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Cultural and Health Literacy Assessment of the Hispanic/Latino Patient Population: Presentation of a Cultural Competence Toolkit for Acute Care Nurses

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Cultural and Health Literacy Assessment of the Hispanic/Latino Patient Population:
Presentation of a Cultural Competence Toolkit for Acute Care Nurses

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Abstract

Background: Barriers to effective communication, such as low health literacy, language, and cultural differences, play a role in the health disparities that affect the Hispanic/Latino population. These barriers have generally been considered in isolation; interventions designed to overcome low health literacy have typically been separate from those focused on decreasing cultural and linguistic barriers. Nurses caring for diverse patient populations must understand that culture and language establish the framework for the attainment of health literacy skills, and strive to work within the cultural context of the patient. *Methods:* Best practices for cultural and health literacy assessment and culturally appropriate nursing interventions were identified through an integrative review of the literature and used to develop a Cultural Competence Training Toolkit which was presented to a group of clinical nurses and educators ($N = 12$). Effectiveness of the toolkit was measured through pre-and post-intervention evaluation of cultural competence using the Inventory for Assessing the Process of Cultural Competence among Healthcare Professionals- Revised as well as a program evaluation survey. *Objectives:*

- 1) Explore the relationship between health literacy, cultural competence, and nursing practice;
- 2) Describe a cultural competence model that can be used as a framework for nursing practice;
- 3) Develop a Cultural Competence Training Toolkit for acute care nurses and evaluate its effectiveness.

Outcomes: Statistically significant improvements were noted in overall cultural competence (12.25 points) as well as all sub-scale scores (desire: 2.42 points; awareness: 2.75 points; knowledge: 2.08 points; skills: 2.91 points; and encounters: 2.09 points) from baseline to post-test, and the program received positive ratings as a resource for cultural competence training ($p < .001$). *Conclusion:* Education focused on providing culturally competent care for Hispanic/Latino individuals may lead to improvements in providers' awareness, knowledge, skills, encounters and desire to learn about the specialized needs of this vulnerable population.

Keywords: *health literacy, cultural competence, transcultural nursing, Hispanic/Latino*

Introduction

Hispanics/Latinos are now the second-largest and fastest-growing minority group in Virginia, where they are estimated to number over 741,000 or 9% of the population, growing 92% since 2000 due to high birth rates and increased immigration (U.S. Census Bureau, 2014). Social determinants of health such as low health literacy, culture, and linguistic barriers, have been shown to play a large role in many of the health disparities that affect this population (Britigan, Murnan, & Rojas-Guyler, 2009; Singleton & Krause, 2009). Cardiovascular disease and its risk factors are areas of particular focus in Williamsburg, Virginia, where local estimates indicate that substantial numbers of Hispanic/Latino adults have cardiovascular health risks related to modifiable, behavioral risk factors such as nutrition, physical inactivity, weight, tobacco, and alcohol, as well as chronic conditions such as high blood pressure, high cholesterol, and diabetes (Sentara Healthcare, 2013; Virginia Department of Health, 2016). Health disparities in this patient population may be due to poor communication between providers and racial and ethnic minority patients and a lack of understanding of how health behaviors can affect risk factors. Recent research suggests that the Hispanic/Latino patient population may be more likely to seek out healthcare services when these services are responsive to their needs (Guerrero, Marsh, Khachikian, Amaro, & Vega, 2013). In a systematic literature review, Guerrero et al. (2013) identified access to culturally responsive care as a key strategy to increase health service utilization among Hispanics/Latinos, particularly when services included culturally competent practices such as race/ethnicity matching, as well as language, regional culture, and belief system congruence. This evidence signals an urgent need for culturally appropriate health promotion and disease prevention programs as well as culturally competent healthcare providers.

According to *Healthy People 2020* (Office of Disease Prevention and Health Promotion [ODPHP], 2016), the goal for reducing health disparities in cardiovascular disease risk factors and care include improving cardiovascular health and quality of life “through prevention, detection, and treatment of risk factors for heart attack and stroke; early identification and treatment of heart attacks and strokes; and prevention of repeat cardiovascular events”. Achieving this goal requires effective communication between health care professionals and their patients. Nurses today, who are providing care to an increasingly diverse patient population, are being challenged by a variety of barriers to effective health communication. These barriers, which include low health literacy, cultural differences, and language, impact provider-patient communication and are directly linked to patient satisfaction, adherence, and health outcomes (Britigan et al., 2009).

The evidence appears to demonstrate that health literacy is related to culture and language (Kutner, Greenberg, Jin, & Paulsen, 2006; Sentell & Braun, 2012). Results of the National Assessment of Adult Literacy (NAAL) found that while 9% of non-Hispanic Whites have below basic health literacy skills, this number is dramatically higher among Hispanic/Latino adults, where 41% lack basic health literacy (Kutner et al., 2006). In a study examining self-reported health status as related to low health literacy and limited English proficiency (alone and in combination), researchers found that individuals with both limited English proficiency (LEP) and low health literacy appeared to be a particularly vulnerable group; prevalence of poor self-reported health status among study participants was more than three times higher in individuals with both LEP and low health literacy than those in the reference group (neither LEP nor low health literacy)- 45.1% vs. 13.8% (Sentell & Braun, 2012). Despite what appears to be an interaction phenomenon between limited English proficiency, culture, and

low health literacy, researchers in health literacy and limited English proficiency (LEP) rarely collaborate and interventions designed to overcome low health literacy have typically been separate from those focused on decreasing cultural and linguistic barriers (McKee & Paasche-Orlow, 2012; Singleton & Krause, 2009). For example, although health literacy researchers have shown that materials written in plain English and at a lower grade level result in better understanding and improved knowledge, individuals from diverse cultures may not understand these easy-to-read materials if Western constructs of health are assumed (Andrulis & Brach, 2007). A similar problem exists when language-focused interventions are practiced in isolation; while language barriers may be overcome through the translation of materials, these interventions will be ineffective with LEP individuals who may have low health literacy in their native languages and may not be able to read translated materials (Andrulis & Brach, 2007). In order to provide effective teaching interventions, healthcare professionals must understand the synergistic negative effects of low health literacy, limited English proficiency, and cultural differences on patient-provider communication.

Interventions designed to improve health knowledge and disease management in limited English proficiency minority populations and among individuals with limited health literacy include patient assessment strategies (e.g., health literacy assessment tools, cultural group membership, primary language, English proficiency, and interpreter needs); workforce strategies (e.g., community health workers, patient navigators, health educators, racial/ethnic concordance, interpreters, bilingual clinicians); and educational strategies (e.g., communication, plain language, cultural sensitivity training, how to work with interpreters) (Andrulis & Brach, 2007). Despite the focus on patient-centered communication as a strategy for reducing health disparities and achieving equitable health care for vulnerable populations, the high rates of self-reported

poor health among individuals with multiple health communication vulnerabilities (LEP, cultural differences, and low health literacy) appears to indicate that considerable needs and challenges remain (Sentell & Braun, 2012). The gap between patients' values, needs, and preferences and the degree to which most health systems and practices use patient-centered communication makes it clear that more research is needed in order to understand how culture, language, and health literacy influence health disparities and health outcomes, and how assessing these factors can enable healthcare professionals to plan appropriate interventions.

Problem Statement

A community needs assessment found that the Hispanic/Latino population in Williamsburg, VA is at increased risk for cardiovascular disease due to health behaviors (poor nutritional status, lack of physical activity, smoking, alcohol use, and poor control of blood pressure, diabetes, and cholesterol) that may result from poor patient-provider health communication (Sentara Healthcare, 2013). Low health literacy, cultural differences between patients and providers, and limited English proficiency are distinct, but related, barriers to health communication (McKee & Paasche-Orlow, 2012; Singleton & Krause, 2009). To determine how these barriers affect the health of the target population, the DNP Project focused on identifying evidence-based best practices for cultural and health literacy assessments and culturally appropriate nursing interventions through an integrative review of the literature. This review validated the pathways by which low health literacy, culture, and LEP impact health across diverse groups, and also helped to identify, target, and design effective interventions and materials for this population. This information was then used to develop a Cultural Competence Training Toolkit which can be used as an educational resource for the acute care nurses that care for this patient population.

Review of the Literature

Appraisal of Evidence

To understand the relationship between health literacy in the Hispanic/Latino patient population and cultural competence in nursing, a search of the literature was performed using the Cumulative Index to Nursing and Allied Health Literature (CINAHL) and PubMed electronic databases. The search was conducted using the key terms health literacy, cultural competence, transcultural nursing, Hispanic/Latino patient population, and limited English Proficiency (LEP). This search yielded 23 results. Using limiters to narrow inclusion criteria to peer-reviewed, English-language research articles published in nursing and public health journals from January 2009 to present returned 13 results. Exact duplicates were removed, leaving 10 articles for review. Of these, three articles described physician-patient interactions and were excluded, leaving seven articles for further examination. The strength and quality of the evidence presented was appraised using the Johns Hopkins Nursing Evidence-Based Practice (JHNEBP) Evidence Level and Quality Guide (Dearholt & Dang, 2012; See Appendix A).

The purpose of this literature review was three-fold: 1) to describe “cultural competence” through the analysis of its constructs: cultural awareness; cultural knowledge; cultural skill; cultural encounters; and cultural desire (Campinha-Bacote, 2002a); 2) to examine the relationship between health literacy, cultural competence, and nursing practice; and, 3) to describe how nurses can use a cultural competence model as a framework for the provision of individualized, culturally competent healthcare. While low health literacy affects a variety of cultural groups, this review was primarily focused on the diverse, and often underserved, Hispanic/Latino patient population.

Synthesis of Evidence

Although there are several models of cultural competence, four of the studies included in this review used Campinha-Bacote's Process of Cultural Competence Model as the theoretical framework (Aponte, 2009; Ingram, 2012; Matteliano & Street, 2012; Singleton & Krause, 2009). Using concept analysis as the methodology, these researchers found the model to be applicable to nursing practice in a variety of healthcare settings and to a wide range of situations. Three of the articles reviewed describe qualitative studies: researchers used interviews, observations, and questionnaires to examine the relationship between health literacy and cultural competence in nursing practice (Benkert, Templin, Schim, Doorenbos, & Bell, 2011; Matteliano & Street, 2012), and to describe the relationship between culture and health literacy (Britigan et al., 2009).

While research appears to support an association between health literacy, cultural competence, and nursing practice (Benkert et al., 2011; Britigan et al., 2009; Matteliano & Street, 2012), it does not demonstrate a causal relationship between culturally competent nursing care and increased health literacy. Future research should expand on these exploratory studies by comparing various models of cultural competence, directly measuring the effects of culturally competent behaviors on health literacy, and evaluating the effects of increased health literacy on health disparities among the Hispanic/Latino patient population.

Culture and health literacy. Researchers have suggested that health literacy may be related to an individual's cultural background. Singleton and Krause (2009) argued that language and culture influence how individuals interpret health information, citing the results of the 2003 National Assessment of Adult Literacy (NAAL). In this study, which measured health literacy disparities among culturally diverse populations, researchers found that 66% of Hispanic

adults exhibited “basic” or “below basic” health literacy as compared to only 28% of white non-Hispanic adults (Kutner et al., 2006). This disparity continues to hold true; in a more recent study, the Program for the International Assessment of Adult Competencies (PIAAC, 2014), which assessed and compared basic skills and competencies (including health literacy) of adults around the world, researchers found that 40% of Hispanic/Latino adults in the United States exhibited “Below Level 1” or “Level 1” health literacy as compared to only 9% of white non-Hispanic adults.

In a study exploring the relationship between acculturation and health literacy, researchers hypothesized that high levels of acculturation into American society would be associated with higher levels of functional health literacy (Britigan et al., 2009). Hispanic/Latino community members ($n=52$) were recruited to participate in this study which used the Bidimensional Acculturation Scale for Hispanics (BAS) and the Short Test of Functional Health Literacy in Adults (S-TOFHLA) to measure these variables and define their relationship. Researchers found that while 100% of participants with high levels of acculturation had “adequate functional health literacy”, only 82% of those with low levels of acculturation shared this trait (Britigan et al., 2009).

Health literacy and cultural competence in health care. While these studies appear to support the idea that cultural values, beliefs, and preferences play an important role in health literacy, the question remains, “How can nurses incorporate interventions designed to overcome health literacy into a culturally competent framework for patient care?” Several studies have attempted to answer this question by examining the relationship between health literacy and cultural competence in nursing practice. Aponte (2009) evaluated the constructs described in Campinha-Bacote’s Process of Cultural Competence Model (cultural awareness; cultural

knowledge; cultural skill; cultural encounters; and cultural desire) and found that these constructs were applicable in all healthcare settings, and that the model can guide the delivery of culturally competent care to the Hispanic/Latino patient population. For example, the construct “cultural skill”, which refers to the nurse’s ability to conduct a cultural assessment in order to develop a plan of care and interventions that are congruent with the patient’s cultural context, requires nurses to understand traditional Hispanic/Latino values. Two of the most important values are “respeto” (respect) and “personalismo” (personal relationship). As Hispanics tend to view nurses and other healthcare providers as authority figures who must be shown respect, etiquette dictates that they not make eye contact, that they greet their nurses with a handshake and use surnames, and most importantly, that they not ask questions or disagree. Additionally, healthcare providers are expected to exhibit confidence, and many Hispanics/Latinos expect a more paternalistic attitude from healthcare providers. Rather than feeling themselves to be a part of the “care team” when healthcare providers ask for their input into the plan of care, Hispanic/Latino patients may perceive this as a lack of confidence on the part of the nurse. This population also tends to be relationship-focused rather than task-oriented and prefer emotional interactions, which can pose barriers between them and their healthcare provider. Hispanics/Latinos may perceive the neutral or businesslike affect of western healthcare professionals as negative. If the provider appears hurried, detached and aloof, the patient may experience resentment and be dissatisfied with care. This of course reduces the likelihood of compliance with recommendations for treatment and follow-up.

In a subsequent concept analysis, Ingram (2012) found that the mnemonic “ASKED”, which represents the constructs of the Cultural Competence Model (Awareness, Skills, Knowledge, Encounters, and Desire), could be used as a guide for achieving cultural competence

by incorporating both health literacy and cultural values and beliefs into healthcare services. For example, nurses can incorporate “cultural awareness” into their practice by acknowledging and respecting patients’ worldviews, particularly their perception of illness. Understanding diverse communication patterns and remaining non-judgmental during provision of care can help nurses to provide culturally appropriate care.

Cultural Competence Model. Finally, several studies focused on how the constructs of the Cultural Competence Model could be adapted to nursing practice (Benkert et al., 2011; Matteliano & Street, 2012). A cross-sectional descriptive study analyzed survey data gathered from underrepresented nurse practitioner groups including non-Hispanic white men ($n=270$), Asian-American men and women ($n=90$), and African-American men and women ($n=114$). The researchers found that although diversity training (“cultural knowledge”) had a direct effect on culturally competent behaviors (CCBs), life experiences (“cultural encounters”) with diversity had a greater impact, affecting CCBs, cultural awareness, and sensitivity (Benkert et al., 2011).

Matteliano and Street (2012) conducted semi-structured interviews and observations of health professionals ($n=41$), and used grounded theory to document differences in their approaches to providing culturally competent care. They found that nurse practitioners were unique in the comprehensiveness of their cultural competence approaches; common themes found in this qualitative study included a holistic approach to care, professional partnerships, culture brokering and patient advocacy, “personalismo”- warmth, empathy, and a willingness to share personal information, and bridging cultural gaps (Matteliano & Street, 2012). These themes support the assertion that cultural competence is an ongoing “process in which the health care provider continuously strives to achieve the ability to effectively work within the cultural context of the client” (Campinha-Bacote, 2002a, p. 181), and not a one-time event.

