STARR, SHARON S., Ph.D. Dimensions of Cultural Competence: Nurse-Client
Perspectives. (2008)
Directed by Dr. Debra C. Wallace. 145 pp.

Cultural competence at the provider-client level has been suggested as a strategy
to address health disparities. This study, using The Model of Culturally Congruent Care
as a framework, examined cultural competence from the perspectives of nurses who
provide care in the community and from the clients they serve. Seventy one nurses from
home health, hospice and public health agencies completed The Cultural Competence
Assessment which examined the nurses' cultural competence. The nurses also
documented personal experiences providing culturally competent care. Sixty nine clients
receiving care at public health agencies completed the Interpersonal Processes of Care –
Short Form that examined the clients' perspectives of the nurses' communication,
decision making and interpersonal style. Measures of central tendency were used to
analyze findings from the Cultural Competence Assessment and the Interpersonal
Processes of Care – Short Form. Multiple regression and one-way ANOVA were used to
analyze additional findings from the Cultural Competence Assessment. Nurses reported
moderately high levels of cultural awareness and sensitivity and moderate levels of
culturally competent behaviors and overall cultural competence. Higher numbers of
cultural diversity training experiences were found to predict higher performance of
culturally competent behaviors and higher cultural competence. Public health nursing
was found to predict lower performance of culturally competent behaviors and lower
cultural competence than home health/hospice nursing. Public health nurses' scores on

the Cultural Competence Assessment were significantly lower than home health/hospice nurses' scores. Content analysis of the nurses' documentation of personal experiences revealed requests for additional cultural competence training, the provision of culturally competent care that dealt with the language barrier and the lack of adequate numbers of appropriately trained interpreters. Clients rated the nurses' communication, decision making and interpersonal style as very high. Similarities were noted between the high frequency of specific nurse-reported culturally competent behaviors and client reported perceptions of the nurses' communication, decision making and interpersonal style indicating consistency between nurse and client responses. Implications for education of current and future health care providers, provision of adequate numbers of appropriately trained interpreters by health care systems and research into client outcomes resulting from culturally competent care are explored.

DIMENSIONS OF CULTURAL COMPETENCE:

NURSE-CLIENT PERSPECTIVES

by

Sharon S. Starr

A Dissertation Submitted to
The Faculty of The Graduate School at
The University of North Carolina at Greensboro
In Partial Fulfillment
Of the Requirements for the Degree
Doctor of Philosophy

Greensboro
2008

Approved by

Debra Wallace, Ph.D, RN
Committee Chair

To Kevin, you washed clothes, bought groceries, cooked food and generally took care of the house and especially cared for me. You are the reason this dissertation is finished. To Erin, our Friday nights were wonderful, the overnight stays were welcome and your listening ear and valuable advice was what kept me sane. To Amy and Brandon, both of you with Sadie Sue and Minnie May provided much needed diversions and joyful times. We accomplished a beautiful wedding and bonded over school issues. All of you have provided unlimited support and encouragement, without which I would not have accomplished this goal. You will never know how much you mean to me.

To my parents, Rev. and Mrs. Darrell Saunders, who, although they are no longer with us, are aware of this accomplishment and are smiling.

APPROVAL PAGE

This dissertation has been approved by the following committee of the Faculty of

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ACKNOWLEDGEMENTS

Great appreciation is extended to my committee, who provided valuable guidance and insight on this dissertation. Your support was a major factor in my success.

To my advisor and dissertation chair, Dr. Debra Wallace, thank you for listening to my musings and for your commitment to guiding me through this process. Your advice was invaluable and I appreciate your patience with my frustrations.

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CHAPTER I

INTRODUCTION

Purpose

Cultural competence of healthcare providers results from the interaction between cultural diversity, cultural awareness and cultural sensitivity (Schim, Doorenbos, Benkert, & Miller, 2007) and has been suggested as an effective strategy to address health disparities (Betancourt, Green, Carrillo, & Ananeh-Firemong II, 2003). Health disparities can occur as a result of mistrust of healthcare providers (Betancourt, et al., 2003; Cort, 2004; Kennedy, Mathis & Woods, 2007; Perloff, Bonder, Ray, Ray, & Siminoff, 2006), ineffective provider-client communication (Betancourt, et al., 2003; Kaplan, Calman, Golub, Davis, Ruddock, & Billings, 2006; Saha, Arbelaez & Cooper, 2003; Sheppard, Zambrana & O'Malley, 2004), lack of participatory decision making between clients and providers (Cooper-Patrick, Gallo, Gonzales, Vu, Powe, Nelson, & Ford, 1999; Saha, et al., 2003) and inappropriate or negative interpersonal styles of providers (Betancourt, et al., 2003; Cricco-Lizza, 2006; Saha et al., 2003; Sheppard et al., 2004). Cultural competence occurring from the interaction of cultural diversity, cultural awareness, and cultural sensitivity can result in culturally congruent care that addresses factors influencing health disparities (Schim et al., 2007).

Nurses providing care in the community interact with and care for clients with diverse health beliefs and values who are at risk for health disparities. Identification of factors influencing the cultural competence of nurses providing care in the community, and examining their personal perspectives about providing culturally competent care, provides an added dimension to the understanding of cultural competence of nurses providing care in the community.

Clients, as recipients of care, can provide a unique perspective about the cultural competence of nurses providing care in the community. They can convey if nurses communicate appropriately and adequately, use participatory decision making and relate in positive interpersonal styles. Examining the client perspective provides an added dimension to the knowledge of cultural competence of nurses providing care in the community.

Examining the perspectives of both nurses and clients is necessary to fully understand cultural competence. Nurses may believe they provide culturally competent care, but clients, as recipients of care, ultimately determine if the care provided is culturally competent. Therefore, the primary purpose of this study was to identify factors influencing cultural diversity, cultural awareness, cultural sensitivity and overall cultural competence of nurses who provide care in the community and to examine their personal experiences of providing culturally competent care. A secondary purpose was to explore client perceptions about the communication, decision making and interpersonal style of nurses providing care in the community. Finally, examination of similarities between

these client perceptions and the cultural awareness, cultural sensitivity, and overall cultural competence of these nurses was completed.

Background/Significance of Issue

The population of the United States (U.S.) is diverse and trends indicate this diversity will increase over the next few decades as numbers of individuals in minority groups increase. In 2006, the U.S. population consisted of whites 80.1%, blacks 12.8%, Asians 4.4%, and Hispanics 14.8% (U.S. Census Bureau, 2008). By 2020 the percentage of whites is projected to decrease to 77.6% while other groups are projected to increase: African Americans to 13.5 %, Asians to 5.4%, and Latinos to 17.8%. The trend is predicted to continue through 2050 when the population will consist of whites 72.1%, African Americans 14.6%, Asians 8.0%, and Latinos 24.4% (U.S. Census Bureau, 2004). This increase in diversity means an increase in the numbers of individuals with perspectives regarding health and health care that may be different from the predominantly Western perspective found in the U.S. Consideration of these diverse perspectives through enhanced cultural competence of providers is essential to reduce or avoid health disparities.

Justification of Need for Study

Additional information is needed about the dimensions of cultural competence of healthcare providers. The perspectives of providers and the clients they serve are excellent sources of this information. Nurses who provide care in the community can provide the provider level dimension, while the clients can provide the client level dimension. Provider level dimensions can be obtained by examining the nurses'

perspectives about their cultural diversity, cultural awareness and sensitivity, culturally competent behaviors and overall cultural competence. Additional dimensions are provided by examining factors influencing the nurses' cultural competence and by examining their personal experiences providing culturally competent care. Client level dimensions can be obtained by examining the clients' perspectives of their nurses' style and substance of communication, decision making style and interpersonal styles. Examining the similarities between the nurses' perspectives of their cultural competence and the clients' perspectives of the nurses' communication, decision making and interpersonal style can provide additional insight into the cultural competence of nurses providing care in the community.

Investigation of factors influencing cultural competence is a recent phenomenon. Clarification of the factors influencing the cultural diversity, cultural awareness, cultural sensitivity, and cultural competence of nurses providing care in the community will assist in program planning and policy development to enhance their cultural competence and address health disparities. Examining the nurse's experiences providing culturally competent care can provide specific, personal information about this phenomenon, thus adding to the information obtained about their cultural diversity, cultural awareness, cultural sensitivity, and cultural competence. Obtaining the client's perspective adds significant information to this body of knowledge and allows evaluation of presently held beliefs concerning cultural competence. Examining dimensions of cultural competence of nurses providing care in the community from the nurses' and clients' perspectives will

contribute significant information to the knowledge of cultural competence of this group of nurses.

Synopsis of Current Knowledge

Culture influences the way an individual experiences and interprets the world and permeates all aspects of life. It guides the thoughts, communications, actions, customs, beliefs, values and institutions of individuals and groups (U.S. Office of Minority Health, 2001). Leininger and McFarland (2006) posit that culture can help know, explain, and predict an individual's lifeways over time. Culture is defined as "…the learned, shared, and transmitted values, beliefs, norms, and lifeways of a particular culture that guides thinking, decisions, and actions in patterned ways and often intergenerationally" (p. 13). Culture is shared by individuals from the same ethnicity and includes the thoughts, communications, actions, customs, beliefs, values and institutions of groups (U.S. Office of Minority Health, 2001). These groups include racial and ethnic minority groups and diverse subcultures such as communities of interest (disabled, elderly, etc), and communities with common needs (substance abusers, homeless, gay, lesbian, bisexual, transgendered [GLBT], etc.) (Schim et al., 2007).

An individual's cultural background serves as a foundation for perspectives of health and health care (Leininger & McFarland, 2006). Culture influences an individual's beliefs, actions and decisions about health care and can determine when and what type of care is received or provided. These influences can lead to incorporation of healthy living behaviors (Airhihenbuwa, 1995; Airhihenbuwa, Kumanyika, TenHave, & Morssink, 2000) but also can lead to negative health behaviors (Airhihenbuwa, 1995). A

comprehensive statement revealing the influence of culture on health care is provided by

the U.S. Office of Minority Health (2001) in the *The National Standards for Culturally*

and Linguistically Appropriate Services in Health Care. According to the definition in

this document, culture is:

> The thoughts, communications, actions, customs, beliefs, values, and institutions
> of racial, ethnic, religious, or social groups. Culture defines how health care
> information is received, how rights and protections are exercised, what is
> considered to be a health problem, how symptoms and concerns about the
> problem are expressed, who should provide treatment for the problem, and what
> type of treatment should be given. In sum, because health care is a cultural
> construct, arising from beliefs about the nature of disease and the human body,
> cultural issues are actually central in the delivery of health services treatment and
> preventive interventions. By understanding, valuing, and incorporating the
> cultural differences of America's diverse population and examining one's own
> health-related values and beliefs, health care organizations, practitioners, and
> others can support a health care system that responds appropriately to, and
> directly serves the unique needs of populations whose cultures may be different
> from the prevailing culture. (p. 4)

Health disparities occur when ethnic or racial differences in the quality of

healthcare occur and are evident in virtually every aspect of health care at the individual,

provider and organizational level (Smedley, Stith, & Nelson, 2003). The *National*

Healthcare Disparities Report (Agency for Healthcare Research and Quality, 2005)

reports disparities in health care for racial, ethnic and socioeconomic groups exist in the

quality of health care, access to care, across many levels and types of care, across many

clinical conditions and care settings and within many subpopulations. The subpopulations

include women, children, elderly, residents of rural areas, and those with disabilities and

other special health care needs.

Reducing and/or eliminating health disparities have become a national initiative, with various government agencies developing definitions and plans of action addressing this phenomenon. The Office of Disease Prevention and Health Promotion (U.S. Department of Health and Human Services, 2005) set 2 overarching goals in its national health promotion, disease prevention initiative: *Healthy People 2010.* One of the 2 goals is to eliminate health disparities which are defined as ". . .differences that occur by gender, race or ethnicity, education or income, disability, geographic location, or sexual orientation" (Healthy People 2010: Understanding and Improving Health, 2001, p. 6). Goals and objectives have been set to measure progress toward this goal.

The Health Resources and Services Administration (HRSA) published a new document titled *Eliminating Health Disparities in the United States* that explains HRSAs strategy to end health disparities in the U.S. (Health Resources and Services Administration, 2001). Health disparities are defined in this document as: "population-specific difference, in not only disease, but in health outcomes, or access to health care" (para 3). Specific strategies and substrategies have been adopted to provide a coordinated, integrated focus for this endeavor. The Office of Behavioral and Social Sciences Research through the National Institutes of Health (NIH) has developed a Strategic Plan for Health Disparities Research that involves development of projects that increase knowledge about the specific causes of health disparities, as well as proposed solutions (National Institutes of Health, 2007). They define health disparities as "differences in the incidence, prevalence, mortality, and burden of disease and other adverse health

conditions that exist among specific population groups in the United States" (National Institutes of Health, 2001, para 4).

The Minority Health and Health Disparities Research and Education Act (2000) (enacted in 2000) amended the Public Health Service Act with the goal to improve the health of minority individuals. The Act established the National Center on Minority Health and Health Disparities and provided a legal definition of health disparities: "A population is a health disparity population if there is a significant disparity in the overall rate of disease incidence, prevalence, morbidity or survival rates in the population as compared to the health status of the general population" (page 114 stat. 2498).

In the Institute of Medicine's report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare,* (Smedley et al., 2003), studies about the extent and potential sources of health disparities were reported with recommendations provided for interventions to eliminate health disparities. They proposed that health disparities are: "racial or ethnic differences in the quality of healthcare that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention" (Smedley et al., 2003, p. 3-4). Health disparities are consistently evident in a range of illnesses and healthcare services. Some studies report that health disparities disappear when socioeconomic factors are controlled. However, a majority of studies report that the disparities remain even when socioeconomic factors and other healthcare access related factors are controlled (Braithwaite & Taylor, 2001; Smedley et al., 2003).

Sources of health disparities have been reported to include health systems, healthcare providers, clients, and utilization managers. Healthcare providers contribute to

health disparities through bias, stereotyping, prejudice, and clinical uncertainty when caring for individuals from diverse cultural backgrounds (Giger, Davidhizar, Purnell, Harden, Phillips, & Strickland, 2007; Smedley et al., 2003). Disparities may occur when providers do not fully accept, appreciate, explore or understand the cultural differences of their clients resulting in miscommunication and negative provider-client relationships (Betancourt et al., 2003).

One source of health disparities, mistrust of the healthcare system and of providers, has been reported especially with the African American racial group. This mistrust is reported to stem from negative experiences with the healthcare system. Those from racial and ethnic minority groups may perceive racism, aversion, disregard, and discrimination by the provider and as a result may refuse treatment and fail to adhere to and comply with treatment regimens (Cort, 2004; Kennedy et al., 2007; Smedley et al., 2003; Zekeri & Habtemariam, 2006). Conversely, if clients convey mistrust, providers may become less engaged and be less likely to provide some services which may result in poorer health and more mistrust (Smedley et al., 2003).

Additional sources of health disparities involve aspects of the interpersonal provider-client relationship which includes inappropriate communication styles and substance, lack of participatory decision making and inappropriate interpersonal styles of providers and office staff. Inappropriate communication styles and substance can lead to health disparities through inability of the provider to adequately elicit and respond to client concerns, use of medical jargon and providing explanations of assessment findings and test results in terms difficult to understand (Stewart, Nápoles-Springer, Pérez-Stable,

1999; Stewart, Nápoles-Springer, Gregorich, & Santoyo-Olsson, 2007). Lack of participatory decision-making style results in health disparities when the client is not included in care decisions, thus poor provider-client interactions and lower satisfaction with care results (Cooper-Patrick et al., 1999; Saha et al., 2003; Stewart et al., 1999; Stewart et al., 2007). Interpersonal styles of providers and office staff can contribute to health disparities when the client perceives racial/ethnic discrimination and lack of respectful care by providers and office staff resulting in mistrust and a reluctance to initiate or continue care (Kaplan et al., 2006; Sheppard et al., 2004; Stewart et al., 1999; Stewart et al., 2007).

Health disparities can also result from negative health behaviors associated with the influences of culture, social environment, gender norms and perceptions of situational power (Airhihenbuwa, 1995; Airhihenbuwa & Liburd, 2006; McLeroy, Bibeau, Steckler, & Glanz, 1988). Multidimensional strategies targeting these influences are necessary to address health disparities. For example, to address the reluctance of African American men to seek healthcare due to high levels of distrust in the healthcare system, strategies promoting trust in the healthcare system and in providers would be necessary (Airhihenbuwa & Liburd, 2006). Social environments lacking access to healthy foods may lead health disparities such as high levels of obesity, heart disease and other associated chronic diseases. Strategies would be most effective if they address the need for convenient access to sources of fresh, healthy foods (Airhihenbuwa & Liburd, 2006).

One strategy to address the sources of health disparities is the delivery of culturally competent healthcare. This has been proposed as an effective strategy for

reducing or eliminating health disparities and their burdens by addressing culturally-specific health needs and optimizing an individual's health care and outcomes (Betancourt et al., 2003; Betancourt, Green, Carrillo, & Park, 2005; Edwards, 2003; Frist, Kennedy, Obama, & Bingaman, 2006; Giger et al., 2007; U.S. Department of Health and Human Services, 2005; U.S. Office of Minority Health, 2001). Examination of culturally competent health care is a relatively recent phenomenon with the first published use of the concept in overall health care by Cross, Bazron, Dennis and Isaacs (1989) in their model for cultural competence. Recent definitions of cultural competence have been proposed by government agencies (U.S. Office of Minority Health, 2001) and groups of healthcare professionals including nurses (Campinha-Bacote, 2003; Schim et al., 2007; Suh, 2004), social workers (Crisp, 2006), and dental hygienists (Notgarnie, 2007). Providers who deliver culturally competent care understand the importance of cultural influences on clients' health beliefs and behaviors. They also consider how these influences interact at all levels of the health care delivery system (Betancourt, et al., 2003). Culturally competent providers possess congruent behaviors and attitudes that promote effective work in cross-cultural situations (Cross et al., 1989; U.S. Office of Minority Health, 2001).

Providing culturally competent health care has been advocated by the Pew Health Professions Commission (1998). Competency #12 directs health care providers to provide culturally sensitive care to a diverse society. Providing care that is sensitive to and consistent with cultural values, beliefs and customs is necessary to provide appropriate and effective care. Delivery of culturally competent care has also been

advocated to decrease the mistrust by African Americans of the health care system (Cort, 2004; Kennedy et al., 2007). The lack of cultural competence by health care providers is one of the most dynamic factors leading to mistrust of the system (Kennedy et al., 2007).

Nursing as a profession advocates for holistic care that attends to the needs of all clients regardless of their racial and ethnic backgrounds and their diverse beliefs and values about health and health care. Several prominent nursing organizations advocate for nurses to be more culturally competent in order to meet the unique needs of clients and to address health disparities (American Nurses Association, 2001, 2003; Dreher & MacNaughton, 2002; Giger et al., 2007). Delivery of care that recognizes and attends to the needs of clients regardless of their cultural beliefs and values is an ethical standard for nurses.

