Nevada State Board of

NURSING

CULTURAL COMPETENCY AND DIVERSITY, EQUITY, AND INCLUSION

By Michelle Johnson, EdD, MS, APRN, CPNP-PC
and Vicki Schmidt, DNP, APRN, FNP-C

AB327 & AB267 CULTURAL COMPETENCY AND DIVERSITY, EQUITY, AND INCLUSION:

A BLUEPRINT FOR NURSES

After reading this article, the reader will be able to:

1. Explain definition relevant to cultural competency, diversity and inclusion
2. Identify various popular religions that exist in the U.S. and discuss some factors that influence healthcare
3. Link healthcare issues significant in the LGBTQ community and define relevant terms related to this population
4. Summarize issues relevant to the pediatric population that can promote cultural competency among healthcare workers
5. Identify significant issues related to the elderly population that are necessary to enhance cultural competency
6. Define disability and examine barriers
7. Articulate cultural barriers that limit access to care for those who are mentally ill
8. Explain terms that help in developing culturally competent care for veterans
9. Relate cultural competency to hospice care

Cultural competency, diversity, equity and inclusion are multiple topics *that require careful consideration for all health care professionals. Ongoing training* is necessary to *provide culturally appropriate care for all patients. Cultural competency* is *learned over time and* is *a* process *that involves inner reflection and growing* awareness *(Young* & *Guo, 2020).* Awareness *of self and others and how one's* actions *and reactions are influenced by culture and lived experiences. It* is *a fundamental right of every human being* to *receive equitable health care. While it can be challenging for* nurses to *provide health care* to *individuals with differing cultural and health beliefs than their own;* nurses *are morally obligated* to *protect the rights and advocate, through* social *justice, for vulnerable populations (Douglas et al., 2014, p. 110). This* is *essential in culturally competent nursing care; and helps reduce health disparities for vulnerable populations by incorporating cultural beliefs and increasing* access to *care (Douglas et al., 2014). This article will explore relevant nursing theories, governmental* responses to *the need for culturally competent care and various populations based on race, gender, age, sexual orientation, ethnicity, religion and vulnerability. Before exploring these listed* topics, *we felt it important* to *establish a foundation by providing definitions of* some *relevant* terms.

AB 327 (2021) & AB 267 (2023)

Some may ask, why do I have to do cultural competency training? Effective January 1, 2022, there was an addition to NRS 632.343 (NRS 632.343(3)(c)) which states: c) For each person licensed pursuant to this chapter (NRS 632), one or more courses of instruction that provide at least two hours of instruction relating to cultural competency and diversity, equity and inclusion to be completed biennially. Such instruction: (1) May include the training provided pursuant to NRS 449.103, where applicable. (2) Must be based upon a range of research from diverse sources. (3) Must address persons of different cultural backgrounds, including, without limitation: (I) Persons from various gender, racial and ethnic backgrounds; (II) Persons from various religious backgrounds; (III) Lesbian, gay, bisexual, transgender and questioning persons; (IV) Children and senior citizens; (V) Veterans; (VI) Persons with a mental illness; (VII) Persons with an intellectual disability, developmental disability or physical disability; and (VIII) Persons who are part of any other population that a person licensed pursuant to this chapter may need to better understand, as determined by the Board (AB327_EN.pdf (state.nv.us)). Effective January 1, 2024, the requirement was increased to four hours of instruction.

Therefore, by reading the information presented in this article, completing, submitting, and achieving a score of 70% or higher on the including post-test, one will earn two continuing education units and thus will meet half the requirements stipulated and the above-mentioned regulation.

MODELS

There are nursing models which can influence cultural competency. For this article, we focus on two prominent nursing models. Campinha-Bacote (2002) *The Process of Cultural Competence in the Delivery of Healthcare Services* and Purnell (1998) *Model for Cultural Competence.* Campinha-Bacote's model focuses on understanding the dynamic and diverse relational processes.

Her framework theorizes that having continuous encounters with patients contributes to cultural knowledge (Botelho & Lima, 2020). The process of becoming culturally competent involves the integration of cultural awareness, cultural knowledge, cultural skill, cultural encounters and cultural desire. The model has five assumptions:

Assumptions of the Model

1. Cultural competence is a process, not an event.
2. Cultural competence