The evidence appears to support that a theoretical framework can be used to guide the delivery of culturally competent care, which is essential in order to improve patient-provider communication and decrease health disparities in ethnic and minority populations (Aponte, 2009; Benkert et al., 2011; Britigan et al., 2009; Ingram, 2012; Matteliano & Street, 2012; Schim et al., 2007; Singleton & Krause, 2009). Cultural competence is an ongoing process of applying skills for self-awareness as well as recognizing the unique perspective that each patient brings to the clinical encounter. Rather than prescribing specific interventions for a particular ethnic or minority population, a cultural competence model proposes seeking out exposure to diverse groups to enhance cultural awareness, acknowledging and respecting patients' view of the world and their beliefs regarding health and illness, and being non-judgmental during the provision of nursing care.

Cultural competency guidelines. A task force of the Expert Panel for Global Nursing and Health of the American Academy of Nursing, along with members of the Transcultural Nursing Society, have developed a set of standards for cultural competence in nursing practice (Douglas et al., 2014; See Appendix B). It is the position of this group that culturally competent nursing care contributes to the reduction of health disparities “through patient empowerment, integration of cultural beliefs into patient care, and expanded access for vulnerable groups to health care services” (p. 109), and the aim of this document is to define standards that can be universally applied by nurses around the world in the areas of clinical practice, research, education, and administration (Douglas et al., 2014). These guidelines, which are systematically developed recommendations from nationally recognized experts based on research evidence or expert consensus panel (Dearholt & Dang, 2012), were prepared after examining documents from various international nursing organizations, as well as related materials from other health

care professions, governmental, nongovernmental (NGO), and health and human service organizations. These included, but were not limited to, the United Nations' *Declaration of Human Rights* (United Nations, 2008), the International Council of Nurses' (ICN) *Nurses and Human Rights* (International Council of Nurses, 2011), the Nursing Council of New Zealand's *Code of Conduct for Nurses* (Nursing Council of New Zealand, 2009), the National Association of Social Workers' *Standards for Cultural Competence in Social Work Practice* (National Association of Social Workers, 2015), the World Health Organization's *Declaration of Alma Ata* (World Health Organization, 1983), the American Nurses Association's *Code of Ethics* (American Nurses Association, 2015), the ICN *Code of Ethics for Nurses* (ICN, 2006), and the American Association of the Colleges of Nursing (AACN) *Toolkits* (American Association of Colleges of Nursing, 2008). As can be discerned from these contributing documents, these guidelines are based primarily on the principles of social justice and human rights.

Summary. Consistent with these guidelines and best practices set forth in the literature, nurses should receive ongoing education and training in culturally and linguistically appropriate care with follow-up to ensure that they can provide “safe, effective, timely, efficient, patient-centered, and equitable care”, the six dimensions of healthcare quality (Institute of Medicine, 2001). Additionally, the Office of Minority Health (2013) recommends not only that healthcare providers take part in cultural competence continuing education but that their competence be evaluated through testing (pre- and posttest), direct observation, and monitoring of client satisfaction. As part of this DNP Project, these recommendations were implemented in the development of a Cultural Competence Training Toolkit whose content included cultural competence models, cultural and health literacy assessment tools, and concepts related to culture, health literacy, and culturally appropriate nursing interventions for Hispanic/Latino patients.

Theoretical Framework

Health literacy and culture are related; based on a comprehensive assessment of these factors, nurses will be able to develop culturally appropriate nursing interventions and to provide health care teaching at appropriate literacy levels (Benkert et al., 2011; Britigan et al., 2009; Matteliano & Street, 2012). Nurses working with minority populations should increase their knowledge of diverse cultures, become familiar with health literacy and cultural health assessment tools, and incorporate health literacy and cultural health assessments into their practice. Campinha-Bacote's (2002a) Process of Cultural Competence in the Delivery of Healthcare Services (See Appendix C) is a model of care that defines cultural competence as "the process in which the healthcare professional continually strives to achieve the ability and availability to effectively work within the cultural context of a client (family, individual or community)" (p. 181). Using this model as a resource can assist nurses to identify health literacy needs while respecting the cultural norms, values, and beliefs of diverse populations. Campinha-Bacote's Process of Cultural Competence (2002a) was used as a theoretical framework to appraise the studies included in the integrative review as well as to guide the development of a Cultural Competence Training Toolkit based on its constructs.

In this model, the five main constructs include: 1) cultural desire, the motivation to become culturally aware; 2) cultural awareness, the process of examining one's own biases towards other cultures; 3) cultural knowledge, the process of obtaining a sound educational base about other cultural groups; 4) cultural skill, the ability to conduct a cultural assessment in order to gather information; and, 5) cultural encounters, the process of engaging directly with culturally diverse groups (Campinha-Bacote, 2002a). In order to advance the quality of care, the journey to cultural competence must begin with an intrinsic motivation to engage in the process.

Project Design and Methods

An integrative review is a specific review method that summarizes experimental and/or theoretical literature to provide an understanding of the state of the science regarding a particular healthcare problem (Whittemore & Knafl, 2005). The integrative review method is unique in that it is the only approach that allows for the synthesis of both experimental and non-experimental research and has the potential to play a greater role in evidence-based practice for nursing, which is a combination of best evidence, client/patient preferences, and clinical expertise. Stages of this integrative review included problem identification, literature search, data evaluation, data analysis, and presentation.

Cultural competence and awareness training for healthcare professionals was identified as an intervention for improving patient-provider communication and decreasing health disparities in the Hispanic/Latino patient population (See Appendix D for Project Logic Model). The DNP Project consisted of an integrative review which formed the basis of evidence for the creation of a Cultural Competence Training Toolkit for acute care nurses (See Appendix E). The project included the presentation and subsequent evaluation of the Toolkit as a resource for cultural competence training. The presentation was provided to a group of nurses ($n = 12$) at a small eastern Virginia community medical center, which included both clinical nurses as well as a nurse educator. Effectiveness of the intervention was measured through pre- and post-intervention evaluation of cultural competence using the Inventory for Assessing the Process of Cultural Competence among Healthcare Professionals- Revised [IAPCC-R©] (Campinha-Bacote, 2002b) [See Appendix F for Contractual Agreement for Limited Use of the IAPCC-R©] as well as a program evaluation survey (See Appendix G).

Setting and Resources

The DNP Project focused on identifying evidence-based best practice for the cultural and health literacy assessment of the Hispanic/Latino community in Williamsburg, VA. This population, which has great needs in terms of health literacy and basic communication regarding health, has few public health resources and does not typically access the health care system in any manner unless they are faced with an acute/emergent problem (Guntzviller, King, Jensen, & Davis, 2016; Raymond-Flesch, Siemons, Pourat, Jacobs, & Brindis, 2014). Identifying and assessing these individuals and their needs while they are in the acute care system will allow for better follow-up in the community.

Incorporating a cultural competence training program and ensuring that nurses can perform an accurate and appropriate health literacy assessment will allow for better care for this population, both within the hospital and in the community at large. Results of the integrative literature review and the Cultural Competence Training Toolkit was presented to a group of clinical nurses and a nurse educator at an eastern Virginia community medical center, a 145-bed acute care facility currently employing 328 registered nurses.

Description of the group, population or community. The Hispanic/Latino community in Williamsburg, VA has more than doubled in the past fifteen years, creating new challenges and opportunities for this population as well as the Williamsburg community in general. Between 2000 and 2015, the Hispanic/Latino population in the city of Williamsburg has increased 134%, and now comprises 7.1% of the overall population (U.S. Census Bureau, 2015). Although Williamsburg and its surrounding areas have traditionally been home to white, upper-middle class individuals, demographics are changing, primarily due to the recent influx of

Hispanic/Latino immigrants looking to take advantage of economic and work opportunities. Given this growth, it is critical for public health professionals to better understand the needs of this population, particularly in small cities like Williamsburg, where immigrant populations have not traditionally settled.

In order to better understand the health care needs of the Hispanic/Latino community, this integrative literature review focused on studies of Hispanic/Latino adults diagnosed with a chronic disease or seeking acute or emergent care requiring health teaching and follow-up. The review considered studies that evaluated patients' health literacy scores and patient adherence to medications, treatment, and/or lifestyle and behavioral factors. Cultural and health literacy assessment, as the interventions of interest, were formalized through the use of validated tools or incorporated into the general patient assessment through the inclusion of questions that addressed the patient's beliefs, values, and practices surrounding health and illness in terms of the patient's unique culture. Studies that investigated the experiences of Hispanic/Latino patients and their families in regard to the cultural competence of their health care providers were also considered.

Organizational analysis and evidence of stakeholder support. This project has received strong support from hospital administrators and educators, who have generously supported the implementation of the Project both in terms of time and financial resources. Organizational stakeholders include the Chief Nurse Executive, Staff Development Educators, and the Director of System-Wide Professional Practice, who has been the site preceptor for this DNP student since beginning clinical practicums in Fall 2015 and who continues to supervise the student's learning and DNP Project. Evidence of stakeholder support for this DNP Project was provided in the form of a "Key Stakeholder Commitment Letter" signed by the Chief Nurse Executive prior to the initiation of the project.

Facilitators and barriers. According to the *Guidelines for Implementing Culturally Competent Nursing Care* (Douglas et al, 2014), nurses should be educated in transcultural nursing practice, which focuses on the knowledge and skills needed to assess, plan, implement, and evaluate culturally competent nursing care. A gap analysis of the clinical site, however, found that there is a wide variety in the cultural competence of the nursing workforce depending on their educational background, and that the organization provides insufficient continuing cultural competence training. While this has not been a problem in the past due to a relatively homogenous population, changing demographics have brought this issue to the forefront.

Barriers to cultural competence training programs include the lack of healthcare organization-specific or accreditation requirement for continuing cultural competence training; without requirements, cultural competence training has not been given a priority by the healthcare organization due to low minority population in the organization's catchment area. Time and cost involved to provide cultural competence training is not perceived to provide an appropriate return on investment (ROI). Finally, nurses' lack of accountability regarding their own professional development and lack of awareness regarding available educational resources for cultural competence training is a barrier to the implementation of culturally competent care.

These barriers can be overcome through enforcement of the Office of Minority Health's (2013) *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care* as a provision of accreditation for healthcare organizations. Although these standards include recommendations for ongoing cultural competence training for the healthcare workforce, only six states mandate (WA, CA, CT, NJ, NM) or strongly recommend (MD) cultural competence training. As these standards are not mandated in the majority of states, there is no assurance that all healthcare organizations provide training or that the training that is

provided meets a prescribed standard of quality education. Accrediting bodies for healthcare organizations need to develop standards for the content and duration of cultural competence training. Additionally, community stakeholders should be involved in obtaining a true picture of the minority population, particularly undocumented immigrants who may not be accurately represented in traditional population counts. Finally, organizations must promote continuing education and ensure that nurses are aware of available educational resources. As the minority population increases, cultural competence training for the healthcare workforce will become an essential factor in positive patient outcomes and a driver of patient satisfaction, and the ROI of the time and cost involved in providing this training will become acceptable to the organization.

The primary facilitator for this project has been the DNP Project “Mentor” who was instrumental in ensuring that the project incorporated planning, implementation, and evaluation components which can demonstrate the integration of clinical scholarship into practice by focusing on the “product”- the Cultural Competency Training Toolkit. The mentor was crucial in clarifying the scope of the final scholarly project, the level of implementation, the impact on system/practice outcomes, the extent of collaborative efforts, and the expected dissemination of findings as recommended by the American Association of Colleges of Nursing (AACN, 2015). Additional facilitators included organizational stakeholders who made a commitment of time and financial resources for the success of this project as it developed in line with the system’s Cultural Inclusion Policy Development Initiative. While cultural competence training was not a priority for the organization a few years ago, when the foundations of this project were laid out by the student, this “barrier” has since disappeared as the goals of the organization have become more aligned with those of the project. Additionally, clinical nurses have become more interested in cultural competence as a result of their own educational and professional pursuits,

due in part to the organization's support of the Institute of Medicine's recommendation that nurses should achieve higher levels of education and training (IOM, 2010). Nurses are now expected to seek out educational opportunities, making them an ideal "target" for cultural competence training initiatives.

Goals, Objectives, and Expected Outcomes

The goals of this project included: 1) raising awareness of the need for cultural competence, nursing knowledge and interventions that fully integrate health literacy, language, and culture in order to improve care to the Hispanic/Latino patient population; and, 2) gaining support for the adoption of the Cultural Competence Training Toolkit as a resource for nurses within the organization. Objectives measuring the attainment of these goals include:

- Objective 1: Nurses will demonstrate improved overall cultural competence.
- Objective 2: Nurses will display the motivation to engage in the cultural competence process.
- Objective 3: Nurses will become cognizant of their personal biases, stereotypes, prejudices and assumptions about other cultures and how these biases can impact their nursing care.
- Objective 4: Nurses will express the intent to seek out and obtain a sound educational base regarding their patient's health-related beliefs, practices, and values, disease incidence and prevalence, and treatment efficacy.
- Objective 5: Nurses will demonstrate the ability to collect relevant cultural data and to perform physical assessments in a culturally sensitive manner.

- Objective 6: Nurses will express the intent to seek out opportunities to interact directly with clients from culturally diverse backgrounds.
- Objective 7: Nurses will agree or strongly agree that the presenter is knowledgeable about the topic, displays effective communication skills, and engages the audience.
- Objective 8: Nurses will express agreement or strong agreement with the benefit of the educational program in providing the knowledge and skills necessary to deliver culturally appropriate care.
- Objective 8: Nurses will express agreement or strong agreement with the value and applicability of this educational program to their practice.
- Objective 10: Nurses will express agreement or strong agreement with the intent to support the dissemination and use of the Cultural Competence Training Toolkit within the organization and to recommend this program to others.

Implementation

Educational intervention. Best practices for cultural and health literacy assessment and culturally appropriate nursing interventions for Hispanic/Latino patients were identified through an integrative review of the literature; this information was then used to develop a Cultural Competence Training Toolkit using the constructs of Campinha-Bacote's Cultural Competence Model (cultural desire, cultural awareness, cultural knowledge, cultural skill, cultural encounters). The Toolkit, which was developed as a resource for nurses caring for the Hispanic/Latino patient population, established the framework of an educational program for nurses. Participants attended a 2-hour presentation based on the Toolkit, which included an oral presentation, written materials, videos, and weblinks for additional information and resources.

Sample size. This project utilized a convenience sample consisting of nurses ($N = 12$) from a step-down critical care unit who attended the cultural competence education program during a scheduled staff meeting. The sample group included various provider roles such as clinical nurse ($n = 10$), nurse manager ($n = 1$), and nurse educator ($n = 1$).

