UNIVERSITY OF SAN FRANCISCO

CHANGE THE WORLD FROM HERE

Nursing Education – Culturally Reforming Patient Care Practices

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This research is dedicated to all patients and families who identify as a non-dominant culture, to advocate for an increased awareness of nursing education as a contributor to healthcare disparities for non-dominant cultures, and hopefully help drive the needle for human service education to embed content which builds the knowledge, awareness, skill, and encounters necessary for culturally intelligent practices.

Abstract

Amidst the increasing healthcare disparities for non-dominant cultures throughout a multiculturally diverse U.S., this project explores the national US standards for curriculum building within nursing education. Through a systematic review of literature, the researcher explores concepts within Patient-Centered Care (PCC) and Cultural Compemility in relation to developing newfound standards which center these concepts in developing patient care practices for nursing students. Data analysis consists of a systematic review of the standards in nursing curriculum, a content analysis of nine documents which provide the standards for building nursing curriculum, and three expert interviews from professionals in the field of managing a health pathways program, an associate dean of a graduate level nursing program, and director for a graduate level nursing program in the United States. While the data recovered by the researcher requires further research to fully understand the presence of concepts within cultural intelligence being taught in nursing curriculum, the lack of US national standards within nursing education directly addressing culturally intelligent patient care suggests a deeper exploration in the US standards for nursing curriculum. Concepts in this project provide implications for further research in student focused teaching models, standardizing terms and research in the concepts regarding culturally intelligent patient care practices in nursing education and advocating for a need to address the intersection between cultural implications which should guide how and what is taught in human service education.

Keywords: culture, cultural competimility, patient-centered care, nursing education

Acknowledgments

Thank you to my mother and sister for motivating me to find my own space to expand knowledge for the US healthcare system, to my father for teaching me the importance of community and servant leadership, and to my partner who has supported me wholeheartedly throughout this journey in pursuit of a career change all the while during a global pandemic.

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Section 1. Introduction

Systemic issues in healthcare that surround fair treatment for all patient populations has been studied for decades and has been studied by world renowned scientific organizations. Many of the studies of the 21st century provide several factors that link health inequities to a patient's determinants of health, which further contribute to systemic inequities within patient care in marginalized populations across the US healthcare system and moreover worldwide. In 2020, the World Health Organization (WHO) published its report on worldwide healthcare disparities, stating the widespread need to better define healthcare disparities as the term has often been synonymous with race or ethnicity.

> Although the term *disparities* is often interpreted to mean racial or ethnic disparities, many dimensions of disparity exist in the United States, particularly in health. If a health outcome is seen to a greater or lesser extent between populations, there is disparity. Race or ethnicity, sex, sexual identity, age, disability, socioeconomic status, and geographic location all contribute to an individual's ability to achieve good health (Healthy People 2020 p. 1)

While without a doubt health disparity among racial and ethnic groups historically are the most prevalent, it is apparent that these issues are widespread across the many intersectionality's of the human identity. Figure 1 is taken from the 2019 US National Healthcare Quality and Disparities Report, showing "Blacks and AI/ANs received worse care than Whites for about 40% of quality measures. Hispanics received worse care than non-Hispanic Whites for about 35% of quality measures. Asians and NHPIs received worse care than Whites for about 30% of quality measures but Asians also received better care for about 30% of quality measures (2019 National Healthcare Quality and Disparities Report | D5)."

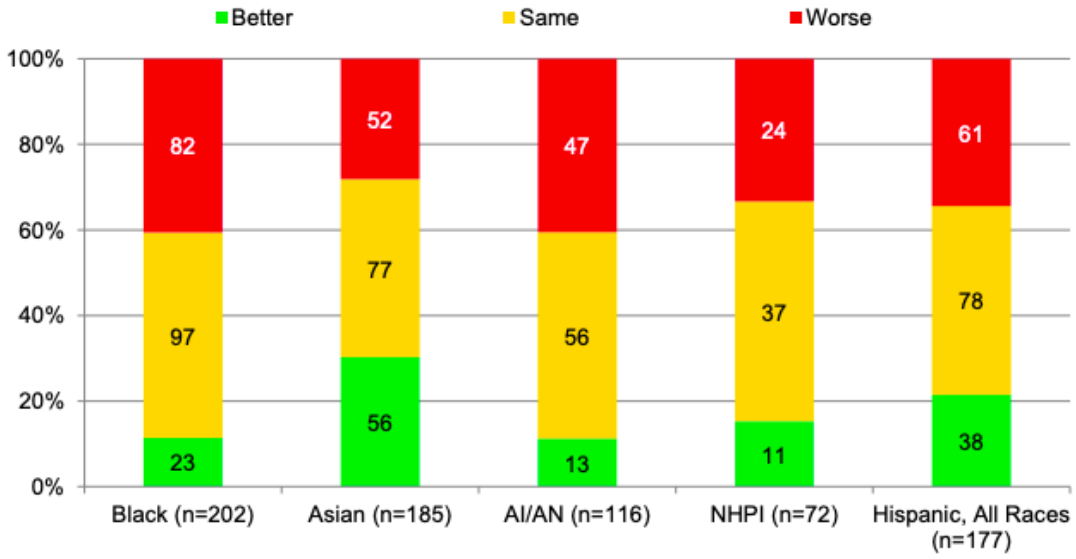

Figure 1 - https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/2019qdr.pdf

Key: n = number of measures; AI/AN = American Indian or Alaska Native; NHPI = Native Hawaiian/Pacific Islander. Note: The difference between two groups is meaningful only if the absolute difference between the two groups is statistically significant with a p-value (1)

The 2010 Census estimates that by 2050 minorities will represent more than half of the total population in the United States. While it is apparent that healthcare disparities already exist and seriously affect minority ethnic groups, we must work harder to get ahead of a problem that will only grow as society continues to become more multiculturally diverse. The cultural factors impacting health disparities are vast and encapsulate prominent issues that predominantly are affecting patients who identify as racial minorities. “Not only is there lack of understanding of how culture may determine patients’ perspectives of health or illness, but also reviewing details of health or illness in a culturally appropriate linguistic manner may escape the provider and leave much to misinterpretation (Young 2020, p.1).” Approaching this widespread health crisis should be addressed, starting within the academic programs that teach the future generation of healthcare providers. While both healthcare and academic institutions hold immense power that effect an individual’s determinants of health, these institutions must be willing to reform certain operational aspects to better equitable services for all students, patients, and their families. Bureaucratic barriers in reforming how both healthcare and academic institutions operate, have linkages to the current standards of the curriculum taught to future healthcare providers and

professors. Further exploring this may provide a high yield solution to approaching the eradication of health disparities worldwide. Prioritization to reforming medical curricula should be added near the top of the list of factors that contribute to an individual's determinants of health, which the World Health Organizations lists as: "High-quality education, Nutritious food, Decent and safe housing, Affordable, reliable public transportation, Culturally sensitive health care providers, Health insurance, and Clean water and non-polluted air (Healthy People 2020, p. 2)." With two out of the eight above aforementioned determinants of health in this list, intersecting with medical curricula – "High-quality education… culturally sensitive health care providers," there seems to be an apparent need to exploring this subcategory which may truly be a root cause to addressing systemic health inequity.

Section 2: Literature Review

For decades researchers have looked at factors that lead to the stark decreases in the quality of care provided to non-dominant patient populations both domestically and internationally. As our population continues to grow in numbers of citizens and density of US metropolitan areas, it seems as though there remains an overabundant need to fully eradicate disparities in our healthcare systems for non-dominant groups. According to the United States Census Bureau – Population Projections for 2020 to 2060 show that there will be three main demographic shifts over the next decade:

> … the U.S. population is projected to grow slowly, to age considerably, and to become more racially and ethnically diverse. Despite slowing population growth, particularly after 2030, the U.S. population is still expected to grow by 79 million people by 2060, crossing the 400-million threshold in 2058 (Census Bureau 2020, p.1).

As our world population becomes increasing multiculturally diverse there is a strong need to reform many systems and institutions that are historically rooted in the values and beliefs of a predominantly white dominant society. To do this, society will need to start embedding culturally intelligent practices within our education system as well as across all human services. This research will focus on embedding cultural intelligent practice within the healthcare education system.

