Latinx Immigrants Cultural Awareness Toolkit in a Psychiatric Outpatient Clinic

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In partial fulfilment of the requirements for the Doctor of Nursing Practice

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01/26/2021

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Latino immigrants who seek mental health services need culturally competent care to improve their healthcare outcomes. Misunderstandings concerning the cultural needs of the Latino population are common among healthcare workers. As a result, health care providers are often unable to identify and understand the role that culture plays in the lives of most Latino people, including mental health (Luque et al., 2018). Many Latinos do not seek treatment for mental issues since they do not recognize their symptoms or do not know where to seek help (Adames, & Chavez-Dueñas, 2016). Current literature demonstrates that the lack of cultural competence in health workers has resulted in misdiagnosis as well as inadequate treatment of mental health issues for the Latino population (Adames, & Chavez-Dueñas, 2016). Latino immigrants, therefore, continue to receive poor quality care when it comes to their mental health needs.

A systematic review determined that access to culturally competent care was essential to increasing health service utilization among the Latino population (Moore, 2017). Additionally, a study conducted by Govere & Govere (2016) demonstrated that cultural competence training of healthcare providers significantly improved patient satisfaction and outcomes. This evidence contributes to the conclusion that in order to increase health service utilization and improve healthcare outcomes for the Latinos, efforts should be made to provide adequate cultural competence training to healthcare providers in the United States. Currently, there are no cultural competence guidelines implemented at the mental health clinic where the DNP project will be taking place. As a result, the purpose of the DNP project is to implement a Latino immigrant cultural competence toolkit (LICCT) for healthcare workers at the project site to improve patient mental health outcomes at the outpatient clinic.

Background

According to Flores (2017), the Latino population accounts for approximately 17.6 percent of the total U.S. population; in 1980, the Latino population represented just 6.5 percent of the total U.S. population (Flores, 2017). The number of Latinos is projected to grow to 107 million by 2025 (Flores, 2017) due to the ever-increasing rate of immigration of Latinos into the U.S. Despite the increasing size in the number of Latinos in the U.S., they are still significantly less represented in the healthcare workforce. According to Fisher (2018), less than 4% of healthcare providers in the U.S. speak Spanish, with Texas having the highest proportion at 9% followed by New Mexico and Florida with 8% and 6%, respectively. Additionally, statistics from the U.S. Census Bureau report show that 29.8% of Latinos are not fluent in the English language (Office of Minority Health, 2020).

Due to this language barrier, most health providers do not understand how to effectively deal with diversity, which raises problems for the Latinx immigrant population. Latinx not only face language and other external barriers to obtaining mental treatment, but also their cultural perceptions of mental health care prevent them from getting help. (Cabassa, Lester, & Zayas, 2007). Moreover, their culture has various aspects concerning mental health that many health care providers fail to understand appropriately and hence cannot provide quality care. For example, primary mental health care providers fail to recognize specific cultural-bound syndromes that are characteristic of Latinos such as fright, an evil eye, and nerves, among others; symptoms that are unique to this ethnic group include uncontrollable screaming, crying, trembling, physical and verbal aggression, seizure-like episodes, as well as suicidal gestures (Caplan, 2019). To cater to the mental health care needs of this minority group, there is a need

for health care providers to understand such syndromes and symptoms for purposes of providing care that considers their cultural perspectives and beliefs (Camacho, 2015).

Problem Statement

Racial and ethnic minorities in the U.S. are generally less satisfied with the health care services that they receive (Adames, & Chavez-Dueñas, 2016). Although there has been policy and research emphasis on delivering culturally competent mental health care, there is little evidence concerning what frontline mental health care providers consider to be culturally appropriate care (Adames, & Chavez-Dueñas 2016). Existing research also suggests that various challenges hinder them from delivering culturally appropriate health care in their everyday practices.

It is essential for healthcare providers to have a proper understanding of the cultural needs of Latino immigrants surrounding mental health issues. Mental health care providers should also be sensitized concerning specific aspects of both Latinos' learning style as well as their illness perception, along with other perspectives such as authority and physical contact issues (De Freitas, Crone, DeLeon, & Ajayi, 2018). To achieve this cultural competency among mental health care providers, it is essential to provide education and training concerning the perspective of Latinos on mental issues (Cabassa, Lester, & Zayas, 2007). Mental health providers at this DNP project site, a mental health clinic in urban Florida, do not yet have training on providing culturally competent care for Latinos.

Purpose statement

This project aims to provide a Latinx immigrant cultural competence toolkit (LICCT) for healthcare workers in an outpatient mental health clinic. When mental healthcare providers are able to approach care with cultural competence, they can gain the trust of their patients to

encourage them to speak freely about their symptoms that can then be used in diagnosis and treatment. This project aims to eliminate cultural barriers that hinder Latino immigrants from receiving appropriate mental health care, such as lack of diversity in the mental health workforce, language barriers, and ineffective communication (Boykin, Schoenhofer, & Valentine, 2014). This will be achieved through training of health care providers on cultural norms and expectations of care of Latinos. Latino immigrants will also be provided with a toolkit of resources to assist them with their mental healthcare.

Project Question

This project shall incorporate the PICOT question method as the guide for answering the project questions. The project question is:

Does the implementation of a cultural competence toolkit aimed at Latino immigrants improve culturally competent care and increase resource referral for this population?

Objectives

In the timeframe of this DNP project, the following objectives will be met:

1. To administer an educational seminar for the multi-disciplinary team in the health facility, consisting of one psychiatrist and two Mental health Nurse practitioners, to train them on culturally competence practice guidelines and the LICCT.
2. To develop a LICCT and implement it at the mental health clinic project site.
3. To increase the resource referral of Latino immigrants during mental health visits at the project site.

Coverage and Justification

Limits for the review of literature were set to achieve the desired results. The selection benchmark used for this review include those examining Latino communities, study design of

systematic reviews or qualitative and quantitative studies, peer reviewed reports, and involving the mental health setting.

The PICOT question was used as the primary search method to obtain sources. The question was: Does the implementation of a cultural competence toolkit aimed at Latino immigrants improve culturally competent care and increase resource referral for this population? Govere and Govere (2016) conducted a general review on of literature to evaluate the effect of cultural proficiency education of physicians on patient satisfaction. They concluded that culturally competent practitioners had a significant positive impact on patient satisfaction (Govere and Govere, 2016). Similarly, Jongen, McCalman, and Bainbridge (2018) undertook a systemic review, and established that culturally proficient training of the health workforce was the main strategy of reducing healthcare disparities among ethnic minorities.

The search terms used to guide the selection of secondary sources include Latino, immigrants, minority communities, culturally sensitive healthcare, mental health clinic, and LICCT. The search results generated over 500 results. Initially, 100 journal articles and academic books were found to have potentially relevant titles and abstracts. Out of those results, 20 duplications in multiple databases were eliminated. Further specifications were used with Boolean phrases such as ‘cultural competence among Latino immigrants and mental health,’ ‘mental health and Latino immigrants,’ ‘cultural themes in mental health among Latino,’ and ‘culturally competent healthcare service among the Latino group.’ Eventually, the search yielded ten peer-reviewed journals and academic books that covered the PICOT question, which had been published in the past five years. A full-text screening followed the screening of titles and abstracts.

Review of Synthesis

The theme development process was based on an analytic examination of the previous studies related to various aspects of social phenomena through literature reviews and analysis of transcriptions. Online data bases use included, Cochrane library, Agency for Healthcare Research and Quality (AHRQ), PubMed, and Cumulative Index of Nursing and Allied Health Library (CINAHL). The emerging themes from the review of literature included lack of knowledge among professionals on the different cultural practices among minority communities, lack of knowledge about traditional remedies, poor representation of minority communities in the healthcare workforce, poor cultural competence education, and diagnostic errors emerging from miscommunication. The themes provided insight into the implications for knowledge, practice, policymaking, and research on mental health among minorities.

Literature Review

The primary objective of the review of literature was to examine the cultural proficiency of physicians among minority communities with a specific focus on the Latino group. In this regard, the project leads used themes that emerged to identify the current state of cultural healthcare perceptions among professionals, patients, and the community members, identify the factors and challenges that influence the cultural competence, relationship, and communication among caregivers and patients, and provide recommendations on how to improve care for cultural competence. The search terms that guided the selection of articles include minority representation in the nursing profession, cultural competency training, barriers to cultural training, and miscommunication in healthcare. An online search produced a total of 800 results. Out of which 200 were journal articles and published books. The search generated 8 articles

when it was further narrowed to peer-reviewed sources published from 2010. The articles were then used to conduct the literature review.

Cultural Knowledge Among Healthcare Workers

The increasing population of minorities in America has triggered the need for an ethnically proficient workforce. However, most healthcare institutions in America are not culturally competent to provide services to minority communities due to sociocultural bottlenecks, namely clinical impediments organizational challenges, and structural constraints (Oriana, Schilgen, & Mosko, 2019). Organizational challenges impede the accessibility of care and include things such as the representation of the minority population in the workforce (Oriana et al., 2019). Structural constraints result from the red tape in healthcare systems. Clinical impediments occur in the patient-healthcare professional interactions. Healthcare institutions must invest in cultural competence strategies to mitigate the glaring disparities evidenced in health outcomes. Barrera & Longoria (2018) performed a systemic literature review to assess some of the cultural obstacles that Latinx face when seeking mental health treatment. The researcher established that cultural sensitivity enhance communication between the physician and the patient (Barrera & Longoria, 2018). Similarly, Larson, Mathews, Torres, and Lea (2017), in their qualitative study, sought to evaluate the relationship practitioners and elderly Latinx in rural areas. They found that healthcare providers need to require cultural sensitivity education to meet the needs of their patients (Larson et al., 2017). Therefore, healthcare stakeholders should promote culturally sensitive training to promote patient outcomes.