Data collection. Pre- and post-intervention data was collected using the Inventory for Assessing the Process of Cultural Competence among Healthcare Professionals- Revised [IAPCC-R©] (Campinha-Bacote, 2002b), a self-assessment tool designed to measure the level of cultural competence among healthcare professionals. The IAPCC-R© consists of a 25-item, 4-point Likert-like scale that measures the five cultural constructs reflecting the response categories of strongly agree, agree, disagree, strongly disagree; very aware, aware, somewhat aware, not aware; very knowledgeable, knowledgeable, somewhat knowledgeable, not knowledgeable; very comfortable, comfortable, somewhat comfortable, not comfortable; and very involved, involved, somewhat involved, not involved. Scores ranging from 25-100 indicate whether a healthcare professional is operating at a level of cultural incompetence (25-50), cultural awareness (51-74), cultural competence (75-90), or cultural proficiency (90-100), with higher scores depicting a higher level of cultural competence. The IAPCC-R© has been used extensively both within the United States and internationally. Studies conducted within the U.S reported an average reliability coefficient Cronbach alpha of .83 (Campinha-Bacote, 2002b), which falls within the recommended range of .70 to .90 suggesting that the IAPCC-R© is a reliable test (Tavakol & Dennick, 2011).

Qualitative data was also collected using a program evaluation survey, an 11-item, 5-point Likert-like scale reflecting the response categories strongly agree, agree, neutral, disagree, and strongly disagree. The evaluation survey focused on the preparation and

knowledge of the presenter (the DNP student), evaluated the various components of the presentation, and assessed its benefits and applicability to nursing practice. Participants were also given the opportunity to comment on their experience with the program.

Data analysis. The hypothesis guiding this project was that nurses who participated in the cultural competence training session would have improved cultural competence as defined by the constructs of desire, awareness, knowledge, skill, and encounters. In keeping with the framework guiding this intervention, outcome evaluation measured each of these domains as well as overall cultural competence. Pre- and post-intervention IAPCC-R© surveys were scored according to the IAPCC-R© Scoring Key (Campinha-Bacote, 2002b). Mean scores for each construct, as well as overall cultural competence, were measured for effects over time using paired sample *t*-tests and analyzed using SPSS Statistics software.

Participants completed the IAPCC-R© prior to participating in the educational session in order to obtain a baseline mean score for overall cultural competence and for each of the subscales (cultural desire, cultural awareness, cultural knowledge, cultural skill, and cultural encounters). Results of all IAPCC-R© instruments and program evaluation surveys were anonymous; participants created a 4-digit pin number to identify and link pre- and post-intervention test scores. After completing the pre-intervention instrument, participants attended the educational session, after which they were asked to complete the program evaluation survey. One week after the educational program, participants completed the IAPCC-R© for a second time in order to obtain post-intervention mean scores for overall cultural competence and each of the subscales.

Ethics and Human Subjects Protection

Consideration of research ethics is an essential part of any proposal. This Project is an evidence-based practice intervention (presentation of the Cultural Competence Training Toolkit), and did not include collection of patient data. Adherence to site policy and procedures was followed in the presentation and evaluation of the Toolkit. Anonymity was maintained in all provider survey responses, and risks to participants were minimal. A Determination of Human Subject Research Form was submitted to the University of Massachusetts and it was determined that the activity did not meet the federal regulation definition of human subject research, and therefore did not require a submission to the IRB (See Appendix H).

Ethical considerations for the integrative literature review portion of the Project included: 1) acknowledging the works of other authors used in any part of the project; 2) obtaining permission for use of any copyrighted materials; 3) maintaining the highest level of objectivity throughout the research; and, 4) disclosure of any conflicts of interest, should they occur at any time in the project implementation process. One reason why ethics is an important consideration when conducting an integrative literature review is that it may not always be possible for the reviewer to identify the procedures that were used to ensure ethical practice in the study being reviewed. During the review process, it is critical to address any ethical questions that are raised by the research, and that the work of existing researchers is treated accurately and fairly.

Results

Demographic Characteristics

Although the project utilized a convenience sample of nurses, the gender and ethnicity of the participants were remarkably congruent with that of the overall U.S. nursing workforce.

Demographic characteristics indicated that the percentage of white, non-Hispanic participants was 75%, and that the percentage of male participants was 8.3%. The most recent national data reports that white, non-Hispanic nurses make up 75.4% of the U.S. registered nurse population, and that men now comprise 9% of nurses (Health Resources and Services Administration, 2013). While small, the sample appeared to be representative of the overall nursing population and appropriate for a pilot project. The region in which the project was implemented has historically consisted of a homogenous population, but has recently experienced a significant influx of diverse individuals. This diversity is now seen not only in the community, but in the workforce itself as more minorities enter the nursing profession. This shift in population demographics may have contributed to “increasing awareness of the existence and significance of cultural differences, along with the need to be culturally competent” (Delgado, 2013, p. 210).

Table 1
Demographic Characteristics

Demographic Variable	Intervention Group (<i>N</i> = 12)
Sex	
Male	1
Female	11
Shift Worked	
Days	6
Nights	6
Race/Ethnicity	
White Non-Hispanic	9
Black	2
Hispanic	1
Mean Years in Nursing	13.83
Mean Years on Unit	7.33

Cultural Competence

The hypothesis that the pre-training ($M = 64.08$, $SD = 3.82$) and post-training overall cultural competence score means ($M = 76.33$, $SD = 3.85$) were equal was tested using a dependent samples t -test. The assumption of normally distributed difference scores was satisfied with skewness and kurtosis levels estimated at $-.64$ and $-.09$ respectively, which both fall between the acceptable range of -2 and $+2$. Additionally, in the Shapiro-Wilk test of normality, $p = .288$ which is not statistically significant, suggested that these data are normally distributed. The correlation between the two conditions was estimated at $r = .88$, $p < .05$, suggesting that the dependent samples t -test is appropriate in this case. The null hypothesis of equal cultural competence score means was rejected, $t(11) = -22.76$, $p < .001$. Thus, the post-training mean was statistically significantly higher than the pre-testing mean. On average, overall cultural competence scores improved by 12.25 points following the intervention. Cohen's d was estimated at 3.19 which is a large effect based on Cohen's (1992) guidelines. Graphical representations of the means and adjusted 95% confidence intervals are displayed following each table.

Table 2
Paired Samples Statistics Overall Cultural Competence

		Paired Samples Statistics			
		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	Competence1	64.0833	12	3.82476	1.10411
	Competence2	76.3333	12	3.84550	1.11010

Table 3
Paired Samples t-test Overall Cultural Competence

		Paired Differences				t	df	Sig. (2-tailed)	
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
Pair					Lower	Upper			
1	Competence1 - Competence2	-12.25000	1.86474	.53831	-13.43480	-11.06520	-22.757	11	.000

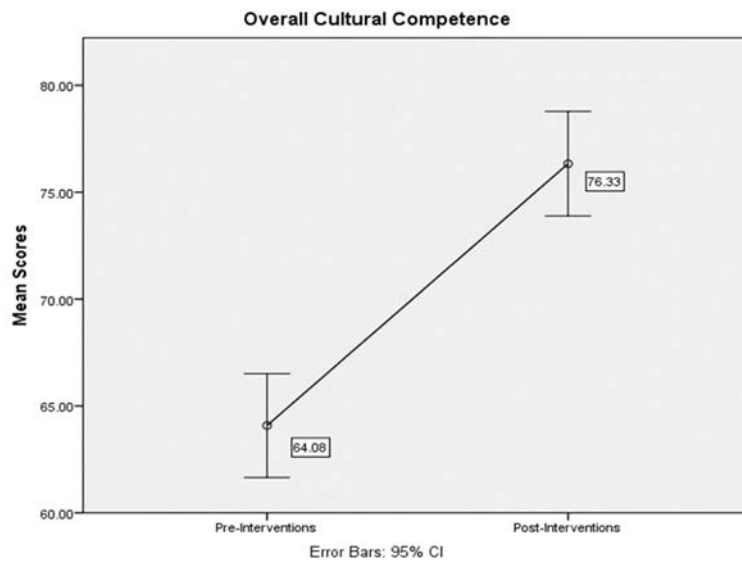


Figure 1. Mean difference of cultural competence scores and 95% CIs, pre-/post-intervention.

Cultural Desire

To test the hypothesis that the pre-training ($M = 15.50, SD = 1.24$) and post-training cultural desire score means ($M = 17.92, SD = 1.16$) were equal, a dependent samples t -test was performed. The assumption of normally distributed difference scores was satisfied with skewness and kurtosis levels estimated at $-.15$ and $-.43$ respectively, falling between the acceptable range of -2 and $+2$. Additionally, in the Shapiro-Wilk test of normality, $p = .133$ which is not statistically significant, suggested that these data are normally distributed. The

correlation between the two conditions was estimated at $r = .72, p < .05$, suggesting that the dependent samples *t*-test is appropriate. The null hypothesis of equal cultural desire means was rejected, $t(11) = -9.30, p < .001$. Thus, the post-training mean was statistically significantly higher than the pre-testing mean. On average, cultural desire scores increased by 2.42 points following the intervention. Cohen’s *d* was estimated at 2.02 which is a large effect based on Cohen’s (1992) guidelines.

Table 4
Paired Samples Statistics Cultural Desire

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	Desire1	15.5000	12	1.24316	.35887
	Desire2	17.9167	12	1.16450	.33616

Table 5
Paired Samples t-test Cultural Desire

		Paired Differences					t	df	Sig. (2-tailed)
		Mean	Std. Deviation	Std. Error	95% Confidence Interval of the Difference				
					Lower	Upper			
Pair 1	Desire1 - Desire2	-2.41667	.90034	.25990	-2.98871	-1.84462	-9.298	11	.000

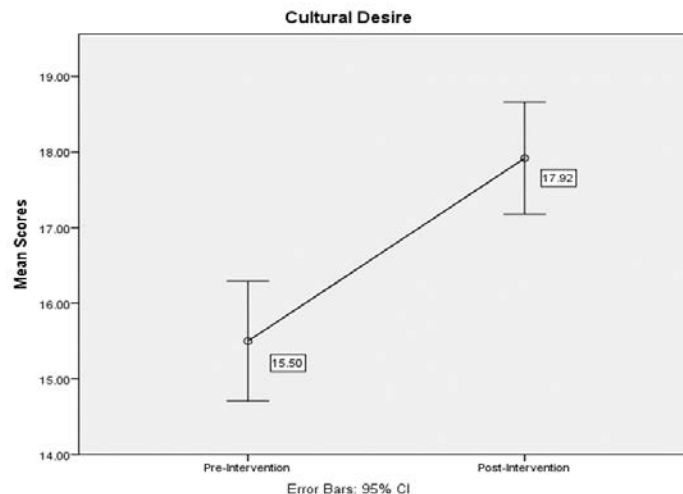


Figure 2. Mean difference of cultural desire scores and 95% CIs, pre- and post-intervention.

Cultural Awareness

To test the hypothesis that the pre-training ($M = 12.67$, $SD = 1.15$) and post-training cultural awareness score means ($M = 15.42$, $SD = .90$) were equal, a dependent samples t -test was performed. Prior to conducting the analysis, the assumption of normally distributed difference scores was examined. The assumption was considered satisfied, as the skewness and kurtosis levels were estimated at $-.44$ and $.23$, respectively, which both fall between the acceptable range of -2 and $+2$. Additionally, in the Shapiro-Wilk test of normality, $p = .099$ which is not statistically significant, suggested that these data are normally distributed. It was also noted that the correlation between the two conditions was estimated at $r = .67$, $p < .05$, suggesting that the dependent samples t -test is appropriate. The null hypothesis of equal cultural awareness means was rejected, $t(11) = -11.00$, $p < .001$. Thus, the post-training mean was statistically significantly higher than the pre-testing mean. On average, cultural awareness scores increased by 2.75 points. Cohen's d was estimated at 2.66 which is a large effect based on Cohen's (1992) guidelines.

Table 6
Paired Samples Statistics Cultural Awareness

		Paired Samples Statistics			
		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	Awareness1	12.6667	12	1.15470	.33333
	Awareness2	15.4167	12	.90034	.25990

Table 7
Paired Samples t-test Cultural Awareness

		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference		t	df	Sig. (2-tailed)
Pair	Awareness1 - Awareness2				Lower	Upper			
1	Awareness1 - Awareness2	-2.75000	.86603	.25000	-3.30025	-2.19975	-11.000	11	.000

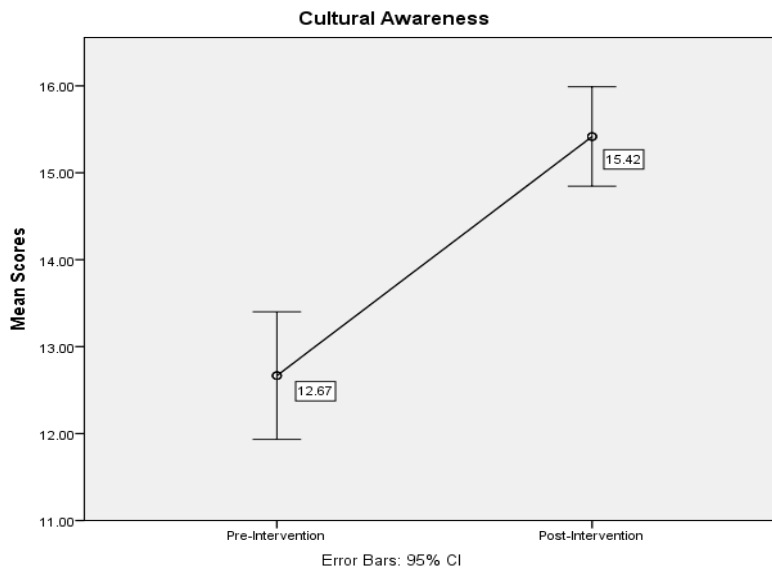


Figure 3. Mean difference of cultural awareness scores and 95% CIs, pre- and post-intervention.

Cultural Knowledge

To test the hypothesis that the pre-training ($M = 10.92, SD = 1.16$) and post-training cultural knowledge score means ($M = 13.00, SD = 1.13$) were equal, a dependent samples *t*-test was performed. Once again, the assumption of normally distributed difference scores was examined and the assumption was considered satisfied as the skewness and kurtosis levels were estimated at -0.16 and -1.26 respectively, which both fall between the acceptable range of -2 and

+2. It was also noted that the correlation between the two conditions was estimated at $r = .76$, $p < .05$, suggesting that the dependent samples t -test is appropriate in this case. The null hypothesis of equal cultural knowledge means was rejected, $t(11) = -9.10$, $p < .001$. Thus, the post-training mean was statistically significantly higher than the pre-testing mean. On average, cultural knowledge scores increased by 2.08 points. Cohen’s d was estimated at 3.56 which is a large effect.

Table 8
Paired Samples Statistics Cultural Knowledge

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	Knowledge1	10.9167	12	1.16450	.33616
	Knowledge2	13.0000	12	1.12815	.32567

Table 9
Paired Samples t-test Cultural Knowledge

		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference		t	df	Sig. (2-tailed)
					Lower	Upper			
Pair 1	Knowledge1 - Knowledge2	-2.08333	.79296	.22891	-2.58716	-1.57951	-9.101	11	.000

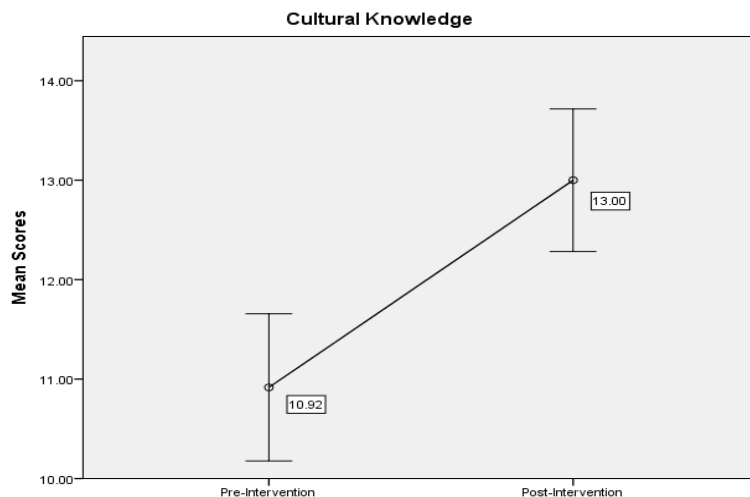


Figure 4. Mean difference of cultural knowledge scores and 95% CIs, pre-/post-intervention.

