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Cultural Competence Among Nursing Faculty

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CULTURAL COMPETENCE AMONG NURSING FACULTY

by

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Dedication

I dedicate this dissertation to my lovely family, especially my sons Ross and Carter in hopes that you will see the inherent beauty of the world around you. This is made more exquisite through the cultural diversity that is present across the United States and in the world. I want you to be able to look around and appreciate the uniqueness that surrounds you. To my amazing husband, Scott, I thank you for your love and support. For my parents, Margaret and John, I thank you for your guidance and support, and for the way you raised me that I might appreciate the importance of education and the value of my fellow human beings across the face of this amazing planet. Finally, I dedicate this to all of those that experience diversity and need someone, especially a health care worker, to recognize their wonderful allure and value and their specific cultural needs.

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Table of Contents

List of Tables

Abstract

CULTURAL COMPETENCE AMONG NURSING FACULTY

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Research of culture and cultural competence in nursing faculty is vitally important when considering the state of the United States health care system and health disparities that can be reduced through culturally competent care. Recent studies address cultural competence among nurses, but there is limited information exploring cultural competence in nursing faculty. A concept analysis of "cultural competence" using Rodger's method further established the need to examine cultural competence from the perspective of nursing faculty, who are responsible for educating future nurses in culturally competent care. The purposes of this study were to determine the level of cultural competence in Texas pre-licensure nursing faculty, identify any demographic data that might predict cultural competence in nursing faculty, and understand faculty members' perceptions of cultural competence. Guided by the Process of Cultural Competence in the Delivery of Healthcare Services model and using a mixed-methods, convergent, parallel design, 89 faculty were surveyed. A subset of seven faculty members were interviewed to explore perceptions of faculty regarding cultural competence. Nursing faculty members have a

moderate level of cultural competence scores as measured with the Nurses Cultural Competence Scale, scoring higher on the subscales of sensitivity and awareness. These findings, strengthened through the qualitative strand of the mixed-method approach, informs educational recommendations, policy development, and further research on improving nursing faculty members' level of cultural competence and ability to model culturally competent care to nursing students.

Chapter 1

Overview of the Research Study

Overall Purpose of the Study

Research suggests that culturally competent health care is one of the key factors in reducing health disparities in the United States (U.S.; Kohn-Wood & Hooper, 2014). This is important considering that health disparities are attributed to 309 billion dollars in additional health care expenditures (Kaiser Family Foundation, 2014). The demographics of the U.S. are rapidly changing. Minorities and those that are culturally diverse are expected to compose the majority of the population by 2030 (Pardansi & Bandyopahyay, 2014). In certain states, like Texas, minorities already compose the majority of the population.

The term "cultural competence" has a variety of meanings and interpretations, and health care providers may have their own unique interpretation and understanding of what it means to be culturally competent. Nursing faculty members are key in shaping nurses for tomorrow, and nurses are expected to work and provide care for an increasingly diverse patient population. The purpose of this study was to explore the cultural competence of nursing faculty in Texas.

The Campinha-Bacote model (2006), The Process of Cultural Competence in the Delivery of Healthcare Services guided this study. It is composed of five inter-related parts that show the process of becoming culturally competent. The process of becoming

culturally competent is shaped by the five concepts of awareness, skills, knowledge, encounters, and desire.

Introduction of Program of Research

This portfolio includes two manuscripts focused on cultural competence. The first, titled *Concept Analysis of Culture Applied to Nursing* explores the concept of culture as it relates to the nursing profession. A discussion of what culture is and what it is not, and examples of how culture is applied within health care, particularly in nursing, are provided. This manuscript has been published in *Creative Nursing*. Permission to include the manuscript in the dissertation portfolio was obtained from the publisher and is located in Appendix A.

The second manuscript, titled *Texas Pre-Licensure Nursing Faculty Members' Cultural Competence,* is the report of an original mixed-methods research study that explores the cultural competence of pre-licensure nursing faculty in Texas. A mixed-methods design was chosen because the mixed-methods approach provided unique insight into cultural issues not evident in a single method study (Bartholomew & Brown, 2012), and a more complete understanding of the concept is obtained (Ponterotto, Matthew, & Raughley, 2013). Previous research has focused on either a quantitative or qualitative approach, limiting the ability to evaluate the complex issue of cultural competence in pre-licensure nursing faculty. The mixed-methods design utilized a quantitative strand to objectively articulate the level of cultural competence in professional nursing educators and a qualitative strand to explore faculty perceptions of cultural competence.

Prior to initiating the research, Institutional Review Board (IRB) approval was obtained (Appendix B). Identified risks were shared with the participants and were minimal. They included feeling negative emotions when thinking about the issue of culture and caring for diverse patients. In some cases, feelings of prejudice or hostility towards a certain group of people may occur. In other cases, participants were cautioned that they might have recalled a painful memory of when they observed or were treated in a culturally incompetent manner. Participants received instructions that they could quit the survey at any time if they are uncomfortable with the questions. Potential benefits included providing the basis for additional research to determine the need and effectiveness for continued education. The quantitative research was conducted in a de-identified manner and participant information remained anonymous. The qualitative information remained confidential, and the contact information and qualitative telephone interview participants, coded with letters, A-H, were stored on an encrypted flash drive to minimize the potential for identification of participants.

Listservs for baccalaureate and associate degree programs across the state of Texas were utilized to distribute the survey to all nursing faculty teaching pre-licensure nursing students. Permission was obtained via email from the Texas Organization of Baccalaureate and Graduate Nursing Education (TOBGNE; Appendix C). An email request to use the Texas Organization of Associate Degree Nursing was sent (Appendix D). Verbal permission to use the Listserv was given. Instruments to collect quantitative data included a demographic survey (Appendix E) that examined factors relevant to cultural competence and the Nurses' Cultural Competence Scale (Appendix F), used to evaluate cultural competence. A subset of participants was interviewed to explore faculty

perceptions of cultural competence in depth. The interview guide for the qualitative strand of the study is found in Appendix G. The results of both quantitative and qualitative study strands are reported and merged. This manuscript also includes recommendations for future cultural competence research, education, and policies.

The final chapter provides recommendations for further research. Practice implications are discussed. Potential policy recommendations are also provided.

Chapter 2

Concept Analysis of Culture Applied to Nursing

Published in *Creative Nursing*

Abstract

Culture is an important concept, especially when applied to nursing. A concept analysis of culture is essential to understanding the meaning of the word. This article applies Rodgers' concept analysis template and provides a definition of the word culture as it applies to nursing practice. The article supplies examples of the concept of culture to aid the reader in understanding its application to nursing, and demonstrates components of culture that must be respected and included when providing health care.

Keywords: culture, nursing

Concept Analysis of Culture

The concept of culture has evolved during the past several centuries. As with many words in the English language, the word *culture* has a variety of meanings, including growing bacteria in a growth medium and an individual's love for fine food, wine, music, and the arts. Nurses and other health care professionals have a vested interest in understanding how culture applies to patient care, and this paper seeks to explore the aspects of the concept of culture with special applications to nursing and health care.

History of the Concept of Culture

Understanding the history of a word is an important part of understanding how it is used today. The etymology of the word *culture* dates back as far as its first known use in 43BC by Cicero, a Roman philosopher, in the *Tuscalan Disputations*, to mean a development or cultivation of the soul (Whiston & White, 1758). Eventually, the use of the word culture evolved; in Europe in the late 18th Century it was used to indicate an improvement, or cultivation, of the soil to bear plants. In the 19th Century, a prevalent use of the word indicated that the mind had been expanded and developed in the arts, sciences, and language. Tylor used the term culture to describe the collective background of an individual based on the individual's understanding of the world (1871); this use of the concept is familiar to us today in providing nursing care to culturally diverse patient populations.

Today, the use of the word *culture* as a verb can mean developing a pearl in an oyster or preparing soil to yield fruit or other desired horticultural goods. In a biochemical setting, a culture provides a means to study a substance using a medium that

supports its growth (Teng, Yi, Sun, & Zhang, 2011). The use of the word as a means for development is relevant to nursing and the health care setting in that an individual's culture is determined in part by his or her home environment (Abraham et al., 2011). Culture can also mean a united form of human manners that includes the feelings, communications, arrangements, traditions, dogmas, beliefs, and associations of a racial, ethnic, religious, or social group (Cross, Bazron, Dennis, & Isaacs, 1989).

The relevant definition of culture depends on the setting and the perspective of the person defining culture. As applied to the nursing profession, the term relates to a sociological and anthropological definition of culture, which is the complex, comprehensive embodiment of learned behavior. This term was used in the 19th Century by anthropologist Edward Tylor in his book, *Primitive Culture*. Tylor wrote that culture includes knowledge, belief, art, law, morals, customs, and any additional competencies and habits acquired by man as a member of a people group, or a group of people that share similar backgrounds and beliefs (Tylor, 1871). It is relevant for us to define the word *culture* in the context of nursing because of the many ways in which the word can be used. The health care infrastructure, including the role of nursing in that infrastructure, involves caring for individuals from different people groups, such as people from different racial and ethnic backgrounds or from any other shared identity that provides a framework by which people may define who they are.

The nursing profession has made great advances in the understanding of culture as it relates to health practices and beliefs. Nurse anthropologist Madeleine Leininger presented one of the first nursing definitions of culture; her definition relates to transcultural nursing and how nurses understand the practices and beliefs of at least two

different cultures to influence the major care requirements related to health care and health services (Leininger, 1991). When caring for people from diverse backgrounds other than that of the health care provider, it is important to act and communicate in a way that recognizes the unique culture of each patient (Health Resources Service Administration [HRSA], 2012). By recognizing the cultural context of each patient, communication and other health care aims can be better met by the health care provider, including the nurse.

Surrogate Terms and Related Concepts

Surrogate terms are a manner of expressing a concept in words or phrases which can be used interchangeably with those selected; these terms are used by the investigator to focus the scholarship (Rodgers, 2000). When describing the culturing of a pearl, the word *development* would be a surrogate term. In describing culturing the ground, the surrogate term *cultivating* could be used. Surrogate terms appropriate for the use of *culture* related to nursing and health care include development, beliefs, society, background, traditions, and customs.

Related concepts are concepts that are similar to the concept under consideration but that do not harbor the same set of qualities as the intended concept (Rodgers, 2000). In this concept analysis, related concepts include the words *ethnic*, *racial*, and *minority*. These words are similar to culture, and are often incorrectly used as surrogate terms for the concept of culture. Ethnicity, race, and minority status often constitute components of culture, but the words do not encompass the overarching, comprehensive definition of the word culture used in this paper.