Defining Culture and Cultural Intelligence

To best understand how health care can be improved through culturally intelligent practices, researchers must first explore how it defines culture and how it impacts care for patients, their families and how healthcare providers conceptualize the treatment process in providing quality healthcare for all individuals. With various definitions of culture, this research will use a definition used by Professor Geert Hofstede, who defines culture as "The programming of the human mind by which one group of people distinguishes itself from another

group. Culture is learned from your environment and is always a shared, collective phenomenon. (Hofstede 2011, p. 3). This definition is further explained through Figure 1.0, which describes the factors by which humans self-identify. With Value at the center of this figure, and the outer layers of the diagram built around each other like an onion, the figure shows how an individual's value and belief systems are created in relation to how they interact within society. This is how Professor Hofstede defines the outer most layers:

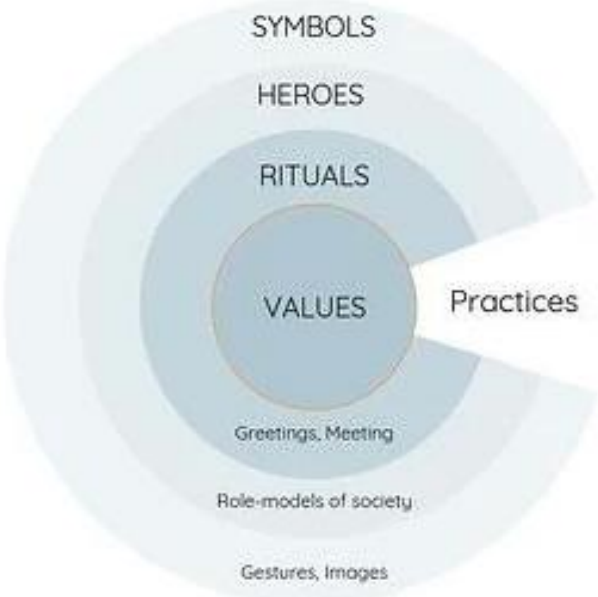

Figure 2 - Layers of Mental Programming

"Symbols are words, gestures, pictures or objects which carry a particular meaning, only recognized as such by those who share the culture. The words in a language or jargon belong to this category, as do dress, hair-do, Coca-Cola, flags and status symbols. New symbols are easily developed, and old ones disappear; symbols from one cultural group are regularly copied by others. This is why symbols represent the outer, most superficial layer of culture. (Hofstede 2011, p. 2)"

"Heroes are persons, alive or dead, real or imaginary, who possess characteristics that are highly prized in a culture, and thus serve as models for behavior. Founders of companies often

become cultural heroes. In this age of television, outward appearances have become more important in the choice of heroes than they were before. (Hofstede 2011, p. 3)"

"Rituals are collective activities, technically superfluous to reach desired ends, but within a culture considered socially essential: they are therefore carried out for their own sake. Ways of greeting and paying respect to others, social and religious ceremonies are examples. Business and political meetings organized for seemingly rational reasons often serve mainly ritual purposes, like allowing the leaders to assert themselves (Hofstede 2011, p. 3)"

This construct sets a framework for Hofstede's research on national and organizational cultures for decades to follow. As a manager of IBM's research and development department, Hofstede analyzed a large data set of global employee scores on individual values. The results of this study would become known as The Dimensions of National Culture and would be used to further build a baseline of knowledge for future research in organizational culture. Hofstede's research on cultural identity, national cultures, and organizational culture has created more nuanced research and application of culturally intelligent practices across sectors, with human service organizations, anthropological frameworks, and cross sector business successes.

In the early 2000s, research on cultural intelligence further expanded on Hofstede's theories of culture, as P. Christopher Earley and Elaine Mosakowski published Best Practices – Cultural Intelligence to the Harvard Business Review as the authors believe that "Unlike other aspects of personality, cultural intelligence can be developed in psychologically healthy and professionally competent people (Earley 2004, p.11)." This has led to a growing understanding of the Cultural Intelligence (CQ) Model as it has widely been used as a tool for global leaders in business to evaluate and apply techniques for developing cross cultural communication. In 2009, Dr. David Livermore published Leading with Cultural Intelligence, which provides an overview and practical application for The CQ Model (Figure 3.0). The CQ model shows a continuum through which cultural intelligence might be evaluated and cultural intelligence can be modeled. This model further addresses the need for our leaders to transform themselves to apply more equitable practices to business, rather than a compliant-based-tolerance of organizational

diversity across the four main areas of CQ - drive/motivation, knowledge/cognition, strategy/metacognition, and action/behaviors.

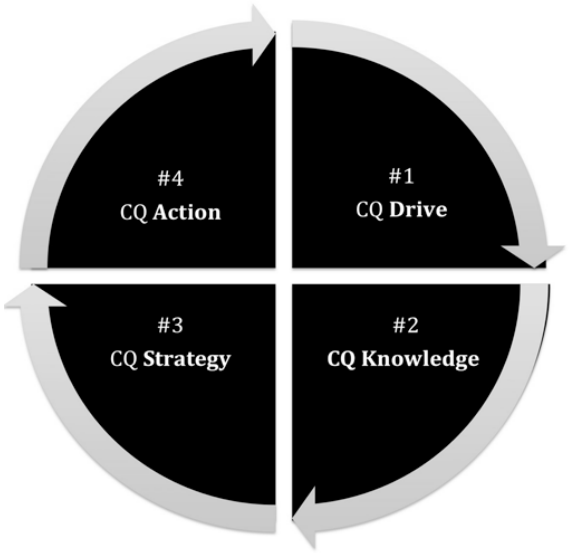

Figure 3.0 – CQ Model

There is a growing need for cultural intelligence (CQ) practice and skill development as our communities become more multiculturally diverse and as population density increases. To achieve this goal, cultural intelligence practice and skill development must be embedded in all academic institutions, from elementary school through higher education. However, this research will focus primarily on post-secondary educational settings which continues to groom and supply the next generation of healthcare leaders. While Dr. Livermore's research particularly centers around leadership there are connections between quality leadership practices and quality care related to a health care provider's communication, human connection, and empathy for a patients values and beliefs within the treatment process. Dr. Livermore states that, "Rather than expecting individuals to master all the norms, values and practices of the various cultures encountered, cultural intelligence helps leaders develop an overall perspective and repertoire that results in more effective leadership (Livermore, 2009 – p.7)." These practices speak to a need for a deeper societal awareness for shared beliefs and differences in beliefs which may largely be built upon an individual's culture.

Professor Hofstede's research in culture build toward exploring organizational cultural, which he defines as, "the way people in organizations relate to each other, to their work and to the outside world compared to other organizations," explains how a system interacts within organizational culture, which should be directly tied to an organizations missions, values and vision. The growth of an individual's cultural intelligence may only lead to incremental societal changes, while further exploration within organizational culture may accelerate the growth of culturally intelligent practices. It seems integral for any human service organizations to engage in teaching, hiring, and promoting the need for its employees to engage in culturally intelligent practices. Within the healthcare industry, there is apparent need to address disparities both within the specific populations most affected, but also through problem solving at a wholistic level with hopes of surfacing systemic root causes. Until providers are better equipped to interact with a patient population that differs culturally from them, these health care disparities will continue to exist.

Defining Terms for Culturally Intelligent Healthcare Services

As standardized language informs a large portion of how humans build concepts, it is important that the researcher addresses terms that have been in debated around the efficacy within healthcare settings. Since the 1960s healthcare has used the term cultural competence as a "cornerstone of fostering cross-cultural communication, reducing health disparities, improving access to better care, increasing health literacy and promoting health equity (Campinha-Bacote 2019 – p.1) While this term derives from a time during the civil rights movement, it "demands respect" for equitable human services and increased awareness to racial and ethnic disparities within society.

> Chiarenza (2012) has asserted that existing concepts of cultural competence share two basic assumptions, namely that cultural competence is a necessary and sufficient condition for working effectively with differences, and that cultural competence can be taught, learned, trained, and achieved (Campinha-Bacote 2019 – p.3)

This debate sparks a real question around truncating the term into its latter parts, explaining that competence shares a common understanding of proficiency which denotes an endpoint which is achievable through a strong focus on knowledge acquisition. Considering the complexities of intersections in which culture exists may suggest that the term cultural competence is flawed, as proficiency in widespread cultural understanding is irrationally attainable. This has led to debates around whether the term cultural humility should replace or augment the use of cultural competence. Melania Tervalon and Jann Murray Garcia in their 1998 research defines cultural humility in relation to healthcare services:

> Cultural humility incorporates a lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances in the patient-physician dynamic, and to developing mutually beneficial and nonpaternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations (Tervalon, 1998 – p. 117)

Rather than using these terms in opposition, researcher Dr. Campinha-Bacote, suggests these two terms be used in apposition, adding to a synergistic relationship and in turn coined a new term - *cultural competemility*. Dr. Campina-Bacote shares its definition "… as the synergistic process between cultural humility and cultural competence in which cultural humility permeates each of the five components of cultural competence: cultural awareness, cultural knowledge, cultural skill, cultural desire, and cultural encounters (Campinha-Bacote 2019 – p.5." The meld of these two terms has high likelihood in accelerating the need for practical application either alongside or within patient centered care models for healthcare providers treating patients across the many complexities of cultural identity. This newly coined term and concept will be used throughout the remainder of this paper, as Dr. Campinha-Bacote clearly states the need for both terms to coexist in building culturally appropriate healthcare services.

Patient Centered Care

Patient-Centered Care also known as "PCC has been depicted as a philosophy, a process, a model, a concept, and a partnership that involves both the patient and health care provider (to include the nurse) arriving at some form of conclusion about the care and treatment of the patient's condition. (Flagg, 2015 - p. 2)." The framework of PCC keeps focus on the patient and family throughout the entirety of the treatment process, to increase the quality of all healthcare services provided.

Patient-Centered Care has been seen to originate from quality management practices that have been used in industrial and business successes through the United States, that date back to the early 1920s. In 1960 Dr. Avedis Donabebian's research on quality healthcare outcomes was one of the first models to examine healthcare quality by assessing three areas in the treatment course: structure, process, and outcomes. This would come to be known as The Donabebian Model, which continues to influence healthcare quality evaluation today (Owens & Koch, 2015 – p. 2). US hospitals in the 1980's began to approach Quality Improvement (QI) alongside Quality Assurance (QA) Models to better identify the root causes of poor-quality care and further prevent any instances related to that poor quality of care. In delineating between the two, "QA models seek to ensure that current quality exists, whereas QI models assume that the process is ongoing, and quality can always be improved (Owens & Koch, 2015 – p. 2)

In the 1980s, the Institute of Medicine (IOM) conducted a national study, requested by Congress, to evaluate QA in current Medicare practices and the study showed a quality care to be inadequate for patients who identified as minority racial groups. A little over a decade later, The Institute of Medicine published "To Err is Human" and "Crossing the quality chasm: A New health system for the 21st century." Together, these publications reported that nearly 98,000 people die annually due to a system wide unwillingness to address preventable medical errors. Six recommendations came out of this report citing the need for "critical improvement Owens & Koch, 2015 – p. 3) and further establishing the following dimensions of care: safety, effectivity, patient centered, timely, efficient, and equitable. However while nurses have been shown to be

large contributors in helping hospitals meet QI guidelines, "Kovner and colleagues found that almost 39% of new graduates thought they were poorly prepared to implement QI measures or to use QI techniques despite having received the content in the prelicensure programs Owens & Koch, 2015 – p. 8)" which led to the development of the Quality and Safety Education for Nurses which built The Essentials of Baccalaureate Education for Professional Nursing, requiring nursing students to participate in evidence based practices that improve patient outcomes. Evidence based QI has built a solid foundation for Patient-Centered Care within the nursing profession to improve the patient experience while better informing QI for hospitals.