Poor Representation in the Healthcare Workforce

Poor representation of minorities in the healthcare workforce is also a challenge to providing culturally sensitive care. Even though minority communities constitute 37% of the

American population, minority nurses only take up 16.8% of the total nursing population (Loftin, Newman, Dumas, Gilden, & Bond, 2012). Minority representation in the workforce significantly influences service delivery across all settings because nurses care for all patients regardless of their background. Loftin et al. (2012) conducted an integrative review to identify the challenges that nursing students face. They concluded that the most common challenge that nursing students experience in the course of their education was financial support (Loftin et al. (2012). Most students work to pay for education and support their families (Loftin et al., 2012). The ever-increasing college expenses and inadequate information on where nursing students can receive financial help in the form of scholarships or grants worsens their situation. A recent study survey indicates that 3 out of 4 Hispanic college students have difficulties completing their coursework because they are more likely to sign up for part-time classes, which allow them to work and support their families (Healthypeople.gov, 2020). Thus, financial support to minority students will increase their completion rate.

Besides, mental illness was another challenge hinder minority student from completing their nursing education. DeFreitas, Crone, Deleon, & Ajayi (2018) conducted a survey to determine perceived mental health stigma among African American and Latino students. The researchers discovered that ethnic minority students were less likely to seek mental health treatment because of fear of being stigmatized (DeFreitas, 2018). Thus, to improve the representation of ethnic minorities in the health workforce, financial support and mental health services are required for nursing students.

Cultural Competence Education

Cultural competence education is vital in promoting healthcare equality. Jongen, McCalman, & Bainbridge (2018) performed a systemic scoping review to determine the role of

cultural proficiency training in effecting healthcare interventions. They discovered that the development and training of healthcare personnel were the most effective means of achieving a culturally sensitive healthcare system. Likewise, Sanchez, Killian, Eghaneyan, Cabassa, and Trivedi (2019) employed a pretest-posttest research technique to evaluate the impact of culturally competent depression education on practitioners understanding of mental health among Hispanic patients. They discovered that education and cultural training reduces stigma and improves patient engagement (Sanchez, 2019). Most studies treat patient satisfaction among minority communities as a secondary issue or tend to have extensive coverage of impacts of cultural competence (Govere & Govere, 2016). Due to the broad coverage of cultural competence in healthcare, managers do not have the information they need to understand how their current cultural knowledge base affects service delivery. Successful cultural competence education involves developing partnerships between communities and healthcare providers (Bhatt & Bathija, 2018). The approach guarantees that policies and organizational management will be reflective of the problems on the ground and representative of the community, respectively. Among the Latinos in North America, patients were generally satisfied with the healthcare services because they are the majority in that region due to the availability of provider-targeted cultural competence in the organizational, clinical, and systemic levels. Cultural competence is directly associated with an increase in patient satisfaction among minority communities.

Miscommunication

Culture defines the rules of communication. According to the Center for Disease Control (CDC) (2019), misunderstanding and miscommunication may result when people use ethnic jargon and dialects, which may lead to increase patients' risk of misdiagnosis and dissatisfaction. A systemic research in Northern Australia to determine the cultural impediments to healthcare

found that language barriers often lead to miscommunication since the aboriginals speak over 100 dialects (Li., 2012). Consequently, lack of speech-language pathologists (SLP) in the region makes patients vulnerable to misdiagnosis due to miscommunication. Moreover, Amirehsani et al. (2018) conducted qualitative research on the healthcare experience Latinx adults residing in North Carolina. They established Amirehsani et al. (2018) that the patients experienced language barriers since most practitioners are not bilingual, and there are few trained interpreters, which often lead to misunderstands and medical errors. Therefore, healthcare institutions need to invest in reducing the cultural disparities that impede healthcare delivery.

Review of Study Methods

The emerging themes from the literature review revealed that Latinos are at an increased risk of poor mental healthcare services due to cultural incompetence. Misunderstandings on the cultural practices and beliefs of the Latino population are prevalent among physicians, which complicates patients' ability to receive care and workers' knowledge on how to tailor interventions to suit their needs. Steinberg, Zickafoose, DeCamp, Valenzuela-Araujo, and Kieffer (2016) performed and secondary data analysis to assess the experience of Latina mothers, who have limited English Proficiency, seeking pediatric care. Steinberg et al. (2016) found that many mothers complain of being misconstrued and stigmatized due to language barriers. Others did not want to attend follow-up visits because they were afraid of being a burden as they would require interpreters (Steinberg et al., 2016). Such misapprehensions on the patients' cultural background or language negatively affect how Latinx receive care.

Another theme in the studies was the common understanding of cultural competencies regarding mental health, and how their operationalization differed according to profession, individual, health setting, or locality (Mollah, Antoniades, Lafeer, Bianca Brijnath, 2018). In the

healthcare workforce, to be culturally competent means having values promotes professional development, reflexive thinking, and flexibility. Whereas flexibility implies having an open-minded approach to a patient's cultural affiliations, reflexive thinking refers to the general sense of awareness and how it influences the conceptualization of the patients' health concerns (Mollah et al., 2018). On the other hand, professional development encompasses having 'working knowledge' about various cultural or ethnic groups. The literature review shows that Latinx workers translate the three values into their mental healthcare conceptualization along with three realms: procedural, functional, and integrated (Mollah et al., 2018). To improve mental health among Latinx, the government needs to incorporate systemic measures that promote the inclusion of people's cultures into the system to enhance communication between patients and healthcare workers.

Significance of Evidence to Profession

The LICCT for healthcare workers in an outpatient mental clinic presents an opportunity for the healthcare sectors to enhance the diversity in its workforce to improve patient outcomes among Latinos. Dune, Caputi, and Walker (2018) performed a systematic review published research regarding the practitioners' attitudes towards linguistically and culturally diverse patients. They established that cultural competencies improve patient outcomes by enhancing the client-physician collaboration (Dune et al., 2018). Additionally, the project creates an opportunity to understand how cultural competence affects mental healthcare service delivery from an institutional, social, and professional perspective. George, Smith, O'Reilly, and Dogra (2019) undertook a participatory research to assess the perceptions of patients with mental disorders and establish ways to promote diversity in healthcare education. They established that the increasing complexities in healthcare systems demand evidence-based educational models for

teaching diversity (George et al., 2019). The institutional angle explores the structural and systemic challenges that impede the creation of a workforce that is representative of the minority communities (George et al., 2019). That is, how educational attainment or financial resource allocation affects the incorporation of sociocultural issues in the provision of mental healthcare services. From a social perspective, this project provides critical insight into understanding how linguistic challenges among professionals affect patient satisfaction among Latinos. Lastly, the project highlights aspects of professional development that require improvement to encourage cultural competence and diversity in the workforce.

Historical Development of the Theory

The Donabedian model was first introduced in the year 1966 by its proponent Avedis Donabedian. He was at the time a scientist at the University of Michigan. His article "Evaluating the Quality of Medical Care" investigated the three elements of the model: structure, process, and outcome. According to the paradigm, quality healthcare has to satisfy all three tenets. The author focused more on making sure that quality and systems worked effectively for the overall healthcare of the patient. Quality is usually the attached judgment to an outcome, and, therefore, it is somewhat subjective (Donabedian, 2005). The Donabedian model was created to avoid the biases of the definition of quality health care. It became prevalent in the 1970s. Although other models were later introduced, for example, the World Health Organization patient healthcare quality model and Bamako initiative, Donabedian has remained a dominant paradigm that continues to be used to assess health care (Ayanian and Markel, 2016). Part of the reason why the model has remained popular is because of its empirical nature. Throughout the years, it has focused on the instrumental goal and shifting the power to patient-centeredness (Berwick & Fox, 2016) to improve patient outcomes.

The Donabedian model played an essential role in the development of the Quality, Implementation, and Evaluation model. The paradigm comprises healthcare policies, patient awareness, healthcare physician's deed, and answerability, among others (Talsma, Mclaughlin, & Bathish, 2014). The policies are currently used in healthcare facilities globally. One of the policies used is in the implementation of a pre-operative skin prep that contains alcohol (Talsma, Mclaughlin, & Bathish, 2014). Some of these programs include aspects of ethics and physician's responsibility and tasks for the overall performance of the healthcare facility. It is utilized to introduce learners into education in the health sciences (Botma & Labuschagne, 2017). Moreover, it helps students comprehend their identity tasks (Bridges, Davidson, Odegard, Maki, & Tomkowiak, 2011). The Donabedian model assists learners in realizing the professional roles that healthcare providers embrace. For instance, through the outcome tenet of the Donabedian model, learners get to see the importance of ensuring they give clear and concise explanation of the drug prescription to the patient (Botma &Labuschagne, 2017). A study shows that through the help of the process tenet in the Donabedian model which looks at what is being done, educators prefer to move from simple to complex during teaching. The use of this structure helps learners to understand the content without feeling overwhelmed (Botma &Labuschagne, 2017).

Major Tenets

Structure

The structure includes the features of a setting that provides care. The structure courses are also known as input measures. The features are both internal and external. The latter include infrastructure and financial resources. The former comprises the healthcare facility's organization and human resources, among others (Larson & Yarzdanny, 2012). If healthcare lacks sufficient financial resources, it may fail to provide quality treatments and acquire the necessary

equipment. Scarce funds also lead to healthcare providers going unpaid, which in turn reduces their motivation to work better. Faulty or outdated equipment, for example, a Computed Tomography scan, makes the work harder. In case it is faulty, it may provide false results. Therefore, it is important to ensure all healthcare facility infrastructures have been evaluated (Larson & Yarzdanny, 2012).

