Equity in Healthcare Access: Using Cultural Competency Training to Bridge the Gap between Providers and Latino Patients in Durham, NC

A cross sectional descriptive study with mixed methods data analysis

A thesis presented
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Abstract

Alongside Asians, Latinos are the fastest growing ethnic group in the United States with a projected population of 99.8 million by 2050 and 111.22 million by 2060. With this significant uptick comes an inevitable diversification of the social, linguistic and cultural landscapes of the country. One’s cultural background influences beliefs about causes of illness, expectations for care, preferred treatment methods, and much more. However, U.S. healthcare providers and the overall systems within which they work are not always equipped with the proper knowledge, tools, and resources to equitably treat all Latino patients seeking care. As a result, the Latino population faces significant inequities in acceptability and appropriateness which asks, “what happens to a Latino patient upon obtaining physical access to a health system?” “How do their sociocultural beliefs influence their interactions” and furthermore, “what is the quality of the relationship between the patient and the provider?”

With this in mind, the aim for the study component was to assess the impact of a cultural competency educational intervention at a Duke Health Clinic via the implementation of an original survey instrument that gauges need satisfaction concordance amongst Latino patients and their providers. The results indicated that both patients and providers reported highest overall satisfaction with the demonstration of cultural comfort, however providers indicated that they felt the weakest about their demonstration of cultural humility and patients felt the weakest about the maximization of cultural opportunities during the clinical encounter.

While there is still much room for improvement, significant progress has been made, especially over the past twenty years, in the incorporation of diversity frameworks within healthcare institutions. The next step is to standardize and equitably disseminate them throughout the country so that all providers are rightfully equipped and all patients are rightfully served.
Dedication

This paper is dedicated to the very population it is meant to serve: practicing doctors and residents, more specifically those within the Duke Children’s Primary Care North Durham Clinic, as well as the Latino patients served both at this clinic and across the country.

Day in and day out, doctors work tirelessly to serve every patient that walks through the door. This paper is written in utmost acknowledgement and deep gratitude for their service to the profession and to the people they serve. Furthermore, for their willingness to be introspective about their own beliefs and practices while in turn, remaining open to their patients’ preferences will forever be noteworthy and always appreciated.

To Latino patients, whom I hope felt empowered, heard, and seen through sharing their voice, some for the first time.
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1. Introduction

Alongside Asians, Latinos are the fastest growing ethnic group in the United States with a current population totaling over 60 million and a projected population expected to reach 99.8 million by 2050.\(^1\) This growth contributed to more than half (52\%) of the United States’ overall population expansion between 2010 and 2020, making Latinos the largest ethnic minority group resting at roughly 18.7\%.\(^2\) With this significant uptick comes an inevitable diversification of the social, linguistic and cultural landscapes of the country, as the Latino population is an inherently diverse group of people, who, despite shared core values, possess unique perspectives tied to their national heritage and background.\(^3\) One area where these differences are of particular relevance is within healthcare delivery, as one’s cultural background highly influences beliefs about causes of illness, expectations for care, preferred treatment methods, and much more.\(^4,5\) Typical health service provision in the United States has historically “[supported] dominant cultural models” that are most ideally-suited for the standard, North American, English-speaking patient. Now, however, as the country’s demography is continuously evolving, these models have rendered themselves obsolete, undoubtedly yielding the need for adaptations to service delivery that will better meet the needs of Latino patients who face prevailing health inequities and widespread patient dissatisfaction in comparison with non-Latino whites.\(^4,6\)

There are a number of critical health disparities faced by Latinos in the U.S. This research centers around increasing equity, defined as the case in which “everyone has the opportunity to attain their highest level of health,” specifically within the realm of access to care.\(^7\) Throughout the years, healthcare access has been defined in many ways; however, within the last decade, recent literature most frequently cites an expanded conceptualization of access as
developed by Levesque et al. in 2013. This definition categorizes access into 5 main dimensions: approachability, acceptability, availability/accommodation, affordability, and appropriateness.

“Approachability relates to the fact that people facing health needs can actually identify that some form of services exist, can be reached, and have an impact on the health of the individual.”

Differential knowledge can exist amongst population groups regarding recent developments, efficacy, or availability of treatments. This, in turn, influences how or if people pursue said services.

“Availability and accommodation refer to the fact that health services (either the physical space or those working in health care roles) can be reached both physically and in a timely manner.”

Subcategories of this dimension include characteristics of the healthcare facility such as distribution within urban vs. rural areas, resource availability, funding, adequate staffing and hours, etc. It can also refer to providers’ availability and service delivery modes (telehealth, community health, etc.).

“Affordability reflects the economic capacity for people to spend resources and time to use appropriate services.” This can be dependent on a number of factors including the baseline price of services in the area, health insurance coverage, copayment fees, etc., that often force an individual to weigh the benefit of paying to receive a service with the cost of potentially “catastrophic expenditure of resources” depending on social and economic standing.

“Acceptability relates to cultural and social factors determining the possibility for people to accept the aspects of the service (i.e., the sex or social group of providers, the beliefs associated to systems of medicine) and the judged appropriateness for the persons to seek care.” This dimension includes everything from the patient’s personal comfort
with seeking care and sociocultural healthcare norms to equitable distribution and provision of services.⁸

“Appropriateness denotes the fit between services and clients need, its timeliness, the amount of care spent in assessing health problems and determining the correct treatment and the technical and interpersonal quality of the services provided.”⁸ This dimension is inclusive of the quality of the patient-provider relationship and the way in which high quality services are administered to best suit the patient’s needs and preferences. This dimension also looks at provider knowledge and comfort working with people who maintain distinct cultural and linguistic backgrounds that could potentially impact their perception of treatment and care.⁸

This paper specifically addresses acceptability and appropriateness access, or in other words, what happens to a patient upon obtaining physical access to a health system? How do their sociocultural beliefs influence interactions with the health system? And as a result, what is the quality of the relationship between the patient and the provider?

Studies reveal that a predominant contributor to Latino health disparities is a breakdown in communication between the patient and provider. One primary way that health institutions across the country have sought to increase equity in acceptability and appropriateness access is by bridging the gap of cultural understanding between healthcare providers and their Latino patients via cultural competency training programs.⁹ Studies show that “providing culturally competent care to patients can greatly facilitate rapport, reduce patients’ stress and uncertainty, while increasing treatment compliance.”¹⁰ Furthermore, culturally competent care is considered “essential to reducing and eliminating health disparities among minorities,” and year after year,
more institutions are adopting cultural competency modules or designing their own in hopes of reducing said disparities in access.\textsuperscript{11}

While cultural competency education has certainly contributed to a more inclusive healthcare model, this is not to say that it is without its faults, as training and expectations for knowledge acquisition are drastically unstandardized across the country, leaving providers with varied skill sets and patients with varied quality of health system interactions. With this in mind, the aims for this study are:

1. to assess the ways in which Latino culture shapes their health behaviors and perceptions
2. to extrapolate some of the most relevant factors that influence the patient-provider relationship
3. to overview the evolution and impact of cultural competency training in the United States
4. to assess the impact of a cultural competency educational intervention at a Duke Health Clinic via the implementation of an original survey instrument that gauges need satisfaction concordance amongst Latino patients and their providers

Latinos are less likely to have a usual source of care on top of having the highest uninsured rate of all racial or ethnic groups in the U.S. at about 37.1%.\textsuperscript{12} These values inevitably reinforce the importance of ensuring that upon physical access to a health system, service delivery is tailored to be equitable for all regardless of racial, ethnic, cultural, or linguistic background.\textsuperscript{7} Granted, achieving true health equity is much easier conceptualized in theory rather than practice, as “health” is not a unidimensional concept, but rather “a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity.”\textsuperscript{13}
Nevertheless, the hope for this study is that it will productively contribute to health sector research that investigates how to ensure that providers are equipped with the knowledge and tools necessary to facilitate the treatment of all those seeking care.

2. Characterizing the Target Population

Terminology

According to Federal regulations, the terms Hispanic and Latino/a refer solely to an ethnicity of people who can, in turn, belong to any particular race.\textsuperscript{14} This designation has a long and concerted history that triggers much confusion in a society that has historically placed much emphasis on ethnoracial categorization.\textsuperscript{15} Though most modern demographic forms as well as the recent 2020 Census allow one to indicate race along with Hispanic or Latino/a origin, this was not always the case; in fact, the term ‘Hispanic’ first appeared on a U.S. Census in 1970 after decades of intense lobbying led by Mexican-American activists and Latino social justice organizations. “Hispanic” specifically refers to those who can trace their heritage back to any Spanish speaking country, excluding Brazil but including Spain.\textsuperscript{16} Members of the Nixon administration agreed that the word “Hispanic,” based on the Spanish word “hispano,” was an appropriate Americanized term to represent this group of people who, for 40 years prior, were statistically counted as white Americans.\textsuperscript{16,17} Though this achievement marked a momentous victory for those who worked tirelessly for better national representation, it was only ten years later that controversy around the term arose due to its association with the colonizing country of Spain. As a compromise, the U.S. Office of Management and Budget, the sector that prescribes all guidelines followed by the Census, issued an amendment in 1997 that added the word “Latino,” a term rumored to have been circulating throughout the United States as early as the 1920s, to government publications.\textsuperscript{18}
Despite its semblance, the term “Latino/a” is slightly different in that it includes all those who can trace their heritage back to at least one country within Latin America, this time including Brazil but excluding Spain. “Latino” is derived from ‘Latino America’ and short for the Spanish-language word ‘Latino Americano,’ meaning Latin American, as popularized by Colombian writer José María Torres Caicedo. The word is reflective of the sustained political and geographic links that uniquely existed between the United States and Latin America. The term was embraced because it “respects the diverse national origins and the waves of population movement from Latin America…” while also “[preserving] the flavor of national origin by being culturally and racially neutral.” “Latino/a has been generally employed to reference an amalgamation of peoples of Latin American descent; a U.S. ethnoracial identity and location; cultural connection and similitude; and political solidarity across ethnic nationalist affiliations.”

Though Latino and Hispanic maintain slight variations in meaning, they are systemically used interchangeably as pan-ethnic identifiers.

Most recently, the term ‘LatinX’ has circulated throughout social sectors, discourse, and academia. Distinguished by its pragmatic and grammatical inclusivity of all people regardless of gender or sexual identity, this term breaks from the typical linguistic patterns of the Spanish language that designate masculine terms with an “o” ending and feminine terms with an “a” ending in order to validate the presence of those who do not fit within the gender binary. “LatinX is a harbinger of two compounded configurations—Latin and X—”…that possesses an inherent sense of “inclusivity and fluidity” that naturally engages audiences in a deeper conversation surrounding the limitless possibilities of what Latinness can ultimately represent. In other words, “LatinX has a very busy life. You can’t pin down the Latin or the X: they both possess inherently hidden qualities and ubiquity in the world.”
In spite of LatinX’s rising popularity, a few critiques arose, one being that it originated within the United States amongst English speakers, ultimately raising the question of whether it has more institutional than community backing. Because it is an English language word, LatinX is pronounced as \\uh-TEE-neks.\^{21} This is practically impossible for a Spanish speaker to enunciate, which would inevitably explain why it has not taken firmer root within the Spanish speaking populations across the United States.\^{16,22} In a 2019 Pew Research study, only 23% of adults who identified as Hispanic or Latino were familiar with the term LatinX, and of that, only 3% used it consistently.\^{16,22} Granted, those within the age range of 18-29 were six times more likely to have heard of the term than those sixty five and older, so this variance could potentially be attributed to different generational acquisition of mainstream terminology, however this remains a speculation.

Despite ‘LatinX’s’ growing traction, the terms Hispanic and Latino are still most commonly used, if for nothing but the fact that they represent the first distinguishable categories of people separate from that of the white race. On the flip side, it must be noted that they are not universally accepted amongst all members of these communities, often due to sentiments that they homogenize and overlook the characteristics that distinguish one Latino population from the next. As previously mentioned, one must remember that these terms are institutionalized pan-ethnic identifiers that represent a range of people with varying lived experiences, all equally deserving of distinction. It is for this very reason that many within the Hispanic and Latino communities would rather refer to themselves according to their country of origin, as it is a more precise tie to their cultural heritage.\^{14} In fact, according to a 2020 Pew Research study, approximately 47% of Latino adults describe themselves as Mexican, Honduran, Guatemalan, etc., while only 39% use Hispanic or Latino and 14% use American.\^{14} It is also essential to note
that all Spanish speakers are Hispanic or Latino, but not all Hispanics or Latinos speak Spanish nor do they have the same level of Spanish production or comprehension.

Thus, when the question arises of who is considered Hispanic, Latino, or LatinX in the United States, the objective answer is “anyone who says they are. And nobody who says they aren’t.”22 Given this varied preference, the term Latino will be used throughout this paper for consistency purposes as well as to most accurately represent the study’s target population in Durham who all traced immediate origins to Latin America; however, to ensure utmost precision out of respect for those who prefer country of heritage, specific demographic backgrounds will be used when known.

