“Providing Culturally Sensitive Care”
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Objectives

The Learner will be able to:

• Describe one’s self-assessment for cultural competency

• Discuss interventions to provide culturally competent care in their individual practice/work setting

The U.S. is projected to become a majority-minority country by 2044

Stephanie has no disclosures
**Distribution of U.S. Population by Race/Ethnicity, 2000 and 2050**

2000:  
- White, Non-Hispanic: 69.4%  
- Hispanic: 12.6%  
- African-American, Non-Hispanic: 12.7%  
- Asian: 2.5%  
- Other: 3.8%  
- Total: 282.1 million

2050:  
- White, Non-Hispanic: 50.1%  
- Hispanic: 24.4%  
- African-American, Non-Hispanic: 14.6%  
- Asian: 8.0%  
- Other: 5.3%  
- Total: 419.9 million

**Why?**

Despite efforts to incorporate psychosocial & cultural factors in traditional nursing education, disparities among diverse groups’ health status persists in the 21st century.

Therefore, heightened awareness is needed of how beliefs, values, religion, language and other socioeconomic factors influence health promotion and help-seeking behaviors.

**Cultural Competence**

“...the attitudes, knowledge, and skills necessary for providing quality care to diverse populations”

(AACN, California Endowment, 2003)
Cultural Sensitive

• TJC requires that all patients have the right to care that is sensitive to, respectful of and responsive to their cultural and religious/spiritual beliefs and values (Coe, nd)

• RNs are likely to encounter patients from diverse cultural beliefs and practices regarding health. Our Scope & Standards of Practice focuses on culturally congruent care

ANA’s Nursing: Scope and Standards of Practice, 3rd Ed.

Standard 8: Culturally congruent practice

• Requires RNs to practice in a manner congruent with cultural diversity and inclusion principles
• Includes 13 competencies for RNs and additional standards for APRNs
• Must be aware that cultures have different systems of beliefs around health, wellness, and practices
• Nurses must have a willingness to work with the patient to adapt their care so that we all get to the same goal of improved health outcomes for our citizens

ANA Code of Ethics for Nurses

The Code is "the nursing profession’s ethical standard of practice and nursing’s contract with society”

Has 9 provisions

• Provision 1: the nurse, in all professional relationships, practices with compassion and the recognition of human dignity and worth that is present in every individual

Code of Ethics

• 1.1 Respect for human dignity. The nurse respects the beliefs and customs of the individual, family, or community…takes into account the values and needs of all persons in the professional relationship,

• 1.2 Relationships to patients. The nurse establishes therapeutic relationships with patients and administers nursing care that respects the unique differences of the patient…the includes considerations of lifestyle, value system, and religious beliefs.
Domain 1: Nurse-led Interventions
Competency 4 (Deliver Client & Family-centered Care)
Demonstrates a collaborative approach to planning, delivering, and evaluating care that acknowledges and honors the client's and family's culture, values, beliefs, and care decision-making.

Domain 4: Competency 2: Implement an Interprofessional Holistic Plan of Care
Develops a plan of care for diverse clients, which prescribes strategies, alternatives, and interventions to attain desired outcomes.

What is Cultural Competency?
“Cultural & linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations.”

U.S. Department of Health & Human Services (www.hhs.gov)
Why is Important?

• It helps to close the gap in health care disparities
• It enhances the conversation between patients and providers
• Health care that is respectful and responsive to the health beliefs, practices, and cultural needs of diverse patients helps to bring about positive health outcomes
• Patient & provider each bring their individual culture and experience which must be transcended to achieve equal access and quality health care

Race... “Sociopolitical concept”

• Used to socially define a group based on common inherited physical characteristics
  • Hair color/texture
  • Skin color
  • Facial features
  • Racism is about how people assign meaning to how one looks racially
  • Most often the most significant factor in how we are perceived even though it’s the least important aspect in character determination

RACE

• Skin color alone does not provide any reliable information about a person’s race, culture or susceptibility to disease.
• Race is a cultural invention based on a set of ideas developed in recent history and science.
• However, skin color may offer insights into a person’s geographic ancestry.
• Scientists theorize that skin color evolved as an adaptive trait linked to the strength of the sun’s ultraviolet rays.
• Human DNA and specific alleles can be traced back to an African population that existed over 100,000 years ago.
• One way that scientists can trace our genetic ancestry is by following the path of mitochondrial DNA and Y-chromosome DNA, which are normally transmitted unchanged from one generation to the next.
RACE

• Racial groupings based on visible physical traits, such as skin color, nose shape or hair texture, tend to be arbitrary distinctions, as traits do not aggregate into categories that can be described as races.
• History has shown that perceptions of race change over time.
• Further, people culturally self-identify differently than others would categorize them.

Ethnicity

“Population within a larger society”

Sometimes, ethnicity and race interchangeably. Ethnicity can be independent of race.