Nurses are often at the forefront of quality care as members of a healthcare team most frequently facing patient interactions as well as serving as a conduit between the patient and their care. We may be able to better solve the disparities in care for marginalized populations through creating a deeper understanding of culturally intelligent patient-provider dynamics. This can be done by creating national standards for accredited institutions to properly administer culturally intelligent Patient-Centered Care models within nursing curriculum. A large barrier in supporting this agenda is due to the many variations of Patient-Centered Care.

A 2009 study of A Dimensional Analysis of Patient-Centered Care found that out of 69 clinical and research articles published from 2000-2006, PCC was often viewed as a "deviation from existing practice… away from task-centered, profession-centered, or disease-centered care (Hobbs 2009 – p. 3)" with a primary focus of PCC to alleviate a patient's vulnerabilities which consist of physiological states and threats to an individual's identity. The objective of PCC was to reduce or eliminate these vulnerabilities through controlling threats to a patient feeling alienated or having lack of control within the treatment process. With the many intersections of culture affecting how a patient manifests a response to illness, it seems integral for nursing schools to approach clinical practices from a culturally appropriate lens. Lippincott Williams & Wilkins cite Benner et al. in nurses exuding three necessary characteristics that are situated around abilities in skills, knowledge, and competencies, and go on to claim, "These characteristics can affect the patient positively or negatively: The more skills, knowledge, and competencies the nurse demonstrates, the more likely he or she is to alleviate vulnerabilities

successfully." It is my understanding here that the term cultural competency should remain in apposition with any other standards of care within nursing, not as an end all be all but more as a baseline for practice nursing within the United States.

Researchers Costand et al (2014) performed a scoping review on 25 different PCC models of Patient Centered Care, showing three main tenants that were common across all models: communication, partnership, and health promotion. Marissa et al. cites research from Little et. al (Costand, 2014 – p. 1) to better define these terms:

- **Communication** – "Effective communication has been defined as the exploration of the patient's disease and illness to develop an understanding of the patient's healthcare experiences"

- **Partnership** – "a partnership with patients occurs when clinicians and patients find common ground upon which a healthcare plan can be developed mutually."

- **Health Promotion** – "… effective health promotion, defined in this study as tailoring healthcare plans based on reflections on the patient's past health history and current health context…"

Through this scoping review the authors, Marissa et al., share the need for a broader reaching definition of PCC, to assist in providing better measures of the quality-of-care throughout the treatment processes with the focus on the patient rather than systemically based on QI. While Patient Centered Care models may provide the foundation for addressing systemic disparities in care within the healthcare industry, by shifting away from a focus on the quality of care toward directly attending to cultural nuances between a provider, the patient and their family. A Dimensional Analysis of Patient-Centered Care (Hobbs, 2009) describes how this heterogeneous PCC models make it difficult for widespread application of PCC. "This lack of conceptual clarity makes PCC exceedingly difficult to operationalize or incorporate into research

projects or clinical applications and demonstrates a need for a comprehensive analysis of the term (Hobbs, 2009 – p.2)."

While historically, models have been built separately for patient centered care and cultural competence there is a centerpiece that connects both frameworks to a space of coexistence, and because of this should be considered for use either synergistically or as one model. This evolution of PCC to more explicitly address the impact that culture plays in patient care, is not only necessary for addressing the current and historically stark disparities for non-dominant populations receiving healthcare services but is further indicative of a societal norm of separating the needs of multicultural perspectives within human service. To further understand methods of culturally intelligent practices within nursing education we must look at the standards with which nursing schools approach curriculum to effectively build skills, knowledge, and competencies.

Nursing Education –Standards for Curriculum Based Learning

There may be mutual benefits to curricular reform, which effects not just patient populations but the healthcare industry itself. "Just as important for patients to have a clear understanding of their health condition, nurses from different cultures may have differing beliefs surrounding health and health care. (Young & Guo, 2016- p.6)" As our population becomes increasingly more multiculturally diverse and many healthcare organizations look to diversify its staff, an integral step to assure that the professional environment with which diverse applicant pools are entering must be welcome and sustainable for widely diverse cultures to coexist. Investing in strategies that further promote our educators in becoming more culturally sensitive, allows for the growth of an increasingly equitable system.

Standards within nursing curriculum can be dated back to the Nursing Care Act of 1964 and it should be stated that national standards in nursing curriculum were created amidst upheavals associated with the civil rights movement. While further investigation of the historical

contexts which impact the creation of the standards in nursing curriculum that were born from the Nursing Care Act - this research will not further explore the historical impacts that led to the creation of the Nursing Care Act of 1964. It is acknowledged that standard historical curriculum centered in dominant white culture will have important implication on curriculum described here.

The three main areas that control the national standards for nursing curriculum within education in the United States are policy, nursing accreditation agencies, and state nursing boards. Outside of national standards, a university's faculty and leadership values also impact on how a school approaches building their curriculum. Many factors affect standards within nursing school curriculum, but this research will focus predominantly on nursing accreditation agencies, educational leadership values, and state nursing boards.

Accredited nursing school programs can be seen at two levels, first for the university and secondarily for the nursing program. Although accreditation is voluntary, participation provides access to federal loans and scholarship programs, which ultimately are to the benefit of their teaching program. The accreditation process asks programs, facilities and faculty for an external review which is performed by peers in nursing education to ensure program quality and integrity. A majority of BSN (Bachelor of Science in Nursing) programs in the United States are accredited by three agencies: The Commission of Collegiate Nursing Education (CCNE), The Accreditation Commission for Education in Nursing and The Commission on Nursing Education Accreditation. Baccalaureate nursing programs, which this researcher's content analysis will primarily focus on, have two types of systematic reviews, which require the school's approval from the state board of nursing to ensure graduates of the program have access to sit for the licensing examinations through the National Council of State Boards of Nursing, Inc

Generally, BSN programs are structured similarly in that the first two years of classes are focused on building a strong foundation of knowledge before entering professional nursing content courses in the latter half of their program. Courses commonly taken the first two years might include subjects pertaining to humanities, social sciences, basic sciences, business,

psychology, technology, sociology, ethics, and nutrition. In the remaining two years of their program "curriculum focuses of the nursing sciences and emphasis moves from the classroom to health facilities" exposing students to "clinical skills, nursing theory, and the varied roles nurses play in the health-care system (American Association of College of Nursing Essentials – Baccalaureate Education 2008)."

> "The education of a nurse must transcend the traditional areas, such as chemistry and anatomy, to enable them to gain a deeper understanding of health promotion, disease prevention, screening, genetic counseling, and immunization. Nurses will have to understand how health problems may have a social cause, often referred to as the social determinants of health, such as poverty and environmental contamination, as well as have insight into human psychology, behavior, cultural mores, and values (American Association of College of Nursing – Baccalaureate Education 2008)." With an estimated "996 baccalaureate programs in the United States… and total enrollment of 363,433 in all nursing programs in 2020 leading to a baccalaureate degree it is important that all programs specifically address a nurse's role in decreasing healthcare disparities within the United States."

In a 2016 article, Dr. Susan Young explores U.S. national standards and research on cultural competency within the field of nursing, supporting the theory that cultural competence is learned over time and is a process necessary for providers to build culturally intelligent care. Dr. Young explains that "Without comprehensive guidelines, health care providers did not have a direction on the best way to treat culturally diverse patients and ensure the best outcomes (Young & Gou, 2016 – p.3)." Citing that the immense complexity of healthcare inequities requires all healthcare stakeholders' attention, "… there is not a one-size-fits-all answer to increasing diversity and increasing cultural competence… training in areas of cultural competency, diversity, race relations, and ethnic sensitivities has been in existence for 30+ years." Dr. Young states "Currently, there is a huge gap between what is being taught and what needs to be learned… making cultural competence a priority relies on expanded roles of leaders in nursing

schools to be willing to take risks and develop a strategic plan that integrates cultural diversity in the nursing school curriculum (Young & Gou, 2016 – p.3)."

While the federal government and nursing and medical school programs have provided guidelines to advance education and training within the realm of *cultural competemility*, there remains inadequate attention, knowledge, and consistency to improving various educational programs. Although this study has shown the importance of cultural competence and the necessary training techniques that are important for providing culturally competent care, this is only the first of several qualitative and quantitative studies to better understand cultural competency in nursing programs. Specifically, recommendations for nursing faculty will be made to help health professionals acquire expertise and embrace the value of cultural diversity and the desire to develop the skills necessary to providing quality and culturally competent care.