Cultural Skill

To test the hypothesis that the pre-training ($M = 11.92, SD = 2.07$) and post-training cultural skills score means ($M = 14.83, SD = 2.12$) were equal, a dependent samples t -test was performed. The assumption of normally distributed difference scores was satisfied with skewness and kurtosis levels estimated at .16 and -1.26 respectively, falling between the acceptable range of -2 and +2. The correlation between the two conditions was estimated at $r = .93, p < .05$, suggesting that the dependent samples t -test is appropriate in this case. The null hypothesis of equal cultural skills means was rejected, $t(11) = -12.74, p < .001$. Thus, the post-training mean was statistically significantly higher than the pre-testing mean. On average, cultural skills scores increased by 2.91 points. Cohen’s d was estimated at 1.39 which is a large effect based on Cohen’s (1992) guidelines.

Table 7
Paired Samples Statistics Cultural Skill

		Paired Samples Statistics			
		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	Skill1	11.9167	12	2.06522	.59618
	Skill2	14.8333	12	2.12489	.61340

Table 6
Paired Samples t-test Cultural Skill

		Paired Differences							
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference		t	df	Sig. (2-tailed)
					Lower	Upper			
Pair 1	Skill1 - Skill2	-2.91667	.79296	.22891	-3.42049	-2.41284	-12.742	11	.000

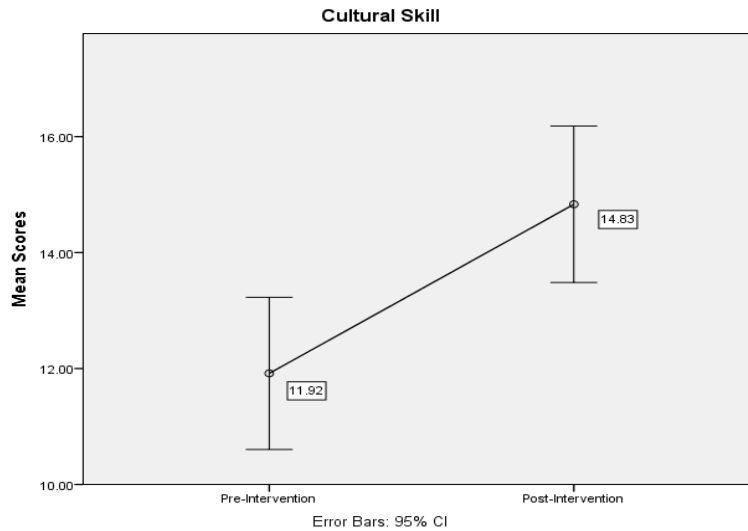


Figure 5. Mean difference of cultural skill scores and 95% CIs, pre- and post-intervention.

Cultural Encounters

To test the hypothesis that the pre-training ($M = 13.08$, $SD = 1.31$) and post-training cultural encounters score means ($M = 15.17$, $SD = 1.40$) were equal, a dependent samples t -test was performed. The assumption of normally distributed difference scores was satisfied with skewness and kurtosis levels estimated at .71 and .53 respectively, once again falling between the acceptable range of -2 and +2. Additionally, in the Shapiro-Wilk test of normality, $p = .056$ which is not statistically significant, suggested that these data are normally distributed. The correlation between the two conditions was estimated at $r = .78$, $p < .05$, suggesting that the dependent samples t -test is appropriate. The null hypothesis of equal cultural encounters means was rejected, $t(11) = -8.02$, $p < .001$. Thus, the post-training mean was statistically significantly higher than the pre-testing mean. On average, cultural encounters scores increased by 2.09 points. Cohen's d was estimated at 1.54 which is a large effect based on Cohen's (1992) guidelines.

Table 7
Paired Samples Statistics Cultural Encounters

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	Encounter1	13.0833	12	1.31137	.37856
	Encounter2	15.1667	12	1.40346	.40514

Table 8
Paired Samples t-test Cultural Encounters

		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference		t	df	Sig. (2-tailed)
					Lower	Upper			
Pair 1	Encounter1 - Encounter2	-2.08333	.90034	.25990	-2.65538	-1.51129	-8.016	11	.000

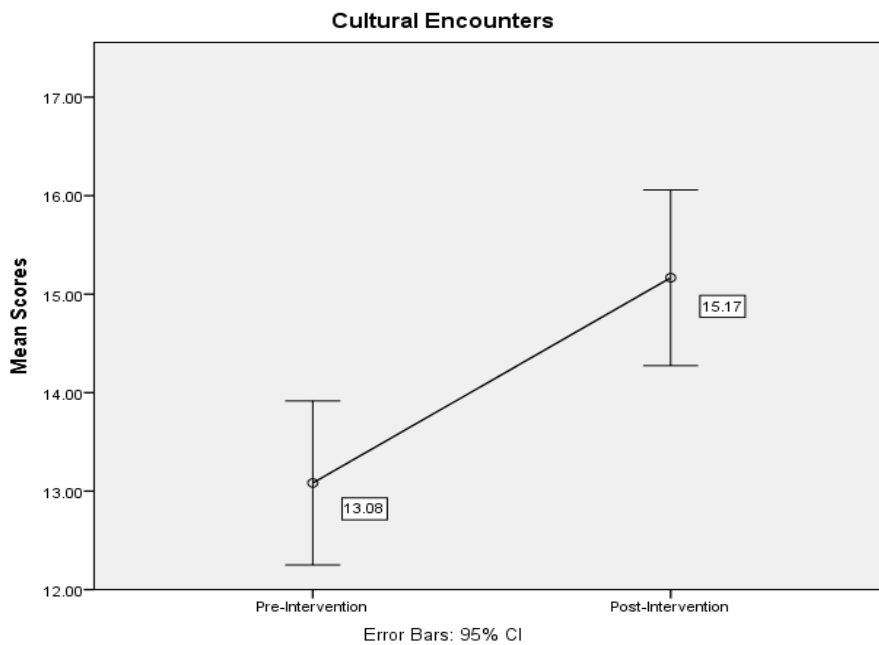


Figure 6. Mean difference of cultural encounters scores and 95% CIs, pre- and post-intervention.

Participant Evaluation of Presenter

After presentation of the educational program, participants were asked to complete a program evaluation survey which asked for their feedback regarding the presenter. Responses regarding participant evaluation of the presenter are detailed in Table 8. The results were very favorable and this objective was fully met, with 100% of participants strongly agreeing or agreeing with all statements. Participants strongly agreed ($n = 8, 66.7\%$) or agreed ($n = 4, 33.3\%$) that the content was well-organized; strongly agreed ($n = 10, 83.3\%$) or agreed ($n = 2, 16.7\%$) that the presenter was an effective communicator; strongly agreed ($n = 11, 91.7\%$) or agreed ($n = 1, 8.3\%$) that the presenter kept the program alive and interesting; and strongly agreed ($n = 7, 58.3\%$) or agreed ($n = 5, 41.7\%$) that the presenter handled group discussions effectively.

Table 8
Participant Evaluation of Presenter

	Strongly Disagree		Disagree		Neutral		Agree		Strongly Agree	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
The content was well-organized.	0	0	0	0	0	0	4	33.3	8	66.7
The presenter was an effective communicator.	0	0	0	0	0	0	2	16.7	10	83.3
The presenter kept the program alive and interesting.	0	0	0	0	0	0	1	8.3	11	91.7
The presenter handled group discussions effectively.	0	0	0	0	0	0	5	41.7	7	58.3

Evaluation of Components of Presentation

After presentation of the educational program, participants were also asked to provide feedback regarding the benefits of the Toolkit as an educational resource by evaluating the components of the presentation. Responses regarding this evaluation are detailed in Table 9. Once again, the results were very favorable and this objective was fully met, with 100% of participants strongly agreeing or agreeing with all statements. Participants strongly agreed

($n = 3, 25.0%$) or strongly agreed ($n = 9, 75.0%$) that the program length was sufficient for their learning needs; strongly agreed ($n = 7, 58.3%$) or agreed ($n = 5, 41.7%$) that the written teaching materials were informative; and strongly agreed ($n = 7, 58.3%$) or agreed ($n = 5, 41.7%$) that the videos included in the toolkit were interesting and effective.

Table 9
Evaluation of Components of Presentation

	Strongly Disagree		Disagree		Neutral		Agree		Strongly Agree	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
The program length was sufficient for my learning needs.	0	0	0	0	0	0	9	75.0	3	25.0
The written teaching materials were informative.	0	0	0	0	0	0	5	41.7	7	58.3
The videos included in the toolkit were interesting and effective.	0	0	0	0	0	0	5	41.7	7	58.3

Usefulness of Program Content

Participants were also asked to provide feedback regarding the usefulness and applicability of the program to their practice. Responses regarding this evaluation are detailed in

Table 10. Once again, the results were very favorable and this objective was fully met, with 100% of participants strongly agreeing or agreeing with all statements. Participants strongly agreed ($n = 5$, 41.7%) or agreed ($n = 7$, 58.3%) that the content of the program was valuable to their practice; strongly agreed ($n = 9$, 75.0%) or agreed ($n = 3$, 25.0%) that the program increased their awareness of the needs of ethnic/minority groups; and strongly agreed ($n = 6$, 50.0%) or agreed ($n = 6$, 50.0%) that they learned new ways to communicate effectively and sensitively with ethnic minority patients and their families.

Table 10
Usefulness of Program Content

	Strongly Disagree		Disagree		Neutral		Agree		Strongly Agree	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
The program was valuable to my practice.	0	0	0	0	0	0	7	58.3	5	41.7
The program increased my awareness of the needs of diverse groups.	0	0	0	0	0	0	3	25.0	9	75.0
I learned new ways to communicate.	0	0	0	0	0	0	6	50.0	6	50.0

Intent to Recommend Program

The final question on the survey asked participants to state whether they would support the use of the Cultural Competence Training Toolkit within the organization by recommending this program to others. This objective was fully met, as 100% of participants ($N = 12$) stated that they would recommend the program to other nurses in the organization.

Qualitative Data

The evaluation survey also provided an opportunity for participants to comment on their experience with the program. Feedback is detailed in Table 11, and coded as “C” for Content, “A” for Applicability to nursing practice, and “P” for Presentation. Comments were all favorable and reflected a positive experience, and gave suggestions for improvement.

Table 11
Participant Comments

Please provide any additional comments you may have (<i>N</i> = 12)	
C	I was not aware of how much the Hispanic/Latino population has increased in our area.
C	I was astonished to learn how many Hispanics and Latinos do not trust the system of healthcare that is provided and that they often do not utilize health care providers to help them manage their healthcare needs.
A	The 12 standards of practice for culturally competent care should be included in our professional practice model to enhance and provide better outcomes.
P, A	Excellent presentation, please share with all staff to benefit our patients.
C	Good introduction to cultural competence.
P	Excellent and fun presentation.
P	Well presented.
P	Excellent live presentation. Would break it down into 3 20-minute modules if provided as computer-based training (a lot of info!).
P, C	Excellent presentation. A lot of valuable information.
A	Would definitely recommend this program. Should be part of nursing orientation.
C	The cultural assessment tools really opened my eyes to areas that should be assessed, such as family roles and organization and alternative health care practices they have used.
A, C	Useful information regarding verbal and non-verbal communication and values that can help us to build rapport with our patients.

Discussion

The primary goal of the project was to increase the cultural competence of clinical nurses working with the Hispanic/Latino patient population. Data collected measured the self-reported cultural competence of participants at baseline and one week after the presentation of a cultural

competence training program. The educational program was designed to reflect the constructs of Campinha-Bacote's model of cultural competence which provides an understanding of the processes nurses experience as they become culturally competent. The traditional view of "competence" as mastery of a body of knowledge may not be an appropriate goal when it comes to culture and interpersonal relationships. Rather than being expected to display expert knowledge of a client's specific culture after participation in the educational session, the goal of the project was for participants to demonstrate "a sense of humility, openness, and readiness to learn from the client", particularly as it relates to health care beliefs and practices (Brathwaite, 2005, p. 362). Cultural humility, which "incorporates a lifelong commitment to self-reflection and self-critique, to redressing power imbalances... and to developing mutually beneficial advocacy partnerships with communities on behalf of individuals and defined populations" may be a more suitable goal (Tervalon & Murray-García, 1998, p. 117).

The educational program focused on key concepts and basic processes related to providing culturally competent care, such as acknowledging that culture affects health and health care; conducting a comprehensive cultural assessment; and accommodating the patient's health beliefs and practices into a plan of care. Specific content of the program included:

- Introduction to cultural concepts
- Model of cultural competence
- Demographics of patient populations
- Standards for cultural competence
- Cultural assessment tools
- Health literacy

- Health literacy assessment tools
- Cross-cultural communication
- Adaptation to a new culture
- Health beliefs and health-seeking behaviors

Findings appear to indicate that a short-term instructional course can be used to develop levels of cultural competence in clinical nurses, and that “cultural competence” can be transferred to practice as evidenced by participants’ comments regarding their experience with the program. These findings are consistent with similar studies (Brathwaite, 2005; Delgado et al., 2013) which measured and compared self-reported cultural competence scores before and after participation in cultural competence training based on the five dimensions of Campinha-Bacote’s model of cultural competence. Overall cultural competence as measured by the IAPCC-R© increased significantly from baseline to post-intervention. Mean scores improved by 12.5 points from pre-test ($M = 64.08, SD = 3.82$) to post-test ($M = 76.33, SD = 3.85$). At pre-test, 100% of participants were at the “culturally aware” level (51-74 points according to the IAPCC-R© scoring key). At post-test, 66.7% of participants increased to the “culturally competent” level (75-90 points); while 33.3% remained at the “culturally aware” level, their scores improved significantly within the level, suggesting that the program was successful and that all participants experienced an increase in their self-confidence to care for diverse patient populations.

Results also showed significant improvement in each of the measured constructs. The most striking increase was noted in the skills domain, with average scores increasing 2.91 points from pre-test ($M = 11.92, SD = 2.07$) to post-test ($M = 14.83, SD = 2.12$). Significant

improvement was also noted within the cultural awareness domain, where scores increased an average of 2.75 points from pre-test ($M = 12.67$, $SD = 1.15$) to post-test ($M = 15.42$, $SD = .90$). Cultural desire scores increased an average of 2.42 points from pre-test ($M = 15.50$, $SD = 1.24$) to post-test ($M = 17.92$, $SD = 1.16$). Average cultural encounters scores increased 2.09 points from pre-test ($M = 13.08$, $SD = 1.31$) to post-test ($M = 15.17$, $SD = 1.40$), while cultural knowledge scores increased an average of 2.08 points from pre-test ($M = 10.92$, $SD = 1.16$) to post-test ($M = 15.00$, $SD = 1.13$).