Process

The tenet comprises of all actions that occur during and after the provision of care. According to Larson and Yarzdanny (2012), the process feature of the Donabedian model analyses the interaction between the healthcare providers and the patient. It also includes the ethical and legal procedures of healthcare provision. The relationship between the patient and the healthcare provider largely depends on their individual judgments on each other's character. (Foot & Raleigh, 2010). Therefore, to achieve effective results, evaluation should be done to ensure that outcomes and interventions are not hindered. The process tenet also focuses on the length of time the patient has to wait for the treatment and whether or not they are informed about the delays. An effective process highlights the value of the healthcare facility. All the underlying issues in the process tenet will impact the quality of the facility.

Outcome

The outcome seeks to answer questions pertaining to the service received. They comprise the following: Did the patient understand the instructions of his medication? Did the patient follow the instructions as advised? Did the health condition of the patient improve? The answers to all these questions describe the outcome, which leads to the determination of the quality of care. The outcome category emphasizes the impact of healthcare on the patient (Larson & Yarzdanny, 2012). The tenet also focuses on the mortality, the quality of life after the treatment,

and the length of admission. From my general deduction, the outcome element is the most important as patients use it to get a recommendation of quality healthcare facilities from their friends and colleagues. It also displays the effectiveness of other tenets since an excellent process and structure seemingly lead to a good outcome.

Theory of Application to the DNP Project

The Donabedian model is well versed in guiding this DNP project. It has been used in the past to develop systematic and evidence-based systems that are applied to improve the quality of healthcare (Kunkel, Rosenqvist, & Westerling, 2007). The tenets will be employed as a guide to implementing this conceptual framework fully. The utilization of the three Donabedian elements will help divide the project into manageable and organized steps. The tenets will form the basis of the data collection, which will eventually lead to an empirical conclusion and recommendation. The application of the Donabedian model is useful as a conceptual framework for this project.

Structure

The DNP project will benefit from this tenet in the formation of an evidence-based guideline. The project will research the organization of the healthcare facility and collect data on how many healthcare providers communicate or are aware of the Latino culture (S1). It will investigate the cultural diversity of the healthcare facility (S2). The DNP project will look at the facilities available in the Latino communities and ways in which to promote cultural competence (S3).

Process

The process tenet is how often do we do what we are supposed to do. To answer this question, there is need to assess current practices around cultural competence before and after

(P1). The process also relates to education implementation. An educational seminar will be administered for the multi-disciplinary team in the health facility to train them on culturally competence practice guidelines and the LICCT (P2). There will also be a need for attendance of all members of the healthcare facility including psychiatrist and a Mental health Nurse practitioner (P3).

Outcome

The outcome tenet deals with the final result after the treatment. A most desirable outcome is to measure staff cultural competence before and after the intervention. The implementation of culturally competent toolkit aimed at Latino immigrants will help assess whether resource referral increases (O1). A culturally competent staff increases trust level with Latino patients and decreases cultural barriers.

Setting

The project setting is an outpatient psychiatric clinic in Hialeah, Florida. Florida is an ideal location for this project because it has a large population of Latinx immigrants. Moreover, the population of Latino immigrants in the USA is set to rise rapidly in the coming years (Adames and Chavez-Dueñas, 2016). The project is thus useful to the clinic and other psychiatry practices both now and in the future. The practice is small and consists of one psychiatrist, two psychiatric-mental health nurse practitioners, one medical assistant, one from desk and one office administrator. The clinic uses Valant Psychiatric Electronic Record as the system for keeping clinical electronic health records.

Valant Psychiatric Electronic Record helps minimize labor at the clinic and makes the provision of services more efficient (Valant, n.d.). It is useful for scheduling patients, billing them, and keeping records of patient information. It also provides continuous access to patient

files for the various cadres of health workers at the clinic, thereby ensuring patient care is seamless. Furthermore, some patients learn about the clinic online because of Valant Psychiatric Electronic Record. Valant Psychiatric Electronic Record will be a useful source of information while collecting data for the project since it contains documentation for patients seen at the clinic (Valant, n.d.).

Population of Interest

This project's population of interest includes both the health care providers at the outpatient psychiatric clinic and the patients seen at the clinic. The health care workers will form the direct population of interest. The staff members are the ones who need to have cultural competence awareness, and the project will focus on them (Adamson et al., 2011). In the clinic, the health workers include one psychiatrist, two psychiatric-mental health nurse practitioners, one front office staff, one medical assistant, and one clinic administrator. The inclusion criteria will be health workers treating patients with mental health conditions that identify as Latinx immigrants. The exclusion criteria will be anyone who works at the clinic, permanently or temporarily, but does not provide care for mental-health patients who are Latinx immigrants, this inclusion criteria will exclude the front-office staff and any other workers who are not involved in the treatment of Latinx immigrants who come to the clinic for mental health treatment.

The indirect population of interest will be the Latinx population with psychiatric mental health illness. The inclusion criteria for the indirect population of interest will be Spanish speaking adults who identify as a Latinx immigrant and are visiting the outpatient psychiatric clinic for treatment of mental health conditions. The exclusion criteria will be any patients apart from Latinx immigrants visiting the clinic; this excludes patients from other ethnicities and Latinx immigrant patients visiting the clinic for issues other than mental health.

Stakeholders

The key stakeholders in this project are the owner of the clinic, the medical director, and the health workers. The clinic owner is an important stakeholder since they have significant control over the clinic's working (Frasier et al., 2017). The owner has an ultimate say in the hiring and firing of employees. Moreover, the owner also helps develop policies for employees' training and the implementation of cultural competence policies (Frasier et al., 2017).

Permission had to be obtained from several people in charge of the clinic at various capacities. Permission was granted from the site administrator, the owner, and the medical director. The permission ensures that carrying out the project at the clinic is both ethical and legal. The site administrator and the clinic owner have oversight over the whole clinic hence the need to get their permission. On the other hand, the medical director is involved in the clinic's day-to-day activities, including the documentation of patients seen and the services offered to these patients. The permission of the director is thus elemental for the success of this project. There is no need for affiliation agreements for this project.

Intervention

Several activities have taken place in preparation for the implementation of the intervention. First of all, there was a selection of the mental health clinic, followed by a signed agreement that authorizes the intervention to be taken place at the clinic site. The proposed project was presented to the Touro University of Nevada and approved by the DNP project chair and members. The site administrator and Medical Director of the site were consulted regarding the enrolment of participants.

The participants have received detailed information on their role and participation in the project to reach the end goal.

The activities are expected to take place at the mental health clinic during regular office hours. The clinic administrator will be in charge of selecting medical assistants whose role will be to identify the Latinx immigrant, ethnicity which will be evaluated through the patient demographic intake form at the clinic. Patients that require community resources and assist the providers with a resource list for them. The project lead will be available to assist the medical providers with any questions about the LICCT tool, as well as the specifics of each of the resources within the tool. I will also be available with questions and guidance for the medical assistants regarding documentation of resources provided to patient. In the event that I am not available on grounds; a telephone and email contact will be provided to all participants for quick access. The intervention will take place on November 4, 2020 through December 1, 2020. The following is a weekly timeline of the implementation.

Week 1: During the beginning of this week the medical providers will take part in educational training. The training will be presented in a power point and the IAPCCR-R pre-test and post-test evaluation will be provided to all medical providers prior to the presentation. The presentation will include a detailed explanation of the resource tool. During the second half of this week implementation of the resource tool will begin.

Week 1-4: Implementation of resource to patients during in-office visits. Ongoing education and support to participants will be available through these weeks. Data collection and assessment of compliance will be conducted on a weekly basis in order to capture any opportunities needed for re-training.

Week 5: During this week compiling of data for analysis should be completed and statistical testing should be performed.

The implementation phase shall commence on November 4, 2020, and end on December 1, 2020. Later, the project lead and the medical providers are expected to have a meeting and share the final data collected and analysis at the end of the intervention.

Tools

The tools that will be utilized during this DNP project include IAPCC-R, the LICCT, educational presentation, and chart review tool. The following is an explanation of each tool.

LICCT (Appendix B)

The LICCT tool is composed of several resource assistance organizations with their address and phone numbers. The five resources included in this tool are food assistance, clothing, vocational training, employment services, and interpretation services.

The food assistance organizations provide USDA food distribution of canned goods, fresh products, and groceries. The centers also provide emergency food, breakfast, lunch, and dinner in different days of the week for those in need.

The clothing assistance organizations clients may obtain free hot showers for men and women multiple days a week and a free exchange of clean clothing, shoes, and shower programs. They also provide blankets and accessories to meet the needs of children, victims of crime, and people affected by poverty, and homelessness.

The vocational training assistance organizations provide the tools and resources necessary to help minorities to achieve financial stability. The services they offer include financial coaching and education, credit counseling, free income tax preparation, and income tax return, job training, interviewing skills and resume building, job orientation and training, resume writing, vocational training, and job placement.

Employment services provide job placement referrals in addition to various course and training through community programs.

Interpretation services will be available to assist the patient with translation of documents, onsite interpretation, and telephonic interpretation.