Patient Centered Care Models & practical application of "Cultural Competemility"

The following material has been found in the researcher's literature review, while not exhaustive, is a compilation of models, theories, and practical solutions to teaching concepts within cultural competence.

The Purnell Model

This model was built to include the traditional metaparadigm within nursing and helps to provide wholistic value to the global perspective. The Purnell Model has been used in clinical practice, continuing education curriculum, within research, and in the administration and management of healthcare services. At a macro level, the outer rings of the Purnell method represent four main concepts - global society, community, family group, and an individual person. Within each of these areas there lies twelve domains, which reside within the outer rings (overview/heritage, communication, family roles, workforce issues, biocultural ecology, high-risk behaviors, nutrition, pregnancy and childbearing practices, death rituals, spirituality, healthcare practices, healthcare practitioners) which are common to all cultures, subcultures, and

ethnic groups and have implications which correlate to the health of an individual living within societal means.

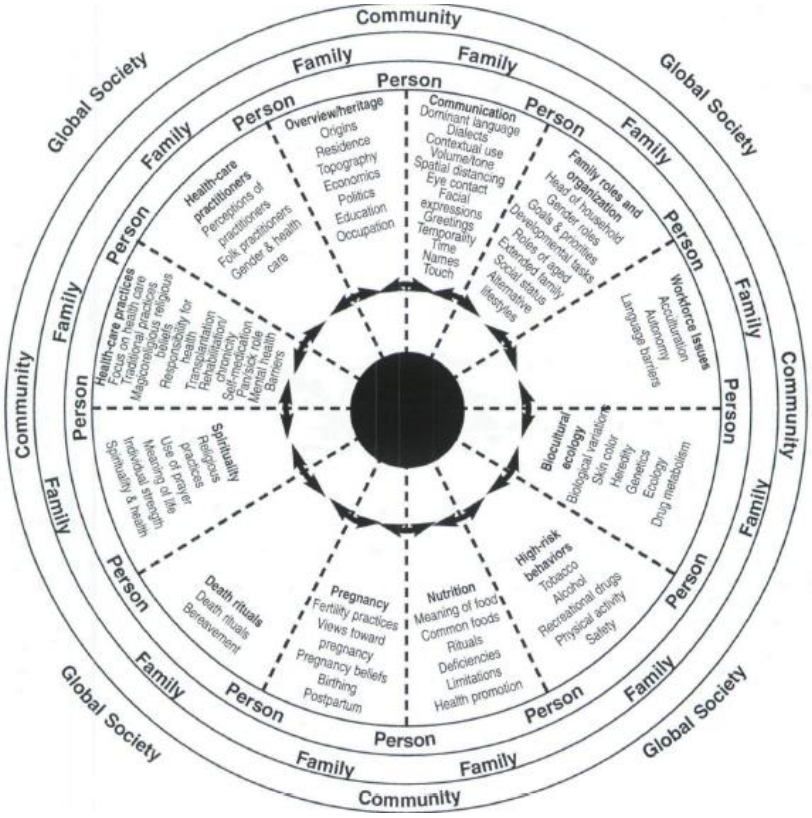

Figure 4 - The Purnell Model

The Campinha-Bacote Model

In recoining the term *Cultural Competemility*, Dr. Campinha-Bacote, has developed The Process of Cultural Competemility in the Delivery of Healthcare Services which asserts the need to combine the terms cultural competence and cultural humility within the healthcare sector. Dr. Campinha-Bacote developed five models between 1991 and 2018 which led to the five main areas that contributed to the newly coined term and an understanding of centrality around Cultural Encounters. These are the five terms defined and shown as a mnemonic which supports providers as they answer the question "Have I ASKED myself the right questions?" in their journey toward Cultural Competemility.

Awareness: Am I aware of my prejudices and biases, as well as the presence of racism and other 'isms?'

Skill: Do I know how to conduct a culturally specific history, physical, mental health, medication and spiritual assessment in a culturally sensitive manner?

Knowledge: Do I have knowledge regarding different cultures' worldview, the field of biocultural ecology and the importance of addressing social determinants of health?

Encounters: Do I have sacred and unremitting encounters with people from cultures different from mine and am I committed to resolving cross-cultural conflicts?

Desire: Do I really 'want to' engage in the process of competemility?

While this mnemonic assists in the informal processes within providing cultural competemility care, Dr. Campinha-Bacote also developed a tool for assessing the process of cultural competence among healthcare professionals, with a version specific to students within medical education and another for current providers. This assessment, "The IAPCC-R© is a pencil/paper or online self-assessment tool that measures one's level of cultural competence in healthcare delivery. It consists of 25 items that measure the five cultural constructs of desire, awareness, knowledge, skill and encounters. There are 5 items that address each construct. The IAPCC-R© uses a 4-point likert scale reflecting the response categories of strongly agree, agree, disagree, strongly disagree; very aware, aware, somewhat aware, not aware; very knowledgeable, knowledgeable, somewhat knowledgeable, not knowledgeable; very comfortable, comfortable, somewhat comfortable, not comfortable; and very involved, involved, somewhat involved, not involved. Completion time is approximately 10-15 minutes. Scores range from 25 -100 and indicate whether a healthcare professional is operating at a level of cultural proficiency, cultural competence, cultural awareness or cultural incompetence (http://transculturalcare.net/iapcc-r/)."

Leininger – Transcultural Nursing & the Theory of Cultural Care

Madeleine Leininger developed the Transcultural Nursing Theory in the early 1950's which later was published in her 1991 book – Cultural Care Diversity and Universality. Transcultural nursing (TCN) was formed from Leininger's experience as a nurse and through her application of culturally congruent care. Leininger defines culturally congruent care as a "patient-provider relationship," together the nurse and "the client creatively design a new or different care lifestyle for the health or well-being of the client. This model requires the use of both generic and professional knowledge and ways to fit diverse ideas into nursing care actions and goals. Care knowledge and skill are often repatterned for the best interest of the clients. Thus all care modalities require co-participation of the nurse and patient working together to identify, plan, implement, and evaluate each caring mode for culturally congruent nursing care. These modes can stimulate nurses to design nursing actions and decisions using new knowledge and culturally based tools to provide meaningful and satisfying wholistic care to individuals, groups, or institutions (Leininger, 1994 – p.3)."

Years after publishing Cultural Care Diversity and Universality, Leininger's nursing theory developed into a global nursing theory – The Cultural Care Theory, also known as Transcultural Nursing Theory "a substantive area of study and practice focused on comparative cultural care (caring) values, beliefs, and practices of individuals or groups of similar or different cultures with the goal of providing culture-specific and universal nursing care practices in promoting health or well-being or to help people to face unfavorable human conditions, illness, or death in culturally meaningful ways (Leininger, 1994 – p.3)" Many major concepts within patient care have derived from this theory which eventually led to founding the Transcultural Nursing Association in 1974 and the Sunrise Model later in 2004.

Sunrise Model

The Sunrise Model addresses issues in conventional practices within the medical system, by decreasing the stereotyping of patient populations and increasing goal setting within three core concepts 1) Culture care maintenance/preservation, 2) Culture care negotiation/accommodation, and 3) Culture care restructuring/repatterning. Researchers Albougami et al. cite, during a review of the Sunrise Model, in their discussion on a Comparison

of Four Cultural Competence Models in Transcultural Nursing, that “Traditional healthcare systems are based on conventional beliefs related to health, whereas professional systems rely on learned knowledge, evidence-based practice, and research. The nursing profession considers patients' physical, spiritual, and cultural needs. A thorough understanding of these needs facilitates the achievement of desired clinical outcomes (Albougami, 2016 – p. 3).”

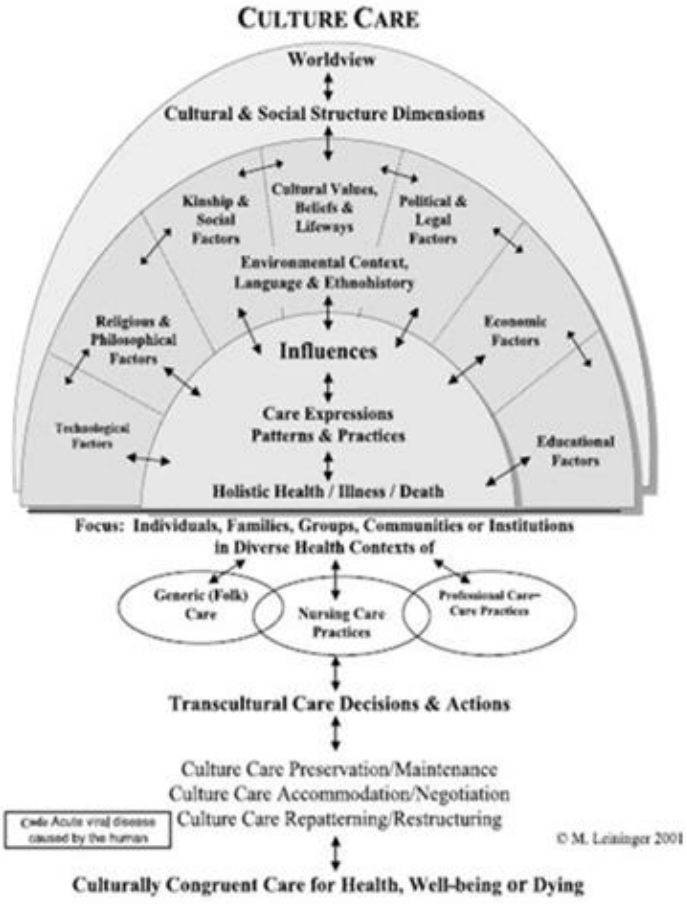

Figure 5 - The Sunrise Model

Transcultural Self-Efficacy Tool (TSET) and the Diverse Standardized Patient Simulation (DSPS)

In 2010 M.R. Jeffreys build the Cultural Competence and Confidence (CCC) Model which would guide educational strategy and design, implementation, and evaluation as a

framework to understand the processes of teaching about caring for patients from other cultures. This model derived from the Transcultural Self-Efficacy Tool (TSET) which Jeffrey's created in the mid 1990s. The TSET is an 83-item questionnaire designed to measure and evaluate learners' confidence (transcultural self-efficacy) for performing general transcultural nursing skills among diverse client populations. The "easy scoring" system has "consistently high estimate of validity and reliability for subscales and total." It has been "requested by researchers worldwide in multiple health disciplines for use with students, nurses, and other health professionals" and "may be used alone or in conjunction with other toolkit items."