Defining Attributes

Defining the attributes of culture includes an analysis of all definitions of culture, whether discussing a urine culture, the culture of an organization, or the cultural background of an individual. Once the analysis of all definitions of culture was completed, the defining attributes were identified and compiled to determine a definition to be used here. Culture implies that something is learned or developed, a process that occurs over time as a result of internal and external forces on the individual. Culture arises from immersion in varying beliefs, attitudes, religious practices, language, art, music, values, morals, behavioral patterns, and food customs. Culture is uniquely interwoven into each individual but shares a background with others in the group of origin.

Antecedents and Consequences

An antecedent is an event or incident that must occur prior to the occurrence of the concept (Walker & Avant, 2005). In the case of culture, antecedent conditions include an individual's background; the basis for how he or she thinks through different situations and makes decisions; how the individual understands the health care setting, the nurses and other health care providers; and how the individual interprets these elements (Maesschalck, Deveugele, & Willems, 2011).

Consequences are those events that result from the occurrence of the concept (Walker & Avant, 2005). One consequence of culture is the presence of individual differences, since no two people are exposed to exactly the same external forces. Even twins have individual encounters with external forces that shape their unique selves.

Another consequence of culture is that individuals from a shared cultural background are often treated as though they are the same. This bias can result in events and circumstances that can be perceived positively or negatively by the patient. For example, a nurse's automatically arranging for a Muslim patient's meals to be delivered after sundown during Ramadan may represent positive bias. An example of negative bias is a nurse's assuming that all patients with tattoos are HIV positive, or that all Caucasians are Christian. Negative bias can have an impact on individuals' health behaviors. For example, administering a medication derived from pork to a Jewish patient without determining whether this is acceptable could have an effect on this individual's seeking care in the future.

The Significance of Culture in Nursing

Understanding culture in the health care setting can have a significant impact on ameliorating health disparities, which are heightened in those from culturally diverse backgrounds. For example, knowledge of culture can guide the health care provider to screen for patterns of disease that the patient may be inclined to develop (Brach & Fraserirector, 2000). Minority Americans currently account for 36.6% of the population; by the year 2042, non-Hispanic whites will be a minority of the population (Nhan, 2012). As the percentage of the population who are from culturally diverse backgrounds increases, the opportunity for errors that negatively impact health outcomes increases, contributing to increases in health care costs and decreases in appropriate preventive care (Baquet & Commiskey, 1999; Barnes Jewish Hospital, 2014; Collins, Hall & Neuhaus 1999; Padela & Punekar, 2009). This trend heightens the need for an understanding of

culture and of how health care providers, especially nurses, can deliver care in a manner that meets the needs of patients from different cultures.

Culture is a word that shows the richness of human diversity and backgrounds. Culture should be understood as a relevant concept in nursing because culture threads its way through human behavior. Individual human behavior is especially apparent in settings in which the patient is dependent upon another person. Individuals' cultural backgrounds shape how they make decisions (Proctor, 2011). It is important for nurses to know how an individual from a particular cultural background may make a decision, in order to prepare interventions and educational tools to meet the needs of that patient. The nurse-patient interaction is shaped by the context of each person's cultural background; therefore, an understanding of culture is imperative. If the nurse and the patient come from differing cultural backgrounds, opportunities for miscommunication, misunderstanding, and missed opportunities for good health care exist.

In addition to decision making, individuals' cultural backgrounds, including ethnicity, minority status, customs, religion, world view, and upbringing, influence their understanding of the health care setting, their interactions with nurses and other health care providers, and their interpretation of their experiences (Maesschalck, Deveugele, & Willems, 2011). An individual's culture shapes how he or she understands, seeks, reacts to, and expresses feelings about health care throughout the continuum of wellness, including pre-sickness, sickness, and recovery. An individual's culture, including holistic healing traditions, can shape whether and/or how quickly he or she utilizes traditional Western medicine. Culture can instill a distrust of health care providers (Gupta, 2010).

Identification to the Concept of Culture Related to Nursing

The concept of culture is applied to nursing in two different ways. The first is in the attitudes and behaviors of individuals within an environment (Janićijević, 2011). Each organization and individual typically has a differing meaning of the word culture (Adams, 1995). The term *culture change* may be used to describe a need for individuals within a health care setting, including nurses, physicians, and other professionals, or an entire organization, to change the way they practice. For example, nurses' adjusting to receiving report on new patients within five minutes of the patient's arrival instead of thirty minutes represents a culture change, as the nurses must adapt to new expectations for receiving report.

The second use of the concept of culture refers to that which represents a patient's heritage: the differing patterns of belief associated with the patient's ethnic and racial background; the context in which he or she was raised to be an adult; exposure to different customs and food; language, and the related need for interpreters; and unique health care decisions. This is similar to Cross' (1989) and Tylor's (1871) anthropological and sociological definitions.

Application of the Concept to Nursing

The following case study illustrates the concept of culture in providing health care, and serves as a basis for interpretation and identification of implications. A hospital in-patient was identified as Muslim. She wore a *hijab* and *abaya* that covered her from head to toe. The nurses providing care for this patient recognized that she was comfortable interacting with women; male nurses and nursing assistants were not

assigned to provide care to this individual. The nurses also recognized that decision making was deferred to the patient's husband.

The patient's family was fasting in observance of Ramadan, but her Imam excused her from fasting so that she could receive nourishment for her recovery, so she was alone during mealtimes; a nurse or nursing assistant would sit with her so that she did not have to eat alone. The nurses facilitated her praying according to her piety. The nurses provided culturally appropriate care to a patient whose beliefs, attitudes, and food customs differed from theirs, and the patient was able to recover within the context of the U.S. health care system.

The word culture is commonly used, but its meaning as a concept is ambiguous. Asking a group of people to define culture will generate a wide range of definitions. Despite the ambiguity of the word culture, its use is extremely relevant today. As our global society becomes more connected, a wide variety of cultures interact on a daily basis. The concept of culture within nursing is particularly relevant now because nurses provide care to the most vulnerable populations, and that care must include meeting the cultural needs of their patients. Awareness of culture helps define the individual receiving care; without an understanding of the patient, the nurse cannot provide care that meets the patient's unique needs.

Implications for Future Study

Based on the implications of culture related to health disparities, nurses should conduct research to determine how the concept of culture may be incorporated into educational programs so that health care providers can more effectively meet the needs of patients. For example, a lack of cultural understanding is an identified cause of medical

errors (Betancourt, Green, & Carrillo, 2002). Future research should aim to identify how cultural needs can be met in the health care setting and how understanding and accepting cultural differences can be taught to health care providers. Studies should examine the acquisition of an understanding of culture and how retention of this knowledge occurs in different learning environments.

Summary

Culture is an important concept to providing care to people from differing backgrounds, and a significant factor in the preferences patients have in their daily lives. The concept of culture is complicated by the ambiguity of terms, but an understanding of how an individual's development shapes his or her health care needs is paramount to the nursing and health care process. Nurses should seek to understand culture and provide care that is appropriate for each patient.

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Chapter 3

Texas Pre-Licensure Nursing Faculty Members' Cultural Competence

Abstract

Nurses are integral in our health care system, and nursing faculty are instrumental in shaping the nursing workforce. Today's nurses are expected to provide culturally competent care to an increasingly diverse population, and nursing faculty are influential in developing cultural competence in nursing students through education and role-modeling. However, it is not clear if nursing faculty members are culturally competent and prepared to serve as role models to students. Therefore, it is important to first establish the level of cultural competence among nursing faculty members.

Purpose. The purpose of this mixed methods study was to determine the cultural competence in nursing faculty in Texas teaching in pre-licensure nursing programs.

Research Question/ Hypothesis. This study aimed to (1) determine the level of cultural competence in Texas pre-licensure nursing faculty and (2) examine the relationships between demographic variables, and cultural competence scores. The study also (3) assessed whether demographic data predicts the level of cultural competence, and (4) explored the perceptions of cultural competence among pre-licensure nursing faculty in Texas.

Methods. Using a convergent parallel mixed-methods design, data was collected using both survey and interview techniques. Full-time faculty members were invited to complete an online survey via a nursing program directors' Listserv. A subset willing to be interviewed was selected from participants that provided their contact information at the end of the quantitative survey. Quantitative data was analyzed using descriptive

statistics, independent t-tests, and ANOVA. Qualitative data was analyzed using a constant comparative method.

Results. The level of cultural competence among nursing faculty members was low to moderate. Findings suggest that nursing faculty have higher mean scores on cultural awareness and cultural sensitivity subscales, and have lower mean scores on cultural knowledge and cultural skills subscales. It was noted that faculty members that received cultural competence education in their undergraduate nursing program of education showed a higher level of cultural competence. Three themes emerged from the interviews: knowledge is experiential, skills require emotional intelligence, and desire requires a catalyst.

Implications for Practice. This study demonstrated that nursing faculty in Texas have a low to moderate level of cultural competence. Research is needed to investigate when to best provide cultural competence education in nursing curriculum for nursing faculty members. Nursing faculty could benefit from experiences with culturally diverse patients and students. Continuing education opportunities that focus on providing meaningful experiences may also increase the knowledge and skills that nursing faculty need to provide culturally competent care.

Texas Pre-Licensure Nursing Faculty Members' Cultural Competence

The United States (U.S.) is a culturally diverse nation, requiring that nurses be prepared to provide culturally competent care to a diverse patient population. More than 37% of the US population is considered ethnically and culturally diverse (US Census Bureau, 2013). However, a fraction of health care jobs are held by those considered to be ethnically and culturally diverse with 24.6% of nurses from minority backgrounds, and minority health care leaders comprising an even smaller number of the total at 13% (Minority Nurse, 2014; Selvam, 2013; Sullivan Commission, 2005). This suggests a mismatch between the demographics of the US population and the demographic profile of those providing health care. The incongruity is important because culturally and ethnically diverse groups account for the majority of health disparities in the U.S. (Bahls, 2011; Giddings, 2005; National Council of State Legislatures, 2014), and are more likely to require hospital care (Agency for Healthcare Research and Quality, 2012; Hausmann, Jeong, Bost, & Ibrahim, 2008; Pesquera, Yoder, & Lynk, 2008). The demographic mismatch is exacerbated in some geographic locations because the population mix is rapidly changing. Five states, Texas included, are now classified as minority-majority states (Aaronson, 2012).