Nurses who deliver care in the community encounter clients and families with diverse health care beliefs and values, providing opportunities for the delivery of culturally competent care. Factors influencing the cultural competence of nurses working in the community include self-efficacy in community health nurses (Bernal & Froman, 1987, 1993), education, years of nursing experience, cultural encounters and participation in cultural competence courses within hospice nurses and public health nurses (Cooper Brathwaite, 2005, 2006; Schim, Doorenbos, & Borse, 2006a, 2006b).

Attributes of culturally competent nurses providing care in the community have been reported as ability, openness, and flexibility (Suh, 2004). Constructs of cultural competence have been proposed including cultural awareness, cultural desire, cultural knowledge, cultural sensitivity, cultural interaction/encounter, cultural understanding and

cultural liaisons and linkages (Campinha-Bacote, 2003; Kim-Godwin, Clarke, & Barton, 2001; Schim et al., 2007).

The Model of Culturally Congruent Care articulated by Schim and Miller (Schim et al., 2007) form the basis for this study. The model postulates culturally congruent care is created with interaction at the provider and client levels (Schim et al., 2007). The provider level is comprised of 4 constructs: cultural diversity, cultural awareness, cultural sensitivity and cultural competence. These 4 constructs are interdependent and necessary for the achievement of culturally congruent care. Constructs at the client level have not been fully articulated (Schim et al., 2007) so further research is required. Understanding of both levels is essential for culturally congruent care to occur (Schim et al., 2007).

Conceptual Definitions

Concepts to be considered in this study include culture, and the provider level constructs of cultural diversity, cultural awareness, cultural sensitivity, and cultural competence. The domains of interpersonal processes of care (communication, decision making and interpersonal style) will also be considered.

Culture as defined by Leininger (Leininger & McFarland, 2006) is "the learned, shared, and transmitted values, beliefs, norms, and lifeways of a particular culture that guides thinking, decisions, and actions in patterned ways and often intergenerationally" (p. 13). Culture also includes social behaviors, values, attitudes and shared symbols that may be taken for granted by the individual (Schim, et al., 2007).

Cultural diversity is a process construct and reflects the diversity that is increasing in the United States. The construct varies in quantity and quality across time and place

(Schim, et al., 2007). Cultural diversity includes differentiation between groups based on factors such as age, gender, physical and/or mental disability, socioeconomic status, race, ethnicity, national origin, sexual orientation, religious affiliation, and generation. This diversity provides opportunities to learn about and interact with those from differing backgrounds and beliefs and values. While differences may be emphasized when considering cultural diversity, the United Nations Educational, Scientific, and Cultural Organization (UNESCO) (2004) recognized the value of the construct in its definition: ". . . a living and thus renewable treasure that must not be perceived as being unchanging heritage but as a process guaranteeing the survival of humanity" (p. 11).

Cultural awareness is a cognitive construct based on knowledge and requires recognition and thinking about facts related to culture. Cultural awareness involves acquisition of knowledge of the various cultures in any given community and being aware of the inter-group and intra-group similarities and differences. (Schim, et al., 2007). Cultural awareness is more than memorizing facts about inter- and intra-group differences and similarities. It is having the knowledge of the areas of differences between and within groups and using that knowledge to ask appropriate assessment questions to obtain the most meaningful responses (Schim, et al., 2007). Cultural awareness also includes understanding the cultural concepts of acculturation, affiliation, socialization and marginalization. Further development of the understanding of the interaction of these concepts at the client level and how they influence receptivity of health care will help articulate the client level of the Model of Culturally Congruent Care (Schim, et al., 2007).

Cultural sensitivity is an affective or attitudinal construct that includes a person's attitude about themselves and others and their willingness to learn along cultural dimensions. It also includes values, beliefs, and practices within an individual's own culture. Emphasis is placed on assuming the role of a learner when encountering individuals from diverse cultures. Cultural sensitivity includes recognizing the need for and appropriately using an interpreter (Schim, et al., 2007).

Cultural competence is a behavioral construct that includes actions taken in response to the previous 3 constructs of cultural diversity, awareness and sensitivity. This construct involves the ability of a person to demonstrate certain behaviors in public such as learning about cultures in the community, adapting care to client needs and documenting assessments and adaptations to care. The goal of efforts to develop cultural competence is to "foster consistent and appropriate demonstration of competency behaviors" (Schim, et al., 2007 p. 107). Cultural competence is an ongoing activity that changes over time in response to individual diversity experiences. The goal of efforts to develop cultural competence is to "foster consistent and appropriate demonstration of competency behaviors" (Schim, et al., 2007 p. 107).

Communication includes the rate and clarity of providers' speech, ability to elicit clients' concerns and the response to them, use of medical jargon and the provision of appropriate and understandable explanations of test and assessment results (Stewart, et al., 1999; Stewart, et al., 2007). This includes whether the provider speaks slow enough and uses easy to understand words when communicating with the client and is not distracted during the interaction (Stewart, et al., 2007).

Decision making includes consideration of the desire and ability of the client to participate in decisions about their care (Stewart, et al., 1999; Stewart, et al., 2007). The client is allowed to decide if they want to be included in care planning decisions (Stewart, et al., 2007).

Interpersonal style pertains to providers as well as office staff. Included is the provision of compassionate and respectful care by providers as well as the perception by the client of the occurrence of racial/ethnic discrimination (Stewart, et al., 1999; Stewart, et al., 2007). The occurrence of a disrespectful and negative attitude by office staff is included as well (Stewart, et al., 1999; Stewart et al., 2007).

Contribution of the Study

Examination of the dimensions of cultural competence of nurses who provide care in the community includes exploring the perspectives of the nurses as well as clients who are recipients of their care. This study will examine the nurses' perspective of their cultural diversity, cultural awareness, cultural sensitivity, and overall cultural competence and factors related to these constructs. Examination of their personal experiences providing culturally competent care will add to knowledge about the cultural competence of nurses providing care in the community and further explain the provider level constructs of the Model of Culturally Congruent Care.

Clients' perspectives will derive from their evaluation of the communication style and substance, decision-making style and interpersonal style of nurses providing care in the community. The similarities between client perspectives with the nurses' perspectives of the nurses' cultural awareness/sensitivity, culturally competent behaviors and cultural

competence of the nurses will provide additional insight into the cultural competence of nurses who provide care in the community.

Summary

Health disparities result when racial or ethnic differences in the quality of healthcare occur and are evident at the individual, provider and organizational level. Elimination of health disparities has become a national initiative. Cultural competence that occurs from the interaction of cultural diversity, cultural awareness and cultural sensitivity at the provider-client level, as postulated in The Model of Culturally Congruent Care, can result in culturally congruent care and has been proposed as an effective strategy to address health disparities. This study focuses on cultural competence as a strategy to address health disparities at the provider-client level by examining the cultural diversity experiences, cultural awareness and sensitivity and performance of culturally competent behaviors of nurses providing care in the community from the nurses' perspective. Additionally, the clients' perspectives of the nurses' communication, decision making and interpersonal styles will be examined. Insight into cultural competence and culturally competent care at the provider-client level will be expanded by obtaining both the nurses' and clients' perspectives. This information can contribute to enhanced cultural competence of nurses who provide care in the community leading to more appropriate and higher levels of quality care for those at risk for health disparities.

CHAPTER II

REVIEW OF THE LITERATURE

Introduction

Cultural competence has been suggested as one strategy to address health disparities in the United States (Betancourt et al., 2003; Betancourt et al., 2005; Capel, Veenstra, & Dean, 2007; Edwards, 2003; Frist et al., 2006; Giger et al., 2007; U.S. Department of Health and Human Services, 2005; U.S. Office of Minority Health, 2001). The value of cultural competence in addressing health disparities is discussed by various disciplines such as social work (Boyle, & Springer, 2001; National Association of Social Workers, 2001); psychology/counseling (Sue, 2006, Sue, D.W., 2001; Sue, D.W., Arrendondo, & McDavis, 1992); and medicine (Betancourt, 2003; Perloff et al., 2006; Reimann, Talavera, Salmon, Nuñez, & Velasquez, 2004; Surbone, 2004). The discipline of nursing has analyzed the concept (Burchum, 2002; Smith, 1998; Suh, 2004), proposing attributes of the culturally competent nurse (Suh, 2004) and antecedents and consequences of cultural competence (Burchum, 2002; Smith, 1998; Suh, 2004).

Various tools exist to measure the concept of cultural competence in nurses and other healthcare providers (Campinha-Bacote, 2003; Kim-Godwin et al., 2001; Schim, Doorenbos, Miller, & Benkert, 2003; Schim et al., 2007). Examples of the constructs examined by these tools include cultural awareness, cultural sensitivity, cultural diversity, culturally competent behaviors, cultural desire, cultural knowledge, cultural encounters

and cultural skill. Examination of these constructs with nurses providing care in the community can provide insight into the nurses' cultural competence.

Culturally congruent care is proposed as a goal or outcome of the interaction of the constructs of cultural competence and the effective interaction between clients and providers (Schim et al., 2007). Examining the cultural competence of providers, such as nurses, providing care in the community and gathering information from clients about the style and substance of communication, decision-making styles and interpersonal styles of these nurses and office staff can provide valuable insight into the connection between these factors and the delivery of culturally congruent nursing care.

Health disparities are evident across a wide range of illnesses and health care settings within racial and ethnic minority groups and those from marginal groups in the U.S. (Smedley et al., 2003). Specific factors influencing health disparities include attributes of the interpersonal provider-client relationship. These factors, identified by clients, include trust and mistrust of providers by clients (Betancourt et al., 2003; Cort, 2004; Kennedy et al., 2007; Perloff et al, 2006); style and substance of communication by providers (Betancourt et al., 2003; Kaplan et al., 2006; Saha et al., 2003; Sheppard et al., 2004); decision-making styles (Cooper-Patrick et al., 1999; Saha et al., 2003) and interpersonal styles of providers and office staff (Betancourt et al., 2003; Cricco-Lizza, 2006; Saha et al., 2003; Sheppard et al., 2004). Cultural competence and the delivery of culturally congruent care have been proposed as an effective strategy to address these disparities (Betancourt et al., 2003; Betancourt et al., 2005; U.S. Office of Minority Health, 2001).

Health Disparities

Barriers to care

Betancourt et al., (2003) identified barriers to care resulting in health disparities at the organizational, structural (agency) and clinical (client-provider interactions) levels from an extensive literature review that included searches in the PubMed database (MEDLINE, PreMEDLINE & HealthStar) for the years 1977-2002, as well as searches of relevant government and foundation publications. An organizational barrier included the lack of availability of minority racial/ethnic healthcare providers resulting in inappropriate and unsatisfactory delivery of care for those from these groups. Structural barriers included communication problems such as lack of interpreter services and a lack of culturally and linguistically appropriate health education materials. Clinical barriers pertained to the interactions between the client and provider include the influence of sociocultural differences on the provider-client relationship and communication. These barriers in clinical encounters were found to result in mistrust, dissatisfaction with care, poor adherence to prescribed regimens and poorer health outcomes (Betancourt et al., 2003).

Trust and mistrust

Trust has been identified as a factor influencing health disparities by being associated with satisfaction with care, continuity of care with providers and adherence to prescribed medical regimens (Thom, Ribisl, Stewart, Luke, & The Stanford Trust Study Physicians, 1999). In a study assessing and validating the Trust in Physician Scale with 343 clients from primary care practices, trust was identified as a significant predictor of

satisfaction with physician care, continuity with the same physician and self-reported adherence to medication. The effect of trust continued to the 6 month follow-up assessment (Thom et al., 1999).

Mistrust has been suggested as influencing health disparities, especially within the African American racial group (Cort, 2004; Kennedy et al., 2007; Perloff et al., 2006). Focus groups of 50 African American undergraduate students identified mistrust as a factor influencing health disparities (Zekeri & Habtemariam, 2006). Participants in the focus groups discussed that mistrust of white health care providers and the healthcare system was prevalent and resulted in a reluctance to seek treatment for health conditions including HIV/AIDS (Zekeri & Habtemariam, 2006). Participants believed this mistrust stemmed from the Tuskegee syphillis experiments conducted by the government from 1932 to 1972.

The influence of trust and mistrust on the clinical encounter and health disparities has been recognized and discussed by the Institute of Medicine (IOM) (Smedley et al., 2003) and the U.S. Office of Minority Health (2001). The IOM views mistrust as a normal reaction stemming from explicit discrimination, aversion, or disregard demonstrated by healthcare providers and/or the healthcare system that may result in refusal of treatment. Research into the sources of this mistrust is recommended (Smedley et al., 2003).

The U.S. Office of Minority Health (2001) in the *National Standards for Culturally and Linguistically Appropriate Services in Health Care* (CLAS) advocates for a healthcare environment where clients from diverse cultural backgrounds are

comfortable in discussing their cultural health beliefs and practices as they participate in the planning and implementation of their plans of care. Health care systems are encouraged to establish an environment where these clients can discuss their spiritual beliefs (U.S. Office of Minority Health, 2001). This environment can only exist when a prevailing sense of trust exists between providers and clients, allowing for openness and discussion of concerns.

Style and substance of communication by providers

Communication styles and substance includes the rate and clarity of providers' speech, ability to elicit clients' concerns and the response to them, use of medical jargon and provision of appropriate and understandable explanations of test and assessment results (Stewart et al., 1999; Stewartet al., 2007). Clear, respectful communication by providers (physicians, midwives, nurse practitioners, and physician assistants) was identified as contributing to trust resulting in increased satisfaction with care and greater adherence to prescribed regimens (Sheppard et al., 2004). Participants of focus groups consisting of 223 African American, 6 white, 2 Latina, and 2 multiracial low-income women receiving prenatal care in a public health clinic expressed the importance of being able to understand issues related to their care as well as being alerted to any negative issues concerning their health. Also, participants expressed the importance of believing the providers understood and empathized with their personal circumstances. Problems with communication related by participants included use of medical jargon, inability to understand non-U.S. born physicians, perceptions that some information was being

withheld and providers that were were not listening to them. These problems were

identified as barriers to trust (Sheppard et al., 2004).

Similar problems with communication resulting in deep and pervasive mistrust

were expressed by residents of the South Bronx in New York City (Kaplan et al., 2006).

Participants in focus groups, consisting of 78 African Americans, 31 Latinos, and 1 non-

Hispanic White, indicated that physicians failed to take adequate time to answer their

questions, listen and attend to their complaints and generally communicate adequately.

They related the physicians used medical jargon and provided difficult to understand

instructions about their care plans (Kaplan et al., 2006).

Communication factors leading to higher quality client-physician interactions

were identified by respondents to The Commonwealth Fund's 2001 Health Care Quality

Survey (Saha et al., 2003). Differences in the quality of provider-client interactions were

found between the 1153 Latino, 621 Asian, 1037 African American and 3488 White

respondents. Providers spending adequate time with respondents and adequately listening

to their concerns were identified as factors leading to higher quality interactions and

greater satisfaction with care (Saha et al., 2003).

Decision- making style

Decision making style includes the consideration of the desire and ability of the

client to participate in decisions about their care (Stewart et al., 1999; Stewart et al.,

2007). Participatory decision making styles include the predisposition of the provider to

include the client in decisions and are considered important in provider-client interactions

(Cooper-Patrick et al., 1999; Saha et al., 2003). A telephone survey involving 1816

African American, Asian, Latino and White clients found that greater participatory

decision making was associated with greater satisfaction with care (Cooper-Patrick et al.,

1999). Participatory decision making style was highest in race concordant relationships,

with a significant and positive relationship found between race concordance and

satisfaction with care (Cooper-Patrick et al., 1999). Saha et al., (2003) found participatory

decision making to be associated with higher quality interactions. Also, more appropriate

use of health care services was positively associated with participatory decision making

among Latinos (Saha et al., 2003).

Interpersonal styles of providers and office staff

Interpersonal styles of providers and office staff include the amount of

compassion and respect the client perceives during an interaction and the amount of

ethnic/racial, economic and educational discrimination and disrespect they perceive from

providers and office staff (Stewart et al., 1999; Stewart et al., 2007). Sheppard et al.,

(2004) found expressions of compassion and respect, such as concern and empathy from

providers, resulted in greater satisfaction with care for low-income women receiving care

in a prenatal public health clinic. Insensitive and uncompassionate care was found to

result in termination of care. Participants expressed perceptions of discrimination from

office staff due to race and lack of insurance coverage that resulted in mistrust (Sheppard

et al., 2004).

In the previously mentioned study by Kaplan et al. (2006) interpersonal styles

were identified as a factor in the mistrust of providers and clinic staff by residents of the

South Bronx in New York City. Participants related incidents of racism; feelings of being

disrespected and undervalued; stigmatized; stereotyped; humiliated and mistreated by providers and office staff resulting in mistrust and in a reluctance to seek care (Kaplan et al., 2006).

Interpersonal styles of providers were identified as factors in the adoption of breastfeeding (Cricco-Lizza, 2006). Eleven African American low-income prenatal and postpartum clients in a Special Supplemental Nutrition Program for Women, Infants and Children clinic participated in an ethnographic study discussing breastfeeding. They related their adoption of breastfeeding was facilitated by the providers' personal treatment and sensitive care (Cricco-Lizza, 2006).

Measurement of communication, decision making and interpersonal style

The Interpersonal Processes of Care Survey (Stewart et al., 2007) was developed to obtain client information about disparities in the quality of care they receive. The tool examines attributes of the interpersonal provider-client relationship that includes the interpersonal processes which are communication, decision making and interpersonal styles. These characteristics of the interpersonal provider-client relationship are considered important to positive health outcomes for those from minority groups, from lower socioeconomic groups or those with limited English proficiency (Stewart et al., 2007). Clients respond to questions about the physicians' and office staff members' responses to aspects of communication, decision making style and interpersonal style in the past 12 months. Communication questions pertain to hurried communication, elicitation of client concerns and appropriate explanations of test and assessment results. Patient-centered decision making questions pertain to how the client and physician decide

about the client's health care. Interpersonal style questions pertain to the presence of

compassionate and respectful interactions, discrimination and disrespectful office staff

(Stewart et al., 2007). English and Spanish versions of a long version (29 items) and a

short form version (18 items) are available.

Cultural Competence

    Background and definitions

An early and much-used model for cultural competence was proposed by Cross,

et al., (1989) in their monograph: *Towards a Culturally Competent System of Care:*

Volume 1: A Monograph on Effective Services for Minority Children Who Are Severely

Emotionally Disturbed. This model focuses on cultural competence at the organizational

level but is pertinent to understanding the concept at the agency and provider levels as

well. According to this model, cultural competence is considered to be:

> A set of congruent behaviors, attitudes, and policies that come together in a
> system, agency, or among professionals and enable that system, agency, or those
> professionals to work effectively in cross-cultural situations. The word "culture"
> is used because it implies the integrated pattern of human behavior that includes
> thoughts, communications, actions, customs, beliefs, values, and institutions of a
> racial, ethnic, religious, or social group. The word competence is used because it
> implies having the capacity to function effectively. (Cross et al., 1989, p. 13)

Although the focus of the model was cultural competence of organizations caring

for seriously emotionally disturbed children and adolescents (Cross et al., 1989), the

definition and tenets have been used by the discipline of Social Work (National

Association for Social Workers, 2001) and the Office of Minority Health (U.S. Office of

Minority Health, 2001) to describe cultural competence. The U.S. Office of Minority

Health (2001) used the definition of cultural competence proposed by Cross et al., (1989)

in the seminal document: *National Standards for Culturally and Linguistically*

Appropriate Services in Health Care (U.S. Office of Minority Health, 2001). This

document provides 14 guidelines and mandates for the delivery of culturally and

linguistically appropriate services at the organizational level. The Standards target

providers of all racial and ethnic minority groups and for other vulnerable groups, such as

the disabled and homosexual/bisexual/transgendered groups (Martinez, Green, & Sañudo,

2004). According to the standards, cultural competence includes access to respectful,

understandable and effective care that is culturally and linguistically appropriate for all

clients. Elements of cultural competence outlined in the Standards include the ability to

recognize and respond to health-related beliefs and cultural values, disease incidence and

prevalence and effectiveness of treatment (U.S. Office of Minority Health, 2001).