3. Latinos within the U.S. Healthcare System

3.1 Patient-Provider Relationship

As previously mentioned, the dynamic between a Latino patient and the provider is cited as one of the most critical determiners of patient satisfaction and treatment adherence. In fact, for any patient regardless of racial or ethnic background, the patient-provider relationship (PPR) is one of the most important dimensions of the entire service delivery process. It lays the groundwork for all subsequent interactions and its health generates a culture of camaraderie and trust between both parties. “High-quality patient–provider relationships are associated with improved patient confidence and information seeking behaviors,” which facilitates diagnosis and treatment due to heightened understanding of the concern.23

The typical relationship between patient and provider is structured such that it reflects a vertical dyad power dynamic where the provider takes the lead and the patient follows. The provider then uses his or her respective medical expertise to determine the appropriate treatment method.23 The reason why a healthy PPR is essential, especially for Latino patients, is because of
the way their diverse sociocultural backgrounds and unique lived experiences converge to their influence health perspectives. These perspectives will, in turn, influence how service delivery should be approached. In an ideal scenario, the patient and provider exchange in productive dialogue that fosters a general sense of understanding between both parties; however, this exchange is not straightforward as many intertwined factors are also at play.

Primary Influential Factors within the Patient-Provider Relationship

It is relevant to analyze some of the primary factors that impact the PPR to better understand how culturally competent behaviors and practices can best fit within this dynamic. Though these factors are incredibly multidimensional, they can be easier understood when broken down into subcategories within the microsystem, mesosystem, and macrosystem. The microsystem is representative of the interdependent relationship between the patient and the provider (PPR). The mesosystem is the specific context within which the microsystem functions, in this case, the healthcare setting. Lastly, the macrosystem is the greater sociocultural environment that envelopes both the micro and the mesosystems.

3.2 Microsystem

Latino Culture: Culture can be understood as an integrated system of patterns that consist of “experiences, expressions, symbols, materials, customs, behaviors, morals, values, attitudes, and beliefs created and communicated among individuals,” that are passed down from generation to generation. Culture largely shapes the way an individual interacts with the environment and can influence everything from behaviors and communication preferences, to styles of dress and perceptions of the world. Each of the 33 countries in Latin America maintains its own culture with “systems of health beliefs to explain what causes illness, how it can be cured or treated, and who should be
involved in the process.” These ideals are upheld and reflected by people despite geographic proximity to their home nation. Because of the great diversity that exists both within and across Latino population groups, it is pertinent to factor in the ways in which culture impacts “how and from whom a person will seek care, how self-care is managed, how health choices are made, and how a patient responds to specific therapy.”

While there are many cultural specifics within each respective nationality, this paper will focus on shared Latino group norms and practices. Latinos view culture through a collectivist lens: “group activities are dominant, responsibility is shared, and accountability is collective.” This contrasts significantly with the United States’ vastly individualistic culture, for Latinos prioritize characteristics of harmony, cooperation, loyalty, unity and reciprocity in their group dynamic that impact they ways they make decisions. For example, in a study conducted by the American Journal of Health Behavior about participant characteristics in a Latino health program, it was found that perceived family support and approval was more likely to influence Latino patients to participate in a heart-health-promotion program than autonomous support because a person’s wellbeing is considered “the responsibility of the family” rather than the individual.

Other shared cultural perspectives that influence behavior include personalismo, which describes the acts of mutual respect and trust building between individuals, jeraquismo, which is respect for hierarchy and authority, respeto, which is respect for adults and simpatía, meaning kindness. It is especially necessary that providers take note of the ways that jeraquismo and respeto might dictate certain behavioral responses during the clinical encounter. For example, Latinos typically avoid questioning those in
positions of power. This could lead to a hesitancy in asking questions, advocating for needs, or raising concerns.²⁴

Because of the potentially limitless impact that culture can have on a Latino patient’s health preferences, behaviors, and responses, it is paramount that a provider utilize said culture as a foundational guide for establishing a strong PPR. In the case that the patient’s cultural perspectives or ideologies are unknown, there must be intentional dialogue to fill this gap in understanding.

**Differing expectations of visit length**: Another prime conflict that arises between the patient and the provider centers around the amount of time spent during the clinical encounter. Typically, patients prefer longer visits whereas providers, due to various reasons relating to system constraints, tight schedules, administrative responsibilities, etc., might not be able to accommodate those needs. Studies show that longer visits are associated with heightened patient satisfaction, however in the case that a provider does not have extensive time, one way to ensure the patient is still pleased with the visit is by making it patient-centered. This means that the patient’s needs and desires are placed at the center of all decision-making processes and conversations (See Table 1).

**Table 1: Doctor vs. Patient Centered Care**²⁷

<table>
<thead>
<tr>
<th>Doctor-centered care</th>
<th>Patient-centered care</th>
</tr>
</thead>
<tbody>
<tr>
<td>The doctor dominates and controls the interview</td>
<td>The patient is considered the source of information</td>
</tr>
<tr>
<td>Patient participation is limited and not expected</td>
<td>Patient participation is active, and doctors respond to patient cues</td>
</tr>
<tr>
<td>The doctor does not elicit or respond to psychosocial issues</td>
<td>The doctor attends to psychosocial factors</td>
</tr>
<tr>
<td>The doctor does not address the impact of the illness on the patient’s life</td>
<td>Doctors use communication skills and empathy to convey an understanding of the impact of illness</td>
</tr>
<tr>
<td>The doctor selects the treatment</td>
<td>Doctors provide options for treatment</td>
</tr>
<tr>
<td>The doctor predominarily makes final decisions</td>
<td>Patient and doctor mutually decide on the care plan</td>
</tr>
</tbody>
</table>

²In pediatric, impaired, and elderly patients, decisions might relate to the parent or caregiver.
Studies also show that patients will be influenced to overestimate the length of their visit if specific dimensions such as high-quality communication, empathy, and trust are present.\textsuperscript{27,28} A provider’s ability to “[assess] patients’ needs, preferences, and values, and then [tailor] communication to align with patients’ perspectives” is a transformational skill that helps account for any potential breakdowns in sociocultural understanding.\textsuperscript{27,28}

Lastly, in situations when feeling particularly rushed during the day, providers can rely on the ‘I’m Late’ mnemonic that introduces the “bare minimum communication skills under time pressure.”\textsuperscript{27}

**Table 2: “I’m Late” Mnemonic**\textsuperscript{27}

<table>
<thead>
<tr>
<th>I’m Late Mnemonic</th>
<th>Communication skill</th>
</tr>
</thead>
<tbody>
<tr>
<td>I: Impression</td>
<td>Invest in the first impression: eye contact, smile, greeting, small talk.</td>
</tr>
<tr>
<td>M: Minute of silence</td>
<td>Resist the temptation to interrupt in the first 1-2 min and fully focus on the patient without looking at the computer screen.</td>
</tr>
<tr>
<td>L: Listen</td>
<td>Be an active listener. Listen attentively with all your senses, paraphrase, reflect on what is said, and withhold judgment and advice. Use nonverbal signs of listening (nodding, eye contact, leaning in, mirroring).</td>
</tr>
<tr>
<td>A: Acknowledge</td>
<td>Acknowledge the role of psychological factors, even if unable to address them. Do not ignore “emotional” openings.</td>
</tr>
<tr>
<td>T: Touch</td>
<td>Do not underestimate the therapeutic effect of touch, physical examination, and the role of rituals in medicine.</td>
</tr>
<tr>
<td>E: Empathize</td>
<td>Understand another person’s experience: attempt to “walk in their shoes.” Look for empathic openings and offer verbal or nonverbal expressions of empathy, including reflection, legitimization, respect, support, partnership. Example: “Going sick while going through a divorce must have been very difficult. You have been doing your best to cope. I would like to help by working together on improving your symptoms.”</td>
</tr>
</tbody>
</table>

**Health Literacy:** Health literacy refers to the “skills required to function in a specific healthcare environment and ‘relates to people’s knowledge, motivation, and competencies to access, understand, appraise and apply health information to make judgements and then take decision in everyday life concerning health care, disease prevention and health promotion to maintain or improve quality of life during the life course.’”\textsuperscript{27} Racial and ethnic minorities have been found to display lower levels of health
literacy, often due to cultural or language barriers, or a lack of educational opportunities. This, in turn, impedes abilities to properly interpret medical advice (which impacts treatment adherence), and understand insurance forms, health educational materials, and more.\textsuperscript{29} As a result, low health literacy often leads to poorer health outcomes, and when intermixed with cross-cultural miscommunication and translation errors, a patient’s health literacy declines even further by default.\textsuperscript{27} Providers must anticipate health literacy variances amongst patients and understand that everyone does not possess the same capacity to interpret medical advice.

\textbf{Gender of patient:} Across the United States it has been found that women are far more likely to seek health care services than men, however structural sexism is still prevalent and reflects itself within instances of gender discrimination and sexual harassment. These instances lead to worsened physical health outcomes like anxiety, depression, emotional distress, functional limitations, and others.\textsuperscript{30} Furthermore, studies have shown that there is a variable difference in the way that men and women are perceived in the healthcare industry, most often due to gender stereotyping.\textsuperscript{30} This results in women being “less likely than men to receive the most effective, advanced treatments and diagnostic procedures available for a variety of health conditions,” especially when their doctors assume that physical ailments stem from emotional or mental health conditions.\textsuperscript{27,30} Men, on the other hand, encounter very opposite assumptions and are less likely to be diagnosed with certain conditions like Irritable Bowel Syndrome because it is considered to be a “female health concern.”\textsuperscript{27} These phenomena are reflective of gendered implicit biases that can have anywhere from mild to severe consequences.
**Gender of Provider:** Research states that female providers are more likely to focus on preventive services, and psychosocial questioning, and emotion-driven cause and effects during visits. Male providers, on the other hand, focus more on technical practice behaviors such as daily patterns, habits or behaviors and do not question as much. These differences do impact patient reception and satisfaction, as studies show that gender concordance for ethnic minority patients can “[improve] quality of care by reducing discrimination in the clinical encounter.”

**Age:** The age of both the patient and/or provider can potentially affect the depth and quality of the conversation. Patients older than 65 are more likely to try to engage with their provider and anticipate a more patient-centered care approach, whereas younger patients are often more accustomed to information communicated via technology measures.

**Racial/Ethnic Concordance:** It must be remembered that members of the Latino community can belong to any particular race, ultimately leaving some at the intersection of a dually marginalized identity. Across the literature, numerous studies have been conducted to measure whether racial or ethnic concordance leads to greater patient satisfaction, and an overwhelming majority of them suggest that they in fact, do. Ethnic and/or racial patient provider concordance is a supposed indicator of shared mutual social, cultural, and linguistic understandings. The Patient-Physician Concordance theory states that concordance “may have advantageous effects on patient and physician communication, beliefs, and behaviors during clinical encounters, while simultaneously reducing miscommunication, prejudice, and unconscious biases,” but when we look at
national diversity rates, Latinos only represent about 6% of all active physicians nationally, a margin that has only increased by roughly 0.3-0.5% since 2010.\textsuperscript{31,32}

All of this is not to say that a racially or ethnically discordant PPR cannot produce similar or better results than a concordant one, as it most certainly can; in fact, just because one is of a shared ethnoracial background does not automatically mean they will inherently understand a patient of the same background. The point is simply to emphasize that shared background can be a facilitator in the service delivery process.

**Interpreters:** While not all Latino patient-provider interactions are mediated by an interpreter, those that are introduce an additional functional element that can completely transform the dynamic in the treatment room. As is widely known, the role of the interpreter is to facilitate communication between the patient and the provider when there is a language mismatch. The interpreter is not meant to communicate, interact, or build a relationship of any kind with the patient outside of delivering the message exactly as articulated by the patient or provider.

A concept that has traditionally characterized the role an interpreter is known as the ‘interpreters-as-conduits’ model, which suggests a purely “mechanical role that transfers information from one language to another neutrally and faithfully.”\textsuperscript{33} Though a popularized ideology, it has faced many critiques, mainly based on the fact that interpreters are often expected to “adopt non-conduit behaviors” that are necessary to “influence the process and content of patient-provider interactions.”\textsuperscript{33} An example of this is the desire for interpreters to detect nonverbal cues or other culturally charged nuances that may appear in verbiage, behavioral, or other associative cues.\textsuperscript{32} In these contexts, the interpreter strays from the classic “conduit” role and exercises a keen sense of awareness.
that could largely impact the extent to which the provider understands the problem and designs a treatment method.\textsuperscript{33}

All in all, an interpreter works alongside the provider to ensure that the patients’ needs and perspectives are properly accounted for. “In a study comparing various methods of interpretation, patients who use professional interpreters are equally as satisfied with the overall health care visit as patients who use bilingual providers,” however patients who rely on family members or children report lesser degrees of satisfaction with their visit.\textsuperscript{29}

Though the provider still assumes primary responsibility, in the case that he or she does not have familiarity with the way that ailments are expressed through dialectal or geographic variants of Spanish, the interpreter then becomes a vital member of the service delivery process.

**Acculturation**

Another incredibly salient aspect within the microsystem is the patient’s level of acculturation to the United States’ sociocultural landscape. Though many definitions exist, acculturation can be broadly defined as “the process by which individuals adapt to a new living environment and potentially adopt the norms, values, and practices of their new host society.”\textsuperscript{31} It is critical to keep in mind that acculturative status is a spectrum, and that simply because one falls under the Latino ethnicity does not mean that they are any more or less acculturated than the next patient, but because of the potentiality, it is relevant to consider because one’s degree of adaptation to a new way of life directly influences their healthcare preferences and perspectives.
Though some commonplace indicators are known to directly contribute to heightened acculturative status such as increased time spent in the United States and generational standing, the literature typically posits the concept of acculturation through two predominant frameworks: unidimensional and bi-dimensional. The unidimensional framework, also known as the “zero-sum game,” views acculturation as a “linear continuum from not-acculturated (total immersion in the culture of origin) to completely acculturated (total immersion in the dominant or host culture).” This definition leaves little room for nuance or reverse progression and highly resembles the process of assimilation by which one “becomes part of the new group, and ‘fold in’ with members of the new culture.” When one assimilates, there is little focus on maintaining the beliefs, values, and systems of the culture of origin in order to fully embrace those of the receiving culture.