Part of the Patient Protection and Affordable Care Act (PPACA) includes preparing health care providers to meet the culturally diverse needs of their patient population. This is increasingly important in the U.S. as preventive care initiatives are becoming an integral part of the new U.S. health care system with the implementation and continued rollout of the PPACA (111th U.S. Congress, 2009). If patients are not treated in a culturally competent manner when they are sick, and the patients feel that

they are treated with prejudice and without sensitivity for their cultural needs, there is little incentive to seek preventive health care when they are well (Martin, 2012). The need to provide culturally competent care is an important concept fundamental to the need to improve the health outcomes in our country made timelier by the implementation of the PPACA.

Evidence suggests that providing culturally competent health care is the strongest method to combat health disparities (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003; Betancourt, 2004; Keehan, 2013; Noe, Kauffman, Kauffman, Brooks, & Shore, 2014). Health care providers that are culturally competent, regardless of race, can help reduce health disparities (Alvarez, 2014; Betancourt, Green, Carrillo, Ananeh-Firempong, 2003; Betancourt, 2004; Esposito, 2013; NIH, 2012). Culturally competent health care enhances patient satisfaction (Andre, Erik, Ara, & Thanos, 2009; Li-Ming et al., 2012) and leads to improved health outcomes and a decrease in health disparities (Pesquera, Yoder, & Lynk, 2008). Care that is culturally competent entails an acceptance of the individual and humility that may exist as a result of cultural differences. It is a complex phenomenon, and health care professionals charged with the task of providing culturally competent care have varying degrees of education and preparation to meet this challenge.

It is expected that undergraduate nursing students are prepared to meet the health care needs of the public, including culturally and ethnically diverse populations (American Nurses Association, 2001; Gardois, Booth, Goyder & Ryan, 2014; Likupe, 2014). Despite recognition of the need to provide care for culturally and ethnically diverse populations, the lack of cultural competence in undergraduate nursing education

has been identified as a national concern (American Association of Colleges of Nursing, 2014; Kardong-Edgren & Campinha-Bacote, 2008; National League for Nursing, 2014; The Sullivan Commission, 2005). The American Association of Colleges of Nursing (2014) states that 71.7% of nursing students are white, non-ethnic and non-culturally diverse indicating a need for cultural competency education in undergraduate nursing students (Tavallall, Kabir, & Jirwe, 2014). This does not limit who should receive cultural competence education, as all nurses, including those that are a racial and ethnic minority, will provide care to someone that is different from their cultural background (Berger, Zane, & Hwang, 2014). Students regard nursing faculty and instructors as models for appropriate behavior (Black, Marcoux, Stiller, Xianggui, & Gellish, 2012; Mokhtari Nouri, Ebadi, Alhani, & Rejeh, 2014).

While nursing faculty serve as role models to students (American Association of Colleges of Nursing, 2014; Davis, 2013; Felstead, 2013), it is not clear that nursing faculty members are prepared to teach culturally competent care (American Association of Colleges of Nursing, 2014; Montenery, Jones, Perry, Ross, & Zoucha, 2013; Sealey, Burnett, & Johnson, 2006). Various terms are used to describe what it means to provide care that is tailored towards the individual, culturally-based needs of each patient. Examples include cultural competence, cultural sensitivity, cultural humility, cultural safety, and culturally congruent care. For the purposes of this study, the term cultural competence will be used.

Within the context of the paper, a culturally competent nurse means a professional that may or may not have completed training regarding interactions with those from diverse backgrounds, and instead, the concept of culturally competent focuses on the

ability to provide culturally relevant care to another (Bean, 2008; Marzilli, 2014). It is essential for nursing faculty to understand and demonstrate cultural competence in their student and patient interactions. In nursing education, the first cultural competency curriculum was written in 1986 (Campinha-Bacote, 2006), but more than 50% of nursing educators received their nursing education prior to this time (Kaufman, 2007, Robert Wood Johnson Foundation, 2013). While nursing educators play a key role in providing cultural competency education for nursing students, there is little research to suggest that cultural competence education is effectively or consistently taught in the nursing curriculum (Kardong-Edgren & Campinha-Bacote, 2008). Since the concept of cultural competence was introduced after many of the current nursing educators received their education, there is a need to evaluate the level of cultural competency in the health care system, especially in nursing faculty, as they are often the first role-model for future nurses.

Purpose

Current research lacks data to measure the existing level of cultural competence in nursing faculty. In addition, faculty members' perception of individual cultural competence is not well-documented. Therefore, the purpose of this mixed-methods study is to determine the level of cultural competence in pre-licensure associate degree, diploma, and baccalaureate nursing faculty in Texas and explore faculty perceptions of what it means to be culturally competent.

Review of the Literature

The literature review focuses on the variable of cultural competence. Beginning with the relationship between cultural competence and health disparities, a discussion of

health disparities, medical conditions, HIV care, mental health, and access to care is included. The purpose of including this discussion is to highlight the importance of cultural competence as a tool to reduce health disparities and improve health outcomes. Discussing cultural competence in terms of health disparities stresses the importance of cultural competence in our society. This is followed by a review of the literature exploring cultural competence in student nurses and nursing faculty members. The literature review was conducted by reviewing the EBSCO, CINAHL, ProQuest, and Sage databases, accessed through the university library.

Health Disparities

Health disparities are defined as "preventable variances in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations," typically defined as racial or ethnic minorities (Centers for Disease Control, 2013). Health disparities are inequitable; are directly associated to the historical and current unequal distribution of social, political, economic, and environmental resources and potentially undermines the health of the nation. Among children who are a racial minority, obesity is a health disparity that is linked to many chronic, costly medical conditions like heart disease and diabetes (Flores & Lin, 2010). White children have a 10% incidence of obesity whereas the prevalence of obesity in ethnic minority children is 25%. Racial minorities are also more likely to suffer from medical conditions such as asthma, dental issues, depression, and diabetes.

Medical conditions.

Many health indicators in the U.S., which are often based on medical health outcomes, are affected by health disparities related to racial and ethnic minorities. Quinn

(2011) found that prevalence of H1N1, which is largely preventable through inoculation, is related to racial and ethnic minority status. Racial and ethnic minorities were also more susceptible to complications related to respiratory failure associated with H1N1 and had less access to care. Burton (2010), evaluating the racial and ethnic disparities present in the US health care system, found the incidence of community acquired pneumonia in black adults, is 2.4 times the incidence found in white Americans. Community acquired pneumonia is often preventable through inoculation. Cancers, such as breast or colo-rectal, that are frequently curable when detected at an early stage are missed in racial minorities as they are less likely to be screened for cancer (Tanne, 2012). The disproportionate representation of medical conditions that are preventable through inoculation or early detection among racial and ethnic minorities is of concern.

Risk behaviors.

HIV, a virus transmitted through contaminated bodily fluids, is not prevented through inoculation or cured through early detection. However, HIV can largely be prevented through education and avoidance of risky behavior, and minority, culturally diverse patients have an increased prevalence of HIV. The incidence of HIV is 3.9 per 100,000 in whites, 49.2 per 100,000 among blacks, and 19.5 per 100,000 in Hispanics (Linley, Prejean, An, Chen, & Hall, 2012), and culturally competent health care interventions could address this disparity. Shun, Senteio, Felizzola, and Rust (2013) found that in Medicaid-eligible pregnant women, Hispanic women were 3.89 times less likely than whites to not receive anti-retroviral therapy for HIV, and they were likely to receive only one to two months of Medicaid therapy compared to their white counterparts, who receive lifelong therapy. Furthermore, barriers to Hispanic women

receiving Medicaid services were related to cultural and immigrant issues, representing a public health issue as the risk for HIV transmission to ethnic and racial minority immigrants increases.

Mental health.

Mental health is a significant issue in the U.S., and racial and ethnic minorities suffer a disproportion prevalence of mental health disorders. Aranda, (2013) reported a higher prevalence of depression, major depressive disorders, and anxiety disorders among older Latino adults than their white counterparts. The findings supported a study by Alexandre, et al. (2010) that found racial minorities are less likely to receive adequate mental health care. Eating disorders are another mental health issue that is disproportionately prevalent among racial and ethnic minorities. Marques et al. (2012) found that ethnic minorities receive less access to health care, especially mental health care related to eating disorders.

Access to care.

Access to health care is a major problem in the U.S. Racial and ethnic minorities are more likely to seek health care at free clinics, public health districts, and federally-funded Community Health Centers (CHCs). The population seeking care at the CHCs is largely unfunded, living below the poverty line, and has many medical co-morbidities (Boutin et al., 2013), yet these co-morbidities are managed at CHCs that are under-funded, under-staffed, and do not have health outcomes equitable to primary care offices. Access to care is also an issue for racial and ethnic minorities when language is a concern. Flores (2012) found that adolescents from non-English primary speaking homes were two to four times more likely than adolescents from English primary speaking

homes to have suboptimal medical and dental health, no health insurance, no personal doctor or nurse, and problems obtaining specialty care. May, Hua, and Flores' (2012) study supports these findings, noting adolescents from non-English primary speaking homes were more likely to report having never seen a dentist and not received any preventive or dental care in the last year. Hispanic children were found to have the poorest dental health and preventive care utilization. Guarnizo-Herreno and Wehby (2012) found that black children also have poor dental health compared with white children, representing another health care disparity.

The proportion of white residents in nursing homes dropped by 10.2% between 1999 and 2008 while the proportion of racial minorities in nursing homes increased (Zhanlian, Fennell, Tyler, Clark, & Mor, 2011). The proportion of Asian residents in nursing homes increased 54.1%, Hispanics 54.9%, and Blacks 10.8% during this same time period. This represents a disparity in health care as racial minorities have less access to community-based resources to help them receive care at home (Zhanlian et al., 2011).

Cultural Competence

Cultural competence is gained through the acquisition of knowledge and behavior change. Like (2011) identified cultural competence as an effective way to reduce health care disparities in the U.S., and suggested that cultural competence be implemented as part of continued professional education to reduce this outcome in health care. Culturally competent health care has been demonstrated to be an effective tool in reducing health disparities (Brusin, 2012; Flaslerud, 2007; Harris, 2010; Harris, 2011; Jackson & Garcia, 2014; Lettlow, 2008; Ornelas, 2008; Padela & Punekar, 2009, Harris, 2011). Harvey and

O'Brien (2011) found that having culturally appropriate educational resources was instrumental in reducing health disparities among Hispanic patients at the Puentes de Salud clinic. Saha, et al. (2013) found that health disparities are worsened when care was provided by culturally incompetent providers. HIV outcomes in patients receiving care from culturally incompetent health care providers had significantly worse health outcomes compared to patients receiving health care from culturally competent health care providers. Saha et al. further concluded that health care cultural competence may reduce racial disparities in quality and health outcomes, suggesting that cultural competence is a key component in reducing health care disparities. Dovidio and Fiske (2012) and Quinn et al., (2011) identified that health care biases negatively impact patient care, and awareness or reflection on one's biases is an important aspect of cultural competence that can reduce health disparities in patients.