Examples of cultural competence in care delivery mentioned in the Standards include:

- Continually striving to overcome cultural, language, and communications barriers

- Providing an environment where clients from diverse cultural backgrounds feel comfortable discussing their cultural health beliefs and practices when negotiating treatment options

- Encouraging clients to express their spiritual beliefs and cultural practices

- Being familiar with and respectful of various traditional healing systems and beliefs and integrating these approaches into treatment plans when appropriate (U.S. Office of Minority Affairs, 2001)

Cultural competence at the organizational, structural (agency) and clinical (client-provider interactions) levels is described by Betancourt et al. (2003). From the previously mentioned extensive literature review, the presence of barriers to care as well as culturally competent interventions at all levels were identified. Culturally competent interventions identified to address health disparities at the organizational level included ensuring diversity in the leadership and workforce of the health care system by increasing the numbers of racial and ethnic minorities represented. Structural interventions included innovations in health care system and structure design to assure that ethnic and racial minorities have full access to quality health care. This category includes interpreter services and culturally and linguistically appropriate educational materials. Increased efforts to provide cross-cultural training for providers to enhance their cultural competence was identified as a clinical level intervention. Salient topics suggested for this cross-cultural training include the effects of communication styles, decision making preferences and the issues of mistrust, prejudice and racism and their effects on care delivery (Betancourt et al., 2003).

Based on analysis of data collected in the literature review, the following definition of cultural competence was proposed:

"Cultural competence" in health care entails: understanding the importance of social and cultural influences on patients' health beliefs and behaviors;

considering how these factors interact at multiple levels of the health care delivery system (e.g., at the level of structural processes of care or clinical decision-making); and, finally, devising interventions that take these issues into account to assure quality health care delivery to diverse patient populations. (Betancourt et al., 2003, p. 7)

Further elucidation of the concept of cultural competence was provided by 37 experts in cultural competence from the areas of managed care, government and academe (Betancourt et al., 2005). Experts in all 3 areas described a link between cultural competence, quality improvement, and the elimination of racial and ethnic health care disparities. Examples of the commonly expressed measures to improve cultural competence included research to assess outcomes of culturally competent interventions, including client satisfaction; increased diversity among health care providers; improved access to culturally and linguistically appropriate services and materials; and appropriate interpreter services (Betancourt et al., 2005).

While the discipline of social work adopted the Cross et al., (1989) definition of cultural competence (National Association for Social Workers, 2001), other professional disciplines proposed additional definitions of cultural competence. The constructs of awareness, knowledge and skills and the recognition of the need to individualize counseling approaches are reflected in the definition of cultural competence proposed by the discipline of psychology and counseling in the Multidimensional Dimensions of Cultural Competence (MDCC) model described by Sue, D.W. (2001):

Cultural competence is the ability to engage in actions or create conditions that maximize the optimal development of client and client systems. Multicultural

counseling competence is defined as the counselor's acquisition of awareness, knowledge, and skills needed to function effectively in a pluralistic democratic society (ability to communicate, interact, negotiate, and intervene on behalf of clients from diverse backgrounds), and on an organizational level/societal level, advocating effectively to develop new theories, practices, policies, and organizational structures that are more responsive to all groups. (Sue, D.W., 2001, p. 802)

Cultural awareness in this definition includes attitudes and beliefs about clients from diverse minority groups, acceptance of multiculturalism, and awareness of personal biases and stereotypes and their effect on the counseling process (Sue, D.W. et al, 1992; Sue, D.W., 2001). Cultural knowledge involves understanding ones' own worldview and having knowledge of the worldviews of diverse clientele and the influence of these worldviews on care (Sue, D.W. et al., 1992; Sue, D.W., 2001). Cultural skills are the actual intervention techniques and strategies used when working with those from minority groups (Sue, D.W. et al., 1992; Sue, D.W., 2001).

A definition proposed for the discipline of nursing by members of the Expert Panel on Cultural Competence of the American Academy of Nursing (Giger et al., 2007) is:

Cultural competence is having the knowledge, understanding, and skills about a diverse cultural group that allows the health care provider to provide acceptable cultural care. Competence is an ongoing process that involves accepting and respecting differences and not letting one's personal beliefs have an undue influence on those whose worldview is different from one's own. Cultural competence includes having general cultural as well as cultural-specific information so the healthcare provider knows what questions to ask. (Giger et al., 2007, p. 100)

Despite differences in definitions of cultural competence, all recognize the influence of culture on health beliefs and behaviors and the need to provide quality healthcare to individuals from all racial and ethnic minorities at all levels of the healthcare system (organizational, agency, provider). Being knowledgeable about personal cultural beliefs, biases and stereotypes and client cultural beliefs and behaviors is identified. The awareness of the influence of this knowledge on care provision leading to the ability to plan and implement individualized care at all levels of the healthcare systems is an important point. The ultimate goal is to provide acceptable, individualized cultural care to all clients.

Cultural competence has been defined as an ongoing process with the provider always striving to become culturally competent (Campinha-Bacote, 2003; Giger et al., 2007). Campinha-Bacote (2003) considers cultural competence to be an ongoing process where "the healthcare professional continuously strives to achieve the ability and availability to work effectively within the cultural context of the client (individual, family, community)" (Campinha-Bacote, 2003, p. 14). She believes the healthcare provider is constantly *becoming* culturally competent rather than *being* culturally competent (Campinha-Bacote, 2003). Cultural competence is believed to be a goal that professionals, agencies and systems continuously strive to attain (Cross et al., 1989; U.S. Office of Minority Health, 2001) and that does not have a specific endpoint (Sue, D.W. et al., 1992).

The process of cultural competence is described as being nonlinear with organizations and providers progressing through various stages. Cross et al., (1989) posit

that when striving toward cultural competence, organizations move through a developmental process along a 6 point continuum through cultural destructiveness, cultural incapacity, cultural blindness, cultural pre-competence, cultural competence and finally to cultural proficiency. Purnell and Paulanka, (2003) believe providers progress toward cultural competence through 4 levels (unconsciously incompetent, consciously incompetent, consciously competent, and unconsciously competent). The levels of unconsciously competent and cultural proficiency are not considered endpoints, rather, individuals and organizations respectively strive to attain higher levels of cultural competence by conducting and participating in research pertaining to cultural competence (Cross, et al., 1989) and continually learning about various cultural groups (Purnell & Paulanka, 2003).

Factors associated with cultural competence

Ethnic match has been found to influence African American clients' opinions of their physicians' participatory decision-making styles (Cooper-Patrick et al., 1999). In the previously mentioned study of 1816 respondents to a phone survey, 784 White and 814 African American clients provided data regarding the participatory decision-making style of their physicians as well as their level of satisfaction with overall health care, their physicians' technical skills (thoroughness, carefulness, and competence), explanation of their problem and its treatment, and personal manner (courtesy, respect, sensitivity, and friendliness) (Cooper-Patrick et al., 1999). Findings revealed that African Americans rated their visits as significantly less participatory than Whites when adjustment was made for client age, gender, education, marital status, health status, and length of

physician-client relationship. Clients in race-concordant relationships with their physicians rated their visits as significantly more participatory than clients in race-discordant relationships, resulting in higher satisfaction with care (Cooper-Patrick et al., 1999).

Ethnic match in the client-counselor relationship has also been proposed as a factor in cultural competence resulting in more favorable treatment outcomes for clients receiving care from counselors (Sue, Fujino, Hu, Takeuchi, & Zane, 1991). A variation of the type of match, cognitive match, may also be a factor in cultural competence resulting in more favorable treatment outcomes. In a survey of 27 White and 33 Asian American clients from a community mental health agency, Zane et al., (2005) investigated the effects of cognitive matching in the client-counselor relationship. Findings revealed positive treatment outcomes in the cognitively matched dyads. Participants who were cognitively matched with their counselors in perceptions of the presenting problem, coping orientation (active or avoidant) and expectations about treatment goals felt more affected by the sessions, and more comfortable and positive about the sessions. After controlling for ethnic match and language preference, cognitive matches still resulted in positive findings (Zane et al., 2005). Results from this study imply that while ethnic match may be a factor in cultural competence, cognitive match may be an even stronger factor. Even if counselors are not similar ethnically, they can still be effective if they try to understand clients' perceptions about problems, coping methods and types of goals expected in treatment.

Communication is considered a vital component of cultural competence in medical care (Perloff et al., 2006). Congruent physician-client communication is considered crucial for the establishment of a therapeutic relationship and for the achievement of therapeutic goals. Physicians and clients from differing racial and ethnic background who are not language concordant experience communication incongruence that can result in misdiagnosis, misunderstanding, the inability of the client to articulate needs and a general breakdown in clients' care (Perloff et al., 2006).

The influence of language on cultural competence in the care of Spanish-speaking clients was noted in a study consisting of dyads of 116 clients and their physicians from primary care clinics (Fernandez et al., 2004). The study explored the specific ways language ability affected health communication for Spanish speakers and determined if aspects of physicians' self-rated cultural competence – other than Spanish language skill – affected health communication. Findings revealed that when physicians had a greater self-rated fluency in Spanish and higher self-rated cultural competence, the Spanish-speaking clients were more likely to discuss their problems and concerns. Additionally, physicians with low self-rated fluency in Spanish who used professional interpreters were unable to elicit clients' problems and concerns as well as the Spanish-speaking physicians (Fernandez et al., 2004). Findings support the importance of language concordance and cultural competence in helping Spanish-speaking clients discuss their problems more openly resulting in higher quality of care and a reduction of health disparities.

Tools measuring cultural competence

Various tools, measuring similar constructs, are available to examine cultural competence of healthcare workers. The Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals - Revised (IAPCC-R) was developed by Josepha Campinha-Bacote to accompany her model The Process of Cultural Competence in the Delivery of Healthcare Services (Campinha-Bacote, 2003). The constructs of cultural desire, cultural awareness, cultural knowledge, cultural skill and cultural encounters are measured. Individuals' scores determine their level of cultural competence which can be culturally incompetent, culturally aware, culturally competent or culturally proficient. This tool has been used extensively by healthcare organizations and graduate students. The instrument is written at a high educational level with 5 different response sets, therefore limiting its use with some healthcare providers such as those with fewer years of education (Doorenbos, Schim, Benkert, & Borse, 2005). Testing of the instrument has yielded positive psychometrics (Campinha-Bacote, 2003).

The Cultural Competence Scale (CCS), based on The Culturally Competent Community Care model was developed to test the dimensions of cultural competence in community and public health nurses (Kim-Godwin et al., 2001). The constructs of cultural sensitivity, knowledge and skills are measured. Initial testing of the scale with a convenience sample of 192 nursing students yielded consistent and positive psychometrics. The authors concluded that instrument is relevant and can be useful in clarifying the concept of cultural competence in community and public health nurses (Kim-Godwin et al., 2001).

The Cultural Competence Assessment was developed to accompany the Model for Culturally Congruent Care (Schim et al., 2003; Schim et al., 2007). The tool consists of 2 subscales examining cultural awareness/sensitivity and culturally competent behaviors. An overall cultural competence score is obtained by averaging the scores from the 2 subscales. The instrument also contains items allowing individuals to identify which racial/ethnic groups and special population groups they encounter in their practices. Individuals are also able to identify the percentage of their practice made up of these racial/ethnic and special population groups. The instrument has been psychometrically tested and refined with positive results. The reading level is low and the items are easy to understand. The conclusion is that it is appropriate for examining cultural competence in multiple types of healthcare providers, including nurses providing care in the community (Schim et al., 2003).

Cultural competence in related disciplines

The disciplines of social work, psychology and counseling, medicine and nursing have recognized the value of knowledge (awareness), attitudes (sensitivity) and skills (behaviors) in developing cultural competence. Professionals in these disciplines encounter a culturally diverse clientele. The development of cultural competence is vital in order for clients to receive care that is appropriate, sensitive and individualized to their cultural beliefs and values.

Social work

The value of cultural competence in educational and practice settings for the discipline of social work is widely recognized (Boyle & Springer, 2001). The 10

Standards for Cultural Competence in Social Work Practice (National Association for Social Workers, 2001) delineates requirements for cultural competence for social workers when caring for those from racially and ethnically diverse backgrounds and to those with disabilities, the elderly, gays, lesbians, bisexuals, and transgendered people (National Association of Social Workers, 2007). According to these standards, cultural competence is a process where respectful and effective care is provided by individuals and systems to clients from culturally diverse backgrounds and/or from other marginal groups. The values and worth of individuals, families, and communities is recognized and affirmed while their dignity is protected and preserved (National Association for Social Workers, 2001).

Social workers, nurses and psychologists identified their beliefs about cultural competence focusing on services for Native Americans (Weaver, 2004). Written responses to open-ended questions from 63 social workers, 40 nurses and 31 psychologists were categorized into the areas of knowledge, attitudes and skills. Knowledge of the culture and diversity of Native Americans was a vital element of cultural competence. Being open and nonjudgmental, valuing diversity, being willing to learn, advocating for social justice and demonstrating caring were noted as valuable elements of cultural competence pertaining to attitude. Social workers were the only group to identify the importance of self-awareness in this category of cultural competence. Skills deemed necessary for the provision of culturally competent care when working with Native Americans included effective communication, listening, and culture

specific skills such as the ability to speak Native languages and the ability to interact with and seek help from Native healers (Weaver, 2004).

Factors associated with cultural competence in social workers were identified by Teasley, Baffour, and Tyson (2005). A convenience sample of 91 African American and 119 White school social workers, practicing in urban schools with high percentages of African American students, responded to a survey pertaining to perceived levels of cultural competence in the areas of knowledge of communities, resources and linkages, and service delivery and practice. In this study, knowledge of communities included the "understanding of community dynamics such as racial composition, socioeconomic status, support systems and the cultural norms and values of people of color" (Teasley et al., 2005, p. 229). Resources and linkages included "availability of relevant information, materials and resources for respondents' access and use" (Teasley et al., 2005, p. 229). Service delivery and practice included "service providers' understanding of appropriate treatment interventions, cultural strengths, historical accomplishments, family support systems, and methods of advocacy for practice interventions involving people of color" (Teasley et al., 2005, p. 229). Ethnic match (African American race) was found to be a significant predictor of resources and linkages, service delivery and practice and their knowledge of communities. Years of experience was found to be a significant predictor of social workers' resources and linkages, and service delivery and practice. The social workers' level of education (Bachelor's in Social Work, Master's in Social Work, Doctorate in Social Work, Ph.D in Social Work) was found to be significantly correlated with their service delivery and practice (Teasley et al., 2005).

Educational interventions can influence the cultural competence of social workers. The influence of an educational intervention on the cultural competence of 47 social workers in a mental health setting was obtained through a pretest-posttest nonequivalent comparison group study (Williams, 2005). The educational intervention included application of concepts of knowledge, awareness and skills to social work practice situations. The intervention group, consisting of 29 social workers, participated in four 3 hour cultural competence education sessions over a 4 week period of time. The control group, consisting of 18 social workers, attended diversity experiences provided by the institution (Williams, 2005). Group differences on the Multicultural Counseling Inventory (MCI) (measures multicultural awareness, knowledge, skills and relationships) and the Multicultural Case Conceptualization (MCC) (measures responses to vignettes) were not found, as both groups had improved scores post intervention (Williams, 2005). The intervention group had significant gains noted on the Awareness subscale of the MCI. Other significant findings included higher scores on the MCI related to racial minority status and Master's in Social Work (MSW) educational status at the first measurement. Qualitative data provided greater insight into the impact of the intervention with participants reporting greater cultural awareness, knowledge and implementation of skills as a result of the sessions immediately and 6-8 weeks afterward. Requests for additional educational opportunities were voiced (Williams, 2005).

Psychology/counseling

Psychologists and counselors consider cultural competence to be important in establishing credibility and the therapeutic relationship (Sue, 2006). The discipline

recognizes that the meaning of cultural competence can differ between racial and ethnic groups. This recognition challenges counselors to tailor counseling approaches to the cultural values and beliefs of the client in order to prevent pressuring the client to acculturate and assimilate in order to benefit from traditional approaches (Sue, D.W., 2001; Sue, D.W. et al., 1992).

Culturally competent counselors are believed to demonstrate characteristics reflective of the constructs of awareness, knowledge, and skill (Sue, 2006; Sue, D.W. et al., 1992). Preferred competencies of culturally competent counselors were delineated using a pair-comparison format (Fraga, Atkinson, & Wampold, 2004). Survey responses from 155 Asian American, 200 European American and 152 Latino undergraduate students revealed their preferences of competencies in culturally competent counselors (Fraga et al., 2004). Participants in all 3 groups preferred counselors demonstrating competencies included in the constructs of cultural awareness, knowledge and skill. A preference for counselors who were aware of how their (counselor's) personal experiences, values, and biases influence the counseling experience was noted by participants in all 3 groups. Also, participants preferred counselors who knew about and were aware of their (counselor's) personal cultural heritage and how it influenced their reactions to clients. The importance of cultural knowledge was also reflected in the preference for counselors who were aware of institutional barriers preventing access to mental health services for minorities from racial and ethnic groups. Counselor skill for intervening with institutions on behalf of clients from racial and ethnic minority groups was preferred by participants in all 3 groups. Ethnic and racial group differences were

noted. Asian American and Latino participants preferred counselors who were aware of their personal stereotypes. Latino participants preferred counselors who understood the sociopolitical factors that adversely affected racial/ethnic minorities. Asian American participants preferred counselors who constantly sought to attain a non racist identity (Fraga et al., 2004).

Medicine

Cultural competence within the discipline of medicine has been described as "a complex multilayered accomplishment" (Surbone, 2004, p. 698) that includes the constructs of attitudes (awareness), knowledge and skills (Betancourt, 2003; Perloff et al., 2006; Surbone, 2004). Predictors of cultural awareness, knowledge and skills have been reported (Reimann et al., 2004). In a cross-sectional paper and pencil survey of 134 physicians caring for Latinos with diabetes, the researchers examined predictive relationships between these 3 constructs of cultural competence and physicians' demographic/background characteristics. For this study, cultural awareness was defined as "the manner of feeling and thinking that shows physicians' disposition or opinion toward cultural issues relevant to Mexican Americans with diabetes" (Reimann et al., 2004, p. 2198) and ". . . an awareness that physicians' preconceptions about the group have the potential to hamper care" (Reimann et al., 2004, p. 2198). Cultural knowledge was defined as "a physician's familiarity with facts relevant to Mexican Americans with diabetes" (Reimann et al., 2004, p. 2198) while cultural skills or behaviors were "specific actions physicians reported taking" (Reimann et al., 2004, p. 2198). Findings revealed predictors of cultural awareness to be cultural knowledge, diverse medical education

setting, Latino ethnicity, and bilingual skills. Predictors of cultural knowledge included community clinic practice and diverse medical education setting. The single predictor of culturally competent behaviors was cultural awareness (Reimann et al., 2004).