IAPCC-R (Appendix C)

The Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-Revised (IAPCC-R) will be used as a pre/post questionnaire before implementation and after all interventions to assess the providers' knowledge. According to Transcultural CARE Associates (2015), the IAPCC-R© was developed by Dr. Campinha-Bacote in 2002. It is a revision of the Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals (IAPCC). The IAPCC, which is no longer available for use, was developed by Campinha-Bacote in 1997 and is based on her cultural competence model, The Process of Cultural Competence in the Delivery of Healthcare Services (1998). Cronbach's alpha of the IAPPC© was established at .81 (Wilson, 2003). The IAPCC only measured four of this model's five constructs (cultural awareness, cultural knowledge, cultural skill, and cultural encounters) and not the fifth construct of cultural desire. In 2002, Campinha-Bacote revised the IAPCC by adding five additional questions to measure the fifth construct of cultural desire. This revision led to the instrument's last name. Further research was conducted on IAPCC-R© to be used with students, and a student version (IAPCC-SV) is currently available (the IAPCC-R website). Permission for the use of the (IAPCC-R) to assess the level of cultural competence of 3 mental health providers was granted on August 29, 2020. The total cost was $48 for 6 tools which will be divided in 3 pre/post questionnaires. The permission only grants administration of

the tool via an onsite pencil and paper method which will be personally hand administered. All other formats of administration are against contractual agreement.

Educational Presentation (Appendix D)

According to Bhui, Warfa, Edonya, McKenzie, & Bhugra (2007), cultural competency is considered an essential requirement for medical providers in the specialty of mental health, providing care to culturally diverse patient groups. Ongoing education and training have proven to yield improved compliance in medical management and healthcare quality for ethnic groups (Bhui, Warfa, Edonya, McKenzie, & Bhugra, 2007). Due to the considerable confusion about what constitutes cultural competence at the organization, the need for competence training is deemed crucial for the project's success. An educational presentation has been developed by the project lead using a PowerPoint presentation, pre/post survey, and LICCT handouts. The training's goal is to provide consistency among the providers of the clinic on how cultural beliefs and practices of Latino immigrants may affect their perception of mental health illness, health behaviors, and acceptance of resource assistance. The training will take place at the organization and will be conducted by the project lead with the medical director and administration's permission. A three-hour session will be allotted for the educational presentation.

Chart Review Tools

Two chart audit tools have been incorporated in the project. The first tool has been composed of two sections (Appendix E) to evaluate participant’s knowledge of cultural competency through educational presentation and pre/post questionnaire. The second tool (Appendix F) is a scale tool to evaluate the knowledge in cultural competence of the participants and the need for further education. Both tools have been developed by the project lead and reviewed for quality by the project team and the stakeholders at the site. In addendum the

participants will also be evaluated for their compliance in providing and discussing the available resources with the patient and documenting the plan accordingly during the office visit.

Data Collection Procedures

Data collection in the healthcare sector is a sensitive activity. Under the stipulated nursing and healthcare principles, it must be done avoiding infringing patients' privacy, confidentiality, or disclosing their essential information to the public and third parties. Data will be made anonymous for confidentiality by hiding patient identities, locations, and addresses. This approach will help protect the patient's information and reaching unintended people.

When collecting data, the project lead will undertake both pre- and post-survey results assessments to profoundly impact the possible statistical analyses' choice to be conducted at the group level (Alessandri et al., 2017). The data will be stored in digital form to avoid manipulation by other parties since it may potentially result in incorrect data.

The IAPCC-R survey will be administered as a pre-test to evaluate cultural knowledge by participants. Immediately after this survey is completed by the providers an educational training via a power point presentation will be conducted by the project lead delineating the purpose, goal, and each step of the project. Following the education training all providers will receive the same survey to evaluate their level of learned competency. Both surveys will be provided to the participants at the same time before the educational session. Since the surveys are the same, the lead will label the surveys as Pre-1 for pre-test 1 and Post-1 for post-test as identifiers. Surveys will be labeled with each participant name but will be entered in the code book with unidentified initials. Directly after the collection of all pre/post survey questions, the audit tool (Appendix F) will be completed, and results entered in the codebook. Once medical provider competency has been established, the intervention will begin, and data will be collected weekly. Data will consist

of whether each Latino immigrant patient seen by a medical provider at the clinic receives the resource information according to their needs. The medical providers will be required to address the resources provided in their assessment and plan portion of their progress note. The compliance of the intervention will be collected weekly by the project lead and entered in the codebook. Finally, once the four weeks of implementation have ended, data analysis will be conducted using the appropriate audit tool (appendix E).

Ethics/Human Subjects Protection

The project site does not have and Institutional Review Board (IRB) committee therefore as per Touro University research guidelines an IRB determination form was used to determine whether that this project does not require IRB review due to being a quality improvement project. The required ethical standards including the data collection and privacy will be met during the project. The project meets the minimum requirements for a quality improvement project and the proposed interventions are viable in the healthcare industry.

While in the process of implementation, the project lead will have access to the data to protect the participant's confidentiality. Equally, data identifiers will be removed and destroyed to keep the information anonymous and attributed to meet the project principles.

All participants will be enlightened on the benefits and risks of participating in the project. Benefits include providing the needed data to help identify interventions that can help bridge healthcare gaps, more so to the Latino people. For instance, the data will help determine if healthcare providers are aware of the Latino culture. This may lead to development of a system that can help health caregivers to determine this population health perception and the care to prioritize. The risks of participation include loss of confidentiality and privacy. However, the project lead will mitigate such risks by appropriately and rigorously reviewing the data collection

process and ensure participants' rights are protected and adhere to ethical norms (Vanderbilt Kennedy Center [VKC], 2020). The participants will not be compensated as per the agreement made with the facility.

Measurable Plan for Analysis

Data were first tested for requisite statistical assumptions prior to data analysis. All assumptions were met, including normality of the distribution of score. However, because the analysis was non-parametric in nature, violations of assumptions are not problematic because non-parametric statistics are employed when requisite parametric assumptions are not met such as sample size or normality. The data collected from the pre- and post-interventions will be assessed through SPSS Statistics software to get insights for an informed conclusion. Because the sample size is small, Fishers' exact test will be applied to analyze the data of the chart review. The data collected from the three participants will be first cleaned by ensuring that there are no null data sets. The Fisher's exact test is a non-parametric test used to determine the correlation between two variables (Datascienceblog, 2018). In this case the comparison would be with no protocol pre-implementation and a newly developed cultural competence protocol implemented at the mental health clinic a practice changes to improve provider competency. The improvement in cultural competence will be evaluated by the pre/post survey using the IAPCC-R Scoring Key (Appendix F), and a descriptive statistic with a simple percentage to report improvement will be utilized. Code book will be developed to collect all data using unidentifiable code names. All project information will be stored in a designated computer provided by the site with project lead only access.

Result

Table 1 presents descriptive statistics and the Pearson's *r* between pretest and posttest IAPCC-R scores for the sample of providers. Figure 1 displays the pretest and posttest IAPCC-R score whereas Figure 2 presents the IAPCC-R change score.

Table 1

Descriptive Statistics and Zero-Order, Bivariate Correlation of Pretest and Posttest Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-Revised (IAPCC-R) Scores

Variable	Pretest		Posttest		*r*
	M	*SD*	*M*	*SD*	
IAPCC-R Score	87.30	4.73	98.00	2.00	0.21

N = 3

Note. M = Mean; SD = Standard Deviation; *r* = Pearson's zero-order correlation coefficient.

Figure 1. Pretest and posttest IAPCC-R scores for each provider.

Figure 2. Change in pretest to posttest IAPCC-R score, taken by subtracting the pretest score from the posttest score, and thus, indicating growth in score.

Results revealed that there was a 10.25-point increase (95% confidence interval = 7.00, 16.00) in IAPCC-R score from pretest to posttest. However, results of the Fisher's Exact Test for dependent samples were not statistically significant, χ^2 (2) = 6.00, p = .103. However, it is important to note that the effect size, Glass' Δ = 2.34, is considered a large effect size, suggesting that although statistical significance was not met, the results are practically significant.

Regarding provider compliance, providers complied 75.9% of the time (frequency = 60), with non-compliance occurring 24.1% of the time (frequency = 19). The 95% confidence interval for compliance percentile is 71.1% to 80.7%.

Discussion of findings

The project question was, "does cultural competence toolkit implementation focused on Latinx immigrants enhance cultural competence care and raise resource referral for the population?" The outcome answered questions regarding received services and rates of resource referral. The project successfully implemented the LICCT that focused on Latinx immigrants.

The project intervention had a positive effect on the providers' cultural competence scores and resource allocation to patients in the clinic. The effective process highlighted the value of the clinical facility.

The project highlighted professional development features requiring advancement to improve cultural competence and the workplace. Latinx immigrants looking for mental health services needed cultural competence care to enhance healthcare results. Misunderstanding of the Latinx population's cultural needs is rampant among clinical professions (Furman, Negi, Iwamoto, Rowan, Shukraft, & Gragg, 2009). Healthcare providers find it hard to identify and understand the role culture plays in Latino people's lives (Barrera & Longoria, 2018).

Mental health provider cultural competence was measured through the IAPCC-R pre and post-test. The results of these finding revealed an increase in 10.25-point increase (95% confidence interval = 7.00, 16.00) in cultural competence and applicability of the knowledge attained. During the scrutiny of the pre and post-test responses by the medical providers, results revealed various areas of improvement post educational training. Most of the providers expressed more knowledge about worldwide views, beliefs, practices, and lifeways of Latinx groups. Also, there was a noted increase in recognition of stereotyping attitudes, preconceived notions, and feeling the providers felt towards this population group which aligns with current literature (Sanchez, Killian, Eghaneyan, Cabassa, & Trivedi 2019). The increased knowledge in these crucial aspects of cultural competency directly impacted the increase in scores. These findings meet the first objective of this project to train all medical providers at the project clinic site on culturally competent practice. Existing research supports the conclusion that culturally competent healthcare is important because it increases health service utilization and improve healthcare outcomes for the Latinx population (Govere & Govere, 2016).