Padela and Punekar (2009) identified cultural practices, language differences and barriers, socioeconomically diverse backgrounds, and religious beliefs as obstacles contributing to the health disparities that occur in racial and ethnic minorities in the emergency room setting. The authors identify cultural competence training as an effective way to reduce the burden of health disparities seen in racial and ethnic minorities. Cooper et al. (2013) identified a lack of cultural competence in health care providers as a significant barrier to improving health outcomes, and Boute, Kelly-Jackson, and Johnson (2010) and Aranda (2013) found that it was essential to meet the cultural needs of patients.

Student Cultural Competence

Many researchers have explored the issue of cultural competence in students through qualitative studies including interviews, focus groups, journaling, and photovoice. Studies identified many tools, such as experiential and international service learning, and case studies that can improve the level of cultural competence (Harris, Purnell, Fletcher, & Lindgren, 2013; Harrowing, Gregory, O'Sullivan, Lee, & Doolittle, 2012; Gillund, Rystedt, Wilde-Larsson, Abubakar, & Kvigne, 2013; Kratzke & Bertolo, 2013; Larson, Ott, & Miles, 2010; Michael, Della, Banner, Duckworth, & Nilson, 2012; Steed, 2010; Torsvik & Hedlund, 2008). While these studies are essential to the body of knowledge regarding cultural competence in students, the studies do not provide quantitative data to evaluate or identify means to improve the cultural competence in nursing students.

Cultural competence education was identified as more effective if the learner desires to be culturally competent (Campinha-Bacote, 2006). Campinha-Bacote (2006) studied the process of cultural competence in undergraduate nursing students who expressed a desire to be culturally competent and found their level of cultural competence was much higher than in their peers that did not express a desire to become culturally competent (Fitzgerald, Cronin, & Campinha-Bacote, 2009).

Quantitative studies found that knowledge gained in an immersion environment or a classroom setting was essential to increasing cultural competence (Michajlyszyn, Thompson, Stiller, & Doherty, 2012; Munoz, DoBroka, & Mohammad, 2009). Wilson, Sanner, and McAllister (2010) found that providing knowledge through a cultural

competence workshop had lasting benefits as cultural competence scores increased at three-, six-, and 12- months.

Ballestas and Roller (2013) used Campinha-Bacote's Inventory for Assessing the Process of Cultural Competence-Student Version (IAPCC-sv) to determine cultural competence in pre-licensure nursing students. The researchers identified that students are not culturally competent prior to a specialized service-learning experience. The IAPCC-sv defined 94.4% as culturally aware, but study participants scored 51-74 out of 100 possible points, indicating a need to improve the level of cultural competence in pre-licensure nursing students.

Faculty Cultural Competence

Faculty members are role models for pre-licensure nursing students (Felstead, 2013). Warner and Esposito (2009) studied the impact that educators can play in role-modeling desired behaviors and found this was an effective method of instruction. Montenery, Jones, Perry, Ross, and Zoucha (2013) explored the role of the nursing faculty member in transferring their cultural competence knowledge to the educational setting so that nursing students can learn this behavior and relate it to patient care. They suggested it is necessary to have knowledge and skills necessary to deliver culturally competent care and that this can be done by exploring the issue of cultural desire and raising awareness among nursing students.

Nursing educators are responsible for providing a good example of cultural competence in their interactions with patients and students. Demonstrating appropriate cultural competence skills can be especially challenging for nursing educators working with students from diverse backgrounds, so it is essential that nursing educators possess

an awareness that they are a role model for culturally competent care and skills to act appropriately (Morton-Miller, 2013). While research has supported the role of faculty in developing student nurse cultural competence, limited studies were identified that examined the cultural competence of faculty and their preparation to provide cultural competent care. Studies show that faculty members are not adequately prepared in cultural competence (Kardong-Edgren, 2007; Kardong-Edgren et al., 2005; Lipson & DeSantis, 2007; Sealey, Burnett, & Johnson, 2006).

Culturally competent health care can help reduce health care disparities and improve health outcomes. This study will add to the scientific knowledge regarding nursing faculty members' level of cultural competence.

Theoretical Framework

The Campinha-Bacote (1998) Process of Cultural Competence in the Healthcare System model is based upon the idea that cultural competence is not a destination. Rather, it is an ongoing process that is a result of exposure to various encounters, and the knowledge, attitudes, skills and cultural competence desire gained from one's life journey (Campinha-Bacote, 2006). Campinha-Bacote's model includes five concepts titled cultural awareness, cultural skill, cultural knowledge, cultural encounters, and cultural desire. These five concepts are woven together as integral to the process of providing culturally competent care to patients, and together, they form the ASKED framework.

Cultural desire is necessary in the process of becoming culturally competent as the individual health care provider must possess some level of desire to meet the needs of those from diverse backgrounds; health care providers that do not have cultural desire will be less likely to provide effective health care to patients from diverse backgrounds.

Nursing educators should model a level of cultural desire in their behaviors and interactions to show nursing students this necessary component of cultural competence. Cultural awareness is essential for the process of providing culturally competent care as self-reflection and an examination of one's own beliefs highlights the attitudes that one may possess towards providing care to those of diverse backgrounds. Cultural knowledge is the process of learning about the differences between unique cultural groups. A culturally competent health care provider must have some working knowledge of the cultural group for which the nurse is providing care, thus enhancing the health care provider's cultural skills. Campinha-Bacote identified cultural encounters as essential to the process of becoming culturally competent. Exposure to and engagement with patients from different racial and ethnic backgrounds allows health care providers opportunity to integrate the cultural skills necessary to be culturally competent. Nursing faculty members play a key role in instilling cultural desire in students, providing cultural awareness and knowledge, modeling culturally competent skills, and facilitating experiences that will increase the exposure to and awareness of the culturally related health care needs of patients.

Methodology

Design

A convergent parallel mixed-methods design was used to examine cultural competence in nursing faculty. A quantitative strand measured cultural competence. A qualitative strand explored faculty perceptions of cultural competence.

Sample

A convenience sample of nursing faculty in Texas was recruited through the Texas Organization of Baccalaureate and Graduate Nursing Education (TOBGNE) and the Texas Organization for Associate Degree Nursing (TOADN) Listservs, which, together, comprise a listing of all nursing program deans and directors in Texas. Inclusion criteria included: full-time nursing faculty; employed by a university or college in Texas; and teaching pre-licensure nursing students. Faculty teaching in both an undergraduate and graduate program were included, but part-time and adjunct faculty members will be excluded from the study. G-power 3.1 was used to determine the required sample size. Based on the most complex analysis planned with a moderate effect size of 0.5 and power of .80, *a priori* sample size was indicated as 89 to compare groups (Faul, Erdfelder, Buchner, & Lang, 2009). A subset of participants was recruited for the qualitative interviews.

Data Collection Procedures and Setting

The quantitative surveys were administered using an online survey tool to nurse educators teaching pre-licensure students at nursing schools in Texas. The survey remained open for a two-week period. The interviews were conducted concurrently via the modality of the participant's choice (e.g. telephone, web-conferencing). All participants elected to complete the interview over the telephone, and the interviews were recorded. Following the interviews, the recordings were transcribed.

Procedures

Following IRB approval and email support from the Deans and Directors Chairpersons, an email was sent to the Deans and Directors Listservs. The recruitment

letter asked the dean or director to distribute the survey link to their full time nursing faculty to help in a research study aimed at understanding cultural competence in nursing faculty members. Potential participants received the email with the recruitment flyer link from their dean or director. Each individual receiving the email was given the opportunity to choose whether or not to participate. When participants clicked on the survey link, they were taken to the first screen within online survey tool, which detailed the informed consent process, the estimated time needed to complete the survey and the potential benefits and risks to the participant. Participants that agreed to participate clicked the "next" button, which served as their implied consent. The last item on the survey asked the participant to submit their responses. Upon clicking submit, the participants were brought to a new one-question survey that asked for participant's consent to be contacted for an interview regarding cultural competence. The one-question survey response was not linked to the original survey, thus protecting participant confidentiality. Participants that volunteered to be interviewed provided their email address or phone number. Participants were contacted in the order in which they completed the survey until data saturation was reached. Each interviewee was emailed an informed consent complete with the purpose, the risks, benefits, and the information that they had the right to conclude the interview at any time. Participants emailed the completed informed consent back to the PI.

Instruments

Demographic questionnaire.

Demographic data was collected through self-report and included age, gender, educational preparation, race, and ethnicity. The degree programs taught, location of

program, whether the program borders Mexico, the level of student taught, the manner in which cultural competence is taught, marital status, primary language spoken, number of and languages spoken, size of the program, percent minorities, countries visited, and desire were also collected as potentially important demographic variables. Three questions were asked about cultural desire.

Nurses' Cultural Competence Scale (NCCS).

Cultural competence is defined as acting in a manner that acknowledges the cultural background of another individual and requires the nurse to tailor their attitudes and behaviors to the individual that care is being provided (Campinha-Bacote, 2006). Cultural competence was measured with the Nurses' Cultural Competence Scale (NCCS), a 41-item survey with four subscales (cultural awareness-10 items, cultural knowledge- 9 items, cultural sensitivity- 8 items, and cultural skills- 14 items) (Perng, Lin, Chuang, 2007). Each subscale uses a five-point Likert scale to measure the participant's response: 1 = totally disagree, 2 = 25% agree, 3 = 50% agree, 4 = 75% agree, and 5 = 100% agree. The total score ranges from 41 to 205. Higher NCCS scores are indicative of a higher level of cultural competence. The NCCS was originally written in traditional Chinese and evaluated by four experts; it has been translated into English. Several studies support the reliability and validity, with a reported Cronbach's α between 0.78 to 0.96 and a reliability between 0.79 to 0.89 of the Chinese version (Lin, 2013; Perng, Lin, & Nuang, 2007; Perng & Watson, 2012).

Qualitative questions.

Qualitative data was obtained through semi-structured interviews based on open-ended questions. These questions were intended to solicit information from the

participants regarding their cultural encounters, existing knowledge, and feelings associated with cultural competence. The qualitative interview also examined their desire related to cultural competence. The interview guide was read to the interview participants. During the interview process, it was determined that a question should be added for clarification. The question, "Do you have one experience that stands out in your mind when you think of cultural competence? Can you tell me about that?" was added to solicit deeper information from the participants.