Trust and communication are 2 dominant themes in the medical literature pertaining to cultural competence and health disparities. Previously noted studies have documented the influence of communication and trust on satisfaction with physician care, continuity with the same physician, adherence to medication (Thom et al., 1999), participatory decision making (Cooper-Patrick et al., 1999), and effective physician-client relationships (Perloff et al., 2006).

Nursing

Cultural competence is essential in nursing, as nurses are at the forefront of providing care to clients at the bedside and in the community (Bau, 2007). The Code of Ethics for Nurses identifies core values of nurses as respect for human dignity, a primary commitment to the client and protection of client privacy (American Nurses Association, 2003). Cultural competence is an outgrowth of these core competencies as they are applied when nurses provide care that is sensitive to the needs of all clients regardless of racial or ethnic background.

In addition to the Code of Ethics for Nurses, which indirectly addresses cultural competence in nursing overall, the Quad Council of Public Health Nursing Organizations identifies competencies related to cultural competence for public health nurses (Quad Council PHN Competencies, 2003). Domain #4 identifies cultural competency skills in which the public health nurse should show proficiency such as using appropriate skills

for interacting sensitively, effectively and professionally with clients from diverse racial and ethnic backgrounds. Additionally, the public health nurse is to identify the role of culture in determining the delivery of services and to adapt approaches to problems that account for cultural differences (Quad Council PHN Competencies, 2003).

The constructs of cultural diversity, cultural knowledge, cultural understanding, cultural skills, cultural awareness and cultural sensitivity are proposed to comprise cultural competence in nursing. Concept analyses have identified these constructs as antecedents of cultural competence. Attributes and consequences of cultural competence have been identified as well (Burchum, 2002; Smith, 1998; Suh, 2004). Attributes of cultural competence in nursing are identified as ability, openness, and flexibility, (Suh, 2004). Ability is the nurse's skill in effectively caring for ethnically diverse populations while openness involves nurses having an open mind, acceptance and respect, being nonjudgmental and having an objective attitude to cultural attributes. Flexibility includes an ability to adapt one's self to different situations by embracing relativistic perspectives, intersubjectivity and commitment to and appreciation of other cultures. Antecedents to cultural competence in nursing are identified as cultural awareness, cultural knowledge, cultural sensitivity, cultural interaction/encounter, and cultural skill (Burchum, 2002; Smith, 1998; Suh, 2004). These antecedents are similar to constructs named in theoretical frameworks describing cultural competence (Campinha-Bacote, 2003; Kim-Godwin et al., 2001; Schim et al., 2007). Cultural understanding is proposed as an antecedent and is described as "ongoing development of insights related to the influence of culture on the beliefs, values and behavior of diverse groups of people" (Burchum, 2002, p. 7). This

relates to the previously discussed constructs of cultural sensitivity and awareness. Cultural proficiency, which represents a commitment to change, is also proposed as an attribute (Burchum, 2002). Some activities that show evidence of cultural proficiency are those that provide for new knowledge and cultural skill and the sharing of this information through publication, education or other means (Burchum, 2002). Smith, (1998) includes cultural liaisons and linkages as antecedents to cultural competence in nursing. Cultural liaisons and linkages are important to help overcome economic barriers to access to care. A greater distribution of culturally competent health care providers is proposed as a means to help overcome these barriers (Smith, 1998).

Consequences of cultural competence in nursing are the client's subjective experiences when receiving culturally competent nursing care which includes holistic nursing care, increased quality of life, good perceptions of healthcare providers, and adherence to treatment (Suh, 2004), client empowerment, feelings of respect, decreased anxiety and fear of the health care system, greater percent of cultural group members seeking and receiving appropriate health care, and greater satisfaction with the health care system (Smith, 1998). Additional consequences of cultural competence include increased quality of nursing care, performance and cost effectiveness with the overall outcome of decreased health disparities (Suh, 2004) and improved health status of minority populations (Smith, 1998).

Various factors influence the cultural competence of nurses providing care in all settings including the community. Nurses' attitudes about caring for culturally diverse clients is central to the construct of cultural sensitivity. A survey of 300 registered nurses

(Whites, African Americans, Jewish and Latino) employed by hospitals and other health

care facilities, found that open- and closed-mindedness influenced nurses' attitudes

toward culturally competent care (Bonaparte, 1979). Open-minded nurses were more

likely to have positive attitudes toward culturally diverse clients and more likely to seek

information about the clients' diet, language, social patterns, values and other factors that

may influence nursing care reflecting the value of the attribute of openness in cultural

competence (Suh, 2004). Close-minded nurses were more likely to demonstrate negative

attitudes and consciously or unconsciously avoid clients from different cultures

(Bonaparte, 1979).

Rooda's (1990, 1993) study of 274 hospital employed White registered nurses

found nurses to have more positive attitudes toward White clients and more cultural bias

toward African American, Asian American, and Latino clients (Rooda, 1990, 1993). The

negative attitudes and bias by nurses toward those clients from different racial and ethnic

groups are aspects of cultural competence that can influence provision of care.

The influence of self-efficacy on nurses' confidence in caring for culturally

diverse clients was reported by Bernal and Froman (1993). Low self-efficacy contributed

to low self-confidence in 206 community and public health nurses when caring for

African Americans, Puerto Ricans, and Southeast Asians (Bernal & Froman, 1993). Low

self-efficacy and low self-confidence can affect the nurses' ability to effectively care for

these clients, revealing the importance of the attribute of ability on cultural competence

(Suh, 2004).

Educational levels and participation in cultural diversity educational experiences have been identified as factors influencing cultural competence of nurses providing care in the community. Findings from a survey of 107 hospice nurses showed cultural sensitivity and awareness significantly associated with the nurses having a baccalaureate degree or higher. Prior diversity training was significantly associated with cultural competence behaviors (Schim et al., 2006a). Similar findings were found in a sample of 113 interdisciplinary hospice workers, 40% of which were nurses (Doorenbos & Schim, 2004). Participants reporting participation in a previous diversity training experience and those who had baccalaureate degrees or higher had significantly higher cultural competence scores (Doorenbos & Schim, 2004). Seventy-six public health nurses participated in a study measuring cultural competence prior to and after a 5-week cultural competence workshop (Cooper-Braithwaite, 2006). Findings revealed that nurses with higher levels of education increased their levels of cultural competence and cultural knowledge more than nurses with lower levels of education (Cooper-Braithwaite, 2006). Overall, the nurses' levels of cultural competence and skill increased significantly after the workshop (Cooper-Braithwaite, 2005). Qualitative and quantitative findings indicated participants experienced higher levels of self-confidence in caring for diverse populations after the intervention. Participants reported a change in behavior and practice, application of knowledge to practice, heightened cultural awareness and a greater willingness to conduct cultural assessments on clients from diverse ethnicities as a result of the educational intervention (Cooper-Braithwaite, 2005). Similarly, Schim et al., (2006b), using a quasi-experimental, longitudinal, crossover design, tested the effects of

an educational intervention by conducting a cultural diversity class with 130 hospice workers (41 nurses). Cultural competence scores increased significantly after the class for those in the intervention groups, and for the wait list control group after they participated in the class (Schim et al., 2006b).

Literature Review Summary

Barriers to health care for minorities resulting in health disparities are found at the organizational, agency and providers levels of the healthcare system. These barriers are highlighted through several small qualitative studies reporting minority clients' personal accounts about experiences with the healthcare system and providers that influence health disparities. Findings from these smaller studies have been corroborated with larger groups of participants in various quantitative studies. The literature documents the influence of communication, decision making and interpersonal styles of providers and office staff on trust and health disparities. Racial and ethnic minority clients report instances of ineffective communication, lack of participation in decision making and inappropriate interpersonal styles, resulting in mistrust and dissatisfaction with the healthcare system and providers. The ultimate consequence of this mistrust may be disparities in healthcare, as clients are reluctant to seek care or to follow through with treatment regimens.

Cultural competence at the organizational, agency and provider levels can promote effective communication, participatory decision making and positive interpersonal styles and ultimately decrease or eliminate health disparities. Failure to establish effective provider-client communication, participatory decision making, and

positive interpersonal styles of providers and office staff can result in reluctance to seek

care and failure to adhere to treatment regimens and ultimately disparities in healthcare.

Factors that influence communication, decision making and interpersonal styles include

ethnic match between providers and clients and language concordance. The lack of

diverse healthcare providers prohibits the possibility of ethnic match and language

concordance in many cases. Cognitive match is one proposed alternative which deserves

further study.

The literature from social work, psychology/counseling, medicine and nursing

identify knowledge, awareness and skills or some variation of these as comprising

cultural competence. The majority of studies are quantitative with instruments examining

and/or measuring these constructs. The studies show that increased knowledge,

awareness and skills can result in enhanced cultural competence of providers. Two

qualitative studies substantiate the need for increased knowledge, awareness and skill to

enhance cultural competence. Problems with communication, decision making and

interpersonal styles can be addressed through enhanced cultural competence.

Theoretical Framework

The Model for Culturally Congruent Care provides a theoretical framework for

the study of cultural competence (Schim et al., 2007). The Model is a revision and

refinement of the Schim and Miller Cultural Competence Model (Schim et al., 2007) and

is derived from Madeleine Leininger's Culture Care Diversity and Universality nursing

theory described by Leininger and McFarland (2006). Culturally congruent care is

defined as "culturally based care knowledge, acts and decisions used in sensitive and

knowledgeable ways to appropriately and meaningfully fit the cultural values, beliefs, and lifeways of clients for their health and wellbeing, or to prevent illness, disabilities or death" (Leininger & McFarland, 2006, p. 15). The Model for Culturally Congruent Care is depicted as a 3-dimensional jigsaw puzzle describing the overall picture of culturally congruent care at the provider and client levels. The provider level constructs of cultural diversity, cultural awareness, cultural sensitivity, and cultural competence constitute the main pieces of the puzzle (see Figure 1). The 4 constructs are interdependent and are necessary for culturally congruent care. The client level constructs have not been formulated so they are depicted as a shadow and outline indicating they are yet to be examined and articulated (see Figure 2). Culturally congruent care is the goal or outcome of the interaction between the provider and client levels which would constitute effective interaction between providers and clients (Schim et al., 2007).

Assumptions of the model are:

1. The desired outcome, culturally congruent care, must be evaluated from the perspectives of the recipients and the providers of care.

2. Specific competencies (cognitive, affective, and psychomotor behaviors) can be defined, learned, and identified in practice.

3. The scope of competence is related to the number and variety of diverse groups and people encountered in community, social, and/or service contexts.

4. The depth of competence is related to the amount of exposure and type of interaction with particular groups and people encountered in community, social, and/or service contexts (Schim et al., 2007, p. 108).

Propositions of the model are:

1. Culturally congruent care, with diverse persons and groups representing a community of service at a given place and time, is necessary for health service quality.

2. Culturally competent behaviors on the part of providers are necessary but not sufficient to produce culturally congruent care (Schim, et al., 2007, p. 108).

The 4 constructs are similar to cultural competence constructs named in other theoretical frameworks such as Campinha-Bacote's Process of Cultural Competence in the Delivery of Healthcare Services: A Culturally Competent Model of Care (Campinha-Bacote, 2003). This model includes the constructs of cultural desire, cultural awareness, cultural skill, cultural knowledge, and cultural encounters while The Culturally Competent Community Care model developed by Kim-Godwin et al., (2001) includes the constructs of care, cultural sensitivity, cultural knowledge and cultural skills.

Cultural diversity is a process construct that recognizes differences between groups based on factors such as age, gender, physical and/or mental disability, socioeconomic status, race, ethnicity, national origin, sexual orientation, religious affiliation, and generation (Schim et al., 2007). Cultural diversity varies in quantity and quality across time and place (Schim et al., 2007) and provides opportunities for encounters and interactions with those from differing backgrounds and beliefs and values (Burchum, 2002; Campinha-Bacote, 2003; Smith, 1998; Suh, 2004). Some communities are homogenous and have fewer opportunities for diverse cultural encounters while others are very heterogenous and have many opportunities for diverse cultural encounters

(Schim et al., 2007). Repeated and extended cultural encounters are considered important to realize the full extent of cultural diversity, and to modify beliefs about and prevent stereotyping of individuals from diverse ethnic and cultural groups (Campinha-Bacote, 2003).

Cultural awareness is a cognitive concept (Burchum, 2002; Campinha-Bacote, 2003; Schim et al., 2007; Smith, 1998; Suh, 2004) that has been equated with cultural knowledge (Burchum, 2002; Campinha-Bacote, 2003; Kim-Godwin et al., 2001; Schim et al., 2007; Smith, 1998; Suh, 2004). Cultural awareness involves being aware of one's own culture and its influence on care delivery (Burchum, 2002; Campinha-Bacote, 2003; Schim et al., 2007; Smith, 1998; Suh, 2004). It also involves being aware of one's own biases and personal worldviews and being sensitive to the effect these beliefs have on one's professional practice with culturally diverse clients (Sue, D.W. et al., 1992). Cultural knowledge is acquiring knowledge about the culture and worldviews of diverse clients and groups and their influence on care reception (Burchum, 2002; Campinha-Bacote, 2003; Kim-Godwin et al., 2001; Schim et al., 2007; Smith, 1998; Sue, D.W. et al., 1992; Suh, 2004). Schim et al. (2007) posit that cultural awareness is the knowledge about areas of major between-group differences and using that knowledge to guide questioning that will yield the most meaningful responses from clients. For example, being aware of and knowing that certain cultural values and beliefs may influence the gender choice of a provider and asking the female client if she needs a female provider (Schim et al., 2007).

Cultural sensitivity is an affective or attitudinal construct that entails recognition of personal attitudes, values, beliefs and practices pertaining to one's own as well as others' culture cultural backgrounds (Schim et al., 2007). Approaching clients with humility and taking the role of learner by being open to learning about cultural diversity are essential elements of cultural sensitivity (Schim et al., 2007; Suh, 2004). Respect, appreciation, understanding, acceptance and valuing of cultural diversity are included as well (Burchum, 2002).

Cultural competence is a behavioral construct and involves observable outcomes or actions taken in response to the constructs of cultural diversity, cultural awareness and cultural sensitivity (Schim et al., 2007), such as culturally appropriate communication, procedures and assessments. They are described as "specific cognitive, affective, and psychomotor skills that are necessary for the facilitation of cultural congruence between provider and client" (Schim et al., 2007, p. 107). The ability to incorporate client beliefs, values and practices into the planning and provision of care is important (Burchum, 2002), as well as the ability to collect relevant cultural data and perform a culturally-based, physical assessment (Campinha-Bacote, 2003).

Client Perceptions of Cultural Competence

Findings from 19 focus groups with 61 African Americans, 45 Latinos and 55 White community-dwelling adults provided information about key components of cultural competence. Participants provided input regarding what their physicians did or did not understand about their culture and health beliefs that might affect their visits (Nápoles-Springer, Santoyo, Houston, Pérez-Stable, & Stewart, 2005). Findings were

grouped into the 2 categories of interpersonal style and communication. Interpersonal styles of physicians identified as enhancing the quality of medical encounters included sensitivity to participant's privacy, a humanistic approach to care and treating clients as equals. Participatory decision making between clients and physicians also was considered important. Eliciting and responding to client concerns, questions and preferences and providing thorough non-technical explanations were communication factors considered important to enhancing the encounter. Key components of cultural competence that emerged included the values, beliefs and attitudes of physicians; communication that was understandable and clear; and client- and family-centered decision making (Nápoles-Springer et al., 2005).

Additional input from clients about important components of cultural sensitivity and cultural competence was provided by focus groups of 52 African American, 38 White, and 45 Latino low income clients in primary health care, community-based clinics (Tucker et al., 2003). Positive interpersonal qualities of physicians were considered important by participants from all 3 groups. These personal qualities included personal, individualized and respectful care; and technical competence including thoroughness in examinations, and complete and effective treatments. Language and communication congruence were considered important by participants in all 3 groups but were considered the most important components by Latinos. Latino and African American participants reported negative encounters with clinic staff including discrimination and racial bias affecting the quality of care (Tucker et al., 2003).

Chapter Summary

Cultural competence has been suggested as an effective strategy to address health disparities. The literature shows that health disparities can occur when clients are dissatisfied with care resulting in poor adherence to prescribed regimens and poor health outcomes. Some factors identified in the literature that influence these health disparities are mistrust of providers, lack of effective communication, lack of participatory decision-making style, and discriminatory and disrespectful interpersonal style. Lack of effective communication can occur at the provider-client level with use of medical jargon, hurried communication and lack of understandable instructions and explanations of assessments and tests. It can also occur at the structural level with lack of culturally and linguistically appropriate educational materials and communication. Problems with communication and decision making styles can occur with provider-client ethnic discordance, emphasizing the need for more providers from ethnic and racial minority groups.

The Model of Culturally Congruent Care is an effective model to explore cultural competence of nurses providing care in the community. The model proposes that interaction between provider level and client level constructs is needed for culturally congruent care to occur. Cultural diversity, cultural awareness, cultural sensitivity, and culturally competent behaviors are proposed to comprise the provider level. Constructs at the client level have not been fully articulated. Understanding both levels is vital for examining culturally congruent care. Literature, though limited, is available regarding cultural competence at the provider level. Research is needed to further delineate and clarify the provider level constructs and to formulate the client level constructs.

Nurses providing care in the community encounter clients with diverse cultural healthcare beliefs, values and behaviors, so examination of their cultural competence is needed to provide foundational knowledge for planning and implementing interventions promoting culturally congruent care. Identification of factors influencing cultural competence can identify target areas for intervention to enhance the cultural competence of nurses. Nurses' level of education and participation in a cultural diversity class are factors identified in the literature influencing cultural competence. Investigation into additional factors will add to and expand this area of knowledge.

The limited literature from clients concerning elements of provider cultural competence is consistent with those areas identified as influencing health disparities. Client reports of cultural competence of providers includes, but is not limited to, clear, understandable communication that elicits and responds to client concerns and questions, participatory decision making and respectful, personal and individualized care. Client input will provide new information regarding provider communication, decision making style and interpersonal style and is vital to articulation of client level constructs of culturally congruent care.

This study proposes to add to and expand existing knowledge about cultural competence of nurses providing care in the community by:

- Examining their cultural diversity, cultural awareness, cultural sensitivity and culturally competent behaviors

- Identifying factors associated with their cultural diversity, cultural awareness, cultural sensitivity and culturally competent behaviors

- Examining nurses' personal accounts of experiences delivering culturally competent nursing care in the community

- Exploring client level perceptions about care delivered by these nurses

- Identifying similarities between the nurses' cultural competence and the clients' perceptions about the nurses' care delivery.

Foundational information about the cultural competence of nurses providing care in the community is an essential element to discovering if the goal of providing culturally competent care is realized. The important next step this study will provide is the client level perspective which can provide new insights into the cultural competence of nurses.