It commonly is seen to be used alongside the Diverse Standardized Patient Simulation (DSPS) to better provide self-efficacy perceptions. The DSPS Researcher Eda Ozkara surveyed graduate nursing students in tandem use of these two models to better explore strategies for providing cultural competence within nursing education models. The results of Dr. Ozkara's analysis shows a positive correlation between the DSPS and the TSET evaluation. Ozkara's model is presented below to show the melding of these concepts which help assess and evaluate general transcultural nursing skills:

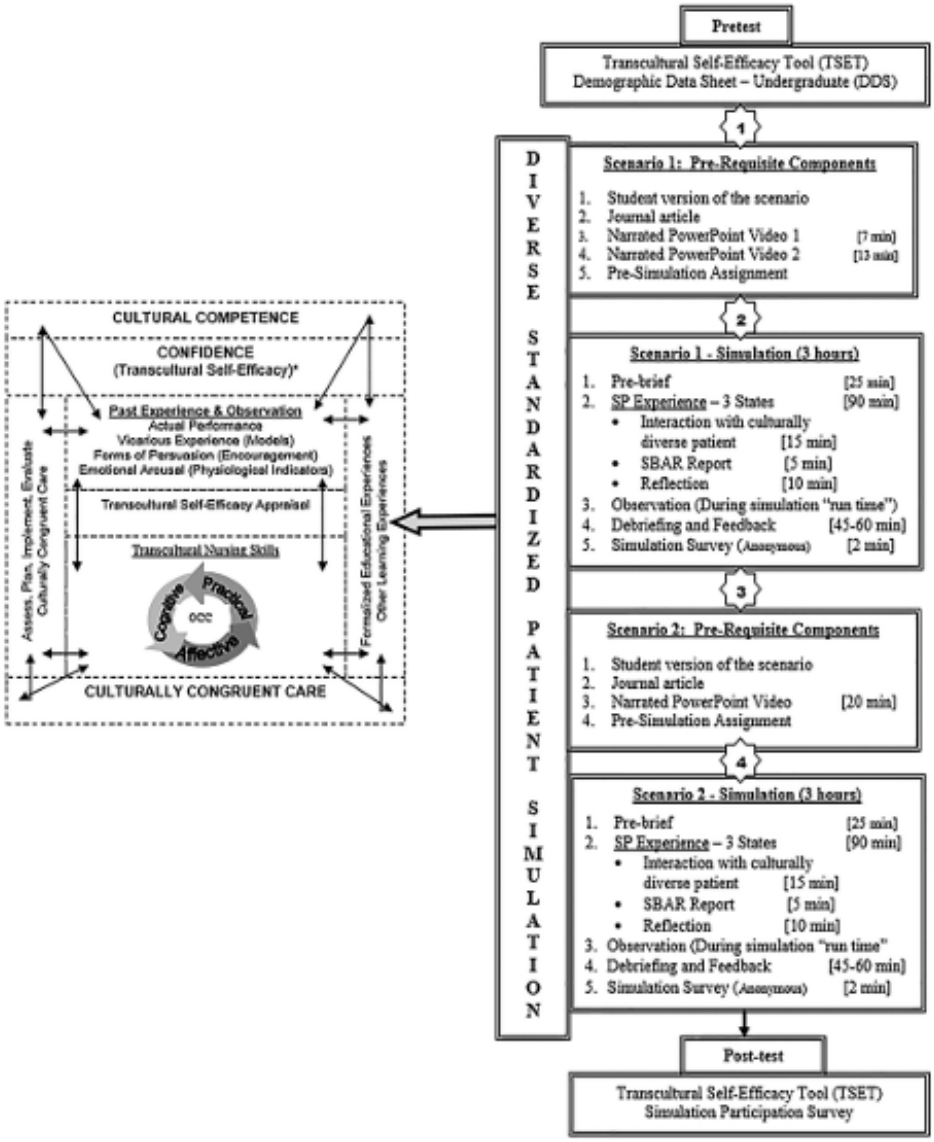

Figure 6 - Transcultural Self-Efficacy Tool (TSET) and the Diverse Standardized Patient Simulation (DSPS) - Ozkara San

Section 3: Methods and Approaches

The purpose of this research is a continued advocacy for culturally intelligent practices to be included in the US standards for medical curriculum. Further the researcher explored optimal teaching methods necessary to enhance students' knowledge, awareness, and skills necessary to effectively engage with diverse patient populations. The researcher assessed how patient centered care practice and cultural competence is defined, taught, and evaluated in medical education with a goal toward properly addressing health inequities.

With nurses at the forefront of patient care within medicine, the researcher focused on a systematic review of the current standards for US nursing curriculum. This review consisted of the current theories, frameworks, and models used to teach culturally intelligent patient care practices within nursing programs, as well as the accreditation agencies and the standards they ask programs to abide by.

Research was conducted to include a systematic review of literature to define culture, cultural competence, patient-centered care (PCC), conceptually understand theories, frameworks and models of PCC and cultural competence in medical education, as well as the national standards for providing culturally intelligent patient care. This research utilized qualitative methods and consisted of a content analysis of the 9 documents which provide standards for curriculum building within BSN programs in the United States. To bolster the knowledge gained from the content analysis, the researcher included 3 expert interviews with individuals engaged in curriculum building for medical education (Program Manager of Health Pathways at a public University, Director of Nurse Practitioner Program at private University, and an Associate Dean for Academic Affairs of a Nursing at a public University) at major US institutions. To better understand the standards for curriculum building in nursing educations, the researcher's content analysis consisted of analyzing a) documents providing standards in nursing curriculum, and b) the organizations websites to understand the values that drive organizational capacity and initiative.

The systematic review, analysis of standards in the creation of nursing curriculum, and expert interviews were set up to answer the following research questions:

***RQ1*:** How is quality patient care connected to culturally intelligent nursing practice?

***RQ2*:** Do the US standards in patient care address cultural competence in the patient care process?

***RQ3*:** Do the organizations which create standards for patient care, also support health equity through providing culturally competent standards of patient care?

Section 4. Data Analysis

The aim of this research was to explore the current standards of patient care for nursing education, and to understand the current state of culturally competent patient care which is linked to the systemic inequities within healthcare. While all topics within patient care were explored the two concepts the researcher focused on were Patient-Centered Care and Culturally Competence. A qualitative analysis was completed on documents presented by national accreditation agencies in standardizing curriculum for nursing education, as well as a comparative assessment of the values of an organization in relation to its efforts in supporting health equity.

Content Analysis

This content analysis was completed utilizing seven documents found within a comprehensive literature review, as well as through expert interviews which both directly and indirectly impact the standards for patient facing care within nursing education (**Appendix A**) In addition, organization values were assessed from the websites of the accreditation agencies which set these standards.

1. CCNE - Executive Summary of Changes to the 2018 *Standards for Accreditation of Baccalaureate and Graduate Nursing Programs*
2. CCNE - Comparing the Commission on Collegiate Nursing Education
3. CCNE – Standards for Accreditation of Baccalaureate and Graduate Nursing Programs
4. The AACN – QSEN – Graduate Level QSEN Competencies *Knowledge, Skills, and Attitudes*
5. The AACN – Cultural Competency in Baccalaureate Nursing Education
6. The AACN – Baccalaureate Education
7. The AACN – The Essentials of Baccalaureate Education for Professional Nursing Practice Oct. 20, 2008

8. The Joint Commission – National Patient Safety Goals Effective January 2021 for the Nursing Care Center Program
9. The ACEN – Accreditation Manual. Section III – Standards and Criteria. Baccalureate

In review of these documents, the researcher found differences between these documents in the frequency of terms present that represent the concepts of patient care in nursing education that in my research, were linked to building *cultural competemility*. Terms were chosen in opposition of each other, focusing on language which suggests patient-centered treatment versus process or facility centered language which may suggest a systematic focus within nursing standards.

Table 1 – Frequency of Terms. Content analysis for terms related to building cultural competemility from nursing accreditation agency documents outlining standards for patient facing care within nursing education.