Research Questions

The following research questions were asked to determine the cultural competence of nursing faculty:

1. What is the level of cultural competence in pre-licensure nursing faculty in Texas?
2. Is there a difference in cultural competency scores of nursing faculty based on the demographic variables (e.g. urban/rural, type of program, years of experience)?
3. What are pre-licensure nursing faculty perceptions of cultural competence?

Data Analysis

Quantitative data was collected online and was imported into SPSS version 20. Research question one, which determined the level of cultural competence in nursing faculty in Texas was analyzed using descriptive statistics. Means and standard deviations were calculated for the each of the four cultural competence subscales and the overall level of cultural competence. Descriptive statistics were also used to evaluate the level of cultural competence in each faculty member.

Research question two examined demographic variables that could potentially predict cultural competence. Data was run to evaluate predictors of cultural competence related to demographic variables and the NCCS. Independent *t*-tests and one-way ANOVAs were used to evaluate demographic data for significant differences. Tests, including the Bonferroni, Levene's, and K-S test were conducted.

Research question three explored the perceptions of cultural competence in the nursing faculty member and was evaluated using the constant comparative method. Trustworthiness was maintained by having a second researcher review, code, and analyze the data for comparison with the PI's coded data. Theoretical constructs were independently conducted and mutually agreed upon. Additionally, triangulation, member checking, and keeping a field journal were used to ensure trustworthiness. Themes were identified using Strauss and Corbin's (1990) qualitative analysis procedure. Constructs and examples of the constructs were used to support each theme. The themes were related back to the Process of Cultural Competence in the Health Care System (Campinha-Bacote, 2006).

Results

An initial 104 faculty members responded to the quantitative survey. After excluding those with more than 15% missing data, 89 participants comprised the final sample. The sample was primarily female, white, educated at the MSN level, with a mean age of 55 (Table 1). Most spoke English as a first language, and the majority had experience traveling abroad. The table below shows that participants greatly desired to provide culturally competent care (97.6%), desired to learn how to provide culturally competent care (95.1%), and teach cultural competence (96.3%).

Table 1. Demographic Description of Study Participants

Demographic	Groups	Frequency	Percentage
Gender	Male	5	5.6
	Female	84	94.4
Age	20-30	3	3.4%
	31-40	5	5.7%
	41-50	16	18.2%
	51-60	34	38.6%
	61-70	26	29.5%
	71 and up	4	4.5%
Highest Degree	MSN	46	51.1%
	Doctorate	43	47.8%
Race	American Indian	1	1.1%
	Asian	3	3.4%
	Black	4	4.5%
	Mixed Race	1	1.1%
	White	79	89.8%
Ethnicity	Hispanic	5	5.7%
	Non-Hispanic	82	94.3%
Borders Mexico	Yes	7	7.8%
	No	82	92.1%
Cultural Competence	Threaded	86	95.6%
Taught	Separate Class	2	2.2%
	Elective	1	1.1%
Marital Status	Married/Partnered	69	76.7%
	Single	19	21.1%
Continuing	Yes	69	77.5%
Education	No	20	22.5%
First Language	English	85	95.5%
	Other	4	4.5%
Languages Spoken	1	66	74.2%
	2	19	21.3%
	3	4	4.5%
Traveled Abroad	Yes	84	94.4%
	No	5	5.6%
Enrollment of	<3,500	31	35.2%
University	3,500-10,000	30	34.1%
	>10,000	27	30.7%
Nursing Program	<160	35	39.3%
Size	160-400	27	30.3%
	>400	27	30.3%
Percent Minorities	<25%	35	39.3%
In Nursing	25-49%	28	31.5%
Program	50-74%	15	16.9%
	>75%	4	4.5%
	Unknown	7	7.9%

Table 2. Demographic Description of Study Participants continued

Years Teaching Experience	0-2 years	8	9%
	3-5 years	15	16.9%
	6-10 years	17	19.1%
	11-15 years	16	18%
	16-20 years	9	10.1%
	21+ years	24	27%
Desire to Provide	Yes	83	97.6%
	No	2	2.4%
Desire to Learn	Yes	77	95.1%
	No	4	4.9%
Desire to Teach	Yes	79	96.3%
	No	3	3.6%
Programs Taught	Undergrad Only	63	70.8%
	Undergrad/Grad	26	29.2%
City Population	<35,000	27	30.7%
	35,000-200,000	33	37.5%
	>200,000	28	31.8%
Level of Students Taught	1 semester left	10	11.2%
	2 semesters left	37	41.6%
	3 semesters left	21	23.6%
	4 or more left	21	23.6%
Faculty Cultural Competence Education	Undergrad	13	14.8%
	Grad	65	73.8%
	Never	10	11.4%

Level of Cultural Competence

Descriptive statistics were used to analyze the level of cultural competence and the four NCCS subscales. Total NCCS scores ranged from 81 to 197. The NCCS total and subscale scores, along with associated Cronbach's alphas, are presented in Table 2. The NCCS total and subscale means as a percentage of the total possible scores also were calculated (Table 2).

Table 3. Descriptive Statistics of NCCS and Subscales

	Mean (S.D.)	Cronbach's Alpha	Mean as a % of Total Possible
Awareness Subscale	41.5 (7.2)	.79	83%
Knowledge Subscale	33.8 (6.5)	.75	75%

Table 4. Descriptive Statistics of NCCS and Subscales continued

Sensitivity Subscale	32.8 (5.3)	.79	82%
Skill Subscale	54.3 (9.2)	.73	78%
NCCS Total with Outlier	162.3 (21.7)	.75	79%
NCCS Total without Outlier	197 (20)		

Differences in Cultural Competence Scores Based on Demographic Variables

The second research question was evaluated using inferential statistics and first included an evaluation to ensure the data was homogenous and normally distributed. The Kolmogorov-Smirnof test (K-S = .116; p = .05) confirmed that data was approximately normally distributed.

ANOVAs were conducted on variables with three or more categories and independent t-tests were used to evaluate variables with bivariate categories. These tests were conducted on all demographic variables in the study to determine significant differences. Independent t-tests were used to evaluate the variables of gender, highest level of education, ethnicity, whether the program resides in a county that borders Mexico, marital status, continuing education, first language spoken, the program taught, and whether they had traveled abroad. The desire variables of desire to be, desire to teach, and desire to learn about cultural competence were also evaluated using the independent t-test. ANOVAs were used to evaluate the variables of age, race, how cultural competence is taught, number of languages spoken, university enrollment, nursing program size, percent of minorities in the nursing program, years of teaching experience, city population, level of students taught, and when faculty received cultural

competence education in their formal education. The independent t-tests did not yield any significant findings, and the ANOVAs found only two significant variables.

The ANOVA found significance based on when the faculty member received instruction in cultural competence ($F = 4.793$, $p = .004$). Post hoc analysis revealed that faculty members who received cultural competence education at the undergraduate level scored significantly higher (M = 165.692, SD = 22.68) than faculty members not receiving any cultural competence education (M = 139.5, SD = 25.9). Those receiving cultural competence education at the graduate level were similar to those receiving cultural competence education at the undergraduate level (M = 164.962, SD = 19.06), but this was not indicative of significance.

ANOVA was also conducted to determine the differences among faculty members based on the number of languages spoken by the faculty member ($F = 2.79$, p = .003). Post hoc analysis for different languages spoken showed that faculty members that spoke more than two languages were more culturally competent (M = 184, SD = 8.67) than faculty members just speaking English (M = 159.93, SD = 22.6).

Power was assessed with Eta and Eta square. For this study, Eta of .380 and Eta square of .145 indicated a moderately low power.

Nursing Faculty Perceptions of Cultural Competence

Content analysis of qualitative data identified three main themes: knowledge is experiential, skills require emotional insight, and desire stems from a catalyst. The three themes and seven subcategories are presented in Table 3.

Table 5. Themes and Sub-themes of Faculty Perceptions of Cultural Competence

Theme	Sub-Theme	Example
Knowledge is Experiential	Distinct Cultural Differences and Experiences	Caring for Hmong patient
	Differences in Populations	Change in student and/or patient population
	Ethnocentrism	Ethnocentrism gets in the way of students seeing the value in others
	Education	Education examples focus on experience
Skills Require Emotional Insight	Cultural Competence	Definition focuses on the needs of the other
	Accommodating	Making trade-offs or breaking the rules for the other
	Modeling	Showing through actions how to care for those that are different
Desire Stems from a Catalyst	Desire	Linked to an individual thought or attitude that causes the individual to buy-into caring for the other

Knowledge is experiential.

Distinct Cultural Differences and Experiences.

Key experiences related to distinct cultural differences were vividly embedded in the thoughts shared by participants. Faculty members recalled experiences with a particular patient or situation that highlighted the knowledge needed to provide care. This experiential type of learning stood out as the basis for providing culturally competent care.

Participant A shared the story of caring for a gypsy patient and being surprised by the family structure. "Gypsies really do not recognize immediate family members as we do or as other cultures do… the entire family is the tribe." As a result of that experience, which the participant described as interesting and challenging, the nurse associated a particular experience with providing culturally competent care.

Participant C shared the experience of providing care to an Arab woman in a battered women's shelter. While the experience occurred several years ago, the participant still remembers having to research the best way of providing culturally competent care to better craft an appropriate plan of care.

Several participants recalled experiences of caring for Hispanic patients as indicative of cultural competence. Participant F recalled caring for a patient, and the patient offering a beverage. The participant had learned about providing culturally competent care to Hispanic patients and the importance of social exchange before initiating care, but the *experience* of accepting the beverage is what came to mind when thinking about providing culturally competent care. Participant G recalled caring for a Hispanic female patient with a hemoglobin that was "not compatible with life." The patient needed to go to the hospital to receive transfusions, but she would not consent to treatment without her husband's approval. Participant C described needing social space needed when conversing with a Hispanic individual. The participant felt that her personal space was being encroached upon so she proceeded to step back, and every time she stepped back, the other person would step forward. The participant eventually recalled learning about the issue of personal space with the Hispanic culture, but that knowledge did not guide her actions until she had the actual experience.

Participant B was providing post-mortem care. The participant could not recall the patient's exact culture but was struck by the differences in the death practices between the patient's and her own and described the experience as "different or conflicted with what I might have done."

Differences in Population.

Participants focused on differences in the population as they considered how they became culturally competent. When participants talked about the diversity of the community and the setting in which students had clinical practicums, Participant A remarked, "…our students work in [a large, metropolitan area] when they graduate so that is very multicultural as far as the work staff and patient population because [the city] itself is very diverse." This participant expressed that the experience caring for this diverse population provided students with the skills to be culturally competent. One participant remarked, "Back in the 80s there was some mention of cultural differences, but it was not the emphasis or focus." Thirty years ago, the participant was surrounded primarily by Caucasian nurses, students, and patients, but this is not the case anymore.