Figure 1

Model of Culturally Congruent Care

3 – Dimensional Puzzle
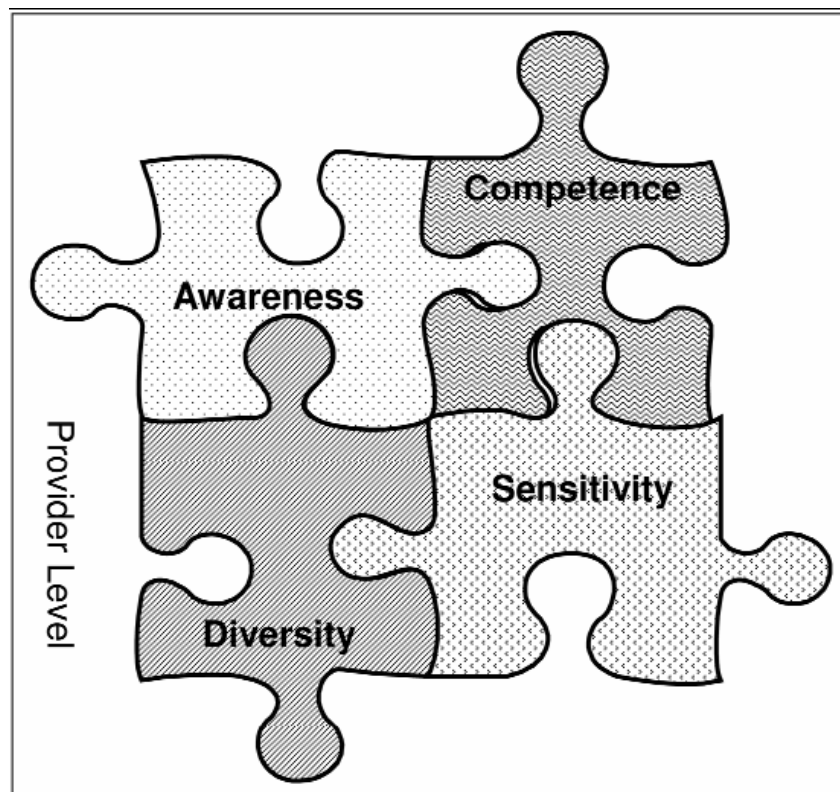
Schim, S., Doorenbos, A., Benkert, R., & Miller, J. (2007). Culturally congruent care:

Putting the puzzle together. *Journal of Transcultural Nursing, 18*(2), 103-110.

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Figure 2

Model of Culturally Congruent Care

Provider and Client Levels
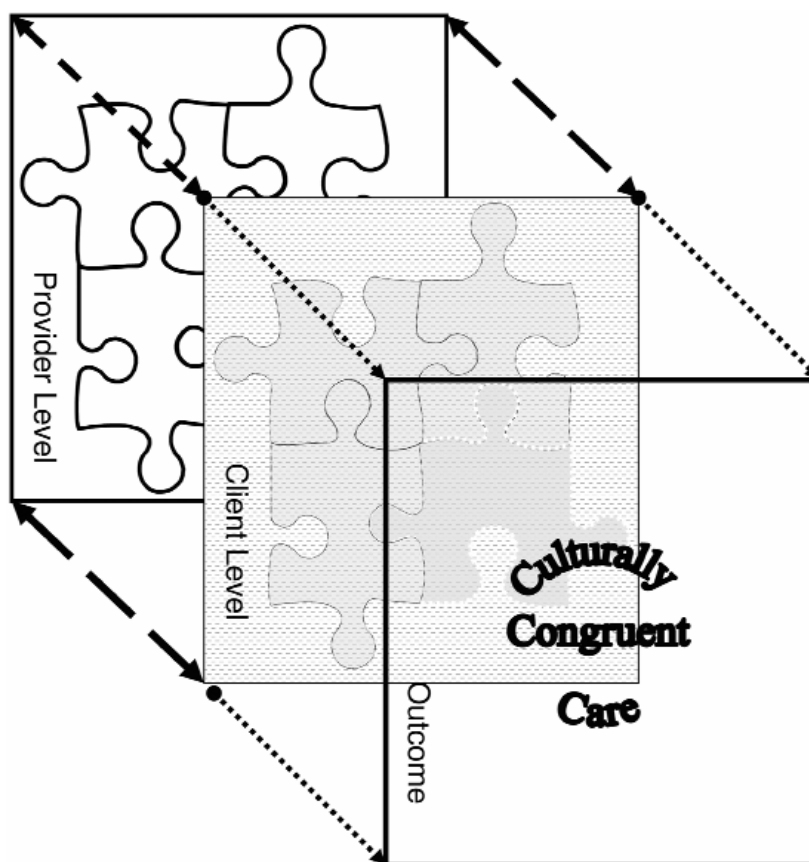
Schim, S., Doorenbos, A., Benkert, R., & Miller, J. (2007). Culturally congruent care:

Putting the puzzle together. *Journal of Transcultural Nursing, 18*(2), 103-110.

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CHAPTER III

METHODOLOGY

Design

This was a descriptive, correlational study exploring the cultural competence of nurses providing care in the community and the association of their cultural awareness/sensitivity, culturally competent behaviors and overall cultural competence with their age, level of nursing education, number of cultural diversity training experiences, participation in cultural diversity training, cultural diversity experience with racial/ethnic groups and special population groups, current professional role, years practicing as a registered nurse, years practicing in the community setting, and type of care delivery in the community. The nurses' self-rating of cultural competence levels was reported as well as their personal experiences providing culturally competent care.

Clients' perceptions of the interpersonal care (communication, decision making, and interpersonal style) of nurses providing care in the community were explored and described. Similarities between the nurses' cultural awareness/sensitivity, culturally competent behaviors and cultural competence with the clients' perceptions of the nurses' communication, decision making and interpersonal style were explored.

Setting and Sample

Data collection occurred in agencies employing nurses who provided care in the community in the piedmont and western counties of North Carolina. Of the 46 targeted counties, all but 4 are designated as medically underserved (Health Resources and Services Administration, 2007) and all but 3 are considered partially or completely rural (Universal Service Administrative Company, 2005). Health disparities are evident in racial and ethnic minorities in North Carolina. In 2006, African Americans and American Indians led the state and all other racial and ethnic groups in infant mortality rates as well as in mortality rates from heart disease, cerebrovascular disease (stroke), and diabetes (NC Department of Health and Human Services, 2008). Additionally, African Americans led the state and all other races in cancer mortality rates (N.C. Department of Health and Human Services, 2008). The prevalence of diabetes was higher in African Americans and American Indians than Whites in 2005 as well (N.C. Department of Health and Human Services, 2005). Examination of cultural competence as a means to address these health disparities is important.

Recruitment of nurses and clients occurred in home health agencies, hospice agencies and public health departments employing nurses in western and central North Carolina. Permission was obtained from the appropriate administrators at each agency to recruit and collect data from nurses and clients. Date and time of data collection was coordinated with agency administrators or their designees. Culturally and linguistically appropriate fliers and announcements (validated by health professionals) were used to recruit clients. Fliers were delivered by nurses to clients receiving care in their homes.

Health department personnel distributed fliers to clients as the clients arrived for care in the health department clinics.

Inclusion criteria for the nurses included:

- Registered Nurse with active license in North Carolina

- Employed by selected agencies for at least 1 year in a Registered Nurse role

- Twenty one years of age and older

- Work at least 25% of the time at the selected agency

The area or division of employment of the nurse at the selected agency did not exclude participation by any nurse. No nurse was excluded from participating due to race, gender, or ethnicity.

Inclusion criteria for clients included:

- Eighteen years of age and older

- Received services in the selected agencies within the past 6 months

- Be able to read or speak English or Spanish

- Be alert and oriented to time, place and person

No client was excluded from participating due to race, gender, or ethnicity.

The participants were a convenience sample of nurses ($N = 71$) who provided care in the community and were employed by 3 public health departments, 2 home health agencies, and 2 hospice agencies. Client participants ($N = 69$) were cared for by nurses employed by public health departments (See Table 1).

Table 1

Data Collection Sites

Agency	Nurse Participants	(%)	Client Participants	(%)
Site #1 (Hospice)	9	(13%)	—	—
Site #2 (Hospice)	15	(21%)	—	—
Site #3 (Home Health)	3	(4%)	—	—
Site #4 (Home Health)	2	(3%)	—	—
Site #5 (Health Department)	20	(28%)	33	(48%)
Site #6 (Health Department)	9	(13%)	21	(30%)
Site #7 (Health Department)	13	(18%)	15	(22%)

Power for the statistical analysis was determined using nQuery Advisor. A power of .93 was achieved with a sample size of 68, alpha of .05 and 10 independent variables in the multiple regression analysis for question #2, the most complex analysis.

Data Collection Procedures

Data were collected at scheduled staff meetings, throughout the day as the nurses were available, and at other times scheduled by the nurses. The nurses were given a short oral presentation about the purpose of the study and that it examined nurses' cultural diversity, cultural awareness and sensitivity, culturally competent behaviors and overall cultural competence as well as their personal experiences providing culturally competent

care. The consent form was read to them and they were given an opportunity to sign indicating their consent to participate. The signed copy was placed in an envelope and the nurses were given an unsigned copy. After completing the survey, nurses placed the survey in an envelope separate from the envelope containing the consent forms. The researcher remained in the room in a separate area to answer questions while nurses completed the surveys. Light refreshments were made available for all nurse participants. As an additional incentive, nurses were informed that participation in the study would make them eligible for one of two $25 Visa gift cards. Participants wishing to receive this incentive wrote their names and employing agencies on a slip of paper. These slips of paper were stored separately from all study materials. A random drawing was conducted by an individual not associated with the study at the completion of data collection to determine the winning participants. Winning participants chose to have the gift cards delivered through the mail. They were mailed to the addresses they requested.

Client data was collected at public health departments. No clients from home health or hospice were referred to the researcher by the nurses and none contacted the researcher volunteering to participate. Clients participated while waiting to be seen in clinics or after clinic visits. The surveys, consent forms and demographic forms were completed by clients in English or Spanish. The surveys and demographic forms were self-administered for those able to read Spanish or English and were read to those unable to read. Interpreter services, not associated with the health department, were available for non-English speaking clients who needed assistance reading and/or completing the surveys and demographic forms. The researcher was available for English speaking

clients who needed assistance reading and/or completing the surveys and demographic forms. Clients were given a short oral presentation of the study and that it examined their perceptions of the communication, decision making and interpersonal styles of their nurse for the past 12 months. They were informed about completion of the demographic form. The consent form was read to them and they were given the opportunity to sign indicating their consent to participate. The signed copy of the consent was placed in an envelope and the clients were given an unsigned copy. The consent form was written at the 6.6 grade level for easy readability for all clients. After completing the survey, clients placed the completed survey in an envelope separate from the envelope with the consent forms. After completing the demographic form, clients placed the completed form in an envelope separate from the consent form and separate from the survey. The researcher and interpreter remained in the room but sat in a separate area from the client, in the event that clients had questions while completing the survey. Client participants were given a $10.00 gift card from a local department store as an incentive for their participation.

Human Subjects Protection

Institutional review board approval was obtained prior to collection of data. Nurse and client participants were assured that participation was voluntary and that confidentiality of the collected data would be maintained. They were informed they could opt out of the study at any time. Nurses were assured that there was no threat to their employment status based on their decision to participate or not participate and that responses would not be shared with the agency except in summary format. Clients were

assured there was no threat to their care provision based on their decision to participate or not participate. Clients were assured their individual responses would not be shared with the agency or the nurse caring for them. Code numbers instead of names were placed on the surveys and/or demographic forms to maintain anonymity.

Measurement/Instrumentation

The cultural competence of nurses providing care in the community was examined using The Cultural Competence Assessment (CCA) (Doorenbos et al., 2005; Schim et al., 2003), a 25 item tool. Permission for use of the instrument in this study was obtained (Stephanie Myers Schim, PhD, personal communication, February 5, 2007). Nurse participants completed the instrument in approximately 15-20 minutes. Readability of the instrument is on the 9th grade level according to the Flesch-Kincaid readability formula.

The survey consists of 2 subscales measuring cultural awareness/sensitivity (CAS) and culturally competent behaviors (CCB), a one item self-assessment of cultural competency, and 4 items measuring diversity encounters (diversity experience and community of service). Construct validity was established comparing the scores on the CCA in relation to the education of the participant and reported previous diversity training (Schim et al., 2003). Scores on the CCA for participants who reported receiving previous diversity training ($n = 72$, $M = 153$, $SD = 17$) were significantly higher than those who reported no training ([$n = 20$, $M = 135$, $SD = 23$] ($t(90) = 2.12$, $p = 0.004$, two-tailed) (Schim et al., 2003). Scores for participants with varying educational levels were significantly different ($F[3, 89] = 5.31$, $p = 0.002$) with those possessing a high school

education scoring significantly lower on the CCA than those with bachelor's degrees ($p =$ 0.017) and those with graduate degrees ($p = 0.001$). Content, construct, and face validity were established with a convenience sample of interdisciplinary hospice workers and volunteers (Schim et al., 2003). Content validity was established through concurrent validity assessment of the CCA with the Inventory for Assessing the Process of Cultural Competence among Health Care Professionals (IAPCC) (Campinha-Bacote, 2003). This survey was chosen because of its widespread use among healthcare providers and because it measures 4 conceptually similar constructs (cultural awareness, cultural knowledge, cultural skill and cultural encounters) (Schim et al., 2003). The scores on the CCA were moderately correlated ($r = 0.66$) to those from the IAPCC (Schim et al., 2003). Face validity was established by having participants evaluate the instrument after completion. Participants reported the CCA took less time to complete than was anticipated, and was easier or about the same difficulty than similar surveys they had completed (Schim et al., 2003). Test-retest reliability for the CCA scale and the 2 subscales was demonstrated with 51 hospice workers in a crossover design control group with high correlations noted for the overall CCA scale ($r = .85$, $p = .002$); the CAS ($r = .82$, $p = .002$) and the CCB ($r = .87$, $p = .002$) (Doorenbos et al., 2005).

The cultural awareness/sensitivity subscale contains 11 items. Using a 7-point Likert-like response set of strongly agree, agree, somewhat agree, neutral, somewhat disagree, disagree, and strongly disagree, participants respond to items pertaining to cultural awareness and sensitivity that may influence healthcare. Some items in this subscale include but are not limited to the role of race in determining a person's culture,

the influence of culture on health and health care and the relationship between a person's culture and their personal preferences for health services. Others ask if spirituality and religious beliefs are important to cultural groups and if health care is defined differently by different groups. Higher scores indicate greater cultural awareness and sensitivity of the nurse. Four items required reverse scoring (6, 7, 10, 13). Subscale scores were then obtained by adding the items and dividing by the number of items. Item means were substituted for missing values if less than four nurse responses were missing on a specific question. Item #8 was found to have a negative item-total correlation (-.018) so this item was deleted from the subscale for statistical analysis.

The 14 item culturally competent behaviors subscale (CCB) is measured with a 7-point Likert-like response set of always, very often, somewhat often, often, sometimes, few times and never. Participants are asked to indicate the frequency of performance of specific culturally competence behaviors including but not limited to conducting cultural assessments, avoiding generalizations to stereotype groups of people and removing obstacles when barriers are identified. The subscale score was obtained by adding the items and dividing by the number of items. Higher scores indicated greater demonstration of cultural competence behaviors by the nurse.

The cultural competence (CCA) score was obtained by adding all items and dividing by 24 (total number of items with #8 deleted). Higher scores indicated greater cultural competence of the nurse.

Internal consistency reliability of the Cultural Competence Assessment and the 2 subscales has been documented through use with healthcare providers in acute care

facilities (Schim, Doorenbos, & Borse, 2005), hospice workers (Doorenbos, & Schim, 2004; Schim et al., 2006b), hospice nurses (Schim et al., 2006a) and in a pilot study (Starr & Wallace, 2007). See Cronbach alpha levels for these studies compared with those from the current study in Table 2.

Table 2

Cronbach's Alpha – Cultural Competence Assessment

| | Cronbach's Alpha | | |
Study	CAS	CCB	CCA
Healthcare providers	0.76	0.93	0.89
Hospice workers			
2004	—	—	0.91
2006	—	—	0.86
Hospice nurses	0.72	0.88	—
Pilot study	0.67	0.89	0.90
Current study	0.64	0.88	0.86

Note. CAS = Cultural awareness/sensitivity subscale. CCB = Culturally competent behaviors subscale. CCA = Cultural competence scale.

The tool included items identifying nurses' demographic, sociocultural, environmental and work factors. Demographic factors identified included nurses' age, level of nursing education, participation in cultural diversity training experience, and type of cultural diversity training. Sociocultural factors were identified (self-report of race/ethnicity) and measured (self-report of cultural competence) while environmental

factors measured included cultural diversity experience, and community of service. Identified work factors included current professional role, years practicing as a registered nurse, years practicing in the community setting, and type of care delivery in the community. These factors, in various combinations, have been examined in studies exploring cultural competence of healthcare workers in the community setting (Cooper-Braithwaite, 2006; Doorenbos et al., 2005; Doorenbos & Schim, 2004; Erkel, 1985) and have been found to be pertinent to the examination of cultural competence of nurses providing care in the community.

The sociocultural factor of self-evaluation of cultural competence was measured by one item with a 5-point Likert-like response set of very competent, somewhat competent, neither competent nor incompetent, somewhat incompetent, and very incompetent. Scores for this item ranged from 1-5, with 3 being neither competent nor incompetent. Higher scores on this item indicated nurses self-evaluate their cultural competence as being higher.

Environmental factors were measured with 4 items measuring the nurses' diversity exposure (diversity experience and community of service). Two items measured the nurses' diversity experience with the first item asking the nurses to identify the types of racial/ethnic groups encountered in their practice in past 12 months. Racial/ethnic groups included in this item were Hispanic/Latino (including Mexican, Mexican American, Chicano, Puerto Rican, Cuban), other Spanish; White/Caucasian/European American; Black/African American/Negro; American Indian/Alaska Native; Asian (Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, or other Asian); Native

Hawaiian/Pacific Islander; Arab American/Middle eastern; and Other. The scores of these items were obtained by counting the number of groups in each item encountered by the nurse. Responses were averaged to obtain a mean score. The score range was 1-8 with higher numbers indicating more diversity experience with the identified racial and ethnic groups. The second item asked the nurses to identify the types of special population groups encountered in their practice in the past 12 months. The special population groups included in this question were Mentally or Emotionally Ill; Physically Challenged/Disabled; Homeless/Housing Insecure; Substance Abusers/Alcoholics; Gay, Lesbian, Bisexual, or Transgendered; Different religious/spiritual backgrounds; and Other. The scores of these items were obtained by counting the number of groups in each item encountered by the nurse. Responses were averaged to obtain a mean score. The range of scores for this item was 1-7 with higher scores indicating more diversity experiences with the identified special population groups. Two questions allowed for description of the nurses' community of service with the first item asking the nurse to identify the percentage of the total population they served that was from the above identified racial/ethnic groups. The second question asked the nurse to identify the percentage of the total population they served that was from the above identified special population groups but was not used in analysis due to the inconsistent manner of nurse responses.