Regarding the compliance of the medical providers, a retrospective chart review was conducted. The chart review indicated a 75.9% % compliance to providing the LICCT to all Latinx immigrant populations visiting the mental health clinic through the project's implementation phase. Lastly, the results also indicated some medical providers that did not comply with providing the LICCT to patients. During one of the post statistical analysis meetings with providers to evaluate the project's results, the medical providers admitted to skipping this step during a few visits as they were not accustomed to this intervention in the day-to-day service to their patients at the clinic. According to Moore, Lavoie, Bourgeois, & Lapointe (2017), access to culturally competent care by healthcare providers is key to increasing health service utilization, increase.

Significance/Implications for Nursing

According to the United States Census Bureau (2011), an estimated 25% of Latino fall under the poverty lines. Low socioeconomic status has significant implications in patient's health, access to care, affordable care. Culturally competent care needs to include appropriate services and resources to eliminate these barriers (Cabassa, Zayas & Hansen, 2006; Kouyoumdjian, Zamboanga & Hansen, 2003). The LICCT for healthcare professionals presented platforms for the healthcare sector to promote diversity and increase outpatient resources. It was composed of many resource organizations, including phone numbers and addresses. The tool's five resources were food assistance, vocational training, clothing, interpretation, and employment services. Food assistance firms offer USDA food distribution of groceries, fresh products, and canned goods. The center gives emergency food, lunch, breakfast, and dinner.

Likewise, the clothing assistance clients receive hot showers in exchange for clean clothing, shower programs, and shoes. They also offer accessories and blankets to meet the

requirements of kids, the homeless, and victims of crime. Vocational training assistant firms offer resources and tools vital in helping minorities achieve financial stability. The services are financial coaching, free income tax education, credit counseling, job training, and interview skills. Employment services give referrals for job placement, courses, and training using community programs. Interpretation service is necessary for assisting the patient to gain documents translation, onsite, and telephone interpretation.

Mental health workers need sensitization regarding specific features of Latinx styles of learning and illness viewpoints. Mental health practitioners at the DNP project site located in urban Florida did not have cultural competence training to handle Latinx resource needs. The project offered LICCT for healthcare providers in an outpatient psychiatric clinic. Generally, mental health providers who approached care concerning cultural competence received trust among patients and encouraged them to talk about their needs (Camacho et al., 2015). The project eliminated cultural barriers, which hindered Latinx immigrants from getting adequate mental health resources. They included language problems, limited workforce diversity, and ineffective conversation. Authorities achieved it through training healthcare workers on cultural expectations and norms associated with Latinx.

The project's success involved community assistance programs in collaboration with medical providers at the clinic site; the strategy guaranteed policies and organization management reflecting on Latinx problems with mental health resource concerns. According to Cabassa, Zayas, & Hansen (2006), Latinx low economic and insufficient knowledge of where to seek care and services have served as barriers for this underserved group. Patients had general satisfaction with healthcare services due to the presence of provider-inclined cultural competence. Cultural competence had a direct link with patient satisfaction among Latinx

communities. Through Florida Health, translation services were available as part of the LICCT in non-bilingual medical providers to lower communication barriers. However, these services were not used since all providers during the implementation process were fluent in Spanish. It is fundamental for healthcare organizations to invest in cultural diversity and promote healthcare delivery to the minority population (Flores, 2017). Through the implementation and use of this LICCT tool, healthcare systems can ensure all Latinx immigrant patients have access to community resources that centers on their individual's distinct needs. By evaluating and training a diverse healthcare workforce to represent the patient population they serve, healthcare systems could provide better access to care and reduce disparities.

Limitations

- Project Design Limitation: The project design of QI project has limitations of producing biased data.
- Data Recruitment Limitation: The setting of the project is single healthcare facility, which cannot provide complete data for implementing an efficient LICCT for healthcare workers.
- Data Analysis Limitation: The post statistical analysis meetings with providers to evaluate the project's results were skipped on several visits, which can also result in biased opinions.

The project design of QI project has limitations of biased data because the use of specific technology, staff being involved and negative behavior of managers towards quality improvement can significantly influence the outcome. An element of bias can also be the healthcare facility failed to provide copies of LICCT due to a technical fault. The shortcoming can have a significant impact on the findings, which should be considered as a limitation. Although the unresponsive respondents have been acknowledged, their exact statistics are not provided, which can potentially lead to biased data.

Additionally, the project is set at a single healthcare facility, which cannot provide complete data for implementing an efficient LICCT for healthcare workers. Every organization has specific environment and culture, which guides employees to engage with each other for achieving different objectives. As Latinx have significant representation in American population (17.6%), they are virtually present in every state (Flores, 2017). Hence, representative data for such large population cannot be obtained from a single location. Thus, the results of the project cannot be generalized for the nurse practitioners working in healthcare organizations across the country.

Additionally, ethnic minorities living at different geographical locations have diverse values and perception about mental health. Therefore, health workers working at one facility cannot claim to have complete knowledge about cultural norms of a specific community. The literature review reveals that scholars recognize specific cultural-bound syndromes that are characteristic of Latinx such as fright, an evil eye, and nerves, among others; symptoms that are unique to this ethnic group include uncontrollable screaming, crying, trembling, physical and verbal aggression, seizure-like episodes, as well as suicidal gestures (Caplan, 2019). However, all these symptoms and abilities to address them cannot be found at a single location. Thus, the findings of the study might have been more reliable if the sample population would be scattered at various geographical locations.

Another limitation in the project is the fact that the post statistical analysis meetings with providers to evaluate the project's results was skipped on several visits, which can also result in biased opinions. Hence, the project may have some reliability issues due to these limitations. Further projects should be conducted to verify the findings of the present project.

Dissemination

Developing an effective dissemination strategy is necessary for increasing awareness about the project findings among the potential audience, which will be helpful in optimizing the impact of the research. Appropriate dissemination will entail getting the study findings to the target group and stakeholders. The project's key stakeholders include the clinic owners, medical director, and health care professionals. The project lead engages with these primary audiences, engaging them from the study planning to findings dissemination the investigator will establish networks, utilize conferences, social networking platforms, and websites to share knowledge and improve awareness of the project. Powerful opinion leaders, including the media and political representatives, will be deployed to serve as champions. I will send the manuscript of my project to different nursing journals for having opinion of the audience. I will also submit my project to the doctorsofnursingpractice.com repository to share my findings with the professionals of my field. I will also produce posters for placing at various places in the nursing conference taking place at our institution during the next month. The project will also be lead can also supplement the publication with formal presentations (formal talks and roundtable discussions), which have numerous opportunities to share the research findings.

Sustainability

The project meets the criteria for sustainability because it uses LCCIT as an intervention resource to teach cultural competency to the medical practitioners of the mental health care clinic. Thus, the findings will also be relevant for the staff of the site in future. The staff will only need LCCIT to learn about cultural values of Latinx population to provide them quality healthcare. The only resource required will be a photocopier or printer to produce multiple copies of the toolkit for the medical staff. Hence, the cost will be almost insignificant to apply

the intervention used in the project in the future. Thus, the literature of the project will considerably contribute to create awareness among healthcare professionals about Latinx population.

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Appendix A

DNP project site attestation.

DNP project site.

From: Manuel Garcia

(magarcia.md@yahoo.com) To:

roegim25@yahoo.com

Date: Tuesday. March 31, 2020,

11:53 PM EDT

I, Dr. Manuel Garcia, with this email, confirm that Roberto Gimenez has my approval to conduct the DNP project at Manuel A. Garcia, MD, PA office. Our facility does not require a clinical or affiliation agreement.
If any further questions, please, do not hesitate to contact our office.

Manuel. A.
Garcia, MD
Psychiatrist/
Neurologist
magarcia.md@y
ahoo.com. Main
phone: (305)
328-9115

Appendix B

Latino Immigrant Cultural Competence Toolkit (LICCT)

Food assistance	**Asistencia de alimentos**
Open Arms - Emergency Assistance Program (305) 263-3259 5556 SW 8th St, Coral Gables, FL 33134. Email: www.openarmscommunitycenter.org We speak English, and Spanish, open at 9:00am the 2nd and 4th Thursday of the month.	Open Arms - Emergency Assistance Program (305) 263-3259 5556 SW 8th St, Coral Gables, FL 33134. Email: www.openarmscommunitycenter.org Se habla Español y Ingles, abierto a las 9:00am el 2do y 4to Jueves de cada mes.
Pass It on Ministries (305) 681-1594 14617 NW 7th Ave, Miami, FL 33168 We speak English, and Spanish. Open at 10:00 am - 3:00pm from Monday-Friday.	Pass It on Ministries (305) 681-1594 14617 NW 7th Ave, Miami, FL 33168 Hablamos Español y Ingles. Abierto de Lunes a Viernes de 10:00 am a 3:00 pm.
Missionaries of Charity - Mother Teresa Home for Women In Distress (305) 326-0032 724 NW 17th St, Miami, FL 33136. We speak English, and Spanish. Emergency Shelter: 4:00 pm - 6:30 am from Friday to Wednesday. Soup Kitchen: 9:30 am - 11:00 am from Friday – Wednesday (Closed Thursdays).	Missionaries of Charity - Mother Teresa Home for Women In Distress (305) 326-0032 724 NW 17th St, Miami, FL 33136. Se habla Ingles y Español. Abiertos de Viernes a Miercoles de 4:00 pm a 6:30 pm para refugio y se ofrese comidas de Viernes a Miercoles de 9:30 am a 11:30 am. Cerramos los Jueves.
Salvation Army - Community Pantry (305) 637-6720 1907 NW 38th St, Miami, FL 33142 Email: www.salvationarmymiami.com. We speak English, Spanish, and Creole. Open at 8:30 am from Monday to Thursday.	Salvation Army - Community Pantry (305) 637-6720 1907 NW 38th St, Miami, FL 33142 Email: www.salvationarmymiami.com. Hablamos Ingles, Español, y Creole. Abierto a las 8:30 am de Lunes a Viernes.
Vocational Training	**Entrenamiento Vocacional**
Association for The Development of The Exceptional. (305) 573-3737. 2801 N Miami Ave, Miami, FL 33127. We speak English, Spanish. Open at 8:00 am - 4:00 pm from Monday to Friday. Email: www.ademiami.org.	Association for The Development of The Exceptional. (305) 573-3737. 2801 N Miami Ave, Miami, FL 33127. Hablamos Ingles y Español. Abrimos a las 8:00 am - 4:00 pm de Lunes a Viernes. Email: www.ademiami.org.
Centro Campesino. Tel: (305) 245-7738 x 225. 35801 SW 186th Ave, Florida City, FL 33034. Email: www.centrocampesino.org. We speak English, and Spanish. Open at 9:00 am - 6:00 pm from Monday-Friday.	Centro Campesino. Tel: (305) 245-7738 x 225. 35801 SW 186th Ave, Florida City, FL 33034. Email: www.centrocampesino.org. Hablamos Ingles y Español. Abrimos 9:00 am - 6:00 pm de Lunes a Viernes.