The bi-dimensional model, on the other hand, suggests that the acquisition of and adaptation to a new culture occurs independently of maintaining original cultural practices. Within this, there are several sub-experiences representative of the way an individual operates between the culture of origin and the receiving culture, some of which include separation, integration, and marginalization. Separation refers to the process in which an individual maintains their culture of origin by means of complete rejection and avoidance of the new culture. Integration refers to the process in which one embraces and values both cultures as equally relevant factors. Marginalization is reflective of both voluntarily and involuntary exclusion by both cultures. This paper supports the bi-dimensional framework in acknowledgement of the varying influences that contribute to
drastically different lived experiences and personal preferences that naturally develop over time.

It can be quite difficult to pinpoint exactly where a patient falls on the acculturation spectrum; so, given these challenges, why is it worthwhile to keep in mind? Studies have found that greater levels of acculturation are associated with “higher frequency of general physical, vision, and dental check-ups; being more satisfied with health care; having insurance; having a self-perception of excellent health; and having ever been hospitalized” despite variations in income, age, or sex. This is not to say that acculturating into a new culture does not also come at a cost, as acculturation stress can present itself in a multitude of ways, one of the most common being “decays in behavioral and mental health.” Essentially, as one acculturates into U.S. society and culture, studies show that Latinos are inclined to engage in riskier behaviors that can lead to a deterioration in health. Some of these behaviors include “substance abuse, risky sexual behaviors, and violence,” which in turn generate poorer physical and mental health outcomes like “depression, obesity, diabetes, cardiovascular disease, and all-cause mortality.”

Another form of acculturation stress comes external to the individual via experiences with discrimination as a result of operating within “a negative context of reception….” For example, as can be seen in Figure 1 by Pew Research Center, roughly 54% of Latino adults experienced at least one of the 8 most commonly cited forms of discrimination.
Overall, discrimination as an index of acculturation has consistently been associated with declines in overall health or increases in risky behavior such as alcohol and drug abuse, so these factors must also be weighted into the overall picture when thinking about aggregate acculturative effect amongst the Latino population.31

How Acculturation Impacts the Patient-Provider Relationship

It must be remembered that it is not uncommon for members of marginalized communities, especially those of an immigrant background, to seek healthcare out of necessity rather than desire. As a result, research has found that “service design [and provision] based on acculturation in general, and acculturation level more specifically, may be effective at
encouraging…healthcare service utilization,” ultimately leading to greater patient satisfaction and likely better health outcomes as well.\textsuperscript{38}

All in all, the possibilities are endless in terms of patient profiles, and in order to account for this diversity, there must be a level of trust and sustained dialogue surrounding past experiences and current preferences embedded within the patient-provider dialogue. Knowledge (as disseminated via cultural competency trainings) about not only about how a patient’s level of acculturation affects their perception of healthcare, but also whether they encounter stress either directly or indirectly as a result of this process can be key in facilitating the healthcare service delivery process to ensure greater patient satisfaction and greater equity in acceptability and appropriateness access as well.

### 3.3. Mesosystem

Significant influences that stretch beyond interpersonal factors in the microsystem can be found in the mesosystem, or the contextual factors of a health system. As with any institution there are many different variables that converge to make a system function successfully. These could be anything from efficient billing procedures and geographic accessibility to Spanish speaking personnel, convenient hours of operation, or high service quality. There are also many time-sensitive administrative and logistical matters that clinicians must factor into their daily schedule such as desk work, responding to patient messages and emails, follow-up calls and staff meetings. The challenge with this lies in allocating enough time to complete these tasks while also ensuring that patients are receiving the dedicated attention they need.\textsuperscript{27} Some examples of these matters include:

**Technology/ the Electronic Health Record:** This factor is very closely associated with visit length expectations, for another contributory element to reduced
time spent with patients is society’s shift towards an ever-increasing reliance on technology. Due to heavy demands and strict time restraints, physicians are incorporating more technology into their typical workday. On top of that, the wake of COVID-19 has put increased pressure on U.S. health systems, leaving them frequently overrun and medical personnel stretched incredibly thin. Decreased time spent with the patient and increased time spent operating technology has left providers feeling as if it is “...more challenging to understand the illness context and fully address patient needs,” while patients “[experience] dissatisfaction and a diminution of their role in the care process.”

One of the most heavily used technologies in health systems across the country is the Electronic Health Record (EHR). “The EHR is designed to promote quality, safety, and efficiency; reduce health disparities; engage patients and families; improve care coordination; and maintain patient health EHR privacy and security.” While considered an essential tool for improving patient satisfaction and care, time spent with its management ineludibly detracts from time that could be spent interacting with patients. To further contextualize this issue, two studies conducted by Gottschalk et al in 2005 and Sinsky et al in 2016, show that eleven year interval, time spent interacting with patients dropped from 55% to 27%, and time spent working with the EHR tripled to around 50%.

**Health Service Design/Delivery:** When determining satisfaction rate, patients often take into consideration numerous dimensions of the service experience, from the dialogue with providers, consistency in follow-up, effectiveness of the treatment plan, and more. On the flip side, however, just as patients evaluate service quality, those responsible for
designing and providing these services must also carefully evaluate their patients’ consumer characteristics in order to account for their acculturation level and other relevant social drivers. Healthcare services are intended to “heighten consumer experiences” to establish greater trust and retention; however, as the United States continues to undergo extreme diversification of its population, we must expand our concept of the typical consumer to be more inclusive of all those seeking services.⁴⁸

**Availability of Culturally and Linguistically Appropriate Resources:** Healthcare systems can provide a range of different resources to facilitate service provision for cultural and ethnic minorities; however, availability is scanty as these resources cannot be consistently found throughout all health systems in one city, let alone throughout an entire country.²⁹

Some examples of these services/resources would include coordinating partnerships with traditional healers, utilizing bilingual community health workers, ensuring that all billing materials, waivers, and forms at the appointment desk are linguistically and culturally translated, requiring baseline Spanish skills, etc. The presence of these resources can have positive, wide-reaching impacts not only on the Latino population, who is more likely to feel welcomed and comfortable navigating within the space, but upon the overall functioning of the health system as well.

### 3.4 Macrosystem: Social Drivers of Health

Lastly, the macrosystem consists of the larger sociocultural environment within which the microsystem and mesosystem are situated.
Despite any shared cultural values amongst the Latino population, there are still many additional variables that must also be accounted for when it comes to assessing a patient’s health status. These differences can be accounted for via the social drivers or determinants of health (SDH). These are “conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of-life risks and outcomes” (think of urban vs. rural housing, food swamp vs. food desert, green space availability, transportation access, etc.).

Briefly, policies and cultural context help to create hierarchies in society, based upon proxy indicators such as race, ethnicity, gender, education, occupation and income. People in different strata of society experience differential exposures and vulnerabilities to health-compromising conditions that lead to health inequities. Intermediary determinants such as living and working conditions, food availability, psychosocial factors, behavioral and biological factors mediate the influence of socioeconomic position on health outcomes.

**Figure 2: WHO Conceptual Framework for Social Determinants of Health**

As seen in **Figure 2**, there are a number of different factors that can easily change from individual to individual throughout the life course. Some determinants that have the most relevancy for providers who treat Latino patients include: education level, immigration status,
socioeconomic status, adherence to folk/traditional customs and beliefs, geographic location, English proficiency level, country of origin, age upon arrival to the U.S. (if applicable), and any unique historical, political, economic, or religious personal experiences. Latinos are “disproportionately affected by poor conditions of daily life, shaped by structural and social position factors…” that “…exert health effects on individuals through allostatic load, a phenomenon purported to cause chronic stress, which elicits behavioral risk factors” that ultimately lead to worse health outcomes and health disparities. Depending on the circumstance, some of these factors exist in constant flux and evolution, thereby exerting an undue influence on the health statuses of the people navigating within them. In turn, these factors will also impact the needs and expectations that patients have of their providers, once again reinforcing the importance of conducting a holistic assessment not only of the patient’s perceived ailment at face value, but of the underlying factors that may be contributing to said issue. Only then is it possible to identify the true root of the problem and develop a sustainable treatment approach. While the provider may have little control over the extent to which their patients are impacted by systemic and structural factors, they can tailor their service provision and treatments accordingly so as to lessen the severity of impact.

Though these were only a few of the many factors that influence the PPR, they are reflective of the multidimensionality of this interaction, that, at the end of the day, can be seen as a collaborative effort from both parties. On the one hand “the level to which a patient participates in treatment decisions is usually a byproduct of a relational style encouraged by the provider…” however, a patient also needs to possess the ability to formulate questions and make decisions, two skills that may be absent or further weakened when paired with a lack of understanding of
the US healthcare system. In the latter cases, patients need providers to detect the specific areas in which they need additional support and/or guidance and tailor their conversations accordingly.

3.5 Social-Ecological Model

To visually illustrate the way the aforementioned dimensions of the PPR coalesce, we will refer to the social-ecological model first devised by psychologist Urie Bronfenbrenner in his book, *The Ecology of Human Development*, published in 1979. The purpose of the model is to establish “a way to recognize that individuals affect and are affected by a complex range of social influences and nested environmental interactions” that facilitates the conceptualization of health as it is impacted by the microsystem, mesosystem, and the macrosystem. As can be seen in Figure 3 below, the social-ecological model as presented by Valdez et al. has been tailored specifically for the Latino population. Within the innermost circles there is an overlap between the patient factors and the provider factors, representative of how the core of the PPR is entirely dependent upon the interpersonal exchange. Note, however, that this relationship is encapsulated by the relevant institutional factors present within the clinic mesosystem. Lastly, the macrosystem—which envelopes both the patient/provider factors and the institutional factors—consists of the community and social drivers of health that lay the groundwork for the context of one’s health status. Though the macrosystem factors are most distal from the intimacy of the PPR itself, it still ultimately exerts some influence over how, when, where and why a patient might need care.
4. Cultural Competency

Up to now, this paper has explored the dimensions of the PPR and the primary factors that impact the Latino patient profile as they relate to the relevant cultural and social drivers of health. This information has helped us understand that, because of these differences, the Latino population is rendered especially vulnerable to experiencing instances of discrimination, misunderstanding, and disadvantage that ultimately results in poorer health outcomes. We also know that because of these systemic and socio-structural factors that influence health outcomes, U.S. healthcare systems need to take into consideration the ways that service delivery has been fundamentally designed for the standard English-speaking patient, who, if not born in the U.S., is at least highly acculturated or assimilated into the dominant culture. As U.S. demography becomes more diverse, it is of utmost importance that providers be equipped with the knowledge, tools, and skills necessary to tend to all patients regardless of their background or country of origin.
With all this said, doctors deserve an immense amount of credit; they dedicate an insurmountable amount of time studying and learning best practices in an ever-evolving field of discovery, and if it were not for their willingness to take on additional challenges, discussions around potential avenues for ensuring greater health equity would be futile. Because of them there lies great hope in the prospect of ensuring greater equity in acceptability and appropriateness access via a number of different education-based interventions for healthcare providers, one of the most common being cultural competency training.

4.1 Origins

Prior to delving into how cultural competency interventions are implemented across the United States, it is important to first understand what it is. The terms “cultural competency” or “culturally competent care” circulate widely throughout health-related discourse surrounding treatment of patients from a marginalized background; however, what do they actually mean? One of the first sightings of the terms can be found in a monograph entitled Towards a Culturally Competent System of Care written by Cross et al. and published in 1989. In it, cultural competence is defined as “a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or amongst professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations.” From this definition we see an emphasis on the interdependency of all respective constituents within a healthcare operation to achieve the desired outcome. The authors then continue to write saying:

“The word competence is used because it implies having the capacity to function effectively. A culturally competent system of care acknowledges and incorporates—at all levels—the importance of culture, the assessment of cross-cultural relations, vigilance
towards the dynamics that result from cultural differences, the expansion of cultural knowledge, and the adaptations of services to meet culturally-unique needs.\textsuperscript{43}

Cross’ definition ultimately laid the groundwork for what cultural competency strives to be in theory; however, throughout the past 30 years, many derivations have been produced that subsequently affects the way it’s accomplished in practice. Table 3 features some the most prominent definitions of cultural competency as they have been produced by the most reputable healthcare organizations both nationally and internationally.

Table 3: Cultural Competency Definitions

<table>
<thead>
<tr>
<th>Healthcare Org</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>World Health Organization</strong></td>
<td>Knowledge, skills and attitudes that a healthcare worker needs in order to provide adequate and appropriate health-care services to all people in a way that respects and honors their particular culturally-based understandings and approaches to health and illness</td>
</tr>
<tr>
<td><strong>Office of Minority Health in the U.S. Department of Health and Human Services/Center for Disease Control and Prevention</strong></td>
<td>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</td>
</tr>
<tr>
<td><strong>American Hospital Association</strong></td>
<td>The ability of systems to provide care to patients with diverse values, beliefs and behaviors, including the tailoring of health care delivery to meet patients’ social, cultural and linguistic needs</td>
</tr>
<tr>
<td><strong>National Medical Association</strong></td>
<td>Cultural Competency (Health) is the application of cultural knowledge, behaviors, and interpersonal and clinical skills that enhances a provider’s effectiveness in managing patient care</td>
</tr>
<tr>
<td><strong>American Association for Health Education</strong></td>
<td>Cultural competence is the ability of an individual to understand and respect values, attitudes, beliefs, and mores that differ across cultures, and to consider and respond appropriately to these differences in planning, implementing, and evaluating health</td>
</tr>
</tbody>
</table>
Despite minor differences, the core of the definition remains the same, which is an emphasis on provider demonstration of knowledge and behaviors that cultivate a healthcare space that is safe for patients with diverse sociocultural lived experiences. For the purpose of this paper, the Cross et al., definition and explanation will be used to remain true to the originally intended integrity of the concept.