Thirteen additional items in the survey evaluated nurses' social bias in responses using the Marlowe-Crowne Social Desirability Scale (Reynolds, 1982). Each item was measured with a True – False choice with scores ranging from 0 – 13. The total score was

a sum of all items. The mean score of 8.1 ($SD = 2.2$) indicates the nurses answered the questions without bias.

The personal experiences of the nurses providing culturally competent care was obtained qualitatively by allowing the nurses to respond to 3 researcher developed open-ended questions. Combining qualitative data with the quantitative data from the CCA expanded the findings and added to present knowledge by allowing nurses to personally share what culturally competent care encompassed (Schim et al., 2007). The 3 open-ended questions were:

1. Briefly describe an incident where you feel you provided culturally competent nursing care to someone in the community who was from a different culture.

2. Briefly describe an incident where you feel you were unable to provide culturally competent nursing care to someone in the community who was from a different culture.

3. Is there anything you would like to add about providing culturally competent care in the community?

Client perceptions of the interpersonal care of nurses providing care in the community were obtained with the Interpersonal Processes of Care Survey: Short Form (IPC-18) (Stewart et al., 2007). Survey items were based on 19 focus groups comprised of 61 African Americans, 45 English- and Spanish-speaking Latinos, and 55 non-Latino Whites (Nápoles-Springer, et al., 2005); an original conceptual framework and survey (Stewart et al., 1999); literature on quality of care and physician-client communication; and cognitive interviews with adults representing the 4 previously mentioned

racial/ethnic groups (Nápoles-Springer, Santoyo, O'Brian, & Stewart, 2006). The IPC

survey was available in a 29 item survey (IPC-29) and an 18 item survey (IPC-18). The

IPC-18 was used in this study because of its lower reading level (7.0 vs 8.6) allowing

ease of understanding to a greater number of clients. The 18-item survey measured

specific attributes of the provider-client interpersonal relationship. These include

interpersonal processes comprising 3 broad domains of communication, patient-centered

decision making and interpersonal style. Clients responded to specific items comprising

interpersonal process scales in each of the 3 domains. Interpersonal process scales in the

domain of communication were lack of clarity (2 items); elicited concerns, responded (3

items); and explained results (2 items). The domain of decision making had 2 items

pertaining to participatory decision making. The domain of interpersonal style consisted

of the interpersonal process scales of compassionate, respectful (3 items); discriminated

due to race/ethnicity (2 items); and disrespectful office staff (4 items). Clients were asked

to respond to statements pertaining to each interpersonal process about their experiences

interacting with their nurse and office staff over the past 12 months. Responses were

measured on a 5 point Likert-like response set of never, rarely, sometimes, usually, and

always. Non-missing item responses in each interpersonal process scale were averaged to

obtain a scale score. Each scale score ranged from 1-5 with higher scores indicating

higher frequency of the specific interpersonal process meaning in some instances, better

processes (e.g., greater respectful care) and in other instances, worse processes (e.g.,

more discrimination) (Stewart et al., 2007).

The instrument was designed to assess care provided by physicians but was appropriate for use in assessing care provided by nurses providing care in the community. Permission was obtained to use the instrument and to change the word "physician" to "nurse" (Anita Stewart, PhD, personal communication, October 22, 2007). The instrument was available in English and Spanish. The English version of the instrument was translated into Spanish by the instrument developers and made available for use. The Spanish version was back translated into English by a college graduate with a degree in Spanish. The Spanish translation was accurate. The IPC – 18 had a readability level of grade 7.0 using the Flesch-Kincaid readability formula (Stewart et al., 2007).

Internal consistency reliability of the IPC was established in a cross sectional study involving 435 African American, 428 English-speaking Latinos, 383 Spanish-speaking Latinos and 418 non-Latino white participants receiving care in adult general medicine practices at an academic health center (Stewart et al., 2007). Internal consistency reliabilities of the subscales from the domains have been previously reported but internal consistency reliabilities of the domains have not been previously reported.

Prior to statistical analysis, for the current study, internal consistency reliabilities of the domains from the IPC-18 Short Form survey were examined (See Table 3).

Table 3

Cronbach's alpha – IPC-18 and Domains

Domain	Cronbach's Alpha
Communication	0.74
Decision Making	0.75
Interpersonal Style	0.88
IPC 18 Short Form	0.84

Client Demographic Form. A client demographic form was developed to collect specific information about the clients and specific information about the care provided by the agency and the personnel providing that care. Client information included age, gender, marital status, race/ethnicity, language spoken at home, if born in the United States, how long living in the United States if not born in the United States, where born if not born in the United States, highest level of education completed, occupation, and method of payment for health care. Specific information about care provided by the agency and the personnel providing that care included the main health issue or problem addressed by the agency, type of care provided by the agency, length of time receiving care by the agency, if the registered nurse is the only health worker or professional providing care, what other types of health workers or professionals providing care if the nurse is not the sole provider, age of the nurse providing care, gender of the nurse providing care, and race/ethnicity of nurse providing care. These were standard

characteristics measured in clients participating in similar studies and will provide

pertinent, descriptive information about the client sample and their care by the agency for

this study. The demographic form had a reading level of grade 4.9 using the Flesch-

Kincaid readability formula.

The English versions of the demographic form and consent form were translated

into Spanish by a bilingual healthcare provider and back translated into English by a

college graduate with a degree in Spanish. The Spanish language demographic form and

informed consent were accurately translated from English to Spanish.

Analysis

All analyses were performed with SPSS for Windows version 15.0 (SPSS,

Chicago, IL). Descriptive statistics were used to describe the nurse sample. Measures of

central tendency (mean, standard deviations, ranges, skewness, kurtosis) were calculated

for each of the interval level variables of age, time practicing as a registered nurse, time

practicing as a registered nurse and diversity experience (racial/ethnic groups, special

population groups), the CCA scale and subscales. Proportions and frequencies were

determined for the nominal level variables of self-report of race/ethnicity, highest level of

nursing education, type of prior diversity training, current role, type of care delivery in

the community, and participation or no participation in diversity training. Descriptive

statistics were calculated and used to describe nurses' diversity experience.

Descriptive statistics were calculated and used to describe the client sample.

Measures of central tendency (mean, standard deviation, ranges, skewness, kurtosis) were

calculated for each of the interval level data: age, how long living in the United States if

not born in the United States, how long receiving care from the agency and age of the nurse caring for the client, IPC domains and subscales. Proportions and frequencies were determined for the nominal level data: gender, marital status, race/ethnicity, language spoken at home, if born in the United States, where born if not born in the United States, highest level of education completed, occupation, type of payment method for health care, main health issue or problem addressed by the agency, type of care provided by agency, if nurse is only care provider from the agency, other types of professionals providing care from the agency, gender of nurse providing care for client and race/ethnicity of nurse providing care for the client.

     Data analysis for each research study question follows:

1. What is the cultural awareness/sensitivity, culturally competent behaviors and cultural competence of nurses who provide care in community settings?

     Measures of central tendency (mean, standard deviation, ranges) were calculated for the cultural awareness/sensitivity, and culturally competent behaviors subscales and cultural competence scale and for the cultural diversity experience items. Proportions, quantities, range, mean and standard deviation were used to report responses to the self-report of cultural competence item.

2. What are the relationships between demographic (nurses' age, highest level of nursing education, participation or not in cultural diversity training, number of cultural diversity training experiences), environmental (cultural diversity experience with racial/ethnic and special population groups) and work factors (current professional role, years practicing as a registered nurse, years practicing

in the community setting, type of care delivery in the community) and the

cultural awareness/sensitivity, culturally competent behaviors and cultural

competence of nurses who provide care in community settings?

The nurses' diversity experience (racial/ethnic groups encountered in practice and

special population groups encountered in practice) variables were computed to reflect the

number of groups encountered by the nurses.

For use in the multiple regression model, three nominal independent variables

were categorized using dummy variable coding. See Table 4 for identification of the

recoded dummy variables.

Table 4

Dummy Coding of Nominal Variables

Variable	Recode
Type of care delivery in community	Public health (1) Other (0)
Highest level nursing education	Diploma/Associate degree (0) Bachelor's/Graduate degree (1)
Current role in community	Staff nurse (1) Other (0)

Independent variables (age, race/ethnicity, highest level of nursing education,

participation in cultural diversity training, type of cultural diversity training, diversity

experience (racial/ethnic groups, special population groups), current role, time practicing

as registered nurse, time practicing in the community, type of care delivery in the community) were examined for multicollinearity. Tolerance levels and variance inflation factor of all independent variables were calculated to assess multicollinearity when all variables were examined together (Munro, 2005). A tolerance level of <0.1 would indicate that multicollinearity is a problem indicating the need to eliminate the variable (Norušis, 2005).

Initially, Pearson product moment correlation coefficients were used to determine the relationships between the independent variables and dependent variables (Gliner & Morgan, 2000). To determine how well the independent variables predicted dependent variables, variables were simultaneously entered into a multiple linear regression model (Munro, 2005). Statistical significance was set at 0.05 for alpha.

3. What are the experiences of nurses who provide care in community settings about delivery of culturally competent healthcare?

Content analysis (Berg, 2007) was used to report findings from question #3. The collaborative social research approach was used. The data from the nurses was used as information to understand nurses' perceptions and experiences providing culturally competent care in the community (Berg, 2007). The data were transcribed and then analyzed to identify the most frequently mentioned experiences and were reported as "frequency counts" (Wilkinson, 2004). Specific situations were identified as exemplars for each frequency category. All responses were analyzed by the researcher. Twenty percent of the responses were randomly selected and reviewed by two doctorally prepared nurses experienced in qualitative analysis and racial/ethnic perspectives. The

review by the two doctorally prepared nurses was done without prior knowledge of the researcher's analysis. Random selection was achieved by choosing response #1 and every 7th response for analysis by Nurse #1. Random selection was achieved by choosing response #7 and every 7th response for Nurse #2. The analyses by the two reviewers were compared with the researcher's analysis of the responses. This process resulted in 99% agreement between the two reviewers' analyses and the researcher's analysis. Identifying factors such as gender and names were changed to maintain anonymity for clients and nurses.

4. What are the perceptions of clients about the interpersonal processes of care included in the domains of communication (lack of clarity; elicited concerns, responded; explained results), decision making (decided together) and interpersonal style (compassionate, respectful; discriminated due to race/ethnicity) of nurses providing care in community settings?

Measures of central tendency (means, standard deviations and ranges) were calculated for the interpersonal processes of care subscales and the domains.

5. What are the similarities between the cultural awareness/sensitivity, culturally competent behaviors, and cultural competence of nurses providing care in the community with the client's perception of the nurse's communication (lack of clarity; elicited concerns, responded; explained results), decision making (worked together) and interpersonal style (compassionate, respectful; and discriminated due to race/ethnicity)?

Initially, the level of nurse cultural competence and level of client perception of the nurses' interpersonal process of care were examined by total, subscale and domain areas. Then specific cultural competence content and interpersonal processes of care content were examined. Findings are reported as proportions of nurses who performed culturally competent behaviors, and proportions of clients who perceived nurses provided culturally competent care in those areas.

Limitations

Generalizability of findings from this study should be made with caution and are limited to nurses providing care in the community and to clients receiving care from nurses providing care in the community. All clients had access to care at health departments so findings are limited to those with access to care. Findings may vary in clients with no or limited access to health care. Also, since participation was voluntary, nurses who felt they were more culturally competent may have been more likely to participate which may have influenced the findings. Responses to the 3 open-ended questions were reflective of individual definitions of cultural competence, as a specific definition of cultural competence was not provided for nurses. Even though clients and nurses were assured findings would not be shared with agency personnel, participant responses may have been influenced by the fact that surveys were completed inside the agencies. Findings may be sample specific due to the sample size.

CHAPTER IV

RESULTS

Findings of the study are reported in this chapter. A description of the nurse and client samples is provided followed by analyses for each research question. Additional tests, based on findings from the planned analyses, are included as well as a chapter summary.

Sample

Nurse participants ranged in age from 25 to 63 years of age ($M = 47.5$, $SD = 9.4$) with the majority being Caucasian and having an associate degree as their highest nursing degree attained. They reported practicing as a registered nurse from 3 to 42 years ($M = 19.4$, $SD = 9.3$) and in the community as a registered nurse 1 to 37 years ($M = 11.8$, $SD = 7.6$). Most nurses reported working full time; as a staff nurse; and in public health departments. The majority reported participating in some type of cultural diversity training, with most nurses reporting participation in an employer sponsored programs (See Table 5).

Client participants ranged in age from 18 to 54 years of age ($M = 25$, $SD = 7.8$). Fifty reported being born in the United States while those not born in the United States ($n = 19$) reported living here from 0.5 to 18 years ($M = 8$, $SD = 6.24$). Clients reported receiving care from specific agencies from 1 week to 38 years ($M = 3$ years, $SD = 6.1$ years). Most clients were female; single and Caucasian with English being the primary

language spoken at home. Most had a high school diploma or GED or less than a high

school education. One third of clients were unemployed with 29% having no insurance to

cover healthcare costs and 30% relying on Medicaid to pay for healthcare (See Table 6).

Clients reported on their care provision at the agency. Clients reported their

nurses' ages ranged from 24 to 55 years ($M = 38$, $SD = 6.5$), with 67 nurses being female

and 1 being male. The race/ethnicity of the clients' nurses were reported as

predominantly Caucasian ($n = 64$) followed by Hispanic/Latino ($n = 6$), African

American ($n = 2$) and Arab American ($n = 1$). Most clients reported being seen for

prenatal care or family planning services (See Tables 7).

Table 5

Nurse Participant Characteristics

Factor	N	(%)
Race/ethnicity		
Hispanic/Latino/Caucasian	1	(1%)
Caucasian	67	(94%)
African American	2	(3%)
Asian	1	(1%)
Highest level nursing education		
Diploma	6	(8%)
Associate degree	42	(59%)
Bachelor's degree	19	(27%)
Graduate/professional degree	4	(6%)
Employment status		
Full time	65	(92%)
Part time	6	(8%)

Current professional role

Charge nurse	12	(17%)
Staff nurse	41	(58%)
Administrator/manager	8	(11%)
Clinical specialist	4	(6%)
Quality assessment/utilization review	1	(1%)
Case manager	4	(6%)
Care coordinator	1	(1%)

Type of care delivery in the community

Public health	38	(54%)
Home health	11	(15%)
Hospice	22	(31%)

Participated cultural diversity training

Yes	63	(89%)
No	8	(11%)

Type of cultural diversity training

Workshop	40	(56%)
Separate college course for credit	7	(10%)
Content covered in a college course	12	(17%)
Professional conference or seminar	20	(28%)
Employer sponsored program	53	(75%)
Online (computer-assisted) education	8	(11%)
Continuing education offering	21	(30%)

Note. Percentages do not equal 100 due to rounding and missing values

Table 6

Client Participant Characteristics	N	(%)
Gender		
Female	67	(97%)
Male	2	(3%)
Marital status		
Married/Partnered	27	(40%)
Divorced	3	(4%)
Separated	3	(4%)
Single	35	(51%)
Race/ethnicity		
Hispanic/Latino	17	(25%)
Caucasian	42	(61%)
African American	8	(12%)
Asian	1	(1%)
Other – Ethiopian	1	(1%)
Primary language spoken at home		
English	52	(75%)
Spanish	15	(22%)
Amhavic (Ethiopian dialect)	1	(1%)
Quiche (Guatamalan dialect)	1	(1%)
Highest level of education		
Less than high school	24	(35%)
High school diploma/GED	21	(30%)
Some college	15	(22%)
Associate degree	4	(6%)
Bachelor's degree	3	(4%)
Graduate/professional degree	2	(3%)
Method of payment for health care		
Private insurance	8	(12%)
Medicare	2	(3%)
Medicaid	21	(30%)
No insurance	20	(29%)
Private pay	15	(22%)
Private insurance/medicare/private pay	1	(1%)
Private insurance/Medicaid	2	(3%)

Occupation

Unemployed	21	(30%)
Housewife/homemaker	8	(12%)
Restaurant/food service	7	(10%)
Student	5	(7%)
Other	20	(29%)

Note. Percentages do not equal 100 due to rounding and missing values

Table 7

Health Care Provision from Agency	N	%

Professionals caring for client at agency

Registered nurse only	41	(59%)
Physical therapy	2	(3%)
Personal care assistant	4	(6%)
Social worker	8	(12%)
Doctor	15	(22%)
Nutritionist	4	(6%)
Doctor associate	1	(1%)
Midwife	1	(1%)
Counselor	1	(1%)

Main health issue or problem for which agency is providing care

Pregnancy	30	(43%)
Birth control	21	(30%)
Illness/general health care	14	(20%)
Annual physical/pap smear	4	(6%)

Type of care provided by agency

Prenatal	25	(39%)
Family planning	15	(23%)
Women's health care	6	(9%)
Physicals/general care	17	(27%)
Women/Infants/Children (WIC)	2	(3%)

Note. Percentages do not equal 100 due to rounding and missing values

Analysis

Question #1: What is the cultural awareness/sensitivity, culturally competent behaviors and cultural competence of nurses who provide care in community settings?

Nurse participants self-identified their cultural competence. Scores ranged from 2 to 5 with a mean of 4.25 (*SD* = .63). Most nurses self-identified themselves as either somewhat competent or very competent. No nurse identified themselves as very incompetent (See Table 8).

Table 8

Self-Report of Cultural Competence	N	%
Very incompetent	0	0
Somewhat incompetent	1	(1%)
Neither competent nor incompetent	4	(6%)
Somewhat competent	42	(59%)
Very competent	24	(34%)

Mean scores on the cultural awareness/sensitivity and culturally competent behaviors subscales and the cultural competence scale ranged from 1 to 7. Nurse participants' scores indicated moderately high levels of cultural awareness and sensitivity and moderate levels of cultural competence behaviors and overall cultural competence (See Table 9)

Table 9

Cultural Competence Scores (range 1-7)

Subscale	Range	Mean	SD
Cultural Awareness/Sensitivity	4.90-7.00	5.97	.42
Culturally Competent Behaviors	2.64-6.93	5.21	1.01
Cultural Competence	3.83-6.96	5.53	.67

Oneway ANOVA revealed significant differences between public health, home health and hospice scores on the culturally competent behaviors subscale ($F = 4.715$, $df = 70$, $p = 0.012$) and the cultural competence scale ($F = 3.723$, $df = 70$, $p = 0.029$). Post hoc findings revealed significant differences on the culturally competent behaviors subscale between public health and home health scores ($p = 0.015$) and public health and hospice scores (0.018) but no difference between home health and hospice scores. Significant differences were also found on the cultural competence scale between public health and home health scores ($p = 0.039$) and public health and hospice scores ($p = 0.027$). No significant differences were found between home health and hospice. Since no differences were found between home health and hospice and all clients were from health departments, the nurses were grouped as home health/hospice or public health for further analysis for the type of care delivery in the community variable. Thus, the variable would more accurately reflect the client population setting.

Further description of nurse participants' cultural competence included the report of their cultural diversity experience. Nurses identified the racial/ethnic groups and special population groups encountered in their work environment. Almost all nurses reported encountering Whites followed by African Americans then Hispanics/Latinos. Of the special population groups, most nurse participants reported encountering clients who were mentally and emotionally ill and those abusing substances and alcohol. The racial/ethnic groups and special population group items were computed to identify the numbers of groups the nurse participants encountered. Nurse participants encountered an average of 4 (range = 1-7, M = 3.94, SD = 1.26) racial/ethnic groups and 5 (range = 2-6, M = 5.01, SD = 1.10) special population groups. Almost 80% of the nurse participants encountered 3-5 racial/ethnic groups in their practice environments while over 70% encountered 5-6 special population groups (See Table 10).