Community Coalition: Refugee Program. (305) 887-4140. 300 East 1st Ave, Suite 201, Hialeah, FL 33010. We speak English, and Spanish. Open at 9:00 am - 5:00 pm from Monday to Friday. Email: http://www.communitycoalition.info/#!/cktc	Community Coalition: Refugee Program. (305) 887-4140. 300 East 1st Ave, Suite 201, Hialeah, FL 33010. Hablamos Ingles y Espanol. Abiertos de 9:00 am - 5:00 pm de Lunes a Viernes. Email: http://www.communitycoalition.info/#!/cktc
Employment	**Empleos**
Abriendo Puertas, Inc. (305) 649-6449. 1401 SW 1st St, Suite 209, Miami, FL 33135. Open at 9:00 am - 5:00 pm from Monday-Friday. We speak Spanish, and English. Email: abriendopuertasfl.org. Provides job placement referrals in addition to various classes and trainings through the Adult and Community Education Program**.**	Abriendo Puertas, Inc. (305) 649-6449. 1401 SW 1st St, Suite 209, Miami, FL 33135. Open at 9:00 am - 5:00 pm from Mon-Fri. We speak Spanish, and English. Email: abriendopuertasfl.org Provides job placement referrals in addition to various classes and trainings through the Adult and Community Education Program**.**
Branches United Way Center for Financial Stability. Email www.branchesfl.org/home/programs-2/achieve/united-way-cfs/. We speak English, Spanish, and Creole. Open 9:00 am - 5:00 pm from Monday-Friday. Call for appointment.	Branches United Way Center for Financial Stability. Email www.branchesfl.org/home/programs-2/achieve/united-way-cfs/. Hablamos Ingles, Español y Creole. Abierto a las 9:00 am - 5:00 pm de Lunes a Viernes. Llame para cita.
Casa - Social Program: Employment and Referral. (305) 463-7468 x10. 10300 SW 72nd St, Building 300, Suite 387, Miami, FL 33173. We speak English, Spanish. Open 9:30 am - 5:00 pm from Monday to Thursday and 9:30 am - 2:00 pm Friday. Email: www.casa-us.org	Casa - Social Program: Empleos y refereridos. (305) 463-7468 x10. 10300 SW 72nd St, Building 300, Suite 387, Miami, FL 33173 Hablamos Ingles y Espanosl. Abiertos de 9:30 am - 5:00 pm de Lunes a Jueves y de 9:30 am - 2:00 pm los Viernes. Email: www.casa-us.org
Centro Campesino- Tel: (305) 245-7738 x225. 35801 SW 186th Ave, Florida City, FL 33034. Email: www.centrocampesino.org. Open doors 9:00 am - 6:00 pm from Monday-Friday. We speak English, and Spanish.	Centro Campesino- Tel: (305) 245-7738 x225. 35801 SW 186th Ave, Florida City, FL 33034. Email: www.centrocampesino.org. Abiertos de 9:00 am - 6:00 pm de Lunes a Viernes. Hablamos Ingles y Español.
Creative Staffing. (305) 362-5300. 6625 Miami Lakes Dr. Suite 382, Miami Lakes, FL 33014. Open 9:00 am - 5:00 pm from Monday – Friday. We speak English, and Spanish. Email creativestaffing.com.	Creative Staffing. (305) 362-5300. 6625 Miami Lakes Dr. Suite 382, Miami Lakes, FL 33014. Abiertos de 9:00 am - 5:00 pm de Lunes a Viernes. Hablamos Español. Email creativestaffing.com.

Clothing	**Ropa**
Camillus House, Inc. (305) 374-1065 x 429. Address: 1603 NW 7th Ave, Miami, FL 33136. We speak English, Spanish, and Creole. Email/correo electronico www.camillus.org.	Camillus House, Inc. (305) 374-1065 x 429. Address: 1603 NW 7th Ave, Miami, FL 33136. Hablamos Ingles, Español, and Creole. Email/correo electronico www.camillus.org.
First United Methodist Church of Miami – Breakfast Club Ministry, 305-371-4706, ext. 400, Biscayne Blvd, Miami, FL 33132. We speak English, and Spanish. Open at 7:30am until food runs out, Wednesdays, Friday, and Sunday. Email: www.fumcmiami.com.	First United Methodist Church of Miami – Breakfast Club Ministry, 305-371-4706, ext. 400, Biscayne Blvd, Miami, FL 33132. Hablamos Ingles y Español. Abiertos de 7:30am hasta que se acabe la comida. Abiertos Miercoles, Viernes y Domingos. Email: www.fumcmiami.com.
Neat Stuff, Inc. (305) 638-5878 2624 NW 21st Ter, Miami, FL 33142. Email: neatstuffhelpskids.org	Neat Stuff, Inc. (305) 638-5878 2624 NW 21st Ter, Miami, FL 33142. Email: neatstuffhelpskids.org
Part of The Solution Foundation, Inc. 786-486-2895. 6023 NW 22nd Ave, Miami, FL 33142 We speak English, and Spanish. Open from 7:30 am - 7:00 pm from Monday-Friday	Part of The Solution Foundation, Inc. 786-486-2895. 6023 NW 22nd Ave, Miami, FL 33142. Hablamos Ingles y Español. Abiertos de 7:30 am - 7:00 pm de Lunes a Viernes.
Part of The Solution Foundation, Inc. 786-486-2895. 6023 NW 22nd Ave, Miami, FL 33142. We speak English, and Spanish. Open from 7:30 am - 7:00 pm from Monday-Friday.	Part of The Solution Foundation, Inc. 786-486-2895. 6023 NW 22nd Ave, Miami, FL 33142. Hablamos Ingles y Español. Abiertos de 7:30 am - 7:00 pm de Lunes a Viernes.
Interpretation and Translation Services	**Servicios de interpretación y traducción**
Florida Health 4052 Bald Cypress Way, Tallahassee, FL 32399 850-245-4444; health@flhealth.gov Subject to available funding, the Refugee Health Program provides bilingual staff in county health departments whose provide on-site interpretation, telephonic interpretation, and document translation.	Florida Health 4052 Bald Cypress Way, Tallahassee, FL 32399 850-245-4444; health@flhealth.gov Sujeto a los fondos disponibles, el Programa de Salud para Refugiados proporciona personal bilingüe en los departamentos de salud del condado que brindan interpretación en el lugar, interpretación telefónica y traducción de documentos.
South Florida Translations Miami Office By Appointment Only 14 NE 1st Ave Miami, FL 33132 305-907-6676 We provided variety of personal documentation translated into English to get a	South Florida Translations Miami Office By Appointment Only 14 NE 1st Ave Miami, FL 33132 305-907-6676 Proporcionamos una variedad de documentación personal traducida al Inglés

job, find legal help, immigration, get driving privileges and more.	para conseguir un trabajo, encontrar ayuda legal, inmigración, obtener privilegios de conducir y más.
Josef Silny & Associates 7101 SW 102 Avenue Miami, FL 33173 (305) 273-1616 Our Purpose is to assist international students, U.S. citizens, and permanent residents educated abroad in foreign credential evaluation and translation to determine the foreign education equivalency in the United States. JS&A is a Member of the National Association of Credential Evaluation Services (NACES) and a Corporate Member of the American Translators Association (ATA).	Josef Silny & Associates 7101 SW 102 Avenue Miami, FL 33173 (305) 273-1616 Nuestro propósito es ayudar a los estudiantes internacionales, ciudadanos estadounidenses y residentes permanentes educados en el extranjero en la evaluación y traducción de credenciales extranjeras para determinar la equivalencia de educación extranjera en los Estados Unidos. JS&A es miembro de la Asociación Nacional de Servicios de Evaluación de Credenciales (NACES) y miembro corporativo de la Asociación Estadounidense de Traductores (ATA).

Appendix C

Permission letter for the use of The Inventory for Assessing the Process Of Cultural Competence Among Healthcare Professionals- Revised (IAPCC-R)

TRANSCULTURAL C.A.R.E.
Clinical, Administrative, Research & Educational Consultation in Transcultural Health Care

J. Campinha-Bacote,
PhD, MAR, PMHCNS-BC, CTN-A, FAAN

Transcultural Healthcare Consultant

☎513-469-1664
513-469-1764
meddir@aol.com

www.transculturalcare.net

11108 Huntwicke Place
Cincinnati, Ohio 45241

Date: August 29, 2020

To: Mr. Roberto Gimenez

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

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

This letter grants permission to Mr. Roberto Gimenez, to use my tool, *Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-Revised (IAPCC-R),* to assess the level of cultural competence of 3 mental health professionals. I have received $48 for 6 tools for this pre/posttest assessment study.