4.2 Cultural Competency as a Continuum

One of the prime advantages of Cross et al.’s definition of cultural competency is that it acknowledges how the acquisition of cultural competence occurs along a continuum that allows for both forward and backward progression. Cultural Competency, much like acculturation, is an abstract concept in that it’s very difficult to pinpoint the specific degree to which someone is culturally competent; therefore, this definition assigns general characteristics to each stage of the continuum while also allowing for nuance in progression. The continuum ranges from the least culturally competent state, cultural destructiveness, to the highest and most ideal state, cultural proficiency, with cultural incapacity, cultural blindness, cultural pre-competence, cultural competence, respectively (See Figure 4).
**Cultural Destructiveness**- this stage represents the lowest level of cultural proficiency and encapsulates the attitudes, practices, and policies that are destructive and degenerative to another culture and the people within it. Anyone within this stage is “actively [participating] in cultural genocide” via acts that specifically disadvantage or rob the agency or opportunity from specific groups people. Additionally, anyone within this category typically maintains a superiority complex in the sense that they believe that one race is better than others and should therefore maintain all control and authority. “Bigotry coupled with vast power differentials allows the dominant group to disenfranchise, control, exploit, or systematically destroy” other cultures deemed as less worthy or valuable.

**Cultural Incapacity**- at this stage, any personnel, agency, or greater system is not intentionally seeking to disadvantage other cultures, but simply lack the tools and knowledge necessary to adequately tend to patience from diverse backgrounds. Extreme
cases of bias are still quite evident, especially in terms of inequitable resource distribution and attention, discriminatory hiring practices, stereotyping or overgeneralizing minority patients, and more.\textsuperscript{43}

**Cultural Blindness** - at this stage, the system and personnel believe that differences in race, ethnicity or culture are negligible because everyone is ultimately the same. This creates the idea that the perspectives and practices of the dominant culture can pertain to everyone. “The consequences of such a belief are to make services so ethnocentric as to render them virtually useless to all but the most assimilated people of color.”\textsuperscript{43} Those who are culturally blind lack the information necessary to expand their viewpoints beyond those set by their ethnocentric beliefs.

**Cultural Pre-Competence** - this begins the “positive end of the spectrum” and in-between stage in which personnel are able to identify weak points in cross-cultural service delivery and work to strengthen them accordingly.\textsuperscript{43} They are receptive to feedback and have a sincere desire to deliver high quality and equitable services to all people. Some system-wide characteristics of this stage include “[trying] experiments, [hiring] minority staff, [exploring] how to reach people of color in their service area, [initiating] training for their workers on cultural sensitivity, [entering into needs assessments concerning minority communities, and [recruiting] minority individuals for their boards of directors or advisory committees.”\textsuperscript{43} The flip side of this, however, is a false sense of fulfillment from completion of one objective or goal, as well as an increased propensity towards tokenism, which is the believe that the onboarding of a few
“usually assimilated” minority workers fill the need for diverse representation across healthcare workers.⁴³

**Cultural Competence**- personnel that have reached a level of cultural competence both accept and respect that inherent differences exist, and understand that because of these differences, regular self-assessments to identify current and future goals in regards to cultural knowledge and resources are necessary. “Culturally competent agencies work to hire unbiased employees, seek advice and consultation from the minority community, and actively decide what they are and are not capable of providing to minority clients.”⁴³ Furthermore, they endorse non-discriminatory policies that will benefit a diverse range of clientele as well as hire minority staff who can facilitate the navigation of cross-cultural communication and interaction.⁴³

**Cultural Proficiency**- the final stage along the continuum is cultural proficiency (also called advanced cultural competence.). In this stage, diversity within and amongst cultures is held to the highest esteem, and research on best practices for minoritized patients is incorporated into daily activity. A provider’s journey to cultural proficiency is not solely based on the cultural competency education they receive but also largely impacted by whether they have had previous exposure to other cross-cultural experiences such as time spent in another country, foreign language training, a diverse set of friends and family, etc. On the system level, there is great focus on hiring personnel who are specialists in culturally competent care and ensuring that cultural competence is implemented throughout all sectors of the system and not just a limited few.⁴³
As one can see, there is much variability along this progression, and there is not one key factor that could drastically catalyze progress; rather, it requires a commitment from every entity that plays some role in healthy delivery, design, or implementation. For years now, in an effort to take strides in the right direction,

“Legislators [have] asked, for example, what policies can foster the cultural competence of our health care system. Administrators want to know what we can do to make managed care organizations or hospitals more culturally competent. Academicians ask what we should teach our health care professional students about cultural competence. Finally, providers ask how we can deliver more culturally competent care at the community level.”

From this, the challenge lies not in the lack of attention, but in the lack of coordination amongst entities to ensure that a streamlined approach is assumed. “At each level, the principles of valuing difference, self-assessment, understanding dynamics, building cultural knowledge, and practice adaptions can be applied,” such that when assessed aggregately, the system as a whole is moved towards a more holistically culturally competent state, but the only way to do this is via multi-system collaboration and coordination.

Considering the variance not only in definition but in multi-system collaboration of cultural competency practices within some of the most notable healthcare organizations, it is understandable why there is confusion around the way that cultural competency translates from theory into practice, or furthermore, what measures are in place to keep healthcare systems and providers accountable for progressing along this continuum.
4.3 Implementation Tactics and Criticisms

One of cultural competency’s primary criticisms is the lack of standardization in terms of definition and implementation procedures throughout U.S. healthcare systems. Typically, educational interventions are designed based on its model’s core principles; however, there is no nationally recognized “golden standard” of cultural competency to delineate these principles. Furthermore, the majority of definitions previously listed mention a set of “behaviors, attitudes, and policies” needed to cultivate an environment that is quote unquote “culturally competent,” however, what kind of specific behaviors, attitudes, and policies are needed to make this happen? And what has happened as a result of allowing these specifics to be left up to interpretation? To answer this question, we will examine the results of a recent (2020) scoping review published by the *Journal of the Association of American Medical Colleges* in which 89 different cultural competency educational interventions were evaluated across the country. The purpose of assessing a scoping review is to provide a baseline understanding of the common approaches, tools, and strategies used to design most cultural competency interventions.

Within the review written by Brottman et al., five major themes were detracted: theories, models, and frameworks, teaching strategies, assessments, curriculum and course design, and educator training.

**Theories, models, and frameworks** facilitate and organize the various concepts within the context of health, culture, and service provision. “Theories are tested knowledge that inform aspects of human behavior, models are visual representations that describe relationships among concepts, and frameworks are structures of concepts used to communicate ideas and values.” Some of the most commonly cited educational models that will not be explored in this paper but are included merely for future reference include...
Campinha-Bacote’s process of Cultural Competence in the Delivery of Healthcare Services, Giger and Davidhizar’s Transcultural Assessment Model, Purnell’s Model for Cultural Competence, and Berlin and Fowkes’s LEARN (Listen, Explain, Acknowledge, Recommend, Negotiate) Communication Model.46

**Teaching strategies** are implemented to disseminate information via various tactics, including “immersion experiences [international trips], simulation [role playing], discussion groups [panels, focus, small-large group], lectures, reflection [portfolios, public forums, journals], educational technology [e-lectures, pre and post-assessment tools, high-fidelity simulators], case-based learning [via real-life and clinical scenarios], papers, presentations, readings, and videos.”46

In regards to presentation style, researchers Jongen et al. reference cross cultural and categorical approaches as frequent within cultural competency interventions. The cross-cultural approach centers around teaching the skills “relevant to navigating any cross-cultural situation…such as … eliciting patients’ explanatory models of health issues and their causes; [strategizing] for negotiating shared understanding and facilitating participatory decision-making; and understanding health and illness in its biopsychosocial context.”47 This approach is distinguished for its emphasis on transferring knowledge into skills and skills into actionable steps that providers can take to better serve populations from a minoritized background. Categorical approaches are historically considered to be the most common intervention strategy and consist of disseminating knowledge regarding the ways that health beliefs, perspectives, and behaviors are shaped by the cultures of different ethnic or racial groups. Included in this approach is also extensive discussion around the primary behaviors to avoid within
clinical interactions, some of those being misrepresenting, stereotyping, or oversimplifying others’ culture as a static rather than fluid element.  

Assessments are used to evaluate the evolution of thought and expansion of skills and capabilities following training. This normally consists of some sort of pre and/or post-test to gauge shifts in attitudes and to encourage introspection throughout the process. The two most popular assessments were the Cultural Self-Efficacy Scale and the Inventory for Assessing the Process of Cultural Competency Among Healthcare Professionals. 

Curriculum and course design focuses specifically on how an intervention is structured, i.e., via “workshops, curricula, courses, clinical rotations, and remote education.” Some within the study were 20 minutes, some were 600 hours, while others lasted years. It all depends on the preferences of the institution which in turn generate differential impacts upon provider education level. 

Educator training focuses on the preparation of the faculty and staff who are leading the trainings. Success has been noted to stem from the top down, however many studies found that most educators leading the interventions did not have extensive cultural competency training themselves. This limits their ability to facilitate conversation and reinforce concepts effectively. Thus, it is recommended that educators undergo intensive training that will properly educate and equip them prior to leading the group. 

Healthcare systems use various combinations of one or more of the previously mentioned tools to create their own cultural competence training for providers, thereby explaining the vast lack of standardization that will only continue to persist without an enforced policy mandate to regulate expectations.
Attempts at Standardization

Throughout the years, there have been many concerted efforts to align the goals and aims of cultural competency training programs across health systems. One of the most notable starting in the early 2000s when government policies and cultural competency experts began to emphasize the importance of framing cultural competence through an organizational/systemic lens rather than an individual one.\(^4\) This approach was deemed ideal because an individual “…self-assessment of power, privilege and biases” was more likely to lead to the “othering” of individuals who exist outside the dominant culture as a result of an “us in comparison to them” framework.\(^4,4^4\) It can also create “oversimplified understandings of other cultures based on cultural stereotypes…” which fuels a sort of cultural essentialism, which is the idea that people within racial and ethnic groups can be distinguished based on fixed and stable cultural patterns that are detectable across all members of that community.\(^4,4^4\) This can “[lead] to health care providers making erroneous assumptions about individual patients which may undermine the provision of good quality care…” via “alienation, marginalization, decreased opportunities…and exclusion.”\(^4\) This behavior places patients at greater risk of experiencing health inequities and disparities, thereby defeating the entire purpose of cultural competency as it was devised. So, in order to counteract that possibility, the CLAS Standards were developed in order to help guide individuals and healthcare institutions along a more “standard” track to cultural proficiency.
4.4 CLAS Standards

The National CLAS Standards, or National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care, were released by the U.S. Health and Human Services Office of Minority Health (OMH) in 2000. They were later relaunched in the fall of 2010 as the National CLAS Standards Enhancement Initiative, reflective of a decade’s worth of continued research and findings. Though they have now been in circulation for over twenty years, these standards are the only ones of their kind to be released on a national level in support of the push for cultural competence standardization.

The Office of Minority Health website references the Standards as a “comprehensive set of 15 action steps that provide a blueprint…” for “…services that are respectful of and responsive to the health beliefs, practices, and needs of diverse patients.”50 The full list of enhanced standards can be found in Appendix D, however the Principal Standard is to “provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.”51

Despite the potential effectiveness of these standards, they were not nationally enforced and stage agencies were given autonomy in deciding whether they would incorporate them into healthcare practices. For example, the most recent 2014-2015 Compendium that charted which state governments had incorporated CLAS into their strategic plans found that thirty-two of the fifty states (North Carolina was not one of them) had a track record of involvement across one or many departments, divisions, bureaus, and the like. Very few states had “enumerated a comprehensive set of strategies, goals, ad action steps for implementation.”41 So, though CLAS
Standards provides a blueprint for greater standardization, sufficient research has not been done to determine their precise effectiveness.\textsuperscript{41}

4.5 Is Cultural Competency Possible?

An assessment of standardization efforts would be incomplete without also addressing a looming doubt that will likely persist even if standardization was achieved: is someone capable of becoming truly culturally competent (proficient), even with the best (standardized) cultural competency training? From this very question, many objections have arisen specifically against the word ‘competency’ and the nuance with which it implies in terms of provider capabilities and understanding.

While cultural competency interventions often place great emphasis on how culture serves as a conduit through which we can better understand an individual, there are many instances in which a patient’s attitudes, preferences, or behaviors cannot be predicted even given the most thorough understanding of their cultural background. This is because these particularities are entirely reflective of an individuality that can be mutually exclusive from their culture.