• Share a common ancestry, history, or culture
  • Cultural norms
  • Religious traditions
  • Language
  • Dietary preferences

Culture

• Learned and shared values, beliefs, and behaviors of a group
  • Art
  • Morals
  • Law
  • Custom
  • Other capabilities and habits

Campinha-Bacote (2002)
Byrd-Giles

Diversity

“Cultural Differences”

• Values
• Beliefs
• Behaviors
• Nationality
• Ethnicity
• Gender
• Age
• Physical characteristics
• Sexual orientation
• Economic status
• Education
• Profession
• Religion
• Org. affiliation
Influence of Culture
- Define health, healing, and wellness belief systems
- Perception of illness, disease, and its cause
- Health seeking behaviors
- Attitude toward health care providers
- Compromises the delivery of care by the provider
- The cultural background and the nurse attitude regarding culture influences the way in which care is delivered

CLAS Standards
- “National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care” (HHS, Office of Minority Health, December 2000)
  - Three CLAS themes:
    - Culturally competent care
    - Language access services
    - Organizational supports

Culturally Competent Care
- Patient-centered focus
- Effective HCW-patient communication
- Balance fact-centered and attitude/Skill-centered approaches to acquiring cultural competence
  - Racial stereotyping vs. Ethnic group’s historic context
- Acquisition of cultural competence as a developmental not an educational process
- Understanding alternative sources of care
  - Folk medicine, herbal remedies, Eastern medicine, rituals

Language Access Services
- Providing language access services to those with limited English proficiency is a federal mandate
- Interpretation services
- Training to work effectively with interpreters
  - During interview, speak directly to patient, not interpreter
  - Assume that everything said is being interpreted
  - Be patient
  - Ask interpreter about potentially inappropriate questions
Organizational Supports

- Strong commitment at every level of the organization
- Community involvement
- Recruitment of minority staff and community health workers
  - Goal is to strive to match community demographics
- Training and professional development for staff
- Conduct organizational assessment to appropriately plan for services

Race in the U.S.

http://www.understandingrace.org/history/index.html

Institute of Medicine (IOM)

“Crossing the Quality Chasm” (2001) documented the American healthcare’s failure to provide equitable, patient-centered care

“Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care” (2003) critique of how HCP’s prejudices, biases and stereotypes contribute to unequal treatment of racial & ethnic minorities

Provider-Client Issues

- Studies support:
  - Providers report higher rate of negative non-productive encounters with non-white patients than with white patients
  - Non-white patients report less participatory interactions with white physicians
  - Non-white patients report greater participatory process when caregiver is of the same race
  - Attending a diverse medical school better prepares providers to work with diverse patient groups

(US News, 2016; AMA, 2008)
The Evidence

- The provision of culturally competent service can potentially improve the health of minorities by improving physician-patient communication and delivering health care in the context of each patient's cultural beliefs (Vermaire, Hearnshaw, VanRoyen, & Denekens, 2001).
- Social, cultural, and language barriers to health care access are numerous and problematic. Culture and linguistic differences and levels of acculturation may affect communication, level of trust, and the ability to navigate the American health system (Coleman-Miller, 2000; Commonwealth, nd).

Health Disparity

- Race and ethnicity account for many disparity’s in public health.
- Alabama's minorities have poorer access to care than Whites often.
  - African Americans, American Indians, Asian Americans, Hispanics/Latinos, and Native Hawaiians/Pacific Islanders.
- Alabama has the 2nd highest percent of Medicare recipients listed as disabled (24%), tied with Mississippi and just below Kentucky at 25%.

Alabama Health Disparity

- 47th in the 2017 edition of America’s Health Rankings.
  - Negatively impacted by high uninsured rate, but positively affected by a low rate of binge drinking and a high rate of high school graduation.
- Causes:
  - Access to care, health insurance coverage, preventive health services, barriers to care.

Alabama Health Disparity

- Alabama ranks 4th in nation in deaths due to stroke.
  - Disparity:
    - African American males highest mortality rate for heart disease and highest stroke death rate.
    - African American and Hispanic women have disproportionately high rates of heart disease.
Alabama Health Disparity

• Diabetes Disparity
  • African Americans have 70% higher diabetes mortality rate than Whites

• HIV/AIDS Disparity
  • African American make up one-tenth of the population, yet nearly 50% of new HIV infections

• Lowest primary care physicians (100 per 100,000 population)
• Alabama has the lowest concentration of mental health providers (85.0 per 100,000 population)
• Pre-term birth is highest for:
  • African American (21.7)
  • Native Americans (18.8)
  • Hispanics (14.6)
  • Whites (14.5)
  • Asians (13.1)

• Youth suicide Disparity
  • Alabama ranks 28th in the nation
  • Suicide 18.8 for American Indians and Alaskan Natives compared to:
    • 11.5 for Whites
    • 7.3 for African Americans
    • 6.1 for Hispanics
    • 6.4 for Asian Americans
  • American Indians/Alaska Native, ages 15-34, suicide is the 2nd leading cause of death

Reducing health care disparity saves lives

In health care there are:

Unequal burdens in disease, morbidity, and mortality experienced by minorities, compared to the dominate group.
Facts

• The United States is racially and ethnically diverse, and growing over time.

• Society’s concerns sparked by research and information confirming astounding healthcare disparities among people of color has renewed the interests in the causes of disparities

• and affirming one such intervention — providing culturally sensitive care.