Table 1 - Frequency of Terms

Document:	***Doc# 1 3-pages***	***Doc #4 21-pages***	***Doc #8 7-pages***	***Doc# 5 12-pages***	***Doc #6 7-pages***	***Doc #2 9-pages***	***Doc# 3 63-pages***	***Doc#7 32-pages***	***Doc #9 9-pages***

Terms									
Patient centered care	0	26	0	1	0	5	0	17	1
Patients or Families	0	89	69	78	4	17	3	175	1
Students	5	1	0	10	20	0	100	22	53
Coordinated Care	0	4	0	0	1	7	1	5	1
Quality Care	0	50	0	11	1	8	20	72	0
Patient/Family Advocacy	0	0	0	1	1	0	0	199	0
Health Equity	0	0	0	2	1	0	0	3	0
Culture/Cultures/ Cultural	0	11	1	83	1	1	0	39	1

Medical professional (nurses, doctors, healthcare practitioners etc.)	4	29	12	24	52	18	69	131	8
Process/Processes	0	12	4	3	5	5	33	24	3
Outcomes	5	15	6	9	0	42	129	60	45
Compliance	18	0	7	0	0	0	2	0	4
Faculty, Professors, preceptors	14	15	0	9	6	21	102	14	24
Healthcare facilities	6	1	0	0	5	2	1	1	0
Standards	24	4	2	8	5	10	72	20	15

The lack of the direct use of terms revolving around concepts in health disparities (Patient-Centered Care, Patient/Family Advocacy, Health Equity, Culture/Cultures/Cultural, Quality Care, Coordinated Care) suggests a lack of focus in addressing health inequities within the standards of nursing education. While the lack of attention in these documents directly addressing standards of cultural competemility in patient care does not indicate activities associated to solving for healthcare disparities at a university level, it does strongly suggest that the standards of care in US nursing curriculum is complicit within its involvement of health disparities for non-dominant and marginalized patient populations. With the CCNE Essentials being the primary document for terms that the researcher has correlated to health equity, it is important that the reader understand the presence of these terms in this document in order to

provide a barometer for these concepts being discussed within nursing education at a systemic level.

In closely assessing the CCNE Essentials for Baccalaureate Nursing Standards, the document outlines a need for culturally intelligent patient care practices. Starting at p. 22, beginning at Essential VI: Interprofessional Communication and Collaboration for Improving Patient Health Outcome through p. 25, Essential VII: Clinical Prevention and Population Health, concepts describe a "rationale" and "sample content" which consistently intertwine healthcare concepts with human facing interactions that require critical thinking through a culturally intelligent lens. Although, language or concepts used in these sections do not specifically refer to like terms such as cultural competemility. Rather this document suggests providers "Advocate for social justice, including a commitment to the health of vulnerable populations and the elimination of health disparities (The Essentials: Core Competencies for Professional Nursing Education, 2021 - p.25)." This document lacks how specifically this advocacy work will occur and therefore becomes an afterthought in the evaluation processes and leads to "teaching to the test," for concepts that are present within NCLEX licensure exams.

Due to time constraints, this research was unable to complete a content analysis on the standards of content in the state licensing licensure in the 2019-NCLEX Test Plan, which "includes an in-depth overview of the content categories along with details about the administration of the exam as well as NCLEX-style item writing exercises and case scenario examples (Online NCLEX - Test Plan, 2021)." This content analysis leads to implications for future research comparative content analysis. While the AACN and CCNE Essentials were paramount in curriculum building for the schools with which the research conducted expert interviews, data provided by this content analysis will take a primary focus on exploring the documents and standards provided by this organization.

Out of the nine documents explored within the standards of nursing curriculum six of the documents reviewed were from the AACN or through the CCNE Essentials. In an attempt at answering the researchers, RQ3 (Do organizations that support health equity also support

culturally competent standards of patient care?) an assessment of the organization's website was completed to assess the organizational values and beliefs in correlation to supporting the movement toward systemic health equity. Within the four other accreditation organizations the researcher explored, the AACN scored most likely to support health equity through the activities provided by its organization's website.

Table 2 – Organizational Values. Content analysis for terms related to cultural values of nursing accreditation agencies, taken from their websites or documents listed above

Table 2 - Organizational Values

	Association of American Medical Colleges (AAMC)	American Association of College Nursing (AACN) - Commission on Collegiate Nursing Education (CCNE)	The Joint Commission	ACEN – Accreditation Commission for Education in Nursing
What type of organization is this?	Association	Association	Enterprise	Association
Does the organization publish a list of its board	Yes	Yes	Yes	Yes

members on its website?				
Is there visual representation of its board members on the website?	No	Yes	No	Yes
Does the organization support health equity?	Yes	Yes	Yes	Yes
To what extent does this org value/support health equity?	5/5 (Strategic Plan, Annual Report Vision/Mission, Home page, Press Releases)	4/5 (Values, 2019 Annual Report, Strategic Plan, Press Release)	2/5 (Home page, Press Release)	2/5 (Home page, Vision/Goals)
Does the annual report address healthcare disparities or health equity/inequities?	No	Yes	No	No

Based on the researcher's content analysis the AACN organizational values seem to directly align with supporting a movement toward decreasing health disparities, although in

review of the six documents compiled from this organization there is comparable information that suggests a separation and lack of attention to defining the concepts within cultural competemility and Patient-Centered Care. With little information directly linking these concepts, the AACN may be unable to properly define standards for evaluation of Patient-Centered Care and Cultural Competemility.

Out of the nine documents reviewed, none of the documents directly use terminology of Patient-Centered Care or Cultural Competemility. While these two concepts are considered as having broad reaching definitions it seems important that this be addressed in establishing standards of Patient Care. While pieces of these broad reaching concepts are described sporadically throughout the documents reviewed, it seems important that these concepts are not organized in ways to properly understand how these terms should be used in partnership to better teach patient care techniques for treating diverse patient populations.

Expert Interviews

Expert interviews were preformed to provide additional in-depth information that could not be gleaned from the content analysis of nursing accreditation documents and websites. Expert interviews were conducted June-July 2021. The questions of the semi-structured interview format created by the researcher are found in Appendix B. While each interview took its own shape organically, the researcher addressed questions and concepts with each interviewer with standard responses. All interviewees were provided a template of the semi-structured interview prior to the. All Participants will remain anonymous to preserve their positions within both the healthcare industry and academia and for compliance with institutional research standards involving human subjects.

Five expert witnesses from nursing accreditation agencies or universities were contacted, all individuals of the nursing accreditation agencies the researcher contacted declined and three of six nursing leaders from universities agreed but ultimately failed to complete the interview

process. Three interviews were conducted. Details of the individual interviews follow as well as a summary of the findings.

Expert Interview - Participant #1

Participant #1 is a Project Manager for Multicultural Education at a prolific public university in medical education, managing six pathway programs available to medical, nursing, pharmacology, and public health students. This individual is responsible for managing 400+ students annually within various levels of their respected programs, providing new curriculum, and connecting certificates of training in clerkships within the six pathways they manage.

Considering the specificity of each pathway program, organized to explore health inequities directed toward a single marginalized group within society, overall concepts of cultural competence were not found. Although, teaching concepts within the literature were. Simulation based learning through clinical rotations and standardized patient interviews were conducted throughout the courses. With focuses of these courses exploring the nuances within care for certain underserved populations, there were no frameworks or models of cultural competence shared with the researcher.

A large topic that seemed to resurface throughout the interview was the strength in the student population to help drive these courses, and further evolve curriculum, practical solutions to learning, and social justice issues within the healthcare industry.

> "I think students have driven a lot for those harder issue talks as far as a system goes… I think it takes a dedicated faculty and staff working quite diligently and with an open mind on how they can improve their offerings or electives or different aspects of clinical rotations, getting a little bit creative with pressing what currently exists and really listening to students and professionals in society" - Participant #1

> "The students that I work with are fantastic, they want to be there, they want the knowledge, they want the experience, and often they are so hungry for more they often times press the staff and faculty to offer more…" - Participant #1

> "… I think students usually have a great impact on how they drive respond to and initiate their own projects with their own voice and a lot of times it does take an understanding and willing faculty and staff onboard to kind of accommodate or allow changes or adjustments, listen to policy makers, listen to what other campuses are doing." - Participant #1

With the emphasis put on students to elect to take these courses within an already competitive curricular course load, the interviewee shared an ease in supporting students as well as a healthy distance from difficulties within the process of healthcare curriculum building. "I kind of live in a fluffy nice world because I work with student who only want to work in pathways, do nonclinical elective research and are already going above and beyond in their own medical school studies that I kind of already separate from any sort of the drama that goes on in advanced healthcare curriculum." They went on to share that the LGBTQ+ pathway was built by students within the Medical Science Training Program, which is typically a Medical Doctor and Research Doctoral dual degree. As empowerment and student engagement in building these pathways is impactful for individual learning, it speaks to a stronger commitment to sustain and embed these concepts within traditional medical education curriculum.

The structure of these pathway programs makes it difficult to consistently adapt or change curriculum, as higher education is strained by bureaucratic processes. "I know its really hard from what I would call a high education standpoint because I know that a lot of that is bureaucratic and strained by budget, which leads back to government and policy (development)…." At a national level, standards of culturally competent patient care must be directly defined, for change to be reflected in that of universities located in even more progressive communities. "I think that something that universities are aware of and are trying to

build on does not always go at a very quick pace as far as national guidelines and accreditation goes."

Expert Interview - Participant #2

My second participant is a Director of a Nurse Practitioner Program, at a private University, an associate professor, graduate nursing coordinator and focuses their research on Community Health Systems. Acting both as an administrator and professor within academia, this participant provided an interesting perspective within the current state of the US standards in nursing curriculum. Participant #2 approaches this interview, providing me overarching views of their program, stating, "For a lot of these things I have a broad view of how things are running, although I might not have the specifics of how things are being taught." With the most familiarity in the DNP program, most answers provided are directly connected to the DNP program and may differ within masters and baccalaureate programs.