Furthermore, some even take the position that cultural competency frameworks promote the idea of a “static level of achievement.”\textsuperscript{44} For example, one can be denoted as sufficiently “competent” in interacting with diverse patients after successfully acquiring certain knowledge and skills, almost in the same way that one can competently read an EKG or complete a physical exam after undergoing the necessary training.\textsuperscript{44} This idea is incorrect because the journey along

\footnote{For further information regarding the specific ways in which these 32 states implemented CLAS standards, refer to source \#49,\# 50, \#51 in References}
the cultural competency continuum has no defined start or end point, but rather is a
developmental process that constantly shapes and evolves itself throughout the life course.

### 4.5.1 Cultural Humility and Other Related Terms

Because the exemplification of cultural competency within the service delivery process is
an inherently dynamic and multilayered exchange, it can be facilitated by an attitude of cultural
humility that, if exercised correctly, can account for remaining gaps in knowledge and
understanding. For this reason, many allied health professions often refer to cultural humility as
“a complementary or alternative language to competence.” Cultural humility was first
developed by Dr. Melanie Tervalon and Dr. Jann Murray-García in 1998 as a way to reduce
health disparities in medicine and promote a greater sense of equity across all institutions.
Cultural humility represents “the ability to maintain an interpersonal stance that is other-oriented
(or open to the other) in relation to aspects of cultural identity that are most important” to the
patient. Intrapersonally, it requires that one has an accurate understanding of personal strengths
and weaknesses. Interpersonally, it requires that one is selflessly “other-oriented” with a lack of
superiority complex. A true exhibition of cultural humility is reflected by ongoing self-
evaluation, introspection, and examination of one’s own beliefs, implicit biases, and inclinations
so as to facilitate the dismantling of any systems of thought that discriminate or stereotype
others. Individuals who demonstrate cultural humility are aware that despite having “cultivated
their cultural awareness,” they “can still have unintentional, unconscious biases about cultures
other than their own.” Because of this, their goal is to demonstrate an openness to the fact that
every person views the world through a different cultural lens that is equally relevant and
respectable despite absence from the North American mainstream viewing.
One of the reasons cultural humility serves as a cornerstone and foundation of almost all cross-cultural interactions is because it promotes a continuous cycle of reflection within the individual. Additionally, many famous medical and global health leaders stand in firm support of it, one of them being the late global health pioneer and humanitarian, Dr. Paul Farmer. Farmer spoke of cultural humility often in both his writing and talks as a viable moral framework through which people could prioritize introspection in their skill assessment. He expressed that cultural humility is being able to say that “I don’t know what I don’t know, and someone else will.” Being able to wholly accept this fact creates space to recognize errors while growing during the process, and this alone is a key skill for cross-cultural communication.

Some additional related terms that are also used interchangeably or in place of cultural competency include cultural intelligence, cultural sensitivity, and cultural safety. Cultural intelligence (CQ) refers to “an individual’s capacity to successfully adapt to a new cultural setting.” It is often conceptualized multidimensionally in a way that encapsulates not only one’s knowledge of cultural conventions and practices, but also one’s capacity to translate that knowledge into practice while remaining adaptive in different cultural contexts. Cultural sensitivity has a number of definitions, but most commonly encourages providers to acknowledge “… the legitimacy of difference and [begin] a process of self-exploration as the powerful bearers of their own life experience and realities and the impact this may have on others” (Table 1). Cultural sensitivity reinforces the importance of being responsive and reactive to even the most minor patterns of behavior in order to fully be cognizant of how it affects a patient’s health. Lastly, cultural safety, though somewhat different, emphasizes the importance of factoring in the influence of power structures within the PPR. First introduced by Dr. Irihapeti Ramsden and Māori nurses in 1990s New Zealand, cultural safety calls for a “a
focus for the delivery of quality care through changes in thinking about power relationships and patients’ rights.”36 This concept’s primary distinguishing factor is that it does not solely encourage a provider to study the culture and customs of diverse ethnic groups but instead promotes more equitable healthcare “through being aware of difference, decolonizing, considering power relationships, implementing reflective practice, and by allowing the patient to determine whether a clinical encounter is safe.”44

Despite the alternative and sometimes preferred use of these terms, the concept of cultural competency still remains one of the most prevalent across the literature, hence the reason it is the central of the focus of this paper. Nevertheless, the other three are central to factor into daily practices.

4.6 Why are Cultural Competency Interventions Worth Developing?

In its essence, cultural competency is not merely language competency, nor is it language fluency, but rather ideally representative of a human-centered approach to understanding how health, society, and culture converge.42 Research has shown that if properly managed, not only could many of the problems affecting both the diverse patient population and the health care workforce be reduced, but many areas in the delivery of quality care could also be improved.”47 For example, countless studies have shown that cultural competency does, in fact, improve providers’ ability to treat patients from a different social, cultural, or linguistic backgrounds. This, in turn, reduces the rates of under-detection and undertreatment and increases Latino patient satisfaction.42,57 Not only this, but true cultural proficiency exemplifies a knowing that the broad generalizations and characterizations of different cultures “are just that: broad generalizations. They are a starting point; not an ending point; in other words, they call practitioners to look more deeply into the particular cultural, linguistic, and socioeconomic
contours of their patients’ backgrounds and to open themselves to alternative ways of understanding and interpreting their patients’ actions and requests.\textsuperscript{59}

Perfection may be an unattainable goal, but continued progress is well within reach for the future of cultural competency in healthcare. Guidelines must be mandated across the country to establish expectations for care, and perhaps even more cardinal, research in this area must be prioritized to aid in understandings of how to best create more standard practices that will impart sustainable improvements to decrease inequities in acceptability and appropriateness access for the Latino population.

5. Characterizing the Latino Population in Durham, NC

So far, this paper has covered 3 of the 4 research aims and will now transition to the final aim, which is to assess the impact of a cultural competency educational intervention at a Duke Health Clinic via the implementation of an original survey instrument that gauges need satisfaction concordance amongst Latino patients and their providers. To do this, it is important to first familiarize ourselves with the study population of Latinos specifically within Durham, North Carolina.

5.1 Historical Demographic Presence in Durham

In the early 1990s, Latinos made up only 1\% of Durham’s overall population and were primarily migrant workers from Mexico and Central America who were attracted to North Carolina’s seasonal agricultural economy.\textsuperscript{60} By the year 2000, the population had skyrocketed and only continued to grow when security at the US-Mexico border was strengthened following the tragic events of 9/11. This resulted in the permanent resettlement of many migrant workers in what became the first predominantly Latino neighborhoods in Durham.\textsuperscript{60}
Flash forward to 2021 and Durham is now one of the top 5 counties in North Carolina with the largest Latino population. According to the 2022 World Population Review, Durham has an overall population of approximately 335,015, with 13.5% identifying as Hispanic or Latino.\textsuperscript{61} Within this group, about 49.6% were born in Latin America and about 33.7% are U.S. citizens.\textsuperscript{62} Throughout the years, Durham has also become home to an increasingly larger population of immigrants, currently representing about 1.1% of the total population. The refugee population from Latin America has also grown by a margin of 1.5% between 2015 and 2019.\textsuperscript{62}

**Figure 5: 2020 North Carolina’s Latino Concentration**\textsuperscript{62}

For comparison purposes across the state level, the total Latino population now reaches over 1 million (See Figure 5 for concentration dispersion).\textsuperscript{62} There is no county-level data on ancestral background, however one can safely assume that the demographic breakdown specifically within Durham mirrors proportions similar to those seen across the state, in which are 54% are Mexican, 11% are Puerto Rican, and about 16% are from Central American countries like Honduras, El Salvador, and Guatemala.\textsuperscript{62}
5.2 Prioritizing Latino Health in Durham

Throughout recent decades, there has been a heavy focus on approving policies that promote holistic, equity-based approaches needed to propel the Latino population towards better overall wellbeing.63 Some of the primary drivers of these policy shifts at the county level in Durham include the Durham County Department of Public Health, the Partnership for a Healthy Durham, and Duke Health. Every three years, they jointly conduct a community health assessment for residents in Durham County in which the top health needs are identified and assessed according to actionable steps that can be taken for improvement.

Within the most recent 2020 Durham Community Health Assessment, the second most pressing issue for Latinos in Durham mirrors that of this study’s overarching focus: acceptability and appropriateness access to care. In this context, access is defined as “difficulty navigating health care services due to language barriers among households with Limited English Proficiency (LEP), or functional illiteracy (verbal and/or written).”63 This paper has covered many reasons why inequities in access to care is a pressing issue for Latinos across the country, however one must not fail to consider the way this need has been further amplified as a result of the COVID-19 pandemic.

Latinos are 1.9 times higher risk of contracting COVID, 2.8 times higher risk of hospitalization, and 2.3 times higher risk of dying than non-Latino whites.64 In Durham alone, Latinos made up about 75% of all COVID cases in June 2020.64 As a result, many intensive care units in the county were overrun with Latino patients, many of whom were experiencing their first ever interactions with the health system as a result of their diagnosis. This circles us back to the question of equity in access—how were these patients treated? How was the quality of communication they experienced whilst receiving treatment?
One of the report’s recommended strategies to remediate inequities in access is to improve health care delivery and enlist community-building strategies by “developing institutional cultures that provide culturally sensitive and multilingual services.” As has been reviewed, one of the best ways to do this is via cultural competency training; so, in conjunction with the healthcare aims of Durham county, the following study centers around how the institutional culture specific to a Duke Health clinic can be enhanced via cultural competency training to ensure that patients not only have access to treatment, but have equitable access to culturally sensitive service provision.

6. Methodology

Thus far, this paper has established the importance of cultural competency training for healthcare providers in order to help reduce inequities in access and improve Latino patient satisfaction across the country; however, it has also been established that due to the pervasive lack of standardization in the definition and implementation of cultural competency, all trainings inherently do not have the same potential to generate a systemic shift towards cultural proficiency. Furthermore, very few studies have demonstrated whether cultural competency can actually improve patient outcomes. As a result, I conducted a cross-sectional descriptive study at a Duke Health clinic that has designed its own cultural competency intervention as part of their pre-clinic conference training for providers.

The study aimed to answer the following three questions:

1. *Does cultural competency training make a difference in how provider's respond to questions?*

2. *How do responses from providers who have received cultural competency training at the Duke Health clinic vs. those who have not compare to the responses of their patients?*
3. Of the 3 need categories cultural humility, cultural comfort, and cultural opportunities, which received the lowest overall satisfaction score, and do the results correlate between groups?

If the findings of this study can be verified through replication, the hope is this knowledge can contribute to national standardization efforts of cultural competency interventions in healthcare systems. Satisfaction in healthcare delivery should be expected of patients and providers alike, so this study assumes a human centered design to incorporate input from both parties.

6.1 Study Purpose

The purpose of this study is to identify unmet needs within the healthcare delivery process between Latino patients and their providers that are often of a different ethnic, cultural, and linguistic background. These needs will be identified via the completion of an identical survey instrument that gauges levels of satisfaction with three fundamental dynamics needed within a healthy PPR—cultural humility, cultural comfort, and cultural opportunities—as outlined by the Multicultural Orientation Framework (MCO).

This approach is based on the idea that in order for Latino patients’ healthcare needs to be met during the service delivery process, providers’ educational needs must first be met in training to ensure they have the tools necessary to equitably treat this population. Satisfaction in healthcare delivery should be expected of patients and providers alike, so this study assumes a human centered design to incorporate input from both parties. Often times, hospitals, healthcare facilities, and universities across the nation spend time developing cultural competency training modules without incorporating the perspectives of the very population they are intending to treat, and this study seeks to do just that. With this perspective, the three dynamics as indicated by the
MCO can be viewed dually as both a Latino patient healthcare need and a provider educational need.

The hypothesis is that there will be slight to moderate incongruencies in the needs identified by both groups due to the respective expectations and responsibilities associated with each role.

6.2 Research Design

This study uses a cross sectional descriptive design with a qualitative data collection method and mixed methods data analysis. In this scenario, the cohort of resident providers and the parents of their pediatric Latino patients at a Duke Health Clinic will be surveyed on questions related to cultural humility, cultural opportunities, and cultural comfort within the PPR to gauge which areas need more critical attention. Both groups will be surveyed using the same, originally designed survey instrument that is based on Davis et al.’s Multicultural Orientation Framework. Of note, some of the providers have undergone the cultural competency training at the clinic and some have not, thus presenting the opportunity to compare survey responses stratified on training status.

6.3 Study Setting

This study was conducted at one of the Duke Health Clinics located in Durham, North Carolina. The clinic was founded in 1990 and now serves over thirteen thousand patients a year. As stated by one of the first pediatricians at the clinic, the core mission of the practice is to “take care of the children who choose to come to Duke in a safe and equitable fashion” so that “everyone receives the same standard of care regardless of their life situation.” The particular unit where the study is conducted is one of four other center constituents that make up part of the larger
Duke University Health System that is comprised of three major hospitals and numerous ambulatory clinics in the Triangle area. In the clinic’s most recent demographic report from 2020, well over 50% of the patients served are under the age of twenty-five, with 52.5% identifying as female and 47.5% identifying as male. In terms of the patient ethnic and racial breakdown, 20.28% identify as Latino, 39.85% identify as Black/African American, 26.86% as White/Caucasian, 0.17% as American Indian or Alaskan Native, 0.16% of Native Hawaiian or Other Pacific Islander, and 6.66% are Not Reported. 57.52% of patients also indicated that they were unemployed while only 9.83% worked either Full Time or were Self Employed.