Notably, the knowledge and skills domains had the lowest pre-test scores, while the awareness and desire sub-scales had relatively high pre-test scores, suggesting that although participants understood the significance of cultural competence and had the motivation to engage in the process, they lacked the basic knowledge and skills required to deliver culturally competent care to their patients. Although the need for cultural competence in health care has been established (Douglas et al., 2014; Office of Minority Health, 2013), the integration of cultural competence approaches has not yet occurred in most healthcare settings due to barriers such as the wide diversity of patient populations, time, lack of training, language barriers, and prejudices and biases (Dreher & MacNaughton, 2002). The smallest increase in scores was seen in the cultural knowledge domain, which is a “process of seeking and obtaining a sound educational base about culturally diverse groups” (Campinha-Bacote, 2002b, p. 37). Since learning about culturally diverse groups is a “process”, results of the cultural knowledge sub-scale would not be expected to increase as much as other measurements after one educational session. Similarly, the cultural encounters sub-scale, which indicates changes in behavior and practice brought about through interactions with diverse cultural groups, showed a modest increase in average scores. As nurses have the opportunity to interact with culturally diverse

patients and gain experience from these encounters, these scores would be expected to increase even more significantly. Nurses draw on their experiences in caring for patients from other cultures, and the nursing literature has shown that cultural encounters contribute to the development of cultural sensitivity, social justice, collaboration, and problem-solving (Bosworth et al., 2006; Reising et al., 2008). As part of cultural competence training, organizations should expose nurses and other healthcare professionals to different cultures by promoting involvement in community projects in diverse communities and by developing an active cultural education program based on the demographics of the target population. The Cultural Competence Training Toolkit can serve as the first step in this journey.

The other goal of this project was to assess the value of cultural competence training and to gain support for the adoption of the Cultural Competence Training Toolkit as a resource for nurses within the organization. Qualitative and quantitative evaluation data suggests that participants found the educational program to be valuable and applicable to their practice. Evaluation feedback was positive, and all participants supported the adoption of the toolkit as a training tool. While the training session was presented live, the toolkit was also formatted as a presentation that could be provided via computer-based training (CBT). Feedback suggested that while participants enjoyed the live presentation, most felt that it included too much information for a CBT module. Suggestions included breaking up the presentation into three 20-minute modules for computer based training and providing them as a resource for staff after the full live presentation.

Strengths and Limitations

The primary limitation of this project was the small sample size which limits the statistical power and significance of the project findings. However, as the goal of the project was not to generalize findings, but to improve the cultural competence of a specific group (acute care nurses working at a community medical center), the findings in this small sample are clinically significant and provide support for the implementation of the Cultural Competence Training Toolkit as an educational resource. Another limitation was the time frame for post-testing which occurred one week after the training session in order to reduce the likelihood of repeat testing bias. In a pre-test/post-test situation, repeat testing bias may occur when subjects remember the questions on the test and may answer differently post-intervention, actually improving scores without the effect of the intervention (Indrayan, 2013). Increasing the time period between pre- and post-intervention testing may decrease the probability that the participants will remember the questions and may result in more accurate testing scores. Additional testing, over a greater time period, would also allow for a better evaluation of the development of cultural competence over time, particularly in the domain of cultural encounters, which require time in order to demonstrate true changes in behavior and clinical practice.

Strengths of this project include the use of a reliable and validated measurement tool (IAPCC-R©); however, it is important to remember that although the tool has been validated, the accuracy of self-report itself must also be considered, as it is not always consistent with observed behavior. Social desirability bias, or the tendency to conform to socially acceptable values in order to present a favorable image, has been found to affect the measurements of both attitudes and self-reported behaviors, and is most likely to occur in response to socially sensitive questions (van de Mortel, 2008). Providing culturally appropriate care to diverse cultures can be

considered a “socially sensitive” topic. Using Campinha-Bacote’s Process of Cultural Competence Model (2002a), particularly the construct of cultural awareness to perform “a deliberate self-examination and in-depth exploration of personal biases, stereotypes, prejudices and assumptions” about other cultures may allow individuals to become aware of deeply ingrained attitudes and make self-reports more consistent with actual behaviors.

Implications for Practice

This project was designed to assess the level of self-reported cultural competence in acute care nurses after the provision of a cultural competence training program which was developed to support and enhance nursing care. Results of the project have implications for research as well as nursing practice. Although the sample used in the implementation of this project was small, results were statistically significant, demonstrating that this initiative would have a high probability of success in raising the cultural competence level of nurses as well as their sense of self-efficacy in providing culturally appropriate care to their patients. However, while measures of overall cultural competence as well as the domains of cultural desire, cultural awareness, cultural knowledge, cultural skill, and cultural encounters demonstrated a statistically significant increase ($p < .001$) between pre- and post-intervention scores, nurses’ actual application of knowledge to their practice was not evaluated and remains unclear. According to Campinha-Bacote (2002b), there is a direct relationship between nurses’ level of cultural competence and their ability to provide culturally appropriate care. A comprehensive cultural assessment, which includes factors such as communication, family roles and organization, biocultural diversity, spirituality, health behaviors, and health-care practices can elicit the patient’s understanding of his or her illness and will help the patient and provider to formulate a mutually acceptable, culturally responsive treatment plan which may influence client’s health outcomes (Purnell,

2002). Future research should focus on exploring the relationship between nurses' cultural competence, their provision of culturally appropriate care, and improved patient experiences with the healthcare system. In terms of practice, it is recommended that the organization adopt a formal program of cultural competence training for its nursing staff, using the Cultural Competence Training Toolkit as an educational resource. Recommendations for educational interventions include a "live" presentation for new nursing staff during the orientation process which would highlight the organization's commitment to cultural competence. Additionally, annual cultural competence training could be provided to current staff through computer-based training which the organization currently uses and would require no additional investment.

Conclusion

The theoretical framework underlying this project posits that cultural competence in nursing is a process that begins with the examination of one's values and beliefs, and the recognition of one's own prejudices and biases toward other cultures ("cultural awareness"). This reflection allows the nurse to develop sensitivity and respect for those cultures, and challenges her to understand the values, beliefs, traditions, and practices of diverse patient populations ("cultural desire"). The nurse can then seek out information ("cultural knowledge") through interactions with culturally diverse individuals ("cultural encounters") in order to develop the ability to perform an accurate cultural assessment ("cultural skill"). A thorough assessment and understanding of the patient's culture may enable the nurse to better assess health literacy and determine which strategies will be the most successful in the patient's plan of care. Changing demographics require health professionals to understand that culture and language establish the framework for the attainment of health literacy skills, and strive to work within the cultural context of the patient in order to provide individualized care. Although nurses can

enhance health communication with their patients by incorporating health literacy and cultural assessments into their nursing practice, these interventions will not result in quality patient care unless they are fully integrated into a practical model designed to improve the patient experience. A challenge to public health professionals and other members of the interdisciplinary health care team is to recognize the role of patient-provider communication, self-management skills, and interdisciplinary care in improving health literacy and in eliminating disparities. The Cultural Competence Training Toolkit, which was developed based on best evidence identified during the integrative literature review, will provide nurses with a resource for developing and integrating these skills into their practice.

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Appendix A
Literature Review Matrix

Source Citation	Purpose	Methodology	Findings	Level of Evidence* (*JHNEBP)
Ingram, R. R. (2012). Using Campinha-Bacote’s process of cultural competence model to examine the relationship between health literacy and cultural competence. <i>Journal of Advanced Nursing</i> .	To discuss the relation between health literacy and cultural competence in nursing practice.	Systematic review using CINAHL, ERIC, Academic Search Premier, Health Source Nursing, MasterFILE Premier and Academic OneFile databases.	Health literacy should be assessed and care should be based on a client’s level of understanding and cultural values and norms.	Evidence Level III: Systematic Review Quality: Good quality with reasonably consistent results; evidence provides support for recommendation.
Matteliano, M. A., & Street, D. (2012). Nurse practitioners’ contributions to cultural competence in primary care settings. <i>Journal of the American Academy of Nurse Practitioners</i> .	To document unique ways Nurse Practitioners (NPs) contribute to the delivery of culturally competent healthcare to diverse and underserved patient populations.	Non-experimental, qualitative descriptive study. Data consist of intensive interviews and field observations of individuals at three health practice organizations.	NPs established culturally sensitive partnerships with patients, encouraged self-advocacy, addressed contextual considerations, and adjusted practices to meet the patient needs.	Evidence Level III: Non-experimental study. Quality: Good quality with reasonably consistent results.
Benkert, R., Templin, T., Schim, S. M., Doorenbos, A. Z., & Bell, S. E. (2011). Testing a multi-group model of culturally competent behaviors among under-represented nurse practitioners. <i>Research in Nursing & Health</i> .	To determine whether diversity training, social justice beliefs, and life experiences with diversity will have a positive effect on cultural awareness/sensitivity and culturally competent behaviors (CCBs).	Cross-sectional descriptive study testing a structural equation model for predictors of CCBs in a survey of three groups of underrepresented nurse practitioners (N=474).	Life experiences with diversity had direct effects on awareness/sensitivity and behaviors, and diversity training had a direct effect on behaviors.	Evidence Level III: Non-experimental study. Quality: Good quality with reasonably consistent results.
Aponte, J. (2009). Addressing cultural heterogeneity among Hispanic subgroups by using Campinha-Bacote’s model of cultural competency. <i>Holistic Nursing Practice</i> .	To describe how nurses in all healthcare settings can deliver culturally competent and sensitive holistic care to a diverse group of Hispanic clients.	Concept analysis.	Nurses must understand the cultural norms and health-related issues of the specific Hispanic/Latino subgroups to which they render services.	Evidence Level IV: Consensus based on scientific evidence. Quality: Low; limited literature search strategy; no evaluation of strengths/limitations.

Appendix A (Continued)
Literature Review Matrix

Source Citation	Purpose	Methodology	Findings	Level of Evidence* (*JHNEBP)
<p>Britigan, D. H., Murnan, J., & Rojas-Guyler, L. (2009). A qualitative study examining Latino functional health literacy levels and sources of health information. <i>Journal of Community Health.</i></p>	<p>To determine the health information sources used by Hispanics/Latinos, identify their functional health literacy levels, and identify any access barriers to those sources of health information.</p>	<p>Non-experimental, qualitative descriptive study. Semi-structured interviews with open-ended questions were used to identify sources of health information; functional health literacy was measured with the Short Test of Functional Health Literacy in Adults (S-TOFHLA) (N=51).</p>	<p>Primary source of health information when ill was a choice of media technology; 82% (n=43) of participants had “adequate” functional health literacy; barriers to accessing health information included language and lack of confidence/knowledge.</p>	<p>Evidence Level III: Non-experimental study. Quality: Good quality with reasonably consistent results.</p>
<p>Singleton, K., & Krause, E. (2009). Understanding cultural and linguistic barriers to health literacy. <i>Online Journal of Issues in Nursing.</i></p>	<p>To offer recommendations for promoting health literacy in the presence of cultural and language barriers and for implementing nursing interventions that fully integrate health literacy, culture, and language.</p>	<p>Concept analysis.</p>	<p>Understanding a patient's level of health literacy requires an assessment of the patient's linguistic skills and cultural norms and the integration of these skills and norms into health literacy strategies for the patient's plan of care</p>	<p>Evidence Level IV: Consensus based on scientific evidence. Quality: Low; limited literature search strategy; no evaluation of strengths/limitations.</p>
<p>Schim, S. M., Doorenbos, A., Benkert, R., & Miller, J. (2007). Culturally congruent care: Putting the puzzle together. <i>Journal of Transcultural Nursing.</i></p>	<p>To define the levels and constructs employed by the 3-D Puzzle Model of Culturally Congruent Care.</p>	<p>Concept analysis.</p>	<p>Cultural diversity experience, awareness, sensitivity, and competence are all necessary but not individually sufficient to produce culturally competent care.</p>	<p>Evidence Level IV: Consensus based on scientific evidence. Quality: Low; limited literature search strategy; no evaluation of strengths/limitations.</p>

Appendix B
Guidelines for Implementing Culturally Competent Nursing Care
(Douglas et al., 2014)

Guidelines for Implementing Culturally Competent Nursing Care	
1: Knowledge of Cultures	Nurses shall gain an understanding of the perspectives, traditions, values, practices, and family systems of the culturally diverse populations for whom they provide care, as well as knowledge of the complex variables that affect their achievement of health and well-being.
2: Education and Training in Culturally Competent Care	Nurses shall be educationally prepared to provide culturally congruent health care. Knowledge and skills necessary for assuring that nursing care is culturally congruent shall be included in global health care agendas that mandate formal education and clinical training as well as required ongoing continuing education for all practicing nurses.
3: Critical Reflection	Nurses shall engage in critical reflection of their own values, beliefs, and cultural heritage in order to have an awareness of how these qualities and issues can influence culturally congruent nursing care.
4: Cross-Cultural Communication	Nurses shall use culturally competent verbal and nonverbal communication skills to identify client's values, beliefs, practices, perceptions, and unique health care needs.
5: Culturally Competent Practice	Nurses shall use cross-cultural knowledge and culturally sensitive skills in implementing culturally congruent nursing care.
6: Cultural Competence in Health Care Systems and Organizations	Health care organizations should provide the structure and resources necessary to evaluate and meet the cultural and language needs of their diverse clients.
7: Patient Advocacy and Empowerment	Nurses shall recognize the effect of health care policies, delivery systems, and resources on their patient populations and shall empower and advocate for their patients as indicated. Nurses shall advocate for the inclusion of their patient's cultural beliefs and practices in all dimensions of their health care when possible.
8: Multicultural Workforce	Nurses shall actively engage in the effort to ensure a multicultural workforce in health care settings. One measure to achieve a multicultural workforce is through strengthening efforts of recruitment and retention in health care organizations and academic settings.
9: Cross-Cultural Leadership	Nurses shall have the ability to influence individuals, groups, and systems to achieve positive outcomes of culturally competent nursing care for diverse and vulnerable populations. Nurses shall have the knowledge and skills to work with public and private organizations, professional associations and organizations, and communities to establish policies and guidelines for comprehensive implementation and evaluation of culturally competent care.
10: Evidence-Based Practice and Research	Nurses shall base their practice on interventions that have been systematically tested and shown to be the most effective for the culturally diverse populations that they serve. In areas where there is a lack of evidence of efficacy, nurse researchers shall investigate and test interventions that may be the most effective in reducing the disparities in health outcomes.