Table 10

Client Groups Encountered by Nurses in Practice	N	(%)
Racial/ethnic groups		
White/Caucasian	70	(99%)
Black/African American	68	(96%)
Hispanic/Latino	58	(82%)
Asian	46	(65%)
Arab American	20	(28%)
American Indian	14	(20%)
Native Hawaiian	5	(7%)

Special population groups

Mentally/emotionally ill	67	(94%)
Substance abusers/alcoholics	67	(94%)
Different religious/spiritual backgrounds	60	(85%)
Physically challenged/disabled	58	(82%)
Homeless/housing insecure	54	(76%)
Gay, lesbian, bisexual, transgendered	47	(66%)

Question #2: What are the relationships between demographic (nurses' age, highest level of nursing education, participation or not in cultural diversity training, number of cultural diversity training experiences), environmental (cultural diversity experience with racial/ethnic and special population groups) and work factors (current professional role, years practicing as a registered nurse, years practicing in the community setting, type of care delivery in the community) and the cultural awareness/sensitivity, culturally competent behaviors and cultural competence of nurses who provide care in community settings?

Pearson correlations were computed to determine relationships between the 10 independent variables and the nurses' cultural awareness/sensitivity, culturally competent behavior and their overall cultural competence. Number of years practicing as a registered nurse in the community had a significant positive correlation with the nurse participants' cultural awareness and sensitivity. The number of cultural diversity training experiences in which nurses participated had a significant negative correlation with the nurses' professional role in the community (staff nurse = 1; other = 0) but a significant positive correlation with the nurses' culturally competent behaviors and their cultural

competence. Type of care delivery in the community (public health = 1; home health/hospice = 0) had a significant negative correlation with the nurses' culturally competent behaviors and cultural competence (See Table 11).

Nurse participants identified the types of prior cultural diversity training in which they participated. For use in the multiple regression model, this independent variable was computed to reflect the <u>number</u> of cultural diversity training experiences in which the nurses participated. Nurse participants reported participating in an average of 2.3 ($SD =$ 1.6) cultural diversity training experiences, with 60% reporting 2 or more experiences.

Assumptions of multiple regression were evaluated prior to analysis of the data. The assumptions of multivariate normality, linearity and homoscedasticity were checked by examining residual scatter plots of predicted values and residuals. The plots had points equally distributed around the middle of the plot and no outliers were noted. The assumption of multicollinearity was checked by examining bivariate correlations. No strong positive or negative correlations were noted (all were correlated <0.85) (Munro, 2005). Additionally, tolerance levels were greater than 0.10 for all independent variables (Munro, 2005). The CAS subscale did not achieve acceptable reliability. Therefore, the cultural awareness/sensitivity score was not used as a dependent variable in this question.

To determine how well the nurse participants' culturally competent behaviors were explained, all 10 independent variables were entered together as a block with the culturally competent behaviors (CCB subscale) as the dependent variable. This model explained 28% of the overall variance of the nurse participants' culturally competent behaviors. According to this model, the number of cultural diversity training experiences

significantly predicted the nurses' culturally competent behaviors, i.e., higher numbers of cultural diversity experiences predicted a higher number of culturally competent behaviors. The type of care delivery in the community also significantly predicted the nurses' culturally competent behaviors. Public health nurses had a lower number of culturally competent behaviors than hospice and home health nurses (See Table 12).

To determine how well the nurse participants' overall cultural competence was explained by the independent variables, all 10 variables were entered together as a block with the CCA score as the dependent variable. This model explained 29% of the overall variance of the nurse participants' cultural competence. Similarly, the number of cultural diversity training experiences significantly predicted the nurses' cultural competence with a higher number of experiences predicting higher cultural competence. The type of care delivery in the community significantly predicted the nurses' cultural competence scale scores with public health nurses having less cultural competence than home health and hospice nurses (See Table 13).

Table 11

Pearson Correlations of Relationships between Independent Variables and Cultural

Competence Scores

Variables	1	2	3	4	5	6	7	8	9	10	11	12	13
1. Age	-	.644 **	.510 **	-.141	-.130	-.009	.093	-.045	-.104	.013	-.023	-.057	-.056
2. YrPractRN		-	.585 **	-.064	.114	.005	.030	-.227	-.168	-.059	-.125	-.168	-.181
3. YrPractPH			-	-.077	.173	.131	.050	.083	-.222	.028	-.283 *	-.148	-.206
4. CulDivTr				-	.151	.368 **	.206	.086	-.124	.025	.181	.083	.121
5. EDUCX					-	.281 *	.073	-.091	-.261 *	.042	-.088	-.069	-.085
6. NumDivTR						-	.215	.151	-.250 *	.086	.103	.248 *	.247 *
7. Ethnic							-	.368 *	-.308 **	.566 **	.120	-.116	-.071
8. Specpop								-	-.171	.348 **	-.083	.107	-.117
9. Nsrole									-	-.225	.118	.131	.147
10. Typecare										-	-.062	-.353 **	-.320 **
11. CAS											-	.314 **	.541 **
12. CCB												-	.968 **
13. CCA													-

Note. Age = age of nurse. YrPractRN = Years practicing as a registered nurse. YRPractPH = Years practicing as a registered nurse in the community. CulDivTR = Participation in cultural diversity training (yes or no). EDUCX = Highest level of nursing education (bachelor's/graduate = 1; diploma/associate = 0). NumDivTr = Number of cultural diversity training types. Ethnic = number of racial/ethnic groups encountered in practice. Specpop = number of special population groups encountered in practice. Nsrole = nurse's professional role in the community (staff nurse = 1; other = 0). Typecare = type of care delivery in the community (public health = 1; home health/hospice = 0). CAS = Cultural awareness/sensitivity. CCB = Culturally competent behaviors. CCA = Cultural competence.
** correlation significant at the 0.01 level
* correlation significant at the 0.05 level

Table 12

Multiple Regression Summary for Nurses' Culturally Competent Behaviors

Variable	Standardized Regression Coefficients	t	p
Number diversity training experiences	.336	2.611	.011*
Type of care delivery in community (public health = 1)	-.413	-2.917	.005*
Nurses' age	.134	.839	.405
Cultural diversity training (yes or no)	-.030	-.242	.810
Highest level of nursing education (bachelor's/graduate degree = 1)	-.084	-.652	.517
Number racial/ethnic groups encountered	.130	.856	.396
Number special population groups encountered	-.111	-.815	.418
Nurses' professional role in community (staff nurse = 1)	.068	.526	.601
Years practicing as a registered nurse	-.242	-1.407	.165
Years practicing as nurse in the community	-.089	-.589	.558

Note. $R^2 = .281$, $F = 2.269$, $df = 10$, $p = .026$.
*$p < 0.05$

Table 13

Multiple Regression Summary for Nurses' Cultural Competence

Variable	Standardized Regression Coefficients	t	p
Number diversity training experiences	.333	2.619	.011*
Type of care delivery in community (public health = 1)	-.379	-2.739	.008*
Nurses' age	.147	.934	.354
Cultural diversity training (yes or no)	.009	.070	.945
Highest level of nursing education (bachelor's/graduate degree = 1)	-.090	-.717	.477
Number racial/ethnic groups encountered	.147	1.005	.319
Number special population groups encountered	-.113	-.853	.397
Nurses' professional role in community (staff nurse = 1)	.094	.758	.451
Years practicing as a registered nurse	-.217	-1.275	.207
Years practicing as nurse in the community	-.148	-.986	.328

Note. $R^2 = .292$, $F = 2.397$, $df = 10$, $p = .019$.
*$p < 0.05$

Question #3: What are the experiences of nurses who provide care in community settings about delivery of culturally competent healthcare?

To answer research question #3, content analysis was used to examine the nurse participants' written responses to three open-ended questions describing their experiences

of delivering culturally competent healthcare in the community. Nurse participants

discussed interactions with various racial/ethnic groups with the majority of interactions

occurring with Hispanics/Latinos (See Table 14).

Table 14

Groups Who Interacted With Nurses

Groups	Frequency
Hispanic/Latino/Spanish speaking	40
Asian	5
Indian (from India)	4
Hmong	3
Vietnamese	2
Laotian	2
Chinese	2
African American	1
Thai	1
Haitian	1
Arabian	1

Open-ended question #1 – Briefly describe an incident where you feel you

provided culturally competent nursing care to someone in the community who was from

a different culture. Sixty two (87%) nurses responded, with most describing incidents

when they intervened to overcome language barriers for the clients. The nurses described

actions taken in response to cultural needs such as honoring cultural customs while in

clients' homes. The nurses identified being interested in learning about their clients'

cultural beliefs and customs and mentioned making culturally appropriate referrals. In

addition, nurse participants described using the therapeutic relationship when caring for

clients that resulted in positive outcomes (See Table 15). Examples describing the

categories are provided.

Table 15

Culturally Competent Care Interventions

Intervention	Frequency
Interpretation	31
Honoring cultural customs and norms	14
Learning about cultural beliefs and customs	5
Culturally appropriate referrals	8
Nurse-client therapeutic relationship	3

Most nurse respondents (14) described utilizing trained interpreters when caring

for non-English speaking clients, but one expressed frustration with the lack of adequate

numbers of interpreters. The provision of a nurse, family member, priest or physician

who spoke the client's language was used when trained interpreters were not available. Other interventions nurses used to overcome the language barrier included using translated materials/pictures, hand signs/charades, speaking or attempting to speak the client's language, allowing extra time, informing referral sources of the need for a translator, accompanying a family member to the hospital to assist in language translation, and phone translation services.

Nurse participants described incidences where cultural customs were honored during home visits. These incidents included removing shoes when entering Japanese and Vietnamese homes and assisting family members from India prepare clients at their deaths by bathing, dressing and wrapping the body. As a result, one nurse wrote the "family co-operated & followed my instructions". Several nurse participants described respecting the role of the male in decision making in the homes of Hispanic families, while one described providing a client with a female provider. Another nurse discussed how he/she allowed family members to provide care for a client from India – food was brought from home, female family members provided personal care and the husband was included in all decision-making.

In addition, consideration of cultural norms and beliefs during pregnancy, with newborn care and with birth control decisions was identified. One nurse documented that she "asked the client to explain cultural practices and beliefs encompassing postpartum and newborn care", and another nurse explained that, "the most culturally diverse issues are with postpartum diets or beliefs about birth control".

Being interested in <u>learning about cultural beliefs and customs</u> was another experience delineated by nurse participants. One nurse wrote, ". . .by asking questions of patient I learned of his culture and belief system. He accepted my questions and we developed mutual respect as I learned more and honored his life style". Another nurse responded, "It was a very interesting time for me" after participating in preparing an Indian client's body after death.

  <u>Referrals to culturally appropriate community resources</u> were described by nurse participants to assure the client's culture would be considered in care delivery. One cared for a Hmong refugee client that viewed her health problems as "bad spirits", by referring the client to an Asian doctor who spoke her language and understood her culture. Another nurse described caring for a Laotian mother with TB who practiced "coining", by helping her obtain medical care with an Asian doctor. Notifying referral sources that a client would need an interpreter when arriving for the scheduled visit was documented, as well as referrals of clients for financial resources such as Medicaid.

  The <u>use of the therapeutic nurse-client relationship</u> when caring for diverse clients was described by three nurses. The following quote describes how developing a relationship with a client with active listening and physical presence resulted in positive outcomes:

> Worked with a Hispanic mother who felt very alienated by the care she received during labor and delivery. She verbalized that she felt that she was "mistreated" due to her race. I listened throughout her tearful reincountment of her experience during a postpartum home visit, as a result of my listening and trying to understand her feelings, we developed an excellent rapport together and she has been enrolled in child services for her son for nearly 5 yrs. The initial concern for

her referral was possible postpartum depression & inability to bond with her infant; however she has proved to be an excellent mother and we have worked well together in understanding expectations of one another, as a result of education I have found that Hispanic mothers feel that it is often necessary to keep their children on the bottle until they go to school.

One nurse described how the use of physical presence overcame the language barrier, "at the end of the visit I said something like. . . . we don't speak the same language but we understand each other. . .while I was holding her hand". *Active listening and sensitivity* by a nurse participant resulted in a positive pregnancy outcome in a Latino client with gestational diabetes. A nurse described making the Hispanic maternity clients *feel safe* when they worry about immigration by assuring them a healthy pregnancy outcome is the primary goal of care and another nurse identified the importance of *establishing trust* with parents of Hispanic children so they would not worry about deportation and give the child needed TB medication.

Open-ended question #2 – Briefly describe an incident where you feel you were unable to provide culturally competent nursing care to someone in the community who was from a different culture. Fifty two (73%) nurse participants provided responses with seven of these writing they had no difficulty delivering culturally competent care. Categories of barriers and the frequency they are mentioned are listed in Table 16 with examples of each category provided.

The language barrier was noted by approximately half as hindering the delivery of culturally competent care. This barrier was identified or experienced as not having interpreters available, concern with accuracy of interpreters, and ineffectiveness of

interpreters if clients spoke an unfamiliar dialect. One nurse participant discussed how she was able to provide culturally competent care because of the use of interpreters. Another nurse expressed that she felt she was unable to provide culturally competent care "When I felt family member wasn't translating exactly what I was saying – added or didn't completely say". A second nurse documented concern, "Family had interpreter/because of Language Barrier worried if interpreter presents information correctly". Some nurses expressed that they did not think female clients were allowed to make choices about birth control or maternity care when their husbands interpreted. One nurse wrote, "Asian woman – no interpreter except her husband – wondered if she was given choice for tx".

Table 16

Barriers to Delivery of Culturally Competent Care

Barriers	Frequency
Language	24
Religious beliefs	3
Others	7

Religious beliefs presented a barrier for some nurse participants. One nurse discussed caring for a Jehovah Witness client who had to be discharged from care because the care needed was directly against their religious beliefs. Another nurse

expressed concern in assisting the wife of a client who was a Buddhist. The nurse described having difficulty helping the wife to understand the dying process and that the husband was not going to get better. A final example identified an incident where someone with strong Protestant beliefs would no longer allow the nurse to care for the client when the person found out the nurse's religion.

Additional barriers to delivery of culturally competent care documented by nurse participants included low income families with history of substance abuse, nutritional beliefs preventing use of prenatal vitamins, and uninsured and underinsured preventing access to specific types of care. Some nurse participants related personal reasons as barriers to the delivery of culturally competent care. One nurse wrote, "Believe it or not I feel challenged by the Caucasian American poor/illiterate community, because I cannot relate or understand how they could live the way they do when every opportunity is afforded them in this country". Another nurse expressed an inability to care for lesbian couples undergoing artificial insemination because she felt she was "squashing my own beliefs and feelings on this issue". Several nurses noted they were unable to provide culturally competent care to children because of differences between what the family wanted and what the nurse wanted. For example, one nurse wrote, "Family did not want to continue getting services for a child who had had a speech delay".

Thirty nine nurse participants (55%) responded to open-ended question #3 – Is there anything you would like to add about providing culturally competent nursing care in the community? Several types of issues were reported. Some nurse participants noted they felt they delivered culturally competent care to everyone. Another 11 (20%) nurses

requested opportunities for more educational experiences and access to resources to learn about culturally competent care. One nurse explained, "We are in a global community now and anything, whether it be resources; (books, on line resources etc.), staff education – to help us work with other cultures to break down these barriers to communicate will help". A second nurse identified that cultural competence training was offered at her agency annually. Other nurses identified the need for more interpreters.

A final review of the responses revealed words or phrases nurse participants used to describe cultural competence included "essential", "hard", "good nursing care", "challenge", "important", "learning experience", and "is a growing need". Some equated culturally competent care with providing holistic care. Other nurses wrote that care should be equal for everyone, regardless of their cultural background. One nurse wrote,

> In providing care in the community you need to provide holistic care to the patient and family in order to have the best outcome and for the patient and family to have the best experience. You need not only to take into account their cultural background but also their spiritual beliefs and many other factors including their educational background.

One nurse participant noted that cultural assessment should be a part of the initial assessment, while another nurse saw this as separate from the physical care. Others explained that nurses needed to take the extra time to learn about new cultures.

Question #4: What are the perceptions of clients about the interpersonal processes of care included in the domains of communication (lack of clarity; elicited concerns, responded; explained results), decision making (decided together) and interpersonal style

(compassionate, respectful, discriminated due to race/ethnicity) of nurses providing care

in community settings?

Client participants' responses to the Interpersonal Processes of Care – 18 Short

Form (IPC 18) were analyzed to answer research question #4. The IPC 18 was completed

by client participants in Spanish ($n = 15$) and English ($n = 54$). Two participants

identified their race/ethnicity as Hispanic/Latino but completed the instrument in English.

An independent samples t-test revealed no differences in the three domain scores by

either language of tool used (Spanish or English) (Communication: $p = 0.178$; Decision

making: $p = 0.391$; Interpersonal style: $p = 0.230$) or race/ethnicity (Hispanic/Latino or

others) (Communication: $p = 0.130$; Decision making: $p = 0.350$; Interpersonal style: $p = 0.226$).

The IPC 18 Short Form interpersonal processes subscale scores ranged from 1-5

with higher scores indicating better interpersonal processes for some subscales and lower

scores indicating better interpersonal processes for other subscales**.** To obtain consistency

in domain means, item responses on lower scored subscale items were reversed so all

higher scores would indicate better processes. In the Communication domain, lower

scores on the lack of clarity subscale indicated nurses rarely communicated in unclear

language. Higher scores on the two additional subscales – elicited concerns, responded

and explained results – indicated nurses allowed clients to voice their concerns,

responded seriously to them and explained tests and physical exam results. Scores from

the lack of clarity subscale were rescored prior to calculation of the domain mean. The

Decision Making domain consists of 2 items pertaining to nurses and clients working

together. Higher scores indicated clients and their nurses worked together to plan treatment and decide between treatment choices.

The Interpersonal Style domain contained three subscales, two of which were used for analysis of this research question. Higher scores on the compassionate, respectful subscale indicated clients' nurses were concerned about the clients' feelings, respected the clients as persons and treated the clients as equals. Lower scores on the discriminated due to race/ethnicity subscale indicated clients' nurses did not pay less attention to or did not demonstrate discrimination toward clients because of the clients' race or ethnicity. Scores for the discriminated due to race/ethnicity subscale were rescored prior to calculation of the domain mean. See Table 17 for interpersonal process subscale means and standard deviations (prior to rescoring of lower scored subscales).

Domain means ranged from 1 to 5 with 5 indicating better interpersonal processes of care. These three means were calculated by averaging respective subscales, after items from the lack of clarity and discriminated due to race/ethnicity subscales were reversed. Including the reversed scored items the communication domain was moderately high and the interpersonal style domain was very high. Reported domain means indicated clients regarded the nurses caring for them to have positive interpersonal processes of care through clear, responsive, explanatory communication; participatory decision making and compassionate, respectful and nondiscriminatory interpersonal styles. See Table 18 for domain means and standard deviations.