**6.4 Cultural Competency Training at North Durham Clinic**

The clinic’s cultural competency training was first designed and implemented over eight years ago. Due to COVID-19, the training was paused around March/April of 2020 and resumed in May 2021. Their cultural competency curriculum is not distinguished unit but rather a component of the larger clinical Community and Advocacy Rotation Training offered to all first-year residents. The information is disseminated via a twenty-two minute instructional video led by some medical interpreters, followed by group-wide discussion. Throughout the year, residents and providers also engage in regular reflection sessions regarding their cross-cultural interactions. These events provide a space to be reflective and introspective on how to collaboratively improve service delivery for this population. Everyone is also given a half hour-long conference on how to properly use interpreter services.

This clinic also features additional assets in the form of other culture-based resources that supplement the clinical encounter. There are two to three social workers present to assist with Latino social needs, as well as a dedicated community health worker with Spanish comprehension.
skills who just joined the staff in January 2022. Furthermore, all documents, visit summaries, and patient instructions are translated into Spanish to avoid confusion in future references.

6.5 Participants

My target population includes Latino patients, or more specifically, the parents of the pediatric patients, and all resident providers.

The inclusion criteria for the patients are that they must have a child being seen at the clinic and that they speak Spanish. The exclusion criterion is if they are younger than 18 years old (as this would exclude them from being treated at this specific clinic).

The inclusion criterion for the providers is that they must be within the cohort of pediatric and medicine-pediatric residents rotating through the clinic. The exclusion criterion for providers is if they are attending physicians and not within the resident cohort.

6.6. Procedures

Two separate procedures were followed for both groups, there was no compensation for either, and the data collection process unfolded concurrently between August 2021 and January 2022.

6.6.1 Patient Procedures:

The patients were recruited using a convenience sample via the clinic’s medical interpreter team. The target sample size was thirty because thirty is the lowest statistically significant number. The interpreter was determined to be the ideal enumerator because they had already developed a rapport with the patient during the visit. Upon the conclusion of the appointment, the interpreter distributed a paper copy of the survey that had been translated into Spanish. He or she did not help the patient complete it nor answer any
specific questions. The only information provided was that participation was voluntary and that the survey should be left in the visitation room for the nurse to collect and store in a lockbox kept in the office. The patient was then left to complete the survey in private. Data collection for patients ran between August and December of 2021.

It was decided that a paper version of the survey was most ideal for patients’ so as to avoid selection bias for those who did not have a computer, smartphone, or Wi-Fi at home.

6.6.2 Provider Procedures:

A convenience sample was used to recruit the sample of resident providers to complete an electronic version of the survey. The providers received an initial email in August of 2021 to inform them of the purpose of the three to five-minute survey, and later received timed follow-up emails throughout the subsequent six months as a reminder. For those who may have received an overflow of emails or simply missed the follow-ups, an additional incentive was implemented in the central office of the Medicine-Pediatric and the Pediatric residents’ central office in the form of a granola bar with a QR code attached (see Appendix C). The target sample size for residents at the clinic was thirty both due to the fact that this represented greater than 50% of the fifty-five member cohort, and the fact that thirty represents the lowest statistically significant sample size. Therefore, I aimed for about a 54.5% response rate minimally, however because I recruited above my baseline value there was a chance more people would complete it and I would end up with a larger sample size. A convenience sampling strategy was ideal for this stage of recruitment because I assumed that not all providers asked would have time to participate, so to increase chances of recruitment, I minimized
exclusion criteria and emailed all the resident providers within the cohort. Data collection for providers ran between August 2021 and January 2022.

It was decided that an electronic Qualtrics version of the survey was most ideal for providers to complete on their own time and convenience without adding physical clutter to their workflow.

6.7 Measures

As previously mentioned, the study approach is framed around the idea that in order for Latino patients’ healthcare needs to be met, providers’ educational needs must first be met to ensure they have the tools necessary to treat a diverse patient population. So, the three dynamics measured on this survey correspond to either a specific Latino patient healthcare need or a specific provider educational need.

There are a number of pertinent needs that could have been indicated on this survey, as the factors deemed most pressing can vary significantly based on study population. With this in mind, the most pressing healthcare or educational needs are likely to fluctuate based on the macrosystem and mesosystem contexts. Because there is great potential for variance, one of the best ways to more explicitly identify needs is to ask the population directly; however, this was beyond the scope of this project, thereby resulting in the utilization of three constructs deemed highly valuable in cross-cultural service delivery by the Multicultural Orientation Framework — cultural humility, cultural opportunities, and cultural comfort.

The Multicultural Orientation Framework (MCO) developed from the Multicultural Competencies (MCC) theory and has taken firm root in the field of psychotherapy throughout the past forty years since its inception in the late the 1980s. Although this framework was originally birthed within the field of psychology, the interdisciplinary nature of public health allows for the
adoption of similar measures as it relates to the treatment of diverse patients in both physical and mental related ailments.

The MCC theory distinguishes three main ideas that say: “(1) there are a set of competencies that predict [healthcare] outcomes, which can be clearly articulated and then acquired by trainees; (2) one can reliably differentiate [providers] who are competent from those who are not; and (3) the competencies are characteristic of the [provider] across [patients].” While these tenets are strong and clearly distinguishable, criticism arose from the fact that it was hard to correlate MCCs with improved patient outcomes, primarily because provider self-reported MCCs do not correlate with patient reports of their MCCs. In order to more pointedly assess the link between MCCs and health outcomes, Owen et al., developed a unit of sub-constructs (cultural humility, cultural comfort, and cultural opportunities) called the Multicultural Orientation Framework. The MCO is “concerned with how the cultural worldviews, values, and beliefs of the client and the [doctor] interact and influence one another to co-create a relational experience that is in the spirit of healing.” Since the development of this framework, researchers have made significant progress in understanding the link between MCC constructs and the patient-provider dynamic, therefore yielding them ideal for practical application within this study.

6.7.1 Measure 1- Cultural Humility

Previously within this paper, cultural humility was framed as a cornerstone principle within culturally competent healthcare delivery; therefore, it is no surprise that it is considered the “organizing virtue” within the MCO. As a brief reminder, “cultural humility is a subdomain of humility that involves “the ability to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to aspects of cultural identity that are most important” to the patient. Maintenance of cultural humility allows a provider to maximize opportunities to
engage the client in discussions around the aspects of their cultural identity that they find to be most salient, especially as it relates to health behaviors and healthcare. The following two measures, cultural comfort and cultural opportunities, are considered pillars of the framework and behavioral manifestations of cultural humility within a patient-provider interaction.  

**6.7.2 Measure 2- Cultural Comfort**

Cultural comfort “refers to the [provider’s] thoughts and feelings that emerge before, during, and after conversations about the [patient’s] cultural identities or cultural focused content.” This measure is representative of heightened feelings of openness, relaxation, comfort, and calmness during interactions with those of diverse backgrounds. This is not to say that cultural discomfort could never arise, for in those moments, the provider is aware of the deeper areas in which they can thoroughly explore with themselves, a loved one, or trained professional.

**6.7.3 Measure 3- Cultural Opportunities**

Cultural opportunities are defined as “markers that occur…” within the PPR “in which the client’s cultural beliefs, values, or other aspects of the client’s cultural identity could be explored.” Cultural opportunities can be maximized every time a patient’s beliefs or values can be further unpacked, especially as it relates to medication adherence, treatment preferences, and behaviors. This measure also encourages the initiation of conversations surrounding cultural beliefs and preferences in relevant contexts so as to ease patient pressure. “The challenge is to do so naturally and without abrupt transitions that feel forced or inauthentic,” and the MCO helps
providers orient their framework of thinking so that they are quickly able to recognize and seize each opportunity to strengthen their repour with the patient.\textsuperscript{52}

In sum, these three measures represent what has been articulated as a holistic “way of being” (cultural humility), a way of identifying and responding to therapeutic cultural markers… (cultural opportunities), and a way of understanding the self in these moments (cultural comfort).\textsuperscript{52} The appeal in using these particular measures centers around the fact that they reinforce the importance of a provider’s wellbeing as an integral foundational element and catalyst for the positive trajectory of the rest of the PPR. Oftentimes the core element of cultural competency training and implementation centers around the patient’s needs and wants, and rightfully so as they are the ones seeking care; however, I personally believe that this approach can often set an undue precedence upon our providers to assume a certain level of comfort that does not necessarily have to be present without the proper training and exposure— and the MCO framework very outwardly acknowledges that.

\textbf{6.8 Instrument}

Though inspired by the MCO, the survey was originally designed with the help of Dr. Gabriela Nagy, an Affiliate of Duke Global Health Institute and an Assistant Professor in the Department of Psychiatry & Behavioral Sciences and the Duke University School of Medicine. Once the English version was finalized, it was translated into Spanish and sent for review by the lead medical interpreter at the clinic to ensure that the verbiage was appropriate for the patients’ literacy level.

The survey consists of a set of demographic questions followed by twelve questions with responses measured by the Likert 5-point scale (See Appendix A and B for full versions). The demographic questions for patients cover age, gender, ethnic background and education. For
providers, the demographic questions cover age, gender, and their status on having undergone the cultural competency training at the clinic. The questions are all categorized under one of three need categories (cultural humility, cultural opportunities, and cultural comfort), and each category had four corresponding questions all measured using the Likert Scale ranging from Strongly Disagree to Strongly Agree. As can be seen in the chart below, each qualitative response along the scale has a numerical equivalent that will later be used to determine the extent of satisfaction regarding the need being met. The most positive responses will generate a “strongly agree,” or a 5, and the most negative response will generate a “strongly disagree” or a 1. This means that an indication of greatest overall satisfaction with a need being met will receive scores closer to 5, and least overall satisfaction with a need being met will receive scores closer to 1.

**Likert Scale Visual**

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>Disagree</td>
<td>Neutral</td>
<td>Agree</td>
<td>Strongly agree</td>
</tr>
</tbody>
</table>

**6.9 Ethical Review**

The survey was specifically designed to minimize the natural risk associated with completing healthcare surveys, as neither provider nor patient was asked to disclose any private health information (PHI) relating to their personal identities or health status and everything was 100% anonymous. There was a minimal risk posed to the residents given that their identities had to be known in order for them to receive an email with the survey link, but Qualtrics is considered a leading experience management software that is strongly trusted by Duke and does not store any specific metadata that one could use to identify the owner of the survey responses post-completion.
Because the surveys were administered to patients by a medical interpreter, there was absolutely no risk of identity exposure to the researchers, and the demographic questions were specifically constructed to avoid sensitive subjects related to immigration status, naturalization, etc.

Lastly, for several months, the study protocol was reviewed by the clinic and returned to the researcher for edits until it was deemed unlikely to disturb clinic workflow. Upon receiving clinic approval, the study was submitted to the Duke University Institutional Review Board. Due to the complete anonymity of the survey, it was eligible to pass through the IRB Application for Exemption which resulted in an expedited approval process rather than a full board review. This granted clearance in June 2021 to proceed with the project and ensured that the identities, health, and wellbeing of the subjects were not compromised for the sake of the study. Once approved, there was full confidence that all methods employed to collect data from the participants were both safe and ethical.

7. Results

After completing all Duke Health and regulatory requirements, data collection for both parties was started in August 2021. During the course of this study, thirty-four patients and thirty-one providers completed the surveys. Of the patients who completed the surveys, twenty-five answered all questions, while 9 returned partially completed forms.

The patient profile is summarized through Figures 6-9. As a brief summation, the vast majority (44%) of the patients who participated in this study were in the 35-44 years age group, followed by 26% 25-34 years age group. Nearly 90% of the participants were female as shown in Figure 7.
When asked about their country of origin, 64% reported that they were from Central America. The education profile as illustrated in Figure 9 shows that 10% had a high school diploma, 7% had a GED or equivalent 7% had a bachelor’s degree.

Figure 6: Patient Age

Figure 7: Patient Gender

Figure 8: Patient Region of Origin

Figure 9: Patient Education
Of the providers who completed the surveys, twenty-nine answered all questions, while two returned partially completed forms.

The provider profile is summarized through Figures 8-12. As a brief summation, Figure 10 shows the vast majority of the providers (81%) who participated in this study were female, followed by 16% male and 3% nonbinary (other gender identities were included as an option). As indicated in Figure 11, the percentage of providers who had undergone cultural competency training at the clinic was highly similar, with 45% having the training and 55% not having the training. In regards to age in Figure 12, 97% were between 25-34 with only 3% within the 35-44 group.
Figure 12: Provider Age

Data Analysis

The following three figures illustrate a comparison between the providers who have received cultural competency training, those who have not received cultural competency training, and their Latino patients’ parents. The percentages are representative of ONLY those who indicated that they agreed (4) or strongly agreed (5) with the given question. Because the overarching goal is to assess need satisfaction (indicated via higher scores on the Likert Scale), these graphs represent the overwhelmingly positive responses which will also inform us of the areas needing more attention.

These three graphs will also be used to answer 2 of the 3 research questions:

1. Does cultural competency training make a difference in how provider's respond to questions?
2. How do responses from providers who were trained at Roxboro vs. those who were not compare to the responses of their patients?