Appendix C
 Process of Cultural Competence in the Delivery of Healthcare Services
 (Campinha-Bacote, 2002b)

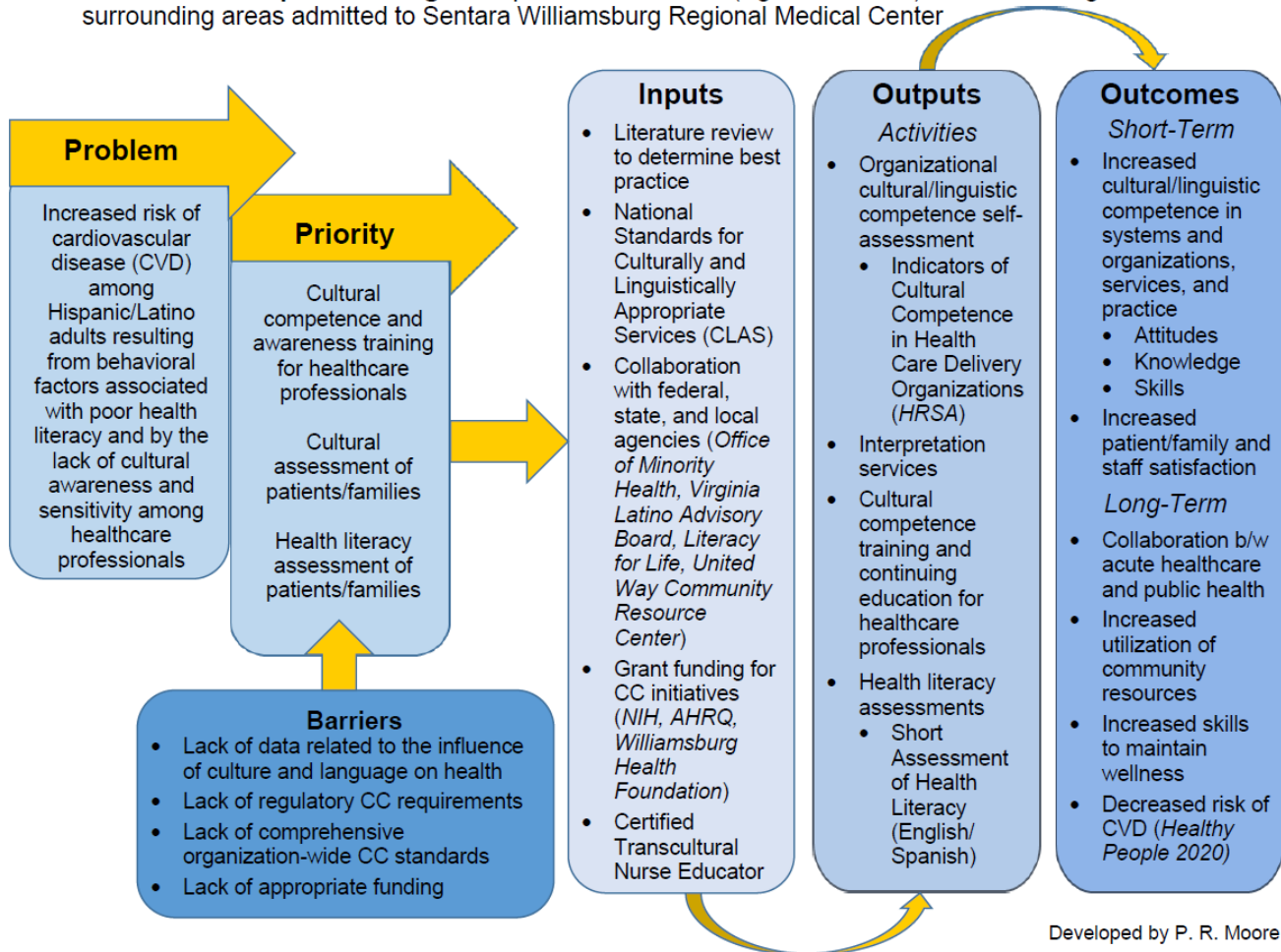
Components of Culturally Competent Care	
Cultural Desire	The motivation of the healthcare professional to “want to” engage in the process of becoming culturally competent; not to “have to”. This motivation is genuine and authentic, with no hidden agendas.
Cultural Awareness	The deliberate self-examination and in-depth exploration of our personal biases, stereotypes, prejudices and assumptions that we hold about individuals who are different from us.
Cultural Knowledge	The process of seeking and obtaining a sound educational base about culturally diverse groups.
Cultural Skill	The ability to collect relevant cultural data regarding the client’s presenting problem, as well as accurately performing a culturally based, physical assessment in a culturally sensitive manner.
Cultural Encounter	The act of directly interacting with clients from culturally diverse backgrounds.

Appendix D
Project Logic Model

Cultural Competence (CC) and Awareness Training for Healthcare Professionals

Public Health Pyramid Focus: Population-Based Services

Public Health Population Target: Hispanic/Latino Adults (Age ≥ 18 Years) in Williamsburg, VA and surrounding areas admitted to Sentara Williamsburg Regional Medical Center



Developed by P. R. Moore 2016

Appendix E
Cultural Competence Training Toolkit

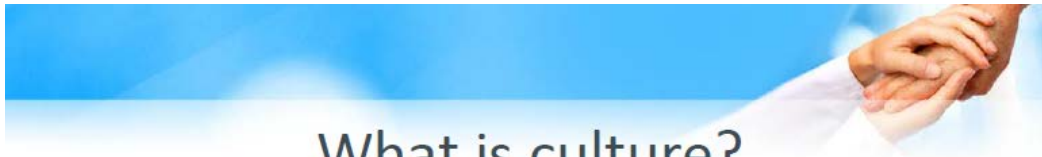


Learner Objectives:

- Increase awareness of the need for culturally appropriate nursing interventions in order to reduce health disparities in the Hispanic/Latino patient population.
- Discuss concepts related to culture, health literacy, and cultural competence in nursing.
- Identify determinants of health affecting the Hispanic/Latino patient population.
- Identify cultural and health literacy assessment tools for use with Hispanic/Latino patients.
- Increase knowledge and skills related to culturally appropriate nursing interventions for the Hispanic/Latino patient population.



Appendix E (Continued)
 Cultural Competence Training Toolkit



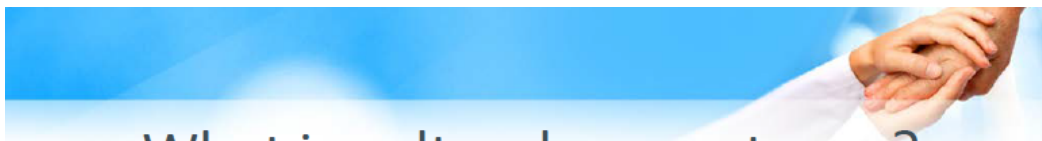
What is culture?

- *Culture is a learned, patterned behavioral response acquired over time that includes implicit and explicit beliefs, attitudes, values, customs, norms, and life ways accepted by a community of individuals (Giger et al., 2007).*

Characteristics of Culture



- Learned
- Shared
- Symbolic
- Integrated
- Dynamic
- Relative



What is cultural competence?

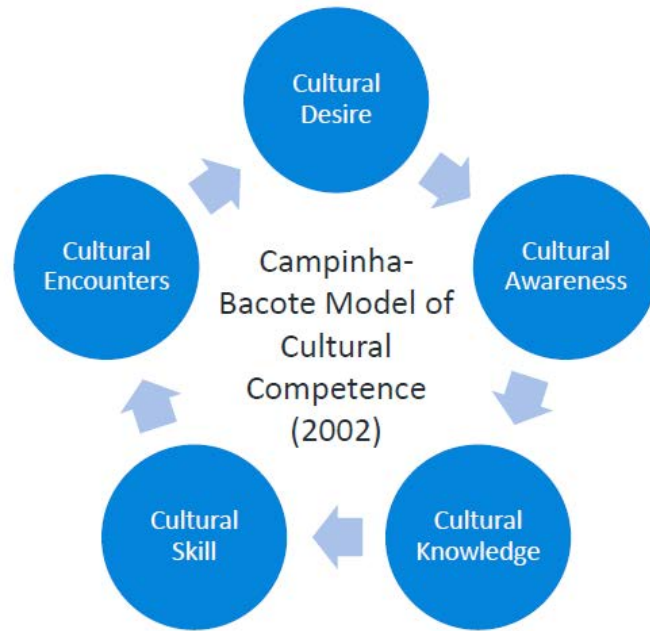
- The attitudes, knowledge, and skills necessary for providing quality care to diverse populations.
- An ongoing process that involves accepting and respecting differences and not letting one's personal beliefs have an influence on those whose worldview is different from one's own.
- Process includes developing cultural:
 - Desire
 - Awareness
 - Knowledge
 - Skills
 - Encounters



Appendix E (Continued)
 Cultural Competence Training Toolkit

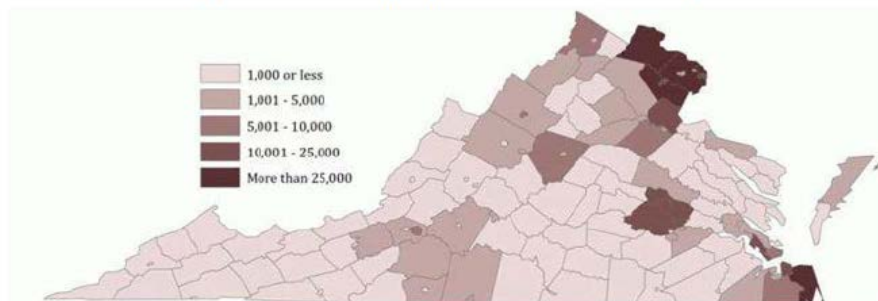


What is cultural competence?



Why cultural competence? Why now?

1. Because Virginia's demographics are becoming more diverse.



- The Hispanic/Latino population in Virginia is estimated to be over 741,000 or 8.9% of the population, growing 92% since 2000 (U.S. Census Bureau, 2014b).
- Hispanics/Latinos are the second-largest and fastest-growing minority group in Virginia.
- Between 2000 and 2015, the Hispanic/Latino population in the city of Williamsburg has increased 134%, and now comprises 7.1% of the overall population (U.S. Census Bureau, 2015).

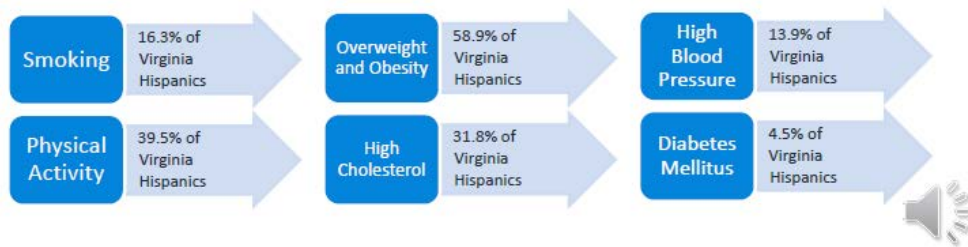


Appendix E (Continued)
Cultural Competence Training Toolkit

Why cultural competence? Why now?

2. Because health disparities still exist. *The vast majority of published research indicates that minorities are less likely than whites to receive needed services, including clinically necessary procedures, even after correcting for access-related factors (IOM, 2002).*

Risk Factors for Cardiovascular Disease

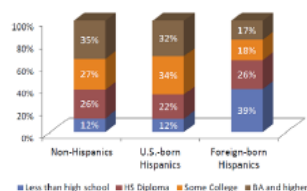


Why cultural competence? Why now?

3. Because cultural competence can help healthcare providers to better understand and respond to factors that can affect the health of the Hispanic/Latino patient population.

Education

- Among adults ages 25+, Hispanic/Latino immigrants have lower educational attainment than U.S.-born Hispanics and non-Hispanic adults.



Language

- 25% of Hispanics have some limitation communicating in English.
- 75% of Hispanics report that they speak Spanish at home.
- >5% of Hispanics report that they have no English skills.



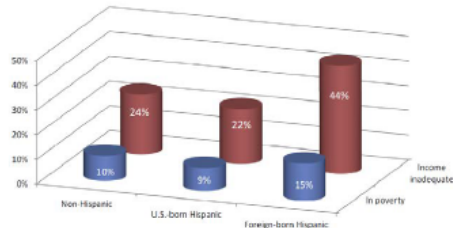
Source: Weldon Cooper Center, University of Virginia, 2011

Appendix E (Continued)
Cultural Competence Training Toolkit

Why cultural competence? Why now?

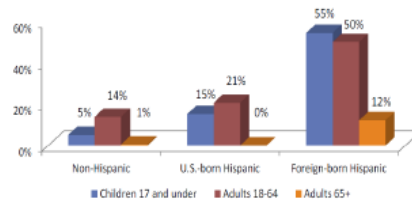
Poverty

- While poverty rates are similar for non-Latinos and U.S.-born Latinos (9-10%) they are much higher for foreign-born Latino-headed households (15%).
- 22% of U.S. born-Hispanics, and 44% of foreign-born Hispanics are income inadequate and at risk of significant economic distress.



Health Insurance Coverage

- Hispanics/Latinos, who often deal with low-wage occupations, high unemployment, and high poverty levels also have significantly lower rates of health insurance coverage than non-Hispanics.



Source: Weldon Cooper Center, University of Virginia, 2011

Why cultural competence? Why now?

4. Because government and accrediting institutions are setting a higher standard for cultural competence in order to improve the quality and accessibility of health care services.

- [National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care](#) (Office of Minority Health, USHHS, 2013).
- [Cultural Competency in Baccalaureate Nursing Education](#) (AACN, 2008) and [Cultural Competencies for Graduate Nursing Education](#) (AACN, 2009).
- [Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals](#) (The Joint Commission, 2010).

Appendix E (Continued)
 Cultural Competence Training Toolkit

Why cultural competence? Why now?

The National CLAS Standards

A BLUEPRINT FOR ADVANCING AND SUSTAINING CLAS POLICY AND PRACTICE

There are
15
standards

with 3 key intentions:

- 1 advance health equity
- 2 improve quality
- 3 help eliminate health care disparities

and explains each Standard

- Purpose
- Strategies
- Meaning
- Resources

The Blueprint

is the implementation guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care

The Blueprint outlines

6 key reasons why health and health care organizations should adopt and implement the National CLAS Standards

- Quality of care
- Changing demographics
- Marketplace
- Health disparities
- Legal mandates
- Risk of liability

discusses the results of the 2010-13 enhancement initiative

expanded definition of culture

a broad understanding of health

an audience of health & health care organizations

Why cultural competence? Why now?

The National CLAS Standards

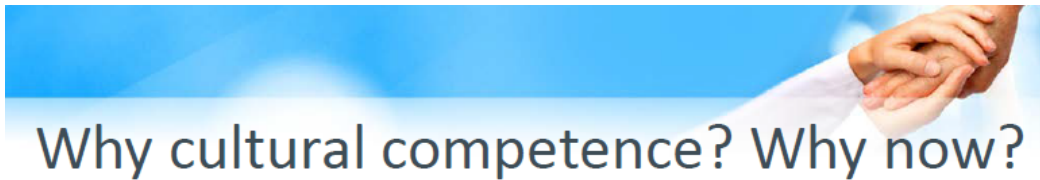
Principal Standard:

- **Standard 1:** Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Purpose:

- To create a safe and welcoming environment at every point of contact that both fosters appreciation of the diversity of individuals and provides patient- and family-centered care
- To ensure that all individuals receiving health care and services experience culturally and linguistically appropriate encounters
- To meet communication needs so that individuals understand the health care and services they are receiving, can participate effectively in their own care, and make informed decisions
- To eliminate discrimination and disparities

Appendix E (Continued)
Cultural Competence Training Toolkit

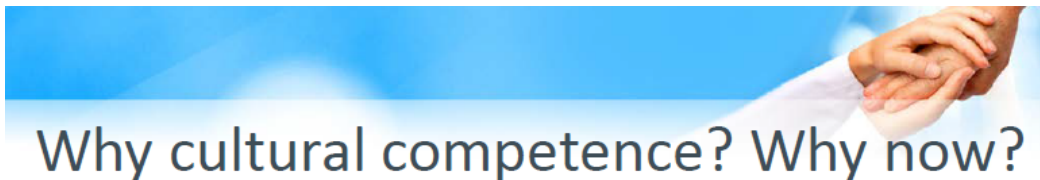


Why cultural competence? Why now?

The National CLAS Standards

Governance, Leadership, and Workforce:

- **Standard 2:** Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
- **Standard 3:** Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
- **Standard 4:** Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.



Why cultural competence? Why now?