Table 17

Interpersonal Processes of Care Subscale Means and Standard Deviations

Domain *Interpersonal Processes Subscale*	Direction of Scoring*	Mean	SD
Communication *Lack of clarity*	—	1.63	.705
Elicited concerns, responded	+	4.58	.626
Explained results	+	4.57	.842
Decision Making *Worked together*	+	4.07	1.12
Interpersonal Style *Compassionate, respectful*	+	4.60	.598
Discriminated due to race/ethnicity	—	1.26	.760

Note. * (−) low score = better IPC, (+) high score = better IPC.

Table 18

Interpersonal Processes of Care Domain Means and Standard Deviations

Domain	Mean	SD
Communication	4.46	.60
Decision Making	4.04	1.2
Interpersonal Style	4.59	.72

Question #5: What are the similarities between the cultural awareness/sensitivity,

culturally competent behaviors, and cultural competence of nurses providing care in the

community with the client's perception of the nurse's communication (lack of clarity;

elicited concerns, responded; explained results), decision making (decided together) and

interpersonal style (compassionate, respectful; and discriminated due to race/ethnicity)?

Nurse cultural awareness and sensitivity was moderately high, and nurse

performance of culturally competent behaviors and overall cultural competence were

moderate. Client perceptions of the nurses' communication, decision making and

interpersonal style were rated as very high. Specific content related to perceptions of care

are discussed. With respect to communication, 57% of the nurses responded that they

very often or always asked clients for explanations about clients' own health and illness.

Almost all clients indicated nurses usually or always asked about client concerns (90%),

allowed clients to say what they thought was important (93%) and took clients' health

concerns seriously (94%). For perceptions of decision-making, more than half of the

nurses indicated they very often or always asked clients about expectations for health

services (61%) and removed obstacles when clients identified barriers (60%). Clients

reported that nurses usually or always included them in treatment plans (77%) and

choices (69%). Regarding interpersonal style, many nurses indicated they very often or

always avoided using generalizations to stereotype groups of people (72%) and found

ways to adapt care for cultural preferences (65%). Clients responded that nurses were

usually or always concerned about their feelings (86%), respected them as persons (94%)

and treated them as equals (91%). Most clients (93%) indicated the nurses rarely or never

discriminated against them because of their race or ethnicity. One additional finding

which pertained to the nurses' cultural awareness and sensitivity was that all nurses

believed that everyone should be treated with respect regardless of their cultural heritage.

These findings indicate consistency between nurse and client perceptions.

Summary

Dimensions of cultural competence were described from the perspectives of 71

nurses who provide care in the community and from 69 of the clients served through their

agencies. The nurses were employed by home health and hospice agencies and public

health departments. All client participants were cared for by nurses employed by health

departments. Nurses cared for a diverse clientele and self-rated themselves as generally

competent with moderately high levels of cultural awareness and sensitivity**.** The nurses'

performance of culturally competent behaviors and cultural competence were moderate.

Clients reported that nurses who cared for them demonstrated high levels of interpersonal

processes of care in the specific domains of communication, decision making and

interpersonal style. Clients found the nurses communicated clearly, listened and

responded to their concerns and explained test and physical exam results clearly.

Decisions about treatment plans and treatment choices were discussed and decided

between clients and their nurses. The interpersonal styles of the nurses were found to be

compassionate, respectful and nondiscriminatory.

CHAPTER V

DISCUSSION

General Discussion

Cultural competence from the perspectives of both the nurse and the client were examined in this study. Most nurse participants in this study considered themselves to be somewhat to very culturally competent. The nurses' moderately high cultural awareness and sensitivity and moderate performance of culturally competent behaviors and overall cultural competence is comparable to hospice staff (Doorenbos & Schim, 2004), a group of public health nurses (Starr & Wallace, 2008), and healthcare workers who had experienced cultural diversity training (Schim et al., 2005). The moderate level of overall cultural competence is similar to hospice staff who had recently participated in a cultural diversity training experience (Schim et al., 2006b) and healthcare workers with graduate education (Schim et al., 2005).

The majority of nurse participants delivered care to clients in public health departments followed by hospice, and home health agencies. The nurses encountered a varied and diverse clientele from groups identified by Healthy People 2010 as experiencing health disparities (Healthy People 2010, Understanding and Improving Health, 2001). Included are those from racial/ethnic and special population groups, such as African Americans and Hispanic/Latinos, and those with physical and mental disabilities and those who are gay/lesbian/bisexual/transgendered. Similar to hospice staff

(Doorenbos & Schim, 2004; Schim et al., 2006b) and hospice nurses (Schim et al.,

2006a), nurses in this study encountered multiple racial/ethnic groups and special

populations in their practice environments.

No significant relationship was found in this study or in previous studies

(Doorenbos & Schim, 2004; Schim et al., 2006a; Schim et al., 2006b) between the

number of racial/ethnic groups encountered in practice and the nurses' performance of

culturally competent behaviors and their overall cultural competence. The Model of

Culturally Congruent Care suggests a relationship should exist between the breadth of

experience but was not reported in those studies. Perhaps examination of the types and

depth of experiences with racial/ethnic and special population groups would yield

significant findings. No significant relationship was found in this study between the

number of special population groups encountered in practice and the nurses' performance

of culturally competent behaviors and their overall cultural competence. No other studies

have reported this type of data to investigate this theoretical relationship.

Of the multiple variables considered, the number of cultural diversity training

experiences and type of care delivery in the community predicted participants'

performance of culturally competent behaviors and overall cultural competence. Higher

numbers of cultural diversity training experiences predicted a higher number of culturally

competent behaviors and higher levels of cultural competence. Previous studies have not

reported this significant finding, but have found levels of educational attainment and

participation in cultural diversity training to be significantly associated with the cultural

awareness and sensitivity, performance of culturally competent behaviors and overall

cultural competence of healthcare providers, hospice workers and hospice nurses (Doorenbos & Schim, 2004; Schim et al., 2005; Schim et al., 2006a; Schim et al., 2006b).

Public health nurses had lower scores in performance of culturally competent behaviors and in cultural competence than home health/hospice nurses. Differences in scores of the two groups were significant. Reasons for this are not evident but could be related to multiple variables within each system of care. For example, home health and hospice nurses actually participate in the client's personal setting while public health nurses care for multiple clients in prescheduled, short visit clinic settings. Also, home health and hospice nurses often have more long term relationships with clients and their families than public health nurses. This may lend the home health and hospice nurses to a better understanding of individual needs. Further research investigating the difference in scores between public health nurses and home health/hospice is warranted. Additionally, research investigating possible differences in cultural awareness/sensitivity, performance of culturally competent behaviors and cultural competence between nurses providing care in the community and nurses providing care in acute care facilities is needed. The differences between these divergent types of care delivery may influence the level ofcultural competence of these nurses.

Nurse participants in this study described personal experiences delivering culturally competent care. Many described incidents where the language barrier impacted delivery of culturally competent care. Communication is a vital component of cultural competence (Perloff et al., 2006) and is impeded when language barriers exist. These barriers can result in miscommunication, misdiagnosis and mistreatment (Perloff et al.,

2006) as well as an increased risk of not receiving recommended healthcare services such as cancer screening and diabetes care (Cheng, Chen, & Cunningham, 2007). Concerns about the lack of adequate numbers of interpreters to meet needs also were documented. Similar concerns have been reported previously by nurses and other healthcare providers (Gerrish, Chau, & Sobowale, 2004; Nailon, 2006). The need for appropriately trained interpreters to improve cultural competence has been well documented (Betancourt et al., 2005). In fact, federal mandates require provision of trained, competent interpreters in organizations and prohibit the use of family members and friends as interpreters unless the client requests their use (U.S. Office of Minority Health, 2001). Even though trained, competent interpreters may be available, appropriate use of their services is not guaranteed. Training of nurses and other healthcare providers in the appropriate use of interpreters is needed and would be a vital component of any type of cultural diversity training. This is essential if language barriers are to be adequately addressed (Nailon, 2006).

Clients' perceptions of the nurses' communication, decision making and interpersonal style were rated very high. Nurses were perceived to have positive interpersonal styles by delivering compassionate and respectful care and not demonstrating discrimination due to race or ethnicity. Similarities were noted between the nurses' performance of certain culturally competent behaviors and the clients' perceptions of their communication, decision making and interpersonal style. These components have been identified as key to cultural competence in the healthcare provider-client relationship (Nápoles-Springer et al., 2005; Tucker et al., 2003) but have

not been previously examined with nurse samples. Clients indicated their nurses used

clear, understandable communication and listened to and responded to their concerns.

They added that the nurses explained test and physical exam results. Clear, respectful

communication by providers (Sheppard et al., 2004), and providers listening to and

responding to clients concerns (Kaplan et al., 2006; Saha et al., 2003) have been found to

result in increased trust and satisfaction in the provider-client relationship.

Clients indicated their nurses used participatory decision making by including

them (clients) in treatment planning and treatment decisions. Greater satisfaction with

care (Cooper-Patrick et al., 1999) and higher quality interactions and more appropriate

use of healthcare services (Saha et al., 2003) have been shown to result from participatory

decision-making between providers and clients. Participatory decision making is

important in culturally competent care in order for clients to incorporate their cultural

beliefs and values into treatment planning.

Clients indicated their nurses delivered respectful and compassionate care by

being concerned about their feelings, respecting them as persons and treating them as

equals. These components of providers' interpersonal style (Stewart et al., 2007) are vital

in the delivery of culturally competent care as they demonstrate respect and value for the

client as a person. Expressions of compassion and respect by providers have been found

to lead to increased trust and satisfaction in the provider-client relationship (Sheppard et

al., 2004) while disrespect has been found to lead to mistrust (Kaplan et al., 2006).

Mistrust has been suggested as a factor in health disparities by leading to a reluctance to

seek treatment for conditions such as HIV/AIDS (Zekeri, & Habtemariam, 2006) and in termination of needed care (Sheppard et al., 2004).

Another component of interpersonal style that can interfere with the provision of culturally competent care and lead to mistrust is discrimination due to race or ethnicity (Sheppard, et al., 2004). Perceptions of discrimination by clients with diabetes have been associated with higher A1C levels, more reports of symptoms and poorer physical functioning (Piette, Bibbins-Domingo, & Schillinger, 2006). Clients in this study indicated they did not perceive discrimination due to race or ethnicity from the nurses providing their care.

Clients rated the nurses' communication, decision making and interpersonal style very high. While high quality care is provided to the clients at these facilities, their overall high ratings could also be contributed to the setting. If care at this facility is the sole source of healthcare access for these clients, the ratings could reflect their appreciation for the care that is provided.

Implications

This study focused on cultural competence of nurses providing care in the community as one approach to address the problem of health disparities. Findings revealed the importance of cultural diversity training and the impact of the language barrier on culturally competent care. Implications for research, education, practice and the community are evident. Including cultural competence content in health professions curricula and provision of ongoing cultural diversity training experiences for practicing

healthcare professionals is essential if culturally competent care strategies are to be effective in reducing or eliminating health disparities.

Even though the clients and many nurse participants considered themselves somewhat to very culturally competent, the nurses requested additional opportunities for cultural diversity training. This request for additional training is similar to findings in a pilot study (Starr & Wallace, 2008). This request, coupled with the finding that additional cultural diversity training experiences predicts performance of culturally competent behaviors and overall cultural competence, supports the need for ongoing education and training to increase and reinforce cultural competence of healthcare providers as a means to address health disparities. The development and implementation of cross-cultural training programs for all current and future healthcare providers has been recommended by the Institute of Medicine (Smedley et al., 2003), calling this training a key intervention strategy in reducing health disparities. Additionally, Standard #3 of the National Standards for Culturally and Linguistically Appropriate Services in Health Care (U.S. Office of Minority Health, 2001) suggests that cultural competence education and training may be the most important element of assuring the cultural competence of an organization and can improve clinical care and outcomes.

Implications for nursing education at all levels are evident. Accrediting bodies for schools of nursing recognize the significance of cultural competence content in curricula by requiring integration of cultural competence content in school of nursing curricula at all levels (American Association of Colleges of Nursing, 2008; National League for Nursing Accrediting Commission, 2008). In North Carolina, cultural competence content

will be integrated in all nursing courses included in a new associate degree nursing curriculum to be implemented in 2009. Cultural competence and diversity will be introduced in the first nursing course then threaded conceptually throughout the remaining nursing courses. This is similar to many baccalaureate and graduate nursing program curricula. Methods to achieve integration of cultural competence content include providing cross disciplinary academic coursework, internships, and research experiences, as recommended by the Pew Health Professions Commission (1998). For example, constructs of cultural competence could be introduced in a specific course taught by multidisciplinary faculty in the first semester, and then integrated in subsequent coursework. Content could be reinforced through internships in free clinics, community centers or nonprofit agencies serving diverse clientele. For example, experiences for nursing, social work, or health education students could be through work with individuals and groups at Section 8 or HUD housing complexes for intergenerational or elderly residents. Completing cultural assessments on clients or communities from diverse backgrounds during home visits with experienced nurses could enhance the experience. Follow-up of these activities through clinical conferencing and/or journaling could emphasize the connection between coursework and real world experiences.

In healthcare facilities, ongoing cultural diversity and cultural competence training through nursing staff development would reinforce and enhance the cultural competence of nursing and non-nursing staff in healthcare facilities. Including this as an expected and evaluated competency each year could increase and sustain cultural competence levels. This training could include classroom didactic experiences as well as

participation in cultural care committees, nursing rounds concentrating on cultural diversity and including clients in treatment planning and decision making. Including participation in cultural diversity experiences to clinical ladders, professional advancement, merit salary increases, and organizational benchmarks or accreditation could provide needed incentives.

Collaboration in the form of partnerships between schools, healthcare facilities and the community would provide opportunities such as community-based participatory research projects and immersion experiences to enhance the cultural competence of nursing students and nursing staff. Higher education schools of nursing and healthcare facilities could collaborate with community members to identify specific cultural healthcare needs and develop appropriate interventions to address those needs. National and international immersion experiences for nursing students and faculty could include incorporation of community health assessments and health teaching projects for specific culturally diverse groups at risk for and experiencing health disparities.

Research into the effectiveness of these instructional methods and others that will result in sustained, increased levels of cultural competence is needed. Quantitative data in the form of pre- and posttests could be collected from first semester nursing students in their initial cultural competence course and at graduation to assess effectiveness of the cultural competence educational strategies. Similar types of data could be collected from nursing staff in agencies at orientation and later at specific intervals. A more comprehensive evaluation would result from the combination of the quantitative data with qualitative description of the effects of the experience on cultural competence.

Implications of the findings for future policy and system change include the need to assure the provision of culturally and linguistically appropriate care which includes the provision and appropriate use of interpreters. The provision of adequate numbers of appropriately trained interpreters, and the training of employees in the appropriate use of interpreters should enhance both provider and client perceptions of care. Implementation of the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS) (U.S. Office of Minority Health, 2001) is one method to assure the provision of culturally and linguistically appropriate care. Evaluation of health care systems for full implementation of these standards is needed to assure culturally and linguistically appropriate care is provided.

Financial resources are needed to fully implement the CLAS standards. Federal funding sources such as Medicare and Medicaid provide access to services but may not be adequate to provide the training and provision of appropriate numbers of interpreters. Policy change is needed to assure adequate funding through these and other sources to provide this service because even if access is provided, care is compromised if the language barrier prevents appropriate care. Creative approaches to the provision of adequate numbers of appropriately trained interpreters are needed when financial resources are limited. These could include the hiring of bilingual staff or collaborating with other organizations to share interpreters. Allowing volunteer interpreters to receive free health screenings or care or collaborating with colleges or universities for upper level foreign language student volunteer interpreters are possible approaches. Investigation into other creative solutions is needed.

Implications for future theory development include further refinement and testing of the Model of Culturally Congruent Care. As indicated in the model, culturally congruent care must be evaluated from both the provider and client perspective. Testing was accomplished in this study with examination of the provider level constructs of cultural awareness and sensitivity, culturally competent behaviors and overall cultural competence with the addition of the clients' perspectives of specific constructs.

The Model indicates cultural competence is not an endpoint but evolves and changes over time as diversity experiences expand and new skills and knowledge are needed. Additional, ongoing cultural diversity training experiences are indicated to accommodate these changes and increase providers' cultural competence. This need is validated by this study's findings that performance of culturally competent behaviors and overall cultural competence increase with additional cultural diversity training.

Clients indicated the nurses provided culturally competent care in attributes of the provider-client relationship which includes the domains of communication, decision making and interpersonal style. Even though studies indicate positive outcomes such as adherence to treatment regimens, positive health behaviors and continuation of care result from these components of culturally competent care in the provider-client relationship; this was not investigated in this study. Further research should include evaluation of client outcomes related to nurses' provision of clear understandable communication, participatory decision making and respectful, compassionate and nondiscriminatory care. Further research could also investigate the impact of the nurses' communication, decision making and interpersonal style combined with or versus other culturally competent

measures such as language concordance, gender match and racial/ethnic match on client outcomes to determine the most effective interventions. This research could contribute to further refinement and expansion of The Model of Culturally Congruent Care by articulating client level constructs that contribute to culturally congruent care.

The Model suggests a significant relationship should exist between experiences with a variety of racial/ethnic groups and providers' cultural competence. This portion of the Model was not fully supported in this study since experience with a variety of racial/ethnic groups was not significantly related to the nurses' performance of culturally competent behaviors and overall cultural competence. Previous studies have reported similar findings. Further research guiding revision of the Model is warranted to clarify this relationship.

According to the Model, culturally congruent care is dependent on the interaction between provider and client level constructs. The client level constructs have not been well articulated, so additional conceptual and methodological research is needed to more clearly determine the measurement and definition of the client level and its contribution to our understanding of culturally congruent care and the related outcomes. This is best done through qualitative means to more fully understand clients' individual experiences as they relate to culturally congruent care. This includes investigation of clients' divergent interpretations and definitions of culture, race and ethnicity and the role each plays in the delivery of culturally congruent care. Other factors to explore include the influence of the length of the provider-client relationship and/or length of time in the U.S. acculturation on the clients' perception of culturally congruent care. Additionally,

exploration of the clients' experiences with health care in their home countries compared to care in the U.S. could yield valuable information. Investigating client level factors can contribute the necessary information to truly understand what encompasses culturally congruent care.

Summary

Clients perceived that their nurses often engaged in actions that are considered to be components of culturally competent care. Nurses perceived themselves to be somewhat to very culturally competent with moderately high cultural awareness and sensitivity and moderate performance of culturally competent behaviors and overall cultural competence. Similarities were noted between specific culturally competent behaviors of the nurses and the clients' perceptions of their communication, decision making and interpersonal style indicating consistency between the nurse and client responses.

Health disparities are multifaceted, so a broad-based, multidisciplinary approach is needed if they are going to be reduced or eliminated. Reducing or eliminating health disparities has become a national initiative and cultural competence, as a component of culturally congruent care, has been suggested as one strategy to address the problem. Cultural competence is best understood by examining the perspectives of providers as well as clients. Examination of these perspectives can inform nursing practice, research, educational programs and quality care initiatives. This can contribute to the enhancement of cultural competence of providers leading to the reduction or elimination of health disparities.

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APPENDIX A

MODEL AND INSTRUMENTATION REFERENCES

Model of Culturally Congruent Care:

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