**Question Key:**

<table>
<thead>
<tr>
<th>Cultural Humility</th>
<th>Provider</th>
<th>Patient (English version)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>I ask my patient questions to understand who they are, their beliefs, culture and traditions. Based on their answers to these questions, I come up with a treatment plan that works for them.</td>
<td>My provider asks me questions to understand who I am, my beliefs, culture and traditions. Based on my answers to these questions, he or she comes up with a treatment plan that works for me.</td>
</tr>
<tr>
<td>Q2</td>
<td>When the treatment plan I recommended does not work with my patient's beliefs, culture and traditions, I'm able to talk about other options with them. Sometimes that might mean I tell them they need to see another doctor.</td>
<td>When the treatment plan recommended by my doctor doesn’t align with my beliefs, cultures, and traditions, my doctor and I talk about other options. Sometimes, that can mean that he/she suggests that I see another doctor.</td>
</tr>
<tr>
<td>Q3</td>
<td>I talk with my patients about how their life in the United States affects their health. I also talk with them about how their experiences living in the United States affect their ability to find healthcare and get medical treatment.</td>
<td>My doctor and I talk about how my life in the United States affects my health. My doctor and I also talk about how my experiences living in the United States affect my ability to find and receive medical attention.</td>
</tr>
<tr>
<td>Q4</td>
<td>I make it a point to find out what my patient feels about the medical problem (whether their culture and beliefs are similar to mine or not). I also make sure I know what my patient wants out to get out of the treatment before I recommend a treatment plan.</td>
<td>My doctors, (some of whom have cultures and beliefs that are similar to mind and some of whom do not), make an effort to find out what I feel about my medical issue. Also, they want to know what I want to get out of a treatment plan before recommending one.</td>
</tr>
</tbody>
</table>
Figure 13: Cultural Humility

Qualitative Analysis:

Does cultural competency training make a difference in how provider's respond to questions?

Yes, cultural competency training appears to have made a difference in how providers responded to questions, but not always in the ways we would expect. For example, as can be seen in Q1 and Q2, providers who had been trained indicated a higher overall satisfaction with their skills related to cultural humility than did those who were not trained. However, for Q4 and Q5, providers who had not been trained indicated greater satisfaction than those who were trained (quite significantly for Q4, with a difference margin of 48%). This raises some interesting questions regarding the reasons behind this shift—are those who have not been trained overestimating their performance, potentially due to a lack of knowledge of what cultural humility entails, or are those who have been trained being hyper-critical of their interactions due to their knowledge of what cultural humility entails? Cultural humility is the only need category in which the X axis only spans to 80%.
How do responses from providers who have been trained at Roxboro versus not trained compare to the responses of their patients?

Building upon the trends reflected in the previous response, we can also see that patients consistently indicated greater need satisfaction than both the trained and untrained providers across all questions. This is a very positive indicator that the patients are overwhelmingly satisfied with the ways in which cultural humility is expressed by their provider during the interaction. Nevertheless, it is important to strengthen provider confidence in the area of cultural humility.

Question Key:

<table>
<thead>
<tr>
<th>Cultural Opportunities</th>
<th>Provider</th>
<th>Patient (English Version)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Q5</strong></td>
<td>If I am not fluent in Spanish, I use interpreters and tools like videos, printed materials, online translation tools, and other materials so we can communicate with each other.</td>
<td>If my provider is not fluent in Spanish, he or she uses interpreters and tools like videos, printed materials, online translation tools, and other materials so we can communicate with each other.</td>
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<tr>
<td><strong>Q6</strong></td>
<td>When using printed materials, videos, and other materials to help my patient understand the medical condition or treatments, I make sure that these materials account for their culture and beliefs.</td>
<td>When my doctor uses printed materials, videos and other materials to help me understand my medical condition or treatment, my doctors makes sure that those materials take into account my culture and beliefs.</td>
</tr>
<tr>
<td><strong>Q7</strong></td>
<td>I learn words, phrases, traditions and beliefs that are specific to my patient's culture. Because of this, I'm able to better understand how my patient responds to assessment, treatment or other interventions that are common in the clinic.</td>
<td>My doctor learns words, phrases, traditions and beliefs that are specific to my culture. Because of this, he or she can better understand the way in which I respond to an assessment, treatment, or other interventions that are common in the clinic.</td>
</tr>
<tr>
<td><strong>Q8</strong></td>
<td>To better understand how my patient manages the medical problem and to inform them of the treatment plan, I</td>
<td>My doctor asks me questions about the different types of treatments, healing, and support that I have</td>
</tr>
</tbody>
</table>
ask them about the types of treatment, healing, and support that they have looked for before coming to this clinic. This way, he or she can better understand how I handle my medical problems and inform me of a treatment plan.

Figure 14: Cultural Opportunities

Qualitative Analysis:

*Does cultural competency training make a difference in how provider's respond to questions?*

Yes, cultural competency training appears to have made a difference in how providers responded to questions, but much like cultural humility, trained providers did not consistently indicate a higher overall satisfaction with their skills than those who were not trained. For example, in Q7 and Q8, trained providers outscored non-trained, but they were practically tied in Q6 and outscored in Q5. One of two major outliers across all three need categories is a 100% satisfaction rate for Q5, representing a belief in the maximization of cultural opportunities within the PPR by untrained providers. This once again raises the question of accuracy versus overestimation. The X axis for this graph
stretches through to 100%, indicating an overall greater satisfaction with the utilization of cultural opportunities during the clinical interaction than the demonstration of cultural humility.

How do responses from providers who have been trained at Roxboro versus not trained compare to the responses of their patients?

Patients consistently indicated greater need satisfaction than both groups of providers across every question but Q5, another positive sign for the effectiveness of clinical service provision at this clinic, however once again, increasing provider’s confidence in their ability to demonstrate these skills will only further facilitate service delivery and patient satisfaction.

**Question Key:**

<table>
<thead>
<tr>
<th>Cultural Comfort</th>
<th>Provider</th>
<th>Patient (English Version)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q9</td>
<td><em>I know when my patient is uncomfortable, confused, or stressed during their clinic visit. I try to make them comfortable by asking them detailed questions about the reason for their visit and any reason why they haven’t been able to find the health care they’ve needed in the past. I also ask if there is anything that will make their visit more comfortable.</em></td>
<td><em>My provider knows when I am uncomfortable, confused, or stressed during my clinic visit. He or she tries to make me comfortable by asking me detailed questions about the reason for my visit and any reason why I haven’t been able to find the health care I’ve needed in the past. My provider also asks if there is anything that will make my visit more comfortable.</em></td>
</tr>
<tr>
<td>Q10</td>
<td><em>I learn about my patient's culture, beliefs, and behaviors while we are interacting. I then try to modify my behavior accordingly.</em></td>
<td><em>My doctor learns about my culture, beliefs and behaviors while we are interacting. He or she them tries to modify their behavior accordingly.</em></td>
</tr>
<tr>
<td>Q11</td>
<td><em>I recognize and adjust for differences in medical treatment, health, and health care across different cultures. I do not impose ideas upon my patients; instead, I tell them why the medical treatment is needed and how the treatment may relate to their understanding of health.</em></td>
<td><em>My doctors recognize and adapt themselves to the differences in medical treatments and healthcare that exist across different cultures. My doctors doesn’t impose ideas upon me. Instead, he or she explains to me the reason a</em></td>
</tr>
</tbody>
</table>
treatment is necessary and how this treatment relates to my idea of health.

<table>
<thead>
<tr>
<th>Q12</th>
<th>Even when I use an interpreter, I still interact with my patient by looking at and speaking to them instead of looking at or speaking to the interpreter in order to make them feel heard and understood during their clinic visit.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q12</td>
<td>Even when my doctor uses an interpreter, he or she still interacts with me by looking and speaking to me instead of looking or speaking with the interpreter. This makes me feel heard and understood during my clinic visit.</td>
</tr>
</tbody>
</table>

**Figure 15: Cultural Comfort**

![Graph showing cultural comfort](chart)

**Qualitative Analysis:**

*Does cultural competency training make a difference in how provider's respond to questions?*

Yes, cultural competency training did appear to make a difference in how providers responded to questions, but overall, responses between both groups were overwhelmingly more similar across all questions than the previous two need categories. For example, 71% of both untrained and trained providers indicated that they would strongly agree or agree with Q9 and 75% and 71% respectively for Q11. The largest differential we see for
this category is 18% for Q10. The second major outlier of the three groups occurs for Q12, where untrained providers once again indicated 100% satisfaction with their levels of cultural comfort during the clinical encounter. Like with cultural opportunities, the X axis also spans to 100%.

How do responses from providers who have been trained at Roxboro versus not trained compare to the responses of their patients?

Cultural comfort is the one need/attitude category in which patients did not consistently indicate greater satisfaction than their providers. The only question in which they did indicate higher scores for both groups is in Q9. This speaks to the need for a greater demonstration of cultural comfort from the providers than is currently presented, however it is positive that there is greater provider confidence in this need category.
The last 3 graphs represent an aggregate of all patient and all provider (non-trained and trained are grouped together) Likert Scale responses spanning from strongly disagree (1) to strongly agree (5). These graphs provide an overall understanding of the ways in which both groups comparatively responded to each question as well as an overall average for each category at the bottom (keep in mind that closer the score is to 5, the greater the satisfaction). These graphs answer the remaining research question: of the 3 need categories, which received the lowest overall need satisfaction score, and do the results correlate between groups?

**Figure 16: Patient vs. Provider Cultural Comfort Scores**

![Chart showing cultural comfort scores for Q9 to Q12 and Total CC Avg.](chart)

On average, providers indicated greater average satisfaction with the demonstration of cultural comfort during the clinical encounter with a score of 4.15 in comparison to patients who scored it a 3.99. The differential between groups was minimal at 0.16, or about 1/6th a degree of satisfaction. Q12 emerged as a standout, receiving almost a perfect provider score of 5 with patient ratings not far behind. No surprisingly low scores present in this category.
Overall, Cultural Comfort received the highest average score amongst both providers and patients.

**Figure 17: Patient vs. Provider Cultural Opportunities Scores**

On average, providers indicated greater average satisfaction with the maximization of cultural opportunities in the clinical encounter with a score of 3.66 in comparison to the patients’ score of 3.07. The differential between groups is 0.59, or a little over a half a degree of satisfaction. The standout question with the greatest overall satisfaction indicated amongst both groups is Q5. The individual question that received the lowest overall score out of the whole survey from providers is Q6 and Q7 and Q8 are tied for patients.

Overall, Cultural Opportunities received the lowest overall satisfaction score amongst patients.
On average, patients indicated greater average satisfaction with the displays of cultural humility during the clinical encounter with a score of 3.84 in comparison with providers who scored it 3.52. The differential between groups is 0.32 or about a third of a degree of satisfaction. The individual question that received the lowest overall score out of the whole survey from both patients and providers is Q3.

Overall, Cultural Humility received the lowest average score amongst providers.

Results Summary:

For a quick summation of the results, there is a correlation between patients and providers in regards to the need category that received the highest overall score: cultural comfort. For this, I reject my hypothesis that there would be slight to moderate incongruencies between groups. This is a positive sign for the clinic and the providers that they are successfully
demonstrating signs of cultural comfort with their Latino patients and furthermore that these patients are in recognition of the value and support it adds to the clinical encounter.

There is discordance between the categories that received the lowest average scores amongst both groups, as providers indicated they felt the weakest about cultural humility and patients felt the weakest about cultural opportunities. For this, I am unable to reject my hypothesis that there would be slight to moderate incongruencies in the needs identified by both groups.

8. Recommendations

Based on the results acquired from the survey, a set of recommendations that are widely applicable for not just this Duke Health clinic, but any entity within the system and beyond are outlined below. The hope is these recommendations can assist in further developing the clinic’s cultural competency training so as to better meet the educational needs of the providers who will in turn, better meet the healthcare needs of the Latino patients.

1. Make cultural competency training a system-wide intervention

- Distinguish the cultural competency training as a stand-alone, continuing education conference attended by all personnel (including administrators) at the clinic each year rather than incorporating it into a greater rotational training.  

- Ensure that the heads of divisions, groups or sub-units have undergone extensive cultural competency education prior to leading a larger group. These people need to serve as point-people/accountability heads to ensure that knowledge is applied to practice within each sector (refer back to ‘educator training’ on pg. 42)

- Make concerted efforts to recruit, retain, and promote diversity that is reflective of the target population at all levels of the clinic.
• Review Enhanced CLAS Standards in Appendix 4 and devise ways for them to be incorporated into the training and all equity-based approaches at the clinic

2. Expand cultural competency teaching and training mediums

• Incorporate additional modes of engaging with the material (online workshops, local conferences, broader community health initiatives etc.) outside the instructional video and group discussions to further reinforce the concepts and themes.

• Design role play scenarios, case study interactions, shadowing, or practicing on standardized patients (this opportunity is available through sites like Objective Structured Clinical Examinations (OSCEs) that focus specifically on some of the most common cross-cultural mismatches and how to handle them.

• Consider incorporating other pre-designed and effective training guides into the pre-established training (refer to ‘Theories, models, and frameworks’ on pg. 44)

3. Strengthen cultural humility amongst providers

• Incorporate LEARN Model
  o **Listen:** “Assess each patient’s understanding of their health condition, its causes and potential treatments. Elicit expectations for the encounter, and bring an attitude of curiosity and humility to promote trust and understanding.”
  
  o **Explain:** “Convey your own perceptions of the health condition, keeping in mind that patients may understand health or illness differently, based on culture or ethnic background.”
o **Acknowledge:** “Be respectful when discussing the differences between their views and your own. Point out areas of agreement as well as difference, and try to determine whether disparate belief systems may lead to a therapeutic dilemma.”

o **Recommend:** “Develop and propose a treatment plan to the patient and their family.”

o **Negotiate:** “Reach an agreement on the treatment plan in partnership with the patient and family, incorporating culturally relevant approaches that fit with the patient’s perceptions of health and healing.”