TIME FRAME: Permission to use the IAPCC-R is time-limited to be used from November 1, 2020 through December 2, 2020. **Upon December 3, 2020, all unused tools must be destroyed.**

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

RESTRICTIONS OF COPYING: Mr. Roberto Gimenez, **agrees that the IAPCC-R nor any of its 25 items cannot be copied** or reproduced for any other reason. This includes, but not limited to, being copied in any formal or informal publications or presentations, a dissertation, a **DNP project/paper**, Capstone project, or thesis, in any academic papers, as handouts for presentations, nor for any PowerPoint or Poster presentations or in any hard copy or electronic formats. The IAPCC-R is only to be used for the above purpose of administering this tool in this above study to only these 3 participants.

PUBLICATIONS: Mr. Roberto Gimenez, agrees that any publications (formal or informal) or presentations of the findings of the study using my tool will be shared with me.

GOVERNING LAW: All parties acknowledge that this Contractual Agreement for Limited Use of the IAPCC-R is a valid contract. This contract shall be governed and construed under the laws of the State of Ohio, except as governed by Federal law. Jurisdiction and venue of any dispute or court action arising from or related to this contract shall lie exclusively in or be transferred to Hamilton County Municipal Court, Hamilton County Court of Common Pleas, or the Federal Court situated in the County of Hamilton, Ohio.

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

Signature_____ Date 8/29/20

Dr. Josepha Campinha-Bacote

Signature_____ Date 9/3/2020

Mr. Roberto Gimenez

Appendix D

Educational Presentation

- Discuss the impact of cultural competence in the workplace to reduce healthcare disparities
- To evaluate the cultural competence knowledge of the providers at the mental health clinic through the IAPCC-R questionnaire
- To implement an LICCT for provider use at the mental health practice
- To evaluate the compliance of the medical providers in providing available resources to the patients during their office visits

Cultural Demographic

- By 2025, 35 % of U.S. population will be members of ethnic minority groups.
- Latino Americans are now the largest minority group African Americans are second
- In early 1900s, most immigrants came from Europe and Canada now they come from Latin America and Asia.

Define Cultural Competence

"Cultural competency in health care describes 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" (American Hospital Association, n.d.).

Latinos as high-risk minority

- Latinos are more likely to belong to high-risk groups, such as the homeless or HIV-infected people.
- Latinos as a minorities are less likely to seek professional mental health treatment than whites.
- Latinos are more likely to lack health insurance.

Comparison between races/ethnics

- 14% of whites are uninsured
- 26% of African Americans are uninsured
- 38% of Latinos are uninsured
- 23% of Asian Americans are uninsured

Latino immigrants at risk for misdiagnosis.

- Latino immigrants more likely to be misdiagnosed.
- Behavior that is normal in some cultures may be seen as pathology if the evaluator does not understand the culture.
- Latino immigrants more likely to drop out of treatment, especially after the first session.

Substance Abuse and Mental Health Services Administration [SAMHSA]. (2014)

Socioeconomic Status in the Latino immigrants

- Stressors make one more vulnerable to mental disorders.
- Latinos tend to experience more stress as a result of their social status.
- However, there is much variation among members of ethnic minority groups. Programs need to take these differences into account as they develop services that are sensitive to the needs of Latino immigrants.

Substance Abuse and Mental Health Services Administration [SAMHSA]. (2014)

Describe the impact in practice

- An organization built on a culturally competent health care system, has the capacity to recognize the need to incorporate cultural knowledge in order to meet individual patient needs.
- Increase cultural competence of all mental health professionals.
- Hire mental health professionals who are members of ethnic minority groups.
- Develop culturally sensitive programs.
- Cultural competency acknowledges the need to adapt services to specific needs in order to reduce disparities in healthcare. (Anderson, Scrimshaw, Fullilove, Fielding, & Normand, 2003).

Effect of cultural awareness in health professionals

- Research shows that matching ethnic minority clients with mental health professionals of the same background helps
- Drop-out rates are lowered more sessions are attended but, except for working with monolingual non-English speaking clients, outcomes are similar, whether there is a match.

Culturally Responsive, Evaluation and Treatment Planning

- Step 1: Engage clients.
- Step 2: Familiarize clients and family members with the evaluation and treatment process.
- Step 3: Endorse a collaborative approach in facilitating interviews, conducting assessments, and planning treatment.
- Step 4: Obtain and integrate culturally relevant information and themes.
- Step 5: Gather culturally relevant collateral information.
- Step 6: Select culturally appropriate screening and assessment tools.
- Step 7: Determine readiness and motivation for change.
- Step 8: Provide culturally responsive case management.
- Step 9: Integrate cultural factors into treatment planning.

Purpose of the project

- This project aims to provide a Latino immigrant cultural competence toolkit (LICCT) for healthcare workers in an outpatient mental health clinic.
- Mental healthcare providers can gain the trust of their patients to encourage them to speak freely about their symptoms that can then be used in diagnosis and treatment.
- This project aims to eliminate cultural barriers that hinder Latino immigrants from receiving appropriate mental health care, such as lack of diversity in the mental health workforce, language barriers, and ineffective communication (Boykin, Schoenhofer, & Valentine, 2014).
- Latino immigrants will be provided with a toolkit of resources to assist them with their mental healthcare.

Intervention

- Week 1: During the beginning of this week the medical providers will take part in educational training . The training will be presented in a power point and the IAPCCR-R pre-test evaluation will provided to all providers prior to the presentation. The presentation will include a detailed explanation of the resource tool. During the second half of this week implementation of the resource tool will begin.
- Week 1-4: Implementation of resource to patients during in-office visits. Ongoing education and support to participants will be available through these weeks. Data collection and assessment of compliance will be conducted on a weekly basis in order to capture any opportunities needed for re-training.
- Week 5: During this week compiling of data for analysis should be completed and statistical testing should be performed.

Latino immigrant culturally competent toolkit (LICCT)

The LICCT tool is composed of several resource assistance organizations with their address and phone numbers. The three-resource included in this tool is Food assistance, Clothing, and vocational training.

1. The Food assistance organizations provides USDA food distribution of canned goods, fresh products, and groceries. Provides emergency food, breakfast, lunch, and dinner in different days of the week for those in needs. (Miami-Dade County Homeless Trust, 2016).
2. The clothing assistance organizations clients may obtain free hot showers for men and women multiple days a week and a free exchange of clean clothing, shoes, and shower programs. They also provide blankets and accessories to meet some of children's basic needs, victims of crime, poverty, and homelessness. (Miami-Dade County Homeless Trust, 2016).
3. The vocational training assistance organizations provide the tools and resources necessary to help minorities to achieve financial stability. The services they offer include financial coaching and education, credit counseling, free income tax preparation, and income tax return, job training, interviewing skills and resume building, job orientation and training, resume writing, vocational training, and job placement. (Miami-Dade County Homeless Trust, 2016).

References

- American Hospital Association. (n.d.). Becoming a culturally competent healthcare organization. Retrieved from https://www.aha.org/ahahret-guides/2013-06-18-becoming-culturally-competent-health-care-organization
- Anderson, L.M., Scrimshaw, S.C., Fullilove, M.T., Fielding, J.E., & Normand, J. (2003). Culturally competent healthcare systems: systematic review. *American Journal of Preventive Medicine, 24*, (3S), 68-79. doi:10.1016/S0749-3797(02)00657-8
- Boykin, A., Schoenhofer, S. O. B., & Valentine, K. L. (2014). Health care system transformation for nursing and health care leaders: implementing a culture of caring. New York, NY: Springer Publishing Company, LLC.
- Miami-Dade County Homeless Trust. (2016). A Community Resource Guide for the Homeless of Miami-Dade. Retrieved from file:///C:/Users/roegi/Downloads/Miami%20Dade%20Trust%20Resource%20Guide.pdf
- Substance Abuse and Mental Health Services Administration [SAMHSA]. (2014). Improving cultural competence. Treatment Improvement Protocol (TIP) Series No. 59. HHS Publication No. (SMA) 14-4849. Retrieved from https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4849.pdf

