more about how your research is going!
Should you have any additional questions or concerns, please let me know.

Sincerely,

Think Cultural Health Technical Team

From: Althea Otuata
Sent: Friday, 26 February 2016 13:43:58 (UTC-05:00) Eastern Time (US & Canada)
To: HHS-CCNM
Subject: Request to Use Culturally Competent Nursing Care: A Cornerstone of Nursing

Hello

I called your office and you requested that I e-mail my request.

I am a graduate student at Walden University and my project is on assessing the cultural competence
of Public Health Nurses. Walden University requires that students obtain permission before using any tool.

I am requesting permission to use your online Culturally Competent Nursing Care: A Cornerstone of Nursing as a tool to conduct my research.

I would greatly appreciate the privilege. Thank you in advance for any assistance you may be able to provide.

Sincerely,

Althea Otuata
E-mail:

Appendix E: Permission for Board of Health Nurses to Participate in Research

From: Sent: Mon 1/3/2017 4:36 PM
To: Otuata, Althea
Cc:
Subject: RE: Request for BOH Nurses to Participate in Research

Good afternoon Althea,

Based on the additional information you have provided; Dr. has no problems approving this project as long as the assessment and training is done outside of work hours.

Sincerely,