- Provide cross cultural communication training techniques with an emphasis on conflict resolution and how to handle complaints and feedback.

- Train providers on how to communicate with their patients in a way that empowers them to advocate for their themselves and preferred services, and treatments.

- Ensure that providers have a baseline idea of the makeup and history of the Latino population in the Durham community, the primary issues that plague that community, and the impact of related stakeholders in the area so as to more thoroughly understand the patient’s condition and context for that condition.

4. **Maximize cultural opportunities within the PPR**
• “Provide ongoing in-service training on ways to meet the unique needs of the population, including regular in-services on how and when to access language services for individuals with limited English proficiency”67

• “Take advantage of internal and external resources available to educate governance, leadership, and workforce on cultural beliefs they may encounter”67

5. Provide intermittent opportunities for self-assessment

• Implement regular self-assessments and questionnaires for providers to track their progress and/or expose them to additional modes of inquiry (refer to ‘assessments’ on pg. 45)67

• Disseminate research findings clinic wide and use weak points as targets for future educational curricula67

• Provide inter and intra system mentorship opportunities67

• “Use results from assessments to identify assets (e.g., bilingual staff members who could be used as interpreters, existing relationships with community-based ethnic organizations), weaknesses (e.g., no translated signage or cultural competency training), and opportunities to improve the organization’s structural framework and capacity to address cultural and linguistic competence in care (e.g., revise mission statement, recruit people from diverse cultures into policy and management positions)”67

6. Engage every level of the institution in culturally competent initiatives
• Establish developed continuing education classes, workshops, and additional enrichment opportunities that are accessible to all staff members outside of what is otherwise required

• Increase the length of the training module and diversify interactive tasks, engagement sessions and application processes that will allow application of the information gathered

• Encourage leadership and collaboration from different members of the clinic and broader health community, as culturally competency knowledge is best disseminated when those from multicultural and multidisciplinary backgrounds impart knowledge on different components

• Promote multidisciplinary dialogue surrounding language and culture issues at the clinic

9. Study Limitations

The primary limitations experienced when designing this survey were a byproduct of my status as an undergraduate researcher with a minimal time frame to receive both clinic and IRB approvals prior to graduation. Additionally, there were numerous clinic-based restrictions around which I had to work to ensure the most minimal burden placed on their work flow. Because of this, I had to simplify my study procedures, for example, eliminating the match between patients and providers that would have provided a more precise self-assessment for each provider.

In regards to the study design itself, a cross-sectional study is not ideal for proving causal relationships, so additional approaches will be required to verify cultural competency training impact and efficacy. Additionally, I had to utilize a convenience sample for both patients due to my inability to be physically in the clinic due to COVID-19. This made it difficult to eliminate
selection bias, meaning that because participation was optional, those with the most extreme opinions on either end were more likely to have chosen to complete the survey. There was also potential for response bias in regards to how patients and providers answered questions i.e., some chose to answer specific questions rather than others, some may have been led to give more positive responses out of fear their identity would be exposed.

An additional limitation with respect to provider’s previous exposure to cultural competency education is the possibility that a provider may not have received the “official” cultural competency training that was incorporated into the clinic rotation, however they might have still received other related diversity, equity, and inclusion training that, though not specifically categorized as cultural competency training, still emphasizes similar skills.

10. Conclusion

In sum, this study informs readers of how the Latino sociocultural landscape converges with standard health system practices in the United States. While there is still much room for improvement, significant progress has been made, especially over the past twenty years, in the incorporation of diversity frameworks within healthcare institutions. The next step is to standardize and equitably disseminate them throughout the country so that all providers are rightfully equipped and all patients are rightfully served. The process of self-evaluation and meta-learning is key within culturally competent service provision, however one of the most vital things to remember is that the journey along this continuum has no end point; rather, it is a continuous process that endures throughout the entire life course. There is always more to learn, and if processed through the lens of cultural humility, will only further bolster cross-cultural interactions.
While this study focuses on a key set of three needs, my hope is that future studies will expand upon this work both within this clinic and across the wider Duke Health enterprise as well. The beauty of the healthcare profession is that it is constantly evolving and devising new and better ways to provide quality care to all. Duke Health has been a predominant leader and transformative changemaker in the healthcare industry for nearly a century and will only continue to adopt additional practices that will further equip them to reduce inequities in acceptability and appropriateness access amongst for all patients regardless of their cultural, linguistic, or ethnic background.

One of the best ways to sustainably serve a population is via collaborating with that very population; therefore, amplifying the Latino voice in spaces where conversations about how to best serve them will forever be a critical step towards achieving greater equity in healthcare access.
11. Appendices

11.1 Provider Survey

Cultural Competency Awareness Survey

NOTICE: Participation in this survey is completely voluntary and you will not be penalized for declining nor will your responses impact the care you receive. Completion of the survey questions indicates your willingness to have your responses used for analysis on how to improve the Latino patient-provider relationship and cultural competency training at this Duke Health Clinic.

PURPOSE: The purpose of the survey is to identify the needs that end up unaccounted for in the healthcare delivery process between Hispanic/Latino patients, and providers that are of a different ethnic, cultural, and linguistic backgrounds via the completion of an identical survey instrument. Your responses will help us gauge the areas where you feel most and least satisfied as it relates to your healthcare experience and patient-provider relationship in general. This information will then be used to make suggestions on how to improve our cultural competency training program so that your overall quality of experience here improves.
PARTICIPATION: This survey should last no more than 10 minutes.

COMPENSATION: There will be no compensation for completing the survey.

CONFIDENTIALITY: All responses collected during this survey will be kept confidential and absolutely no identifying or protected health information (PHI) will be requested throughout any part of the process. This means that upon completion of the survey, no one will be able to link your survey responses back to you.

RIGHT TO DECLINE/WITHDRAW: As with all research studies, your participation is voluntary. You have the right to decline or withdraw from the study at any time.

CONCLUSION: Our main goal is to gauge the satisfaction you experience while interacting with your healthcare provider here at the Roxboro Clinic. Please try to answer these questions as earnestly and accurately as possible.

CONTACT: For questions about the study or research-related injury, contact Azana Green at (828)-751-1475 during regular business hours or email akg45@duke.edu. You may also contact the Duke University Health System Institutional Review Board (IRB) Office at (919)-668-5111.

Age
18-24 years
25-34 years
35-44 years
45-54 years
55-64 years
65-74 years
75 years or more

Gender
Male
Female
Transgender man
Transgender woman
Nonbinary
Prefer not to say

Have you received cultural competency training at the Roxboro Clinic?
Yes
No
Cultural Humility

I ask my patient questions to understand who they are, their beliefs, culture and traditions. Based on their answers to these questions, I come up with a treatment plan that works for them.

strongly disagree
disagree
neutral
agree
Strongly agree

When the treatment plan I recommended does not work with my patient’s beliefs, culture and traditions, I’m able to talk about other options with them. Sometimes that might mean I tell them they need to see another doctor.

strongly disagree
disagree
neutral
agree
strongly agree

I talk with my patients about how their life in the United States affects their health. I also talk with them about how their experiences living in the United States affect their ability to find healthcare and get medical treatment.

strongly disagree
disagree
neutral
agree
strongly agree

I make it a point to find out what my patient feels about the medical problem (whether their culture and beliefs are similar to mine or not). I also make sure I know what my patient wants out to get out of the treatment before I recommend a treatment plan.

strongly disagree
disagree
neutral
agree
strongly agree
Cultural Opportunities

If I am not fluent in Spanish, I use interpreters and tools like videos, printed materials, online translation tools, and other materials so we can communicate with each other.

- strongly disagree
- disagree
- neutral
- agree
- strongly agree

When using printed materials, videos, and other materials to help my patient understand the medical condition or treatments, I make sure that these materials take into account their culture and beliefs.

- strongly disagree
- disagree
- neutral
- agree
- strongly agree

I learn words, phrases, traditions and beliefs that are specific to my patient’s culture. Because of this, I’m able to better understand how my patient responds to assessment, treatment or other interventions that are common in the clinic.

- strongly disagree
- disagree
- neutral
- agree
- strongly agree

To better understand how my patient manages the medical problem and to inform the, of the treatment plan, I ask them about the types of treatment, healing, and support that they have looked for before coming to this clinic.

- strongly disagree
- disagree
- neutral
- agree
- strongly agree
Cultural Comfort

I know when my patient is uncomfortable, confused, or stressed during their clinic visit. I try to make them comfortable by asking them detailed questions about the reason for their visit and any reason why they haven’t been able to find the health care they’ve needed in the past. I also ask if there is anything that will make their visit more comfortable.

strongly disagree
disagree
neutral
agree
strongly agree

I learn about my patient’s culture, beliefs, and behaviors while we are interacting. I then try to modify my behavior accordingly.

strongly disagree
disagree
neutral
agree
strongly agree

I recognize and adjust for differences in medical treatment, health, and health care across different cultures. I do not impose ideas upon my patients; instead, I tell them why the medical treatment is needed and how the treatment may relate to their understanding of health.

strongly disagree
disagree
neutral
agree
strongly agree

Even when I use an interpreter, I still interact with my patient by looking at and speaking to them instead of looking at or speaking to the interpreter in order to make them feel heard and understood during their clinic visit.

strongly disagree
disagree
neutral
agree
strongly agree
### 11.2 Patient Survey

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<th><strong>Humildad Cultural:</strong></th>
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<td><strong>5.</strong></td>
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<tr>
<td>** totalmente en desacuerdo en neutral de acuerdo totalmente de acuerdo**</td>
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<p>| (a) | Mi médico me hace preguntas para entenderme, entender mis creencias, cultura y tradiciones. Basado en mis respuestas, mi médico crea un plan de tratamiento que funciona para mí. |
| (b) | Cuando el plan de tratamiento recomendado por mi médico no funciona debido a mis creencias, cultura y tradiciones, mi médico y yo hablamos sobre otras opciones. A veces, eso puede significar que me sugiera que consulte a otro médico. |
| (c) | Mi médico y yo hablamos sobre cómo mi vida en los Estados Unidos afecta mi salud. Mi médico y yo también hablamos sobre cómo mis experiencias viviendo en los Estados Unidos afectan mi capacidad para encontrar atención médica y recibir tratamiento. |
| (d) | Mi(s) médico(s), (aquellos que tienen una cultura y creencias diferentes a las mías como también aquellos con creencias similares), se esfuerzan por averiguar lo que siento sobre mi problema médico. También quieren saber qué resultados quiero obtener con un tratamiento antes de recomendármelo. |</p>
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<td>6.</td>
<td>Cuando mi médico no habla español con fluidez, el/ella utiliza intérpretes o herramientas como videos, materiales impresos, herramientas de traducción en línea y otros materiales para que podamos comunicarnos.</td>
<td></td>
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<tr>
<td></td>
<td>Cuando mi médico utiliza materiales impresos, videos y otros materiales para ayudarme a entender mi condición médica o el tratamiento, mi médico se asegura de que estos materiales tengan en cuenta mi cultura y mis creencias.</td>
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<td></td>
<td>Mi médico aprende palabras, frases, tradiciones y creencias que son específicas de mi cultura. Debido a esto, él/ella puede comprender mejor la manera en que yo respondo a la evaluación, al tratamiento u otras intervenciones que son comunes en la clínica.</td>
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<td></td>
<td>Mi médico me pregunta sobre los diferentes tipos de tratamiento, curas y apoyo que he buscado antes de venir a esta clínica. De esta manera él/ella puede entender mejor la forma en que yo manejo mi problema médico y así darme información sobre el tratamiento.</td>
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### Comodidad Cultural:

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<th>totalmente de acuerdo</th>
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<tr>
<td>(a)</td>
<td>Mi médico sabe cuándo me siento incómodo(a), confundido(a) o estresado(a) durante mi cita. El/ella intenta hacerme sentir cómodo(a) haciéndome preguntas detalladas sobre el motivo de mi cita y cualquier motivo por el cual no he podido encontrar la atención médica que he necesitado. También me pregunta si hay algo más que pueda hacer para hacerme sentir más cómoda(a) durante mi cita.</td>
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<tr>
<td>(b)</td>
<td>Mi médico se educa sobre mi cultura, creencias y comportamientos mientras nos comunicamos. Luego, mi médico intenta modificar su comportamiento basado en lo que aprendió.</td>
<td></td>
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<td>(c)</td>
<td>Mis médicos reconocen y se adaptan a las diferencias de atención médica que existen en diferentes culturas y sus tratamientos. Mi médico no me impone ideas. Al contrario, me explica la razón por la cual el tratamiento médico es necesario y cómo este tratamiento se relaciona con mi idea de lo que es la salud.</td>
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<tr>
<td>(d)</td>
<td>Incluso, cuando mi médico utiliza un intérprete, se dirige a mí, mirándome y hablándome en lugar de mirar o hablar con el intérprete. Esto me hace sentir que me presta atención y me entiende durante la cita médica.</td>
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11.3 Provider Granola Bar Incentive
11.4 CLAS Enhanced National Standards

**Figure 1** The Enhanced National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards)

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:

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

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

**Communication and Language Assistance**
5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

**Engagement, Continuous Improvement, and Accountability**
9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization’s planning and operations.
10. Conduct ongoing assessments of the organization’s CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization’s progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.
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65. Duke Health Center at Roxboro Street Demographic Data