Today’s estimates

• Three largest minority groups in U. S. Workforce

  • Hispanic/Latino (14.7%)
  • Black/African American (11.6%)
  • Asian American (4.6%)
  • Pacific Islanders (0.5%)

African American Health Disparities

“Four Key Areas to Reduce Health Care Disparities and Save Lives of African Americans and Hispanics” (2008)

Robert Wood Johnson Foundation

RWJ Study

Improve deaths by improving disparity in:

• Cardiovascular Disease
• Influenza Vaccination
• Cancer treatment
• Kidney Transplant
Blacks less likely to survive heart attacks in hospital

A study by the National Registry of Cardiopulmonary Resuscitation (2009), a program aimed to improve survival rates found:

- Examined about 10,000 patients who went into cardiac arrest in 274 U.S. hospitals
- Black patients have a 10–27% lower chance of surviving to discharge than white patients
  - were attributable in part, to black patients being more likely to receive care at hospitals with lower outcomes
  - more likely sicker at time of cardiac arrest

Health Status

African American “High” lights

- Highest Heart Disease death rate
  - (both African American men and women)
- Highest Breast, Lung, and Colorectal Cancer death rate
- Higher rate for Diabetes than whites
- Higher rate for Stroke than whites (see RAND study)
- Highest rate of Obesity

Health Status

African Americans vs. Whites:

- Experience Severe Sepsis at nearly twice the rate
- Twice the mortality rate in prostate cancer
- Five-year cancer survival rate for all cancers is lower
- Amputations nearly five times greater
- 57% receive recommended mammograms compared to 64%
- About one in seven diabetic patients received blood sugar tests as part of treatment

New AIDS Cases and HIV-Infection Deaths by Race/Ethnicity

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What can we do to move toward **BECOMING MORE COMPETENT?**

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**Sex and Aging**

- Western cultures tend to view menopause and sexuality in aging negatively
- Survey of Hong Kong women did not generally view menopause as negative, but as a neutral occurrence
- Muslim culture of Pakistan-menopause viewed positively and a “happy” event
- In a symptom profile of 420 Singapore women, menopause complaints markedly lower compared to European studies. And that menopausal symptoms less impact than in the West.

*Campana, 2017*

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**Transcultural Nursing**

Defines …

*How professional nursing interacts with the concept of CULTURE, supported by theory, research and practice*

This supports the proposed Cultural Competency in baccalaureate nursing programs by American Association of Colleges of Nursing (AACN) to combat persistent health status disparities

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**Leininger’s Transcultural Nursing Sun Rise Model**

Nursing links patient’s culture to healthcare system
Leininger’s (1978) Sunrise Model

Nine Domains that influence care and health status
- Pattern of lifestyle
- Specific cultural values and norms
- Worldview and ethnocentric tendencies
- General features patient perceived as different or similar to other cultures
- Caring behaviors
- Health and life care rituals and rites of passage to maintain health
- Folk and professional health-illness systems used
- Degree of cultural change

LEARN Model (Berline & Fowkes, 1983)

Use as a supplemental component to the typical structured history-taking medical interview
- **Listen** with sympathy and understanding to the patient’s perception of the problem
- **Explain** your perceptions of the problem
- **Acknowledge** and discuss the differences and similarities
- **Recommend** treatment
- **Negotiate** agreement

“Becoming” culturally competent

Have I **A-S-K-E-D** myself right questions?
- **A**wareness, of personal biases and prejudices
- **S**kill, to conduct culturally-based & sensitive assessment
- **K**nowledge, of the patient’s world view & culture
- **E**ncounters, how many have I had
- **D**esire, genuinely want to be culturally competent

You don’t need the institution to do it!

- Recognize cultural differences and diversity of the population
- Build self-awareness and examine your own belief systems
- Make assessments based on facts and direct observations
- Solicit the advice of team members with experience
- Give your time and attention when communicating
- Attend diversity and inclusion seminars/classes
You don’t need the institution to do it!

- Share experiences honestly with co-workers to keep communication lines open
- Practice politically correct communication—avoiding making assumptions or stereotypical remarks
- Refrain from making judgment based limited personal interaction
- Attend diversity and inclusion seminars
- Engage the community

Conclusions

- A laundry list of traits, habits, and stereotypes of a particular group is ill-served
- However, seek cultural awareness of significant issues that may impact the care of clients served is our responsibility as professional competent nurses
- Studies prove that perceived racial discrimination in health care by certain groups is associated with a worsen health status
- Nurses are pivotal in their role as patient advocates and social justice seekers to make the difference
- Challenge is for nurses to provide care to culturally different patients

Conclusions

- Lack of cultural competence is oftentimes a barrier to effective communication amongst interdisciplinary teams, often trickling down to patients/families
- Nursing remains mostly unchanged (mostly white), though we face a global mobility of people and ethnically diverse population
  - Organizations should strive to reflect the diversity of the population it serves
  - Provide culturally congruent care through communication, available resources, knowledge, and creativity.

QUESTIONS?

“If you talk to a man in a language he understands, that goes to his head.
If you talk to him in his language, that goes to his heart”

Nelson Mandela