Following the interview format provided to the participant, I was able to succinctly engage in a discussion of specific standards and frameworks through which this program guides curriculum choices, citing the uses of Quality and Safety Education for Nurses competencies, the Institute of Health Improvement principles in patient centered care, the Clinical Nurse Leader Framework, core competencies set by the National Organization of Nurse Practitioner Faculty, the Agency for Healthcare Research and Quality, and the American Association of College of Nursing essentials. "… the Agency for Healthcare Research and Quality, would certainly drive what we use for our quality improvement, and as for our practice AACN is going to drive it (Patient-Centered Care Models) and Nurse Practitioners National Organizational documents." The participant describes the AACN as a primary source for standards within nursing curriculum within its program standards as "to remain accredited we need to show that our learners are meeting the competencies of those essentials…" and secondarily to the State Board of Registered Nursing to prepare students for the national certification exam.

When engaging the participant as to how their programs evaluate for cultural competence with Patient-Centered Care, they suggested an embeddedness throughout both foundational curriculum as well as within clinical courses. Frameworks and theories within the curriculum building, regarding evaluation and teaching methods used were based on the values of the University. In terms of practical application of these models, the researcher was interested in how the evaluation process might differ from lecture-based courses to clinical courses:

> "…our learner might be out in the field with a clinical preceptor who is not faculty so they do provide an evaluation based on an evaluation form, which is based on Nurses On Board Coalition competencies and AACN essentials which include patient centered care and cultural competence, so the clinical preceptor does the evaluation and then they have clinical faculty assigned to each student so they go out and make a site visit and make an evaluation of the student and then we also use in class simulations and they are evaluated on that same rubric in a simulated patient experience and then of course we have our standard didactic type of testing i.e. midterm and a final." - Participant #2

In addressing barriers within building culturally competent medical education, the participant shared the 2020-2030 Nursing Future of Nursing Report from the National Academies, specifically citing "more of a focus on community health, prioritizing public health, and improving pay for those of us who choose to work in the community health sector… trying to meet the needs of underserved populations, so nursing calls out better pay for those who choose community primary care, increasing the diversity of the healthcare workforce, creating pipelines, increasing the diversity of the nursing faculty." Many of these issues addressed spark the need for a deeper recognition of health inequities at a systematic level. Similarly in explaining the need to diversifying the healthcare workforce, the participant explains the need for students to practice is diverse healthcare settings, which is a twofold problem that lacks resources and federal funding, as well as the capacity of community health organizations to take on a trainee. "You take a trainee, you have one more body in there, you're using time from you clinicians. All those factors. The reality of running an underfunded service to diverse populations and adding one more body in there just stresses the system." To further complicate this problem

a lot of university's are located around metropolitan cities and are much less accessible to rural health organizations where there may be more underserved patient populations.

Expert Interview - Participant #3

The last participant was an associate dean from a top 10 public nursing school in the United States, working as an advocate for educational policy reform at the state level, as well as an AACN accreditor. Participant #3 provided similar perspective as my other two interviews, although from a more neutral position representing three different parties that are engaged in curriculum building within nursing programs. They stated, while the AACN Baccalaureate Essentials drive standards in nursing curriculum within this nursing program, "Creativity (in curriculum building) is encouraged by AACN and doesn't feel held back this."

In addressing the teaching of patient-centered care, participant #3 mentioned the utilization of simulations modules as a form of applying knowledge build to build skills toward a providers patient facing practice. In order to address health equity, the program applies the HEALS acronym to handle situations that may occur in the classroom which either cause microaggressions for students, lectures, professors, or preceptors throughout the program. Participant #3 described activity and curriculum building within its Pathway program that was like participant #1. While this empowers students to own their education and help evolve the classroom dynamic, putting the onus on the student to speak up when faced with cultural differences may be problematic for many reasons i.e. power dynamics between students and faculty/lectures/administrators, unequitable opportunity geared toward dominant voices to decide when it is and when it not appropriate to use the acronym to pause the class for all students to learn, and lastly not fully taking responsibility to address problematic conversations that negatively affect marginalized student populations.

In addressing the engagement of curriculum teaching in cultural competence, the participant stated that "we are past cultural competence and looking toward anti-racism and health equity." While I believe this speaks true to the current state of the social climate for racial

justice, my research shows a direct linkage between culturally intelligent patient care and anti-racist initiatives. In conclusion participant #3 shared an apparent need to improve work within social justice within the nursing program, stating other goals that need to be met to achieve health equity:

- Admission departments need to embrace holistic admissions, to recruit and retain students with diverse backgrounds
- Must diversify a workforce that will mirror that of a diverse student population
- Promoting and retaining a diverse leadership

As these concepts continue to resurface throughout the social sector during a time of racial justice, it is important that organizations must show that it values diversity within its workforce, through proactively creating a space for belongingness among a multiculturally diverse leadership and employee base. These values come through in other areas of this interview such as: reforming admission criteria, the associate dean building an anti-racism center, although suggest that these efforts may be disjointed from the central values of the program.

Finding and Summary of Content Interviews

In all interviews, participants struggled with the specificity of questions relating to terms and content within Patient-Centered Care (PCC) and Cultural Competemility. The following themes emerged from these interviews:

- Policy and legal issues are a barrier for schools to support students expanding skills and encounters within clinically settings that serve diverse patient populations both in metropolitan and rural areas
- Advocacy is necessary for standards in nursing to change to better support culturally intelligent patient care, which has primarily shown through student and faculty engagement
- Nursing programs must promote diverse leaders, faculty, and students to better address health disparities for non-dominant cultures in the US

While it seems common, across all three interviews, that schools are creating incremental changes to their nursing curriculum both at public and private universities, gate holders such as the department of education, accreditation agencies, and policy makers must step forward to exact change in healthcare education to include a deeper embeddedness of culturally intelligent patient practices throughout all courses included in patient facing nursing education. Building the skills necessary to engage with diverse patient populations is an integral part of addressing health inequities for future generations and must be included as a core competency in all patient-facing educational activities.

Strengths and Limitations of this Research

While this content analysis provides a foundation for which terms and concepts of Patient-Centered Care (PCC) and *Cultural Competemility* are present in documents which present the standards for nursing curriculum in the US. Further exploration must be done to fully understand how nursing programs are addressing content of PCC and *Cultural Competemility* within patient facing care techniques to understand how these concepts are taught and evaluated.

Expert Interviews provided in depth information from key stake holders in nursing education and provided rich context for summarizing the state of standardized nursing curriculum and for the research to give recommendation for improvement. This research was conducted during the summer months, while many professors, administrators, and leaders within nursing schools were unavailable for interviews. Secondly, a tie constraint inhibited the researchers' ability to properly access expert interview within the US standard of nursing. In future projects, a stronger focus on compiling analysis for understanding how to drive the needle toward raising the US standard of culturally congruent patient care. Lastly, these interviews would be best used in a comparative format looking at concepts explored both within academic leaders and leaders within accreditation agencies.

Section 5: Implications and Recommendations

My findings show that while national standards in nursing curriculum address cultural aspects within patient care, standards lack the necessary attention to building culturally intelligent patient care practices. This quite possibly is at odds with a surge of nurses stepping into new careers due to mistreatment during the Covid-19 pandemic, as the healthcare system is looking to replace an experienced nursing population with newly graduating nurses. As our population continues to increase both in size and density around metropolitan areas in the United States, it is in the best interests of accreditation agencies to include curriculum focused on providing care to multicultural populations. While specialty programs and pathways may provide a more specific focus in caring for diverse patient populations it is the baseline standards of care which need to evolve to treat patients wholistically rather primarily by illness and symptoms. If this step is not taken soon, we may continue to see disparities in care among marginalized patient populations increase even while our population continues to grow more multiculturally diverse.

To drive these topics forward there is a need for further research in determining the right blend between concepts in patient-centered care and cultural competence. Currently, review literature shows that the terms are not clearly defined and allow for many variations and iterations throughout the research. By creating baseline definitions and evaluators within clinical practice for these terms agencies create much more simplistic form of application in nursing programs. Accreditation agencies that create standards in nursing education, such as must take responsibility for driving the needle in research as many universities may be allocating on what is necessary to become accredited due to lack of ability to capacity build in creating more culturally congruent curriculum. Universities, whether their values align with concepts within health equity or not, need assistance in building these concepts into its nursing programs curriculum for the sake of future nurses and patients alike. Private universities must also accept a similar role to accreditation agencies in driving research through practical application of teaching culturally intelligent patient care within program curricula as well as formal research. While private institutions may operate in a more open environment than that of many public

universities, due to bureaucratic processes, it is also important that private institutions understand their role in paving the way for the future of nursing education. This in turn marks as an important reason for private universities to hire culturally intelligent leaders, who are willing to engage in building out program objectives that deeply explore the presence of cultural aspects within patient care. These recommendations are listed in order of priority:

1. Accreditation agencies must act by funding research centered in culturally intelligent patient-centered care by standardizing:
    - Definitions of Patient-Centered Care and Culture Competence
    - Evaluators/Measures necessary for building a baseline standard of Patient-Centered Care and Culture Competence
    - Holistically embedding these concepts within other core competencies

2. Private Universities must advantage of their position to build curriculum that best suits the values of the school and leadership and furthermore driving future standards of nursing education

3. Prioritize hiring culturally intelligent leaders in academia, healthcare, and accreditation agencies, while establishing a workplace culture that successfully retains diverse works by investing in creating a space for all individuals to belong.

Largely this has implications for all areas of academia that provide education within human services to invest in culturally intelligent practices that support the needs of diverse learners, as well as producing curriculum with content that explores culturally competemility within whatever the area of focus is. Taking initiative to create culturally intelligent human services should be the goal, and while this may be extremely complex in certain contexts, Figure 8 below should serve as a starting point for leaders at academic institutions to begin moving forward toward equity within all human service.