Another participant remarked that the diverse student population was really a key factor in providing culturally competent care. Another participant remarked, "The change in our student population over the last 20 years that I have been teaching. When I first started teaching, we were 95% Caucasian…. I would imagine 10-20% [are now] Caucasian." One participant remarked, "I was big on cultural competence because we have a diverse group of students, and the group that I was focused on was minority students." The situation of educating diverse students created an experience where the nurse educator was aware of being and becoming culturally competent.

Ethnocentrism.

Participant A noted that students lacked experiences in interacting with people from diverse cultures which contributed to their ethnocentrism, "Just making them aware that there are different cultures and belief systems." Participant A went on to say

"Unfortunately a lot of my students are very ethnocentric and they only view their culture and they are not aware of others or their beliefs or practices." Another participant noted "The biggest challenge is students either not believing in culture or not believing that it matters. That sort of ethnocentrism. That belief that oh well, all patients have the same symptoms."

Participant F shared an interaction with a faculty colleague selecting a course textbook. When remarking to colleagues about a textbook containing pictures of minorities, the participant noted the importance of seeing diverse people in the book. However, this was not a selling point to anyone else. A colleague remarked with shock exclaiming, "Does that matter?" The participant noted "It really struck me that people's world views are different. They can look right at you but they see through you, especially people of color, and if you cannot see people, you are not really culturally competent."

Education.

Education, while important, emerged as secondary to the experiences that cemented cultural competence. Participants shared that they received a wide variety of education in cultural competence ranging from separate classes in cultural competence, to a curriculum that threaded it throughout the nursing school experience, to graduate school electives, immersion experiences, and continuing education courses. One participant interviewed disclosed, "It wasn't in the curriculum … so it was more part of going to the clinical" where the students could experience it.

Skills require emotional insight.

Three sub-themes; cultural competence, accommodating, and modeling, underscored the need for a culturally competent nurse to be aware of the feelings of a diverse patient population while also being cognizant of their own feelings and thoughts. Participant A epitomized this noting, "If you stayed small and in your own values I don't know that you could be successful." Participant A continued, "As a nurse, you take care of patients that on a personal level you could not stand. You just go into your persona of 'I am a nurse' and whatever my own personal, religious, cultural values, I am a nurse."

Cultural Competence.

One participant defined cultural competence as "A skillset that helps you interact with people [so] you are mindful and operating [based on] the values and beliefs and things that are familiar to them." Identifying cultural competence as a skill set based on value supports the idea that emotional intelligence is key to becoming culturally competent. Further, another participant defined cultural competence as "Recognizing that people whose cultures are different than your own are going to have different ways" further noting "It is important for the health care provider to realize that even if those ideas clash with their own they are not wrong and they have very, very strong beliefs that work for them."

Accommodating.

The skill of accommodating included the actions of incorporating, negotiating, honoring, explaining, and integrating thoughts, values, and actions. Participants described how they would focus on what the patient wanted or needed based on their cultural values and adapting nursing care accordingly. For example, one participant

talked about caring for a patient before cultural competence was "a big deal" and said, "He wouldn't eat, and… once we figured out that the food was just not acceptable [based on his culture], … we also allowed the family to bring in food for the patient."

Another faculty member demonstrated accommodation when describing communication with students from a different cultural background. "[The student] might have difficulty understanding what I am saying whereas others may not have a difficulty so I kind of have to look back to see if it is maybe the terms."

Modeling.

Participant G disclosed faculty should "think modeling to students and showing what [cultural competence] look[s] like so they can try it next time." Participant A remarked that cultural competence comes later in a nursing student's career, once they get past the anxiety of doing procedures correctly. This participant stated, "Modeling for [students] so they at least tuck it away so when their anxiety goes down and their skill level goes up they are more competent with the basics and can add that next layer [of providing culturally competent care]." Participant H noted that colleagues modeled cultural competence well because their peers "are very good at assessing culture and incorporating that into how they teach and model in a day-to-day situation."

Desire stems from a catalyst.

Desire emerged as an important theme in the interviews. One participant identified desire in students and shared an example of a "student who took it upon herself to research a culture when she found that no one could communicate with the patient and he really wasn't doing well so she found someone that could speak his language."

Two participants identified the desire to provide culturally competent care stemming from childhood. One participant talked about growing up as an "army brat" and moving every few years. The participant identified that "Each time, we would move, it would be from vastly different areas of the country to another so I think I very quickly learned to assess the local culture [and adapt to what was desirable]." Participant F identified the experience of growing up with parents that had traveled abroad and having grandparents from another country. This created a desire from childhood to seek out experiences with other cultures- a desire that was realized when the participant took a study abroad course in Mexico.

Desire motivated participants to seek educational opportunities to improve cultural competence. Travel abroad experiences and self-studies in different cultures represented fulfilling the desire for increased understanding of other cultures. Participant G said she would read all the material they could locate on different cultures in order to recognize differences and skillfully provide patient care.

Discussion of the Findings

Level of Cultural Competence

Texas nursing faculty members' cultural competence score as measured with the NCCS was moderate. There was one outlier with a score of 81. With the outlier removed, the mean changed significantly (with outlier, $M = 162.3$, $SD = 21.7$ vs. without outlier, $M = 197$, $SD = 20$). The outlier scored 50 points lower than the next lowest NCCS score, but a decision was made to leave the outlier in the analysis as this faculty member was a minority and indicated no desire to be culturally competent. This could be more representative of other Texas nursing faculty. Texas nursing faculty scored lower

on the skills and knowledge subscale but scored slightly higher in the awareness and sensitivity subscales. This is consistent with the literature that shows that nurses typically score higher in sensitivity and awareness and lower in knowledge and skills (Kawashima, 2008; Mahabeer, 2009; Molewyk Doornbos, Zandee, & Degroot, 2014). The Cronbach's alphas indicated an acceptable level of reliability.

Differences in Cultural Competency Scores Based on Demographic Variables

The examination of demographic variables that could serve as predictors for cultural competence in nursing faculty was not significant. Analysis yielded no data to predict the level of cultural competence in nursing faculty, and this is consistent with Campinha-Bacote's (2006) model and theory (Liu, 2013; Truong, Paradies, & Priest, 2014). Campinha-Bacote's theory is based on the idea that cultural competence is a journey and an ongoing process rather than something that can be obtained through certain criteria or meeting specific requirements on a checklist (Harris, Purnell, Fletcher, & Lindgren, 2013; McMillan, 2012: Montenery et al., 2013).

Part of the journey and ongoing process to cultural competence is through education. The point at which a nursing faculty member received cultural competence education appeared to be important. The nursing faculty members that received cultural competence education as an undergraduate student score significantly higher than those receiving no education in cultural competence. This may be explained as early exposure to clinical competence provides nursing faculty increased opportunity to practice cultural competence (Shuang, 2014). It could also be argued that receiving cultural competence education at the graduate level is too late and the ability to provide culturally competent care is already engrained in the faculty member at the graduate level.

Nursing faculty members that spoke two or more languages had higher cultural competence scores suggesting that exposure to language is part of an experience that can increase cultural competency (Costea, Buluc, & Tomescu, 2013). This may be explained as learning new languages typically exposes an individual to a different culture. Similarly, an individual often chooses to learn a language, suggesting a component of desire, and this concept of desire is consistent with the Campinha-Bacote model and the research findings.

Power in this study is moderate. The power obtained from this study would ideally be higher, but the sample, with only one exception, included only those that voiced a desire to be culturally competent so the participants did not differ significantly and may not represent pre-licensure nursing faculty in general.

Nursing Faculty Perceptions of Cultural Competence

The qualitative data provided key insight into faculty members' perceptions of cultural competence. There was a wide range of interpretation among the faculty participants, but the data shared similar themes whether the participant was discussing nursing, being a faculty member, or working with students.

Knowledge is experiential.

Nursing faculty in Texas work with patients and students from distinct cultural backgrounds. Though faculty members' experiences vary, their work is greatly impacted by the changes in population demographics that have occurred over time. Repeatedly, it was the experiences working with students, patients, and other faculty members from different cultures that shaped faculty members' perception of cultural competence. Nursing knowledge may have been formally introduced through any number of

educational processes, but these formal educational settings did not integrate the knowledge needed to enable nursing faculty to provide culturally competent care, rather, experience was the key to cultural competence care. It appears that experience is the key to cultural competence, and there are several aspects of experience that are interrelated. Distinct cultural differences and experiences, differences in populations, ethnocentrism, and education are subthemes of this theme.

Skills require emotional insight.

Skills are an important part of Campinha-Bacote's model (2006), and the interview process identified that skills are essential to cultural competence. Interestingly, when participants discussed cultural competence skills, they focused on the emotional insight necessary to be culturally competent. The concept described by the participants identified by the researcher as emotional insight really epitomizes the concept of emotional intelligence. The idea of emotional intelligence exists in the literature as a concept that explains "the ability to monitor one's own and others' feelings and emotions, to discriminate among them and to use this information to guide one's thinking and action" (Salovey & Mayer, 1990, p. 189). Cultural competence, modeling, and accommodating are subthemes of this theme.

Desire stems from a catalyst.

Desire is a fundamental concept represented in Campinha-Bacote's model, and desire emerged as a major theme in the qualitative interview process (2006). Participants excitedly discussed their own onset of interest in providing culturally competent care. This was described similarly to a spark or catalyst that ignited an internal desire to

experience and provide the appropriate skills to a patient that was from a culturally diverse background.

Comparison

In keeping with the mixed methods study, the quantitative and qualitative findings were compared, examining the data for similarities and differences. Within the framework of the Campinha-Bacote model, these comparisons are discussed below (2006).

Awareness

Awareness was measured with the NCCS score, and participants scored well on the subscales of cultural awareness and cultural sensitivity. Consistent with the quantitative findings are the qualitative findings that cultural competence requires emotional insight, and this is supported with the subcategories of cultural competence as a subjective concept, accommodating, and modeling. Nursing faculty are required to assess both physical and non-physical differences in their patients, and culture is a key aspect of each patient (Caplan & Black, 2014)

Skills

Campinha-Bacote identifies the construct of skills as important in the process of providing culturally competent care. The NCCS scale assesses cultural skills, and nursing faculty did not score as high on this subscale. Consistent with this finding, the qualitative findings showed that nurses focus more on the experience of providing culturally competent care than the actual skills needed to provide the care. The finding of "knowledge as experiential" was supported with the categories of distinct cultural differences and experiences, differences in population, ethnocentrism, and education.