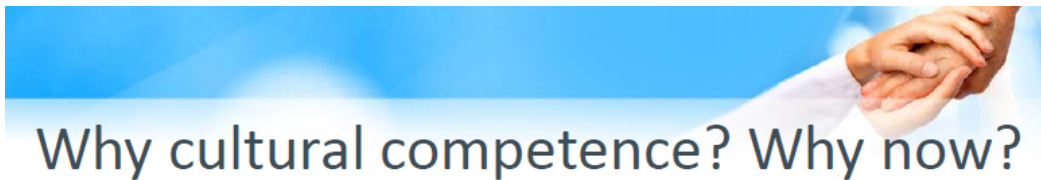
The National CLAS Standards

Communication and Language Assistance:

- **Standard 5:** Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
- **Standard 6:** Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
- **Standard 7:** Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
- **Standard 8:** Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.



Appendix E (Continued)
Cultural Competence Training Toolkit

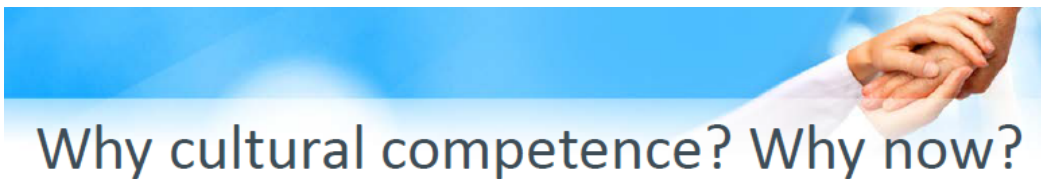


Why cultural competence? Why now?

The National CLAS Standards

Engagement, Continuous Improvement, and Accountability:

- **Standard 9:** Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
- **Standard 10:** Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
- **Standard 11:** Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
- **Standard 12:** Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.



Why cultural competence? Why now?

The National CLAS Standards

Engagement, Continuous Improvement, and Accountability:

- **Standard 13:** Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
- **Standard 14:** Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
- **Standard 15:** Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.



Appendix E (Continued)
 Cultural Competence Training Toolkit



Why cultural competence? Why now?



American Academy of Nursing
transforming health care policy and practice through nursing knowledge

Standards of Practice for Culturally Competent Nursing Care

- Standard 1. Social Justice
- Standard 2. Critical Reflection
- Standard 3. Knowledge of Cultures
- Standard 4. Culturally Competent Practice
- Standard 5. Cultural Competence in HealthCare Systems and Organizations
- Standard 6. Patient Advocacy and Empowerment
- Standard 7. Multicultural Workforce
- Standard 8. Education and Training in Culturally Competent Care
- Standard 9. Cross Cultural Communication
- Standard 10. Cross Cultural Leadership
- Standard 11. Policy Development
- Standard 12. Evidence-Based Practice and Research





Why cultural competence? Why now?

5. Because cultural competence is needed to understand and respond effectively to diverse belief systems related to health and well-being.



Quality Health Care:

- Safe
- Effective
- Timely
- Efficient
- Patient-Centered
- Equitable

(Institute of Medicine, 2001)




Appendix E (Continued)
 Cultural Competence Training Toolkit

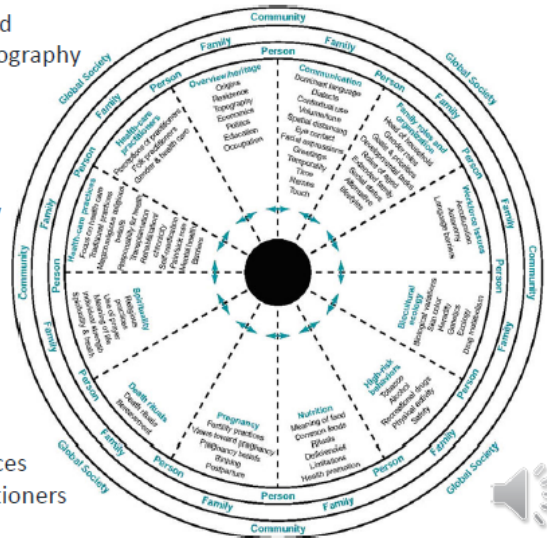


Cultural Assessment Tools

The Purnell Model for Cultural Competence and Assessment (2003)

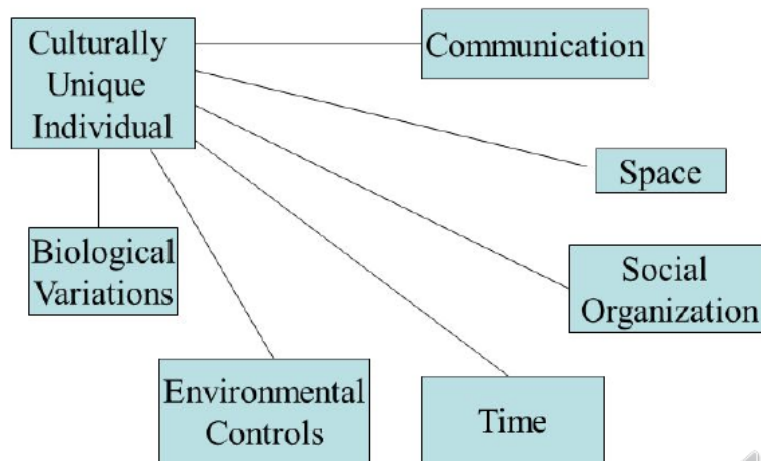
12 Domains

- Overview, Inhabited Localities, and Topography
- Communication
- Family Roles and Organization
- Workforce Issues
- Biocultural Ecology
- High-Risk Health Behaviors
- Nutrition
- Pregnancy and Childbearing
- Death Rituals
- Spirituality
- Health-Care Practices
- Health-Care Practitioners



Cultural Assessment Tools

Transcultural Assessment Model
 (Giger and Davidhizar, 2003)



Appendix E (Continued)
Cultural Competence Training Toolkit



Health Literacy



Health Literacy



Appendix E (Continued)
 Cultural Competence Training Toolkit



Health Literacy Assessment Tools

(Agency for Healthcare Research and Quality, 2016)



- Short Assessment of Health Literacy- Spanish and English (SAHL-S&E)
- Rapid Estimate of Adult Literacy in Medicine- Short Form (REALM-SF)
- Short Assessment of Health Literacy for Spanish Adults (SAHLSA-50)
- Newest Vital Sign



Hispanic/Latino Culture

Learner Objectives:

- Understand the differences between the terms “Hispanic” and “Latino”.
- Define the term acculturation and its impact on providing culturally competent care.
- Discuss the role of religion, traditional health care beliefs, social values, and family structure of Hispanics/Latinos and the impact these factors have on health care.
- Identify specific culturally sensitive practices that can be incorporated into your work with Hispanic/Latino patients.



Appendix E (Continued)
Cultural Competence Training Toolkit

Hispanic ≠ Latino

Individuals from Brazil are considered Latino but not Hispanic

Individuals from Argentina are considered both Latino and Hispanic

Individuals from Spain are considered Hispanic but not Latino

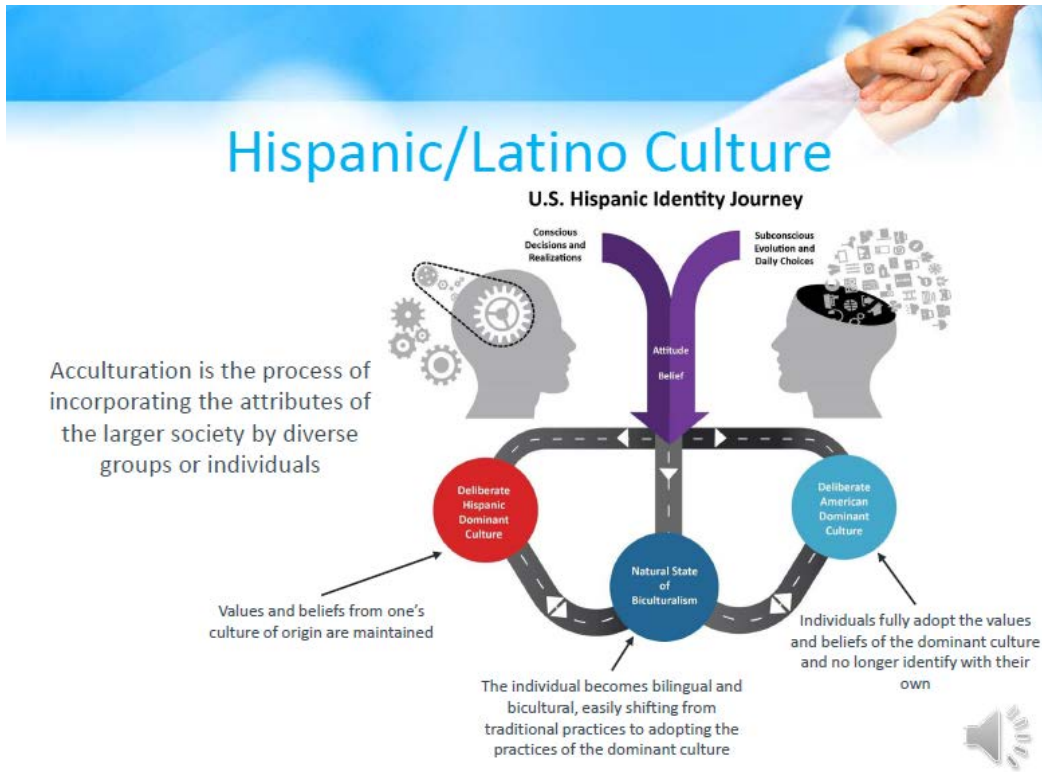
- Latino is a term that refers to GEOGRAPHY.
- Hispanic is a term that refers to LANGUAGE.

Hispanic? Latino? None of the Above?

“ Words such as Hispanic or Latino are limiting. We come in all shapes, sizes, colors, and dialects. There’s no one word that fits all.”

Lawrence Hernandez

Appendix E (Continued)
 Cultural Competence Training Toolkit



Hispanic/Latino Culture

What can acculturation tell us about the health of this population?

- Acculturation has been associated with obesity risk, suboptimal dietary choices, lack of breast-feeding, low intake of fruits and vegetables, higher consumption of fats and refined sugars, smoking, and alcohol consumption (Pérez-Escamilla & Putnik, 2007).
- In contrast, acculturation has been positively associated with an increased likelihood for access to certain health screenings and health care in general, as well as a lower likelihood of type 2 diabetes (Pérez-Escamilla & Putnik, 2007).
- Other studies have shown that Hispanics live longer than non-Hispanic Whites, despite a high prevalence of cardiovascular disease (CVD) risk factors and an average low socioeconomic status, both strong predictors of CVD and mortality (Medina-Inojosa, 2014).



Appendix E (Continued)
 Cultural Competence Training Toolkit



Hispanic/Latino Culture

Verbal and Non-Verbal Communication



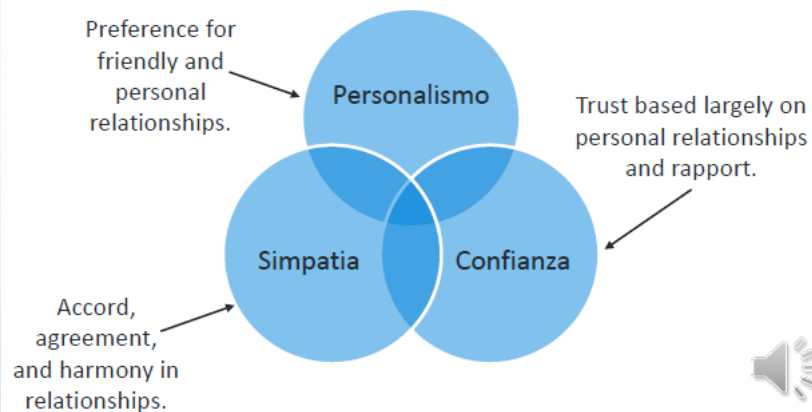
- Respect is key
 - Although personal space is close, Hispanics/Latinos do not appreciate familiarity and/or physical touch by strangers or casual use of first names.
 - Hispanics/Latinos show affection through touch.
 - Prolonged uninterrupted eye contact is considered rude and disrespectful.
 - Authority is not questioned.
 - May nod affirmatively but does not always mean agreement. Silence may mean failure to understand and embarrassment about asking or disagreeing.
 - Modesty and privacy are important. Health issues should not be discussed with family members, but should be discussed with an interpreter.
 - Same gender interpreters should be used for sensitive issues.
 - May communicate intense emotion and appear quite animated in conversations.



Hispanic/Latino Culture

Verbal and Non-Verbal Communication

- Attention to building rapport will go a long way to facilitate communication.
 - Rapport begins through exchange of pleasantries.
 - Hispanics/Latinos like to establish warmth and trust prior to addressing issues.
 - Healthcare professionals are expected to be warm and personal.



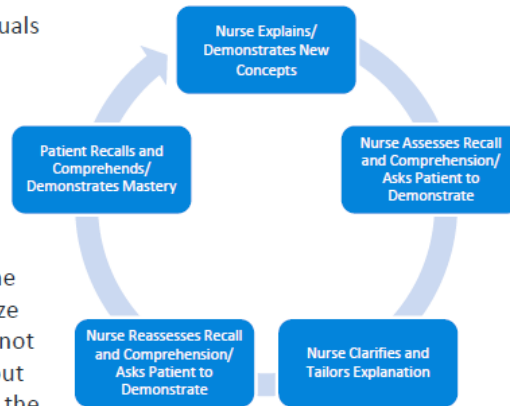
Appendix E (Continued)
 Cultural Competence Training Toolkit



Hispanic/Latino Culture

Interventions for Respectful Communication

- Address older individuals by their last name.
- Avoid gestures which may have adverse connotations.
- Encourage patients and their families to ask questions.
- Communicate with the patient that you realize that some things are not normally discussed, but are necessary so that the best care can be planned.



Teach-Back Method

- Use closed-loop communication in order to evaluate if questions or instructions have been understood.



Hispanic/Latino Culture


Family and Social Structure: The Concept of “Familismo”

The feeling of community within the whole family.

- Characterized by interdependence, affiliation and cooperation.
- Family (nuclear and extended) and community (friends and neighbors) are the most important social and supportive entities.
- Collectivist worldview- The needs of the family take precedence over those of the individual.
- Decision-making among members of the family.
- Non-Hispanics may diagnose behaviors as “pathological”- enmeshed and codependent; healthcare professionals should examine their own view of family and connectedness while being open to positive aspects of familismo.

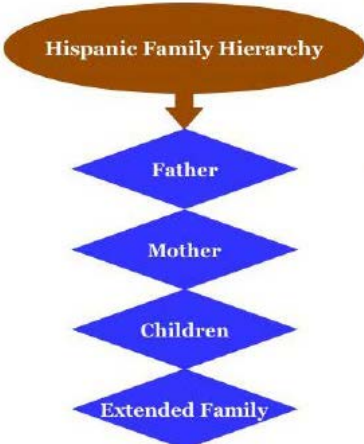


Appendix E (Continued)
 Cultural Competence Training Toolkit



Hispanic/Latino Culture

Family and Social Structure: Family Roles



Hispanic Family Hierarchy

- ◆ Father
- ◆ Mother
- ◆ Children
- ◆ Extended Family

- The father is responsible to provide for and be in charge of the family.
 - “Machismo” or macho is the sense of honor that is vital to the Hispanic sense of self, self-esteem and manhood.
- The woman is the primary force holding the family together, the primary caregiver and responsible for most of the parenting.
 - The wife is expected to show respect and submission to the husband.
 - The mother determines when medical care is needed, but the male head of household (often the oldest adult male) gives permission.