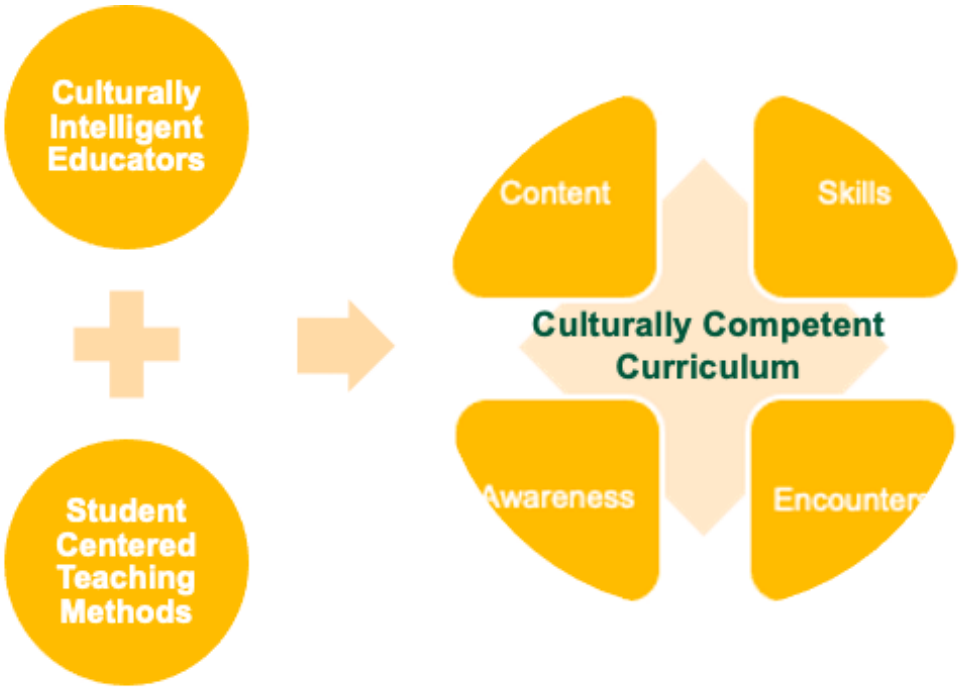

Figure 7 - Approaching Culturally Intelligent Education

While these changes may head toward large-scale systemic reform, that could set back areas with major industries, this is necessary for widespread changes in widespread disparities for marginalized populations. These changes may remain incremental over time, although there must a commitment to drastic steps toward providing an access to future healthcare providers the knowledge necessary, to end the spread, and overtime abolish healthcare inequities which seriously affect disenfranchised US citizens.

Section 6: Conclusion

Healthcare education may be a largely unexplored factor which contributes to the health inequities in the United States. While this research attempted to find this correlation, through a lack of culturally intelligent patient facing practices which are being taught in nursing curriculum, further analysis must be done. To fully understand the impact which the national standards of nursing curriculum contribute to health inequities further research must be done at a programmatic level through nursing schools and a deeper exploration of concepts in Patient-Centered Care and Cultural Competemility must be done to standardize how the healthcare profession will define and evaluate these concepts within patient facing care practices. With accreditation agencies and nursing programs at the forefront of developing the future of the nursing profession, it seems apparent that these parties are particularly responsible for driving research and advocacy toward truly meeting the needs of communities they serve ie. Students and patients.

Systemically, the healthcare system needs cultural reform to better form standards of care for a forever growing multiculturally diverse population. While workforces continue to focus on recruiting diverse educators, healthcare professionals, and leaders of institutions, we must be pay attention to the nature of the environments where these professionals are valued through culturally intelligent practices at an organizational level. This holds strong within all academic institutions who develop future human service leaders, including human services outside of the healthcare field. To do this, we must fully explore the standards through which academic institutions teach, define, and evaluate competence for students to develop into professionals within their field of service.

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Appendix A: Content Analysis

1. Area of your content analysis project's focus: US Standards in Nursing Curriculum
2. The purpose of my content analysis research is to assess the US standards of culturally appropriate patient centered care in nursing education
3. State your two research questions:

RQ1: How is quality patient care connected to culturally intelligent nursing practice?

RQ2: Do the US standards in patient care address cultural competence in the patient care process?

RQ3: Do organizations that support health equity also support culturally competent standards of patient care?

4. What is the Unit of Analysis? Standards/Competencies in Nursing education
5. Where will you find your sample of the units of analysis? Throughout my interview process as well as the resources gained from my literature review process.

Which Research Question Does this Content Analysis Question Answer?	Content Analysis Question to Analyze Unit of Analysis	Answers to the Content Analysis Question	Explanation and Definitions of Answers needed to Clearly Understand How the Unit of Analysis should be Coded
RQ1	1 – How frequently are these terms used?		Number of times mentioning or directly related to the following: • Patient-Centered Care • Patient/Family • Student • Coordinated Care • Quality Care

			• Patient/Family Advocacy/Advocate • Health Equity • Culture • Medical professional titles (nurses, doctors, healthcare practitioners etc.) • Process Oriented • Outcomes • Compliance • Faculty/Professors/Preceptors/Educators • Healthcare facilities • Standards
RQ1	2 – Does the content define patient centered care?	Yes or No	Definition is met by 2/3 criteria: 1. Layout of how Patient Centered Care is to be evaluated 2. Proving models or theory to support PCC 3. Listing competencies within patient care
RQ1/RQ2	3 – Does the content directly define culturally appropriate patient care?	Yes or No	Definition is met by: • Stating the need or providing practical application for providers to understand culturally appropriate behaviors in the treatment process
RQ1/RQ2	4 - Do the standards directly state the need for cross cultural competence?	Yes or No	Content is met with: • Does state need for cross cultural care Providing necessary skill sets that are centered in cultural humility

RQ2	5 – Do the standards indirectly state the need for cross cultural competence ?	Yes or No	Content is met by: • Not stating need for cross cultural care • Providing skill sets that are centered in cultural humility
RQ2	6 – Do these standards address health equity?	Yes or No	Standards are met by using words such as: • Health disparities • Health equity • Transcultural nursing • Equitable patient care
RQ3	7 – What type of organizatio n is this?	Associatio n, NPO, NGO, Other	How is this organization incorporated?
RQ1	8 – Are there standards for evaluating patient-centered care?	Yes or No	Do these standards have practical application or allow for skill building in this area and how are they evaluated?
RQ2	9 – Are there standards for evaluating culturally intelligent patient care?	Yes or No	Do these standards have practical application or allow for skill building in this area and how are they evaluated?

RQ3	10 – Does the organization publish a list of its board members on its website?	Yes or No	
RQ3	11 – Are there visual representation of its board members on the website?	Yes or No	From what I can see in these visuals (ie. Videos or photographs) does the board seem racially diverse?
RQ3	12 – Does the organization support health equity?	Yes or No	Does this org engage in activity attempting to solve health disparities or promote health equity? On the company/institution's website, documents explored: • Press releases • DEI statements • Values or Mission driven to serve marginalized groups
RQ3	13 – To what extent does this org value/support health equity?	0-5 score	Support is measured on a scoring system from 0-5, which will serve as 1 point for each time health equity is address on the organizations website in the following areas: • Mission statement, Vision statement, or Values • Annual Report • Strategic Plan • Most current top 10 Press Releases • Home page

RQ3	14 - Does the annual report address healthcare disparities?	Yes or No	This includes all encompassing terms: • Health equity or inequities • Health Disparities • Social justice in medicine or academia • Social determinants of health

Appendix B: Semi-Structured Interview Template

Interview Format & Informed Consent

- The interview will last about 30-45min
- I will be recording our session so that I don't miss any of your comments, although you may see me taking notes during the session
- Before we start the interview, I will ask for your consent to the use content we discuss to better inform my research.
- We will discuss your expectations for anonymity within my project, which I will consent to abiding by what is comfortable to you
- You do not have to discuss anything that may cause you discomfort during our interview and may choose to end our interview at any time.

Interview Questions

- Describe how your program approaches teaching concepts centered in Patient-Centered Care (PCC)?
    a. What factors or resources help guide these practices?
    b. Can you elaborate on any processes that have informed these theories?
- Describe how cultural competency is woven into patient centered care practices at your institution?
    a. What factors or resources help guide these practices?
    b. Can you elaborate on any processes that have informed this ideology?
- Please describe how your program believes students should apply knowledge gained from the classroom to develop a well-informed patient care practice? i.e. simulations, role play, group projects etc.
    a. What are students doing outside of the classroom to build these skills?
- What kind of assessments or evaluations are involved in your decisions for programs to assess readiness or proficiency of patient care?
- Which barriers exist in academia that impact equitable patient care practices?
    a. From your experience how can medical education teach students to provide quality care across cultural difference between a provider and patient
- Ideally how would you approach addressing the disparities in care for non-dominant groups in healthcare?

Author's Bio

Most recently Matt has participated as the sole grad student member of the University of San Francisco's Student Success Workgroup, and organizer of Seattle Sockeye's Equity Initiatives. His role in these spaces has been built upon knowledge gained from his presences as a graduate student pursuing his masters in Nonprofit Administration and as a 2021 Spring Fellow at InclusionLab's. Matt's passions in building equitable teams and workspaces for institutions to engage in building a deeper sense of cultural humility organization wide, speaks to the theory that cultural intelligent leaders can vastly change educational and healthcare gaps for marginalized populations worldwide.