When nursing faculty thought about the skills they needed, they referenced other nurses or their own memories for their experience in caring for a patient of that particular cultural background. This is consistent with the literature that supports experience as an important aspect of providing culturally competent care (Bohman & Borglin, 2014; Easterby et al., 2012; Riley, Smyer, & York, 2012).

Knowledge

Campinha-Bacote's theory breaks apart knowledge and skills as two separate components required for becoming culturally competent, but the results of this study suggest that knowledge and skills are not differentiated as indicated in the Campinha-Bacote model. The quantitative NCCS data indicated nursing faculty do not score as high on this subscale, similarly to what was assessed in the subscale of cultural skills. The qualitative data indicated that cultural knowledge was more about the experiences interacting with and caring for diverse patient populations, the increasing number of diverse patients, ethnocentrism, and the educational aspect of learning about cultural competence through experience.

Encounters

The fourth component of Campinha-Bacote's model is cultural encounters. The demographic data suggested a wide range of cultural encounters in the nursing faculty members, but this was not linked to a higher level of cultural competence in the NCCS score. The qualitative data supported this, highlighting the different experiences as more important than the number of experiences. Nursing faculty members that had cultural competence education as undergraduate students had a richer body of experiences from which to make connections between culture, cultural competence, and their clinical

experience. Additionally, nursing faculty members who spoke more than two languages were able to draw upon the experiences gained while learning a new language to help facilitate their knowledge of cultural competence. The qualitative findings support that richer experiences shaped a nursing faculty member's knowledge of cultural competence more than classroom education about cultural competence.

Desire

Campinha-Bacote highlights desire as central to the process of cultural competence. A high level of desire was reported from participants both quantitatively and qualitatively. When participants talked about desire, it was accompanied with a story that relayed there was an experience or situation that caused a spark, or catalyst, for the nursing faculty member to become culturally competent.

Strengths and Limitations

External validity was strengthened because the demographics of this sample closely match that of the entire U.S. as compared to Texas alone. The demographics of Texas nursing faculty members are more diverse compared to the demographic makeup of nursing faculty across the US. In Texas, 74.9% of nursing faculty members are white, 10% are African American, 9.4% are Hispanic, and 5.7% are other (Texas Center for Nursing Workforce Studies, 2011). In the US, 86.9% of nursing faculty members is white, and 13.1% report being of other ethnicity (Robert Wood Johnson Foundations, 2009). The percentage of faculty members that responded to this study is similar to that reported as the composite for the U.S.

Power is an important weakness in this study. A moderately low power is important to consider when attempting to replicate this study in the future. To increase power, future studies should include more participants.

A weakness of the study is the underrepresentation of male faculty members. Additionally, it was noted that some participants did not answer the NCCS in entirety making the results unusable for this particular study. Another weakness is that the convenience sample confined to one state limits external validity as the experience of nurse faculty in Texas may not reflect other geographic areas of the country. A weakness related to internal validity is that subjects may anticipate a desirable answer choice and select a number that does not correctly represent their true answer. Internal reliability of the NCCS was acceptable when considering this was the first time the instrument was used in an English-speaking sample.

Nursing faculty members that are interested in cultural competence and diverse patients may be more likely to participate in the study thereby increasing the level of cultural competence in the study. This is supported through the finding that desire is an important aspect of cultural competence.

Recommendations

The importance of cultural competence is well established in the literature for reducing and improving health disparities. Because of this, and the need to improve the health outcomes in the US and the change in health care legislation in support of the ACA, nursing faculty members have a vested interest in modeling culturally competent care to nursing students so they can be the change necessary to create a healthier U.S. Since nursing faculty members in Texas are moderately culturally competent, it is

important to consider that there is room to improve the level of cultural competence in these faculty members. Additionally, cultural competence is a journey so faculty members need continued reinforcement related to providing culturally competent care to truly serve as good role models by modeling cultural competence to students. There is a need to conduct further research on this topic.

It is recommended that continuing education programs for nursing faculty members should focus on educational modalities that will give an authentic feel to different cultural experiences. In today's technologically rich environment, perhaps high-fidelity virtual simulations of culturally diverse experiences can provide experiences that nursing faculty will adopt as their own experiences by which they can improve their level of cultural competence.

It is also recommended that cultural competence education that creates experiences and desire while enriching the emotional insight in nursing students should be integrated into the undergraduate curriculum. Examples of experiences include study abroad programs and service-learning opportunities.

Further research should be conducted to determine the most effective way to provide cultural competence education that focuses on experiences, emotional insight, and desire. Research should also be conducted in non-minority-majority states to see if there are any statistically significant differences between the cultural competence score and the demographic factors of the nursing faculty members. Future research should explore the possibility that nursing faculty members residing in a minority-majority state may be more culturally competent or have distinct differences between non-minority-majority states.

Policy makers may be interested in ways that nurses can cost-effectively reduce health disparities. If culturally competent care can reduce health disparities, it may be cost effective to require high-quality, effective cultural competency experiences and education as part of the nursing curriculum. It may be necessary for policy makers to recommend that existing nurses or existing nursing faculty members take a continuing education course in cultural competence however, additional research should be done to determine the most effective way for this to occur.

Conclusion

Cultural competence is an important skill for nursing faculty as they serve as role models for nursing students and future practitioners. Understanding the level of cultural competence in nursing faculty will provide a basis to develop an educational program to increase the cultural competence in nursing faculty. The research suggests that there are opportunities for further research related to an understanding of how nursing faculty members acquire cultural competence and an opportunity to evaluate whether cultural competence exposure makes a difference on the nursing faculty member's ability to model cultural competence to students.

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Chapter 4

Summary and Conclusions

The U.S. is a diverse environment with minorities soon to comprise the majority of the population (Pardasani & Bandyopadhyay, 2014). Texas, as one of five minority-majority states, is already comprised of a majority of minorities. The situation where minorities comprise the majority presents challenges to the U.S. health care system. Research supports that patients from minority backgrounds suffer disproportionately more health disparities. Health disparities are a significant economic concern for the U.S., and in light of the Affordable Care Act, (ACA), and the emphasis of preventative health care, there is a great need for culturally competent health care as a tool to reduce health disparities (Kaiser Family Foundation, 2014; Kohn-Wood & Hooper, 2014).

This study aimed to provide an understanding of the concept of culture and a discussion of the cultural competence in nursing faculty. The manuscript *A Concept Analysis of Culture Applied to Nursing* provided the basis for understanding the concept of culture as it relates to health care, especially in nursing. Information provided in this manuscript highlights the confusion with which the word "culture" is used in a variety of settings.

The manuscript *Cultural Competence in Texas Pre-Licensure Nursing Faculty*, was based on the Process of Cultural Competence in the Healthcare Delivery System theoretical framework. Cultural competence was measured with the Nurses' Cultural Competence Scale (NCCS) that provided a numerical score associated with the level of cultural competence in the nursing faculty member. The model has five constructs, including knowledge, skills, awareness, desire, and encounters. The NCCS measured

knowledge, skills, and awareness; encounters and desire were measured with the demographic data and the qualitative interviews.

Pre-licensure nursing faculty in Texas had a moderate score on the NCCS indicating a need to increase the level of cultural competence in these faculty members. The NCCS score also showed that the faculty members scored higher on the subscales of cultural awareness and cultural sensitivity, consistent with the findings in the qualitative results showing that cultural competence requires emotional intelligence. The subscales of knowledge and skills were not scored as highly in these faculty members, consistent with the qualitative finding that knowledge requires experience, something not captured in the NCCS score.

The study also examined desire and encounters through demographic data and the interview process. Nursing faculty participating in the study desire to provide culturally competent care and serve as role models for their students. This was echoed in the quantitative and qualitative findings. The qualitative findings identified a theme of "desire requires a catalyst" suggesting a link between desire and experiences garnered by the faculty member. The issue of encounters was not effectively captured in the quantitative research indicating a need for additional research to capture this information reliably. The qualitative findings suggested an emphasis on experience rather than encounters signifying a need for further study. The idea of experience is important to consider regarding the theme of "knowledge requires experience." Future research will address distinguishing between "experience" and "encounter."

Knowledge and skills are commonly addressed in continuing education venues for nurses and nursing faculty members, and the faculty members indicated participation in

these learning activities. The nursing faculty members' scores in cultural knowledge and cultural skills were lower than expected, and based on these findings suggest that the current manner in which cultural competence education is taught may not be the most effective way to deliver this information. The interview participants highlighted experiences as the manner in which they gained cultural knowledge, suggesting that cultural competence education should be focused more on experiences.

Nurses are typically very intuitive and sensitive to the needs of others. It is not surprising that nurses scored high in the area of cultural awareness and cultural sensitivity. This suggests that nurses are poised to deliver culturally competent care with the right catalyst to spark desire and the right experiences to provide the knowledge and skills necessary to provide culturally competent care.

Further research should be conducted to determine whether cultural experiences should be included in the undergraduate level of education. Providing intentional cultural experience may not only prepare nurses for delivering culturally competent care but also equip potential nursing faculty to serve as role models to nursing students. Another area worth investigating is the best practices approach to providing cultural competence education to future nurse educators as part of the graduate nursing curriculum. This education could be designed in such a way to create the experiences necessary to gain the knowledge and the skills required to provide culturally competent care.

Additional research should be conducted on cultural competence in nursing faculty as a precursor to designing continuing educational opportunities that increase the level of cultural competence in these crucial members of the health care team. Nursing educators serve as role models to future nurses and should be modeling cultural

competence that demonstrates a high level of knowledge and skills to undergraduate nursing students.

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Appendix A. Permission from Journal to Include First Manuscript

Colleen:

Permission granted. We appreciate your asking and asking is always the right thing to do. Our stance is that we try to not block authors from using their research when compiling their dissertations.

Best regards,
Jim Costello
Vice President, Journal Publishing Program
Springer Publishing Company, LLC
11 West 42nd Street, 15th Fl
New York, New York 10036
T: 212-804-6223
Hi Jim,

I received your contact information from Marty Lewis-Huntsinger at Creative Nursing. I hope you can help me!!

I have perhaps a unique question for you.
I am finishing my PhD in nursing, and my dissertation is of the European style, where a portfolio of manuscripts is compiled all relating to the dissertation research project. I would like to include my article *Concept Analysis of Culture Applied to Nursing,* which will appear in *Creative Nursing, 20*(4) as article 5.
However, I do not want to violate any copyright laws. I need to request permission to include this in my dissertation portfolio, but I am unsure of the process. Can you point me in the right direction?