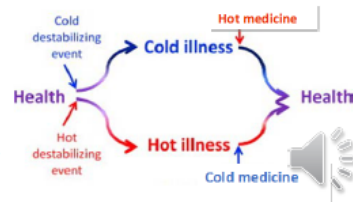


Hispanic/Latino Culture

Views of Illness: Hot-Cold Theory of Illness

Illness is seen as an imbalance between internal and external sources (person and environment) expressed as too much “hot” or “cold”.

- Hot and cold do not pertain to actual temperature, but to a symbolic power contained in most substances.
 - Cold Diseases/Conditions:
 - Characterized by vasoconstriction and low metabolic rate
 - Ex. Menstrual cramps, rhinitis, pneumonia, colic
 - Hot Diseases/Conditions:
 - Characterized by vasodilatation and high metabolic rate
 - Ex. Pregnancy, high blood pressure, diabetes, indigestion
- Health is restored by re-establishing the internal balance by exposing one’s self to, or ingesting, items of the opposite quality to that believed to be responsible for the illness.
 - Cold conditions are treated with hot medications to bring back balance.
 - Hot conditions are treated with cold medications to bring back balance.



Appendix E (Continued)
Cultural Competence Training Toolkit



Hispanic/Latino Culture

Views of Illness: “Fatalismo”

- Fatalism refers to a general belief that the course of fate cannot be changed and that life events are beyond one’s control.
- In the health literature, fatalism usually is conceptualized as a set of pessimistic and negative beliefs and attitudes regarding health-seeking behaviors, screening practices, and illness (Abraído-Lanza et al., 2007).
- The idea that illness is punishment for past deeds, or “meant to be”, may inhibit participation in preventive or therapeutic procedures.
- Disease prevention is not highly valued, leading to a high incidence of chronic illness such as high blood pressure and diabetes.
- While fatalismo as worldview may be part of the Hispanic/Latino culture, it is only one factor affecting health behaviors.

**Fatalismo + Mistrust + Poverty =
Health Disparities**



Hispanic/Latino Culture

Folk Medicine

- Folk medicine is the mixture of traditional healing practices and beliefs that involve herbal medicine, spirituality and manual therapies or exercises in order to diagnose, treat or prevent an ailment or illness.
- Knowledge of folk medicine beliefs and practices can provide healthcare professionals with valuable information about the patient.
- Folk healing shows a cultural blend with religion.
- There is use of complementary and alternative medicine, such as chiropractic, acupuncture, massage and herbal use.
- Home remedies may be preferred because of the high cost of medicines.
- Standard prescriptions may be more acceptable when traditional remedies can continue to be taken.
- Prescriptions tend to be shared within their social networks; for example, antibiotics may be shared with ill family members leading to antibiotic resistance.



Appendix E (Continued)
 Cultural Competence Training Toolkit



Hispanic/Latino Culture

Folk Medicine



- A *“sobador”* is a manual therapist who offers chiropractic or physical therapies. A common cultural understanding regarding spirituality and healing builds trust between the patient and the sobador.
- Herbalism is also a common practice where components of a plant or plants (berries, root, leaves, etc) are used for their medicinal properties. A person who practices herbalism is called a *“yerbero”*. Some examples of medicinal herbs include chamomile which is taken as a tea for its calming properties, aloe vera which is used topically on the skin to cure bites, rashes, etc., and eucalyptus, which is used as a tea to alleviate and help symptoms associated with the common cold.
- *“Curanderismo”* is a relationship between illness, healing and religion, and an underlying belief and trust among the Hispanic community about symptoms, healing practices and the source of illness. The practice assumes a social network of relatives who can diagnose the illness and act as *“curandero”*.



Hispanic/Latino Culture

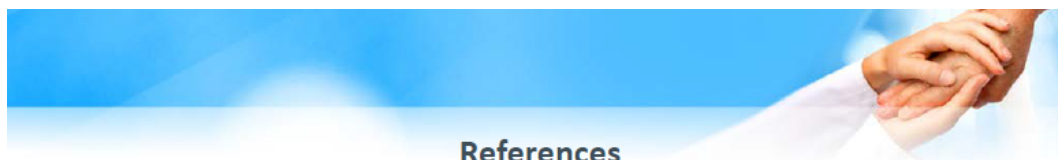
Conclusion

- Culture plays a large role in health and health care, and can pose barriers to effective patient-provider communication. These include:
 - Cultural differences in explanatory models of health and illness.
 - Differences in cultural values.
 - Cultural differences in patients’ preferences for patient-provider relationships.
 - Discrimination, racism, and perceptual barriers.
 - Linguistic barriers.
- While it is important to be familiar with the range of belief systems found among the Hispanic/Latino patient population, it is critical that healthcare providers do not assume that any individual maintains traditional beliefs.



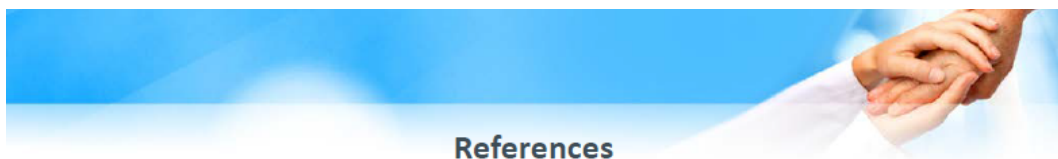
Appendix E (Continued)

Cultural Competence Training Toolkit



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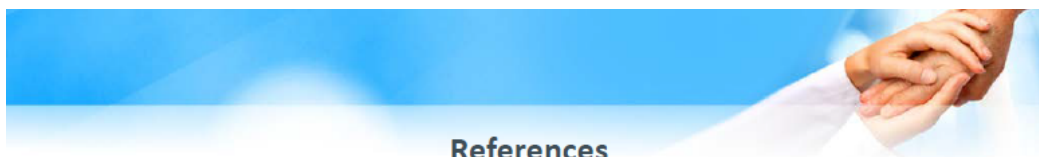


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Appendix E (Continued)

Cultural Competence Training Toolkit



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Appendix E (Continued)
Cultural Competence Training Toolkit
Glossary of Terms

Advocacy- To protect the interests of patients when the patients themselves cannot because of illness or inadequate health knowledge.

Cross-Cultural- Any form of activity between members of different cultural groups; or, a comparative perspective on how cultural differences and similarities shape human behaviors and events.

Cultural Brokering- Bridging, linking, or mediating between groups or persons of different cultural backgrounds to effect change.

Cultural Competence- The ongoing capacity of health care systems, organizations, and professionals to provide for diverse patient populations high-quality care that is safe, patient-centered and family-centered, evidence-based and equitable.

Cultural Diversity- Differences between peoples based on a shared ideology and valued set of beliefs, norms, customs, and meanings evidenced in a way of life.

Cultural Safety- Health care that recognizes and respects the cultural characteristics of the patient, the patient's family, the environment, and the patient's community. This occurs through ongoing self-reflective practices by the nurse. Culturally safe practices by the nurse protect patients against devaluation or obliteration of their cultural histories, cultural expressions, and cultural experiences.

Culture- Integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. The totality of socially-transmitted behavior patterns, arts, beliefs, values, customs, lifeways, and all other products of human work and thought characteristics of a population of people that guides their worldview and decision making. These patterns may be explicit or implicit, are primarily learned and transmitted within the family, and are shared by the majority of the culture. Cultural patterns can also be transmitted from outside the family by means of pressures exerted by society.

Empowerment- Increasing the ability or opportunity of patients and their families to be in control of their health, spiritual, political, social, and/or economic destinies.

Ethnicity- The identification with population groups characterized by common ancestry, language, and customs.

Ethnocentrism- A universal tendency to believe that one's own culture and worldview are superior to another's. In the health care arena, it can prevent effective therapeutic communication when the health care provider and client are of different cultural or ethnic groups and each perceives their own culture to be superior.

Evidence-Based Practice- The practice of health care in which the practitioner systematically finds, appraises, and uses the most current and valid research findings as the basis for clinical decisions. The integration of the best research evidence combined with clinical expertise and patient values.

Health Disparities/Inequalities- Health status disparities refer to the variation in rates of disease occurrence and disabilities between socioeconomic and/or geographically defined population groups.

Health Care Disparities/Inequalities- Differences in access to or availability of facilities and services.

Human Rights- The right of every individual including the right to life, the right to live in freedom and safety, the right to equality before law, the right to free and equal treatment, the right to privacy, the right to public assembly, and the right to freedom of thought and expression.

Multicultural- A concept or philosophy that recognizes that all cultures have a value of their own and must be represented or recognized in the broader society or international context, and encourages enlightenment of others in the worthwhile contributions to society by those of diverse ethnic backgrounds.

Nonverbal Communication- The forms of communication that include use of eye contact, facial expressions, use of touch, body language, spatial distancing, acceptable greetings, temporality in terms of past, present, or future orientation of worldview, clock versus social time, and the degree of formality in the use of names. These forms of nonverbal communication often vary among cultures.

Nursing- A healthcare profession that encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles.

Race- A social category or social construction on the basis of certain characteristics, some biological, that have been assigned social importance in the society. It is not the biological characteristics per se that define racial groups, but how society assigns people to racial categories such as Black, White, and so on, not because of science, logic, or fact, but because of social experience.

Social Justice- Social justice is the creation of social and political institutions to ensure fair treatment and equal distribution of costs and benefits to all people, regardless of race, religion, ethnicity, and gender. It requires that social and economic institutions allocate resources to benefit the least advantaged members of society. Social justice views the redistribution of goods and resources based on the rights of disadvantaged categories of people, rather than on compassion or national interest.

Stereotype- A simplified standardized conception, image, opinion, or belief about a person or group. Stereotypes are qualities assigned to an individual or group of people related to their nationality, ethnicity, sexuality, socioeconomic status, and gender, among others. Most often they are negative generalizations. A health care provider who fails to recognize individuality within a group is stereotyping.

Transcultural- A descriptive term implies that concepts transcend cultural boundaries or are universal to all cultures, such as caring, health, and birthing. In contrast, cross-cultural refers to a comparative perspective on cultures to generate knowledge of differences and similarities.

Transcultural Nursing- Study and practice focused on comparative cultural care (caring) values, beliefs, and practices with the goal of providing culture-specific and universal nursing care practices in promoting health or well-being.

Translation versus Interpretation- The key difference between translation and interpretation lies within the choice of communication channel. Translation deals with written communication, while interpretation involves the spoken/signed word.

Verbal Communication- The form of communication that includes the dominant language and dialects, contextual use of the language, and paralinguistic variations, such as voice volume and tone, intonations, reflections, and willingness to share thoughts and feelings.

Appendix F

Contractual Agreement for Limited Use of the Instrument for Assessing the Process of Cultural Competence among Healthcare Professionals- Revised [IAPCC-R©] *
(Copy of the Instrument can be found in Campinha-Bacote, 2007, p. 121)



Clinical, Administrative, Research & Educational Consultation in Transcultural Health Care

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11108 Huntwicke Place
Cincinnati, Ohio 45241

Date: March 10, 2017

To: Ms. Patricia Moore

From: Dr. Josepha Campinha-Bacote
President, Transcultural C.A.R.E. Associates

RE: **Contractual Agreement for Limited Use of the IAPCC-R**

This letter grants permission to Ms. Patricia Moore to use my tool, *Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-Revised (IAPCC-R)* to assess the level of cultural competence of 12 nurses. I have received \$192 for 24 tools for this pre/posttest study.

TIME FRAME: Permission to use the IAPCC-R is time-limited to be used from March 12, 2017 through April 7, 2017. **Upon April 8, 2017, all unused tools must be destroyed.**

ONSITE ADMINISTRATION: This onsite permission only grants administration of the IAPCC-R via an onsite pencil and paper administration in Ms. Patricia Moore personally hand-administers the tool to each participant and immediately collects these tools following its completion. Ms. Patricia Moore agrees that the IAPCC-R cannot be administered in an offsite format such as in an online course, internal or external mailings, or via an Internet website offering without granted permission.

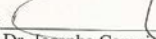
RESTRICTIONS OF COPYING: Ms. Patricia Moore agrees that the IAPCC-R nor any of its 25 items cannot be copied or reproduced for any other reason. This includes, but not limited to, being copied in any formal or informal publications or presentations, a dissertation, a DNP project/paper, or thesis, in any academic papers, as handouts for presentations, nor for any PowerPoint or Poster presentations or in any hard copy or electronic formats. The IAPCC-R is only to be used for the above purpose of administering this tool in this above study to only 12 participants.


PUBLICATIONS: Ms. Patricia Moore agrees that any publications (formal or informal) or presentations of the findings of the study using my tool will be shared with me.

GOVERNING LAW: All parties acknowledge that this Contractual Agreement for Limited Use of the IAPCC-R is a valid contract. This

contract shall be governed and construed under the laws of the State of Ohio, except as governed by Federal law. Jurisdiction and venue of any dispute or court action arising from or related to this contract shall lie exclusively in or be transferred to Hamilton County Municipal Court, Hamilton County Court of Common Pleas, or the Federal Court situated in the County of Hamilton, Ohio.

ATTORNEY'S FEES AND COSTS: In any action to enforce any provision of this Agreement, the prevailing party will be awarded reasonable attorney's fees and costs.

Signature  _____
Dr. Josepha Campinha-Bacote

Date  _____

Signature  _____
Ms. Patricia Moore

Date  _____

Appendix G
Cultural Competence Training Toolkit Evaluation Survey

**Cultural Competence Training Toolkit
Program Evaluation Survey**

- | | | | | | |
|---|----------------|-------|---------|----------|-------------------|
| 1. The content was well-organized. | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree |
| 2. The content and program was valuable to my practice. | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree |
| 3. The program length was sufficient for my learning needs. | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree |
| 4. The presenter was an effective communicator. | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree |
| 5. The presenter kept the program alive and interesting. | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree |
| 6. The presenter handled group discussions effectively. | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree |
| 7. The written teaching materials were informative. | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree |
| 8. The videos included in the toolkit were interesting and effective. | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree |
| 9. This program increased my awareness of the needs of various ethnic/minority groups. | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree |
| 10. I learned new and effective ways to communicate effectively and sensitively with ethnic/minority clients/patients and their families. | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree |
| 11. I would recommend this program to others. | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree |
| 12. Comments: | | | | | |

Thank you for your participation!

Appendix H
Human Research Protection Office Memo



University of Massachusetts Amherst

108 Research Administration Building
70 Butterfield Terrace
Amherst, MA 01003-9242

**Human Research Protection Office
Research Affairs**

Telephone: 545-3428 **FAX:** 577-1728

FAX: 577-1728

MEMORANDUM

To: Patricia Moore, Nursing
From: Human Research Protection Office
Date: September 28, 2016

Project Title: *The Effectiveness of Cultural and Health Literacy Assessment on Hispanic/Latino Patients' Understanding and Adherence to Health Education: An Integrative Review and Toolkit for Practice*

IRB Number: 16-109

The Human Research Protection Office (HRPO) has evaluated the above named project and has made the following determination:

- The activity does not involve research that obtains information about living individuals and therefore does NOT require IRB review and approval.
- The activity does not involve intervention or interaction with individuals OR does not use identifiable private information and therefore does NOT require IRB review and approval.
- The activity is not considered research under the human subject regulations (Research is defined as "a systematic investigation designed to develop or contribute to generalizable knowledge.") and therefore does NOT require IRB review and approval.
- The activity is determined to meet the definition of human subject research under federal regulations and therefore DOES require submission of applicable materials for IRB review.

For activities requiring review, please see our web pages for more on [types of review](#) or [submitting a new protocol](#). For assistance do not hesitate to contact the Human Research Protection Office at 545-3428 for assistance.