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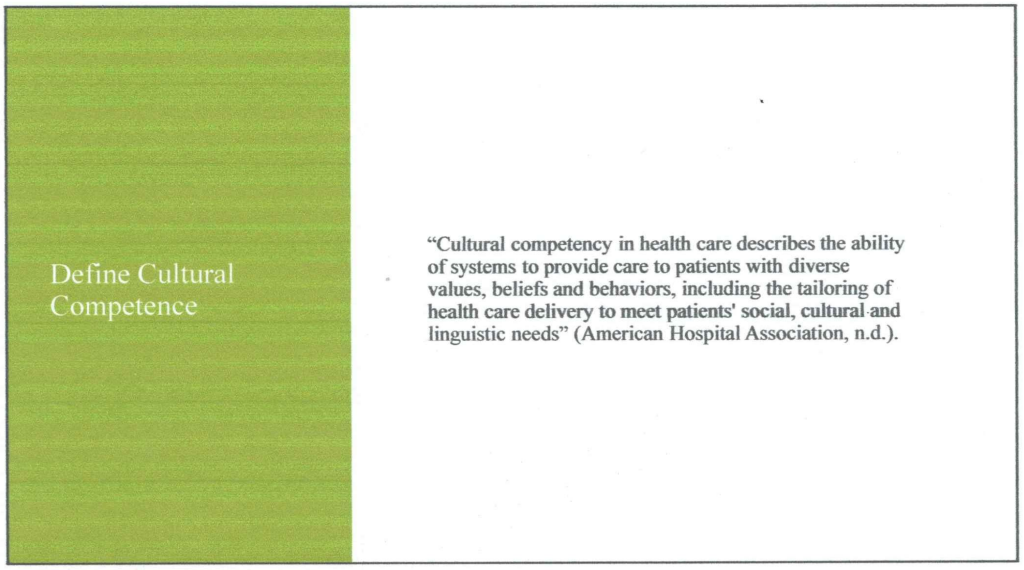
Define Cultural Competence
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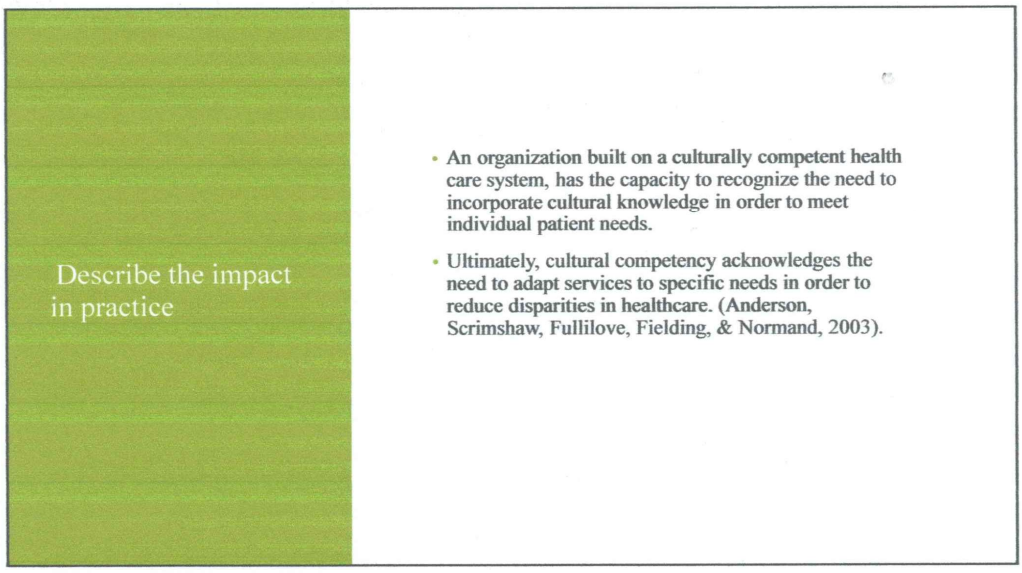
Describe the impact in practice
An organization built on a culturally competent health care system, has the capacity to recognize the need to incorporate cultural knowledge in order to meet individual patient needs.
Ultimately, cultural competency acknowledges the need to adapt services to specific needs in order to reduce disparities in healthcare. (Anderson, Scrimshaw, Fullilove, Fielding, & Normand, 2003).

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9/9/2020

Purpose of the project

- This project aims to provide a Latino immigrant cultural competence toolkit (LICCT) for healthcare workers in an outpatient mental health clinic.
- Mental healthcare providers can gain the trust of their patients to encourage them to speak freely about their symptoms that can then be used in diagnosis and treatment.
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- Latino immigrants will be provided with a toolkit of resources to assist them with their mental healthcare.

5

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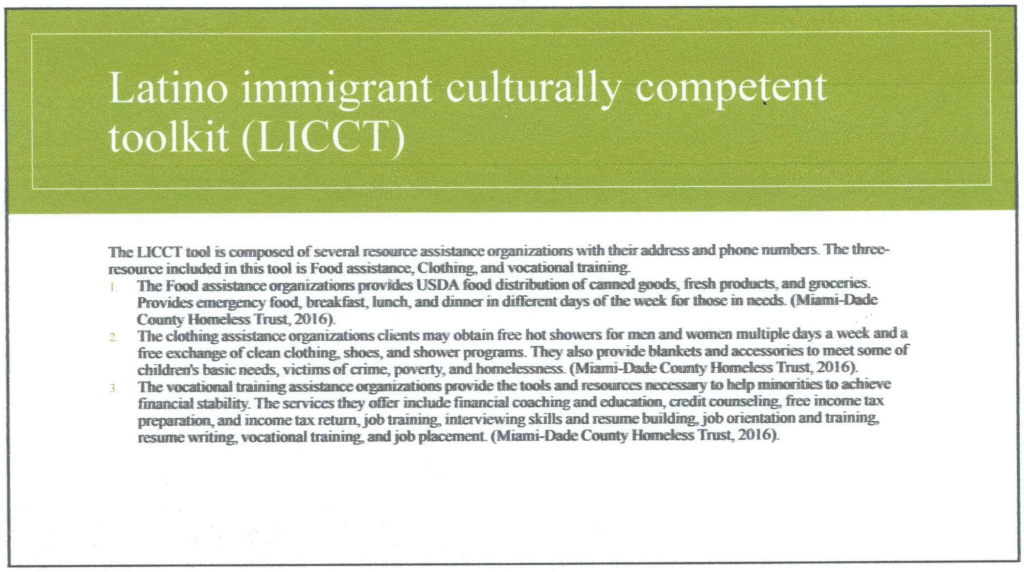
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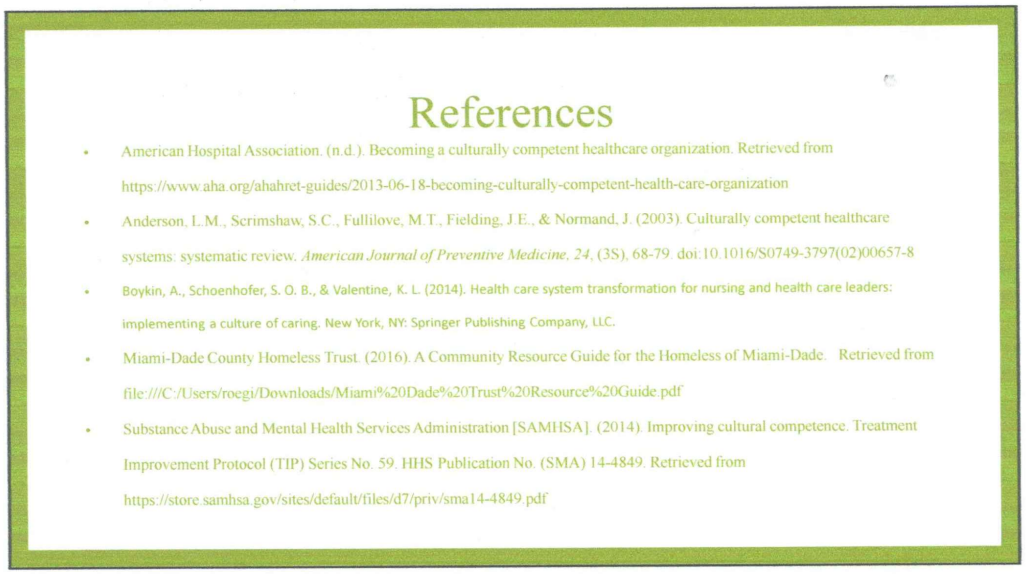
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Substance Abuse and Mental Health Services Administration [SAMHSA]. (2014). Improving cultural competence. Treatment Improvement Protocol (TIP) Series No. 59. HHS Publication No. (SMA) 14-4849. Retrieved from https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4849.pdf

8

Appendix E

Chart review tool

Developed by Roberto Gimenez RN, AGNP-BC

Chart Review Tool	
Medical providers were present for cultural competence presentation?	**Yes/No**
Medical providers completed an IAPCC-R evaluation pre implementation?	**Yes/No**
Medical providers provided resources information to patients according to LICCT tool?	**Yes/No**
Medical providers completed an IAPCC-R evaluation post implementation	**Yes/No**

Appendix F

IAPCC-R Scoring Key

IAPCC-R Scoring Key

LEVEL OF CULTURAL COMPETENCE:	
Culturally Proficient	91 – 100
Culturally Competent	75 – 90
Culturally Aware	51 – 74
Culturally Incompetent	25 – 50

ITEMS #2, 4, 5, 7,13,14,16,19, 24, 25
4 pts. = Strongly Agree
3 pts. = Agree
2 pts. = Disagree
1 pt. = Strongly Disagree

ITEMS #6, 8, 10
4 pts. = Very Knowledgeable
3 pts. = Knowledgeable
2 pts. = Somewhat Knowledgeable
1 pt. = Not Knowledgeable

ITEM #23
4 pts. = Very Involved
3 pts. = Involved
2 pts. = Somewhat Involved
1 pt. = Not Involved

ITEMS #1, 3, 11, 17, 21
4 pts. = Strongly Disagree
3 pts. = Disagree
2 pts. = Agree
1 pt. = Strongly Agree

ITEMS #9, 12,15,18, 20
4 pts. = Very Aware
3 pts. = Aware
2 pts. = Somewhat Aware
1 pt. = Not Aware

ITEM #22
4 pts. = Very Comfortable
3 pts. = Comfortable
2 pts. = Somewhat Comfortable
1 pt. = Not Comfortable

CONSTRUCTS & REFLECTED ITEMS:	
Cultural Awareness:	1, 2, 3, 15, 18
Cultural Knowledge:	6, 8, 10, 11, 12
Cultural Skill:	5, 9, 20, 21, 22
Cultural Encounters:	14, 16, 17, 23, 25
Cultural Desire:	4, 7, 13, 19, 24