In advance, thanks so much for your time.

Best regards,
Colleen

Appendix B. IRB Approval

September 25, 2014
Dear Dr. Marzilli,
Your request to conduct the study: *Cultural Competence among Nursing Faculty in Texas,* IRB #F2014-09 has been approved by The University of Texas at Tyler Institutional Review Board under expedited review. This approval includes the written informed consent that is attached to this letter, and your assurance of participant knowledge of the following prior to study participation: this is a research study; participation is completely voluntary with no obligations to continue participating, with no adverse consequences for non-participation; and assurance of confidentiality of their data.
In addition, please ensure that any research assistants are knowledgeable about research ethics and confidentiality, and any co-investigators have completed human protection training within the past three years, and have forwarded their certificates to the IRB office (G. Duke).
Please review the UT Tyler IRB Principal Investigator Responsibilities, and acknowledge your understanding of these responsibilities and the following through return of this email to the IRB Chair within one week after receipt of this approval letter:

- This approval is for one year, as of the date of the approval letter
- Request for Continuing Review must be completed for projects extending past one year
- Prompt reporting to the UT Tyler IRB of any proposed changes to this research activity
- **Prompt reporting to the UT Tyler IRB and academic department administration will be done of any unanticipated problems involving risks to subjects or others**
- Suspension or termination of approval may be done if there is evidence of any serious or continuing noncompliance with Federal Regulations or any aberrations in original proposal.
- Any change in proposal procedures must be promptly reported to the IRB prior to implementing any changes except when necessary to eliminate apparent immediate hazards to the subject.

Best of luck in your research, and do not hesitate to contact me if you need any further assistance.

Sincerely,

Gloria Duke, PhD, RN

Gloria Duke, PhD, RN
Chair, UT Tyler IRB

Appendix C. Permission to Use TOBGNE Listserv

Yes we can do that. You can direct your email to Nicole Ellis. Jellis@tamhsc.edu and she will forward it to the members.

Sent from my iPad

Sharon Wilkerson, PhD,RN

Dean and Professor

College of Nursing

TAMHSC

To:
wilkerson@tamhsc.edu;
Dear Dr. Wilkerson:
I am a doctoral student at The University of Texas at Tyler, and I am in the dissertation phase of my education. For my dissertation, I am researching the level of cultural competence in nursing faculty teaching in pre-licensure nursing programs. In order to collect data for my dissertation, I respectfully request your assistance. I would like to request permission to send an email through the Texas Organization of Baccalaureate and Graduate Nursing Education (TOBGNE) listserv. By using the contacts in your listserv, I will ask the deans and directors to forward the link to my study to their faculty members. I feel this is the best way to reach as many Texas nursing faculty as possible to contribute to this important research.
Please note this study will be approved by The University of Texas at Tyler's IRB prior to distribution.
If you have any questions, please feel free to contact me or my dissertation chair, Dr. Barbara Haas, at the following contact information.
Thank you for your consideration.

All my best,
Colleen

Appendix D. Permission to Use TOADN Listesrv

Please note that permission to use this Listserv was obtained verbally by the UTTyler Nursing Director and conveyed to the doctoral student

jbecker@dcccd.edu;
Dear Ms. Becker:
I am a doctoral student at The University of Texas at Tyler, and I am in the dissertation phase of my education. For my dissertation, I am researching the level of cultural competence in nursing faculty teaching in pre-licensure nursing programs. In order to collect data for my dissertation, I respectfully request your assistance. I would like to request permission to send an email through the Texas Organization for Associate Degree Nursing (TOADN) listserv. By using the contacts in your listserv, I will ask the deans and directors to forward the link to my study to their faculty members. I feel this is the best way to reach as many Texas nursing faculty as possible to contribute to this important research.
Please note this study will be approved by The University of Texas at Tyler's IRB prior to distribution.
If you have any questions, please feel free to contact me or my dissertation chair, Dr. Barbara Haas, at the following contact information.
Thank you for your consideration.
All my best,
Colleen

Appendix E. Demographics

Demographic Data Survey

Age

- 0-2 years
- 3-5 years
- 6-10 years
- 11-15 years
- 16-20 years
- 21+ years

Gender

Male
Female
Other

Highest level of Educational preparation

BSN
MSN
PhD/ DNP/other doctorate

Race

American Indian/Alaskan Native
Asian
Black or African American
Mixed race
Native Hawaiian or Other Pacific Islander
White

Ethnicity

Hispanic
Non-Hispanic

Program(s) in which you teach (select all that apply)

Diploma
ADN
BSN
MSN
DNP
PhD

What is the approximate population of the city where your program is located?

Is your program located in a county that borders Mexico?

Yes
No

Level of students

Last semester (they will graduate when this semester is complete)
Two semesters left (they will graduate after completing this and one more semester)
Three semesters left (they will graduate after completing this and two more semesters)

Four semesters left (they will graduate after completing this and three more semesters)

Five or more semesters left (they will graduate after completing this and at least four more semesters)

How is cultural competence taught in your nursing curriculum?

Threaded throughout the curriculum

Separate class required

Elective offered

Marital status

Married or cohabitating

Single

What language is your first language spoken?

How many languages do you speak?

Please specify languages spoken

Have you traveled to other countries?

What is the approximate enrollment for your university or college?

What is the approximate enrollment for your nursing program?

What is the approximate minority in your program and/or school?

<25%

>25 - <50%

>55% - <75%

>75%

Do not know

Please select when you received formal education in cultural competence. (You may select more than one answer.)

- Associate's level stand-alone course in cultural competence
- Associate's level integrated curriculum in cultural competence
- Bachelor's level stand-alone course in cultural competence
- Bachelor's level integrated curriculum in cultural competence
- Master's level stand-alone course in cultural competence
- Master's level integrated curriculum in cultural competence
- Doctoral level stand-alone curriculum in cultural competence
- Doctoral level integrated curriculum in cultural competence
- Post-doctoral work
- Never

Excluding the coursework mentioned in the previous question, have you received any training in cultural competence within the past five years? (You may select more than one answer.)

- Continuing education session
- Case presentation(s)
- Webinar(s)
- Clinical cultural competence consultation training
- No training in cultural competence in the past five years.
- Other: _____

Appendix F. NCCS Tool

Awareness Subscale

1. One's belief and behavior are influenced by one's cultural background.
2. Those who came from diverse cultural backgrounds usually have different value systems.
3. People's belief/behavior about health and illness are influenced by cultural values.
4. Understanding the client's cultural background is very important to nursing care.
5. When immersed into a different culture, the acceptance level among individuals is quite different.
6. A client's behavioral response originates from his/her cultural system, therefore care providers should understand client's subjective interpretation of his/her own behavior.
7. Nursing education is itself a cultural system.
8. Understanding a client's cultural background can promote the quality of nursing care.
9. A nurse's cognition of health and illness is deeply influenced by nursing education.
10. Nursing knowledge and the client's comprehension of interpretation of health/illness are usually different.

Knowledge Subscale

11. I understand the social and cultural factors that influence health and illness.
12. I can identify the specific health problems among diverse groups.
13. I can use examples to illustrate communication skills with clients of diverse cultural backgrounds.
14. I can comprehend diverse cultural groups' interpretations of their health beliefs/behavior.
15. I can list the methods or ways of collecting health-, illness-, and cultural-related information.
16. I am familiar with health- or illness-related cultural knowledge or theory.
17. I can explain the possible relationships between the health/illness beliefs and client's culture.
18. I can compare the health or illness beliefs among clients with diverse cultural background.
19. I can easily identify the care needs of clients with diverse cultural backgrounds.

Appendix F. NCCS Tool (Continued)

Sensitivity Subscale

20. I appreciate the diversities among different cultures.
21. The type of health practices adopted by an individual do not matter, as long as they work.
22. I can tolerate diverse cultural groups' beliefs or behavior about health/illness behavior.
23. Even if a client's use or adoption of a health maintenance method differs from my professional knowledge, I usually don't oppose it.
24. Even if a client's use or adoption of a treatment method differs from my professional knowledge, I usually don't prohibit it.
25. I usually discuss differences between the client's health beliefs/behavior and nursing knowledge with each client.
26. I usually actively strive to understand the beliefs of different cultural groups.
27. In addition to traditional medical treatments, I also try to understand alternative treatment methods.

Skills Subscale

28. I can communicate with clients from different cultural backgrounds.
29. I can interpret non-verbal expressions of clients from different cultural backgrounds.
30. Before planning a nursing activity, I collect cultural background information on each client.
31. To me, collecting information on each client's beliefs/behavior about health/illness is very easy.
32. I can explain the influence of culture on a client's beliefs/behavior about health/illness.
33. I can explain the influences of cultural factors on one's beliefs/behavior towards health/illness to clients from diverse ethnic groups.
34. I can establish nursing goals according to each client's cultural background.
35. When implementing nursing activities, I can fulfill the needs of clients from diverse cultural backgrounds.
36. When caring for clients from different cultural backgrounds, my behavioral response usually will not differ much from the client's cultural norms.
37. I can teach and guide nursing students about the differences and similarities of diverse cultures.
38. I can teach and guide nursing students about the cultural knowledge of health and illness.
39. I can teach and guide nursing students about required communication skills for clients from diverse cultural backgrounds.

40. I can teach and guide nursing students about planning nursing interventions for clients from diverse cultural backgrounds.
41. I can teach and guide nursing students to display appropriate behavior when they implement nursing care for clients from diverse cultural groups.

Appendix G. Qualitative Interview Guide

How do you define cultural competence?

Have you had experience with cultural competence? Will you tell me about that?

Did your educational preparation teach you about cultural competence? Will you tell me about that?

Tell me about other experiences that impacted your cultural competence?

Have you had continuing education in cultural competence? Will you tell me about that?

T me about your nursing students and cultural competence.

What is the biggest challenge with cultural competence in pre-licensure nursing students? Will you tell me about that?

What has influenced your personal cultural competence?

Will you tell me about your perceptions of your colleagues related to cultural competence?

Do you have a desire to provide culturally competent care?

Do you have a desire to learn how to provide culturally competent care?

Do you have a desire to teach students how to provide culturally competent care?

Biosketch

Colleen Marzilli was born in Hutchinson, Kansas. She graduated from The University of Texas at Tyler with her Bachelor of Science in Nursing, Master of Science in Nursing, Master of Business Administration, and post-MSN certificate in education. She finished her Doctorate of Nursing Practice in Public Health Nursing from The University of Tennessee Health Science Center at Memphis. She teaches at The University of Texas at Tyler in the nursing program and does research in culture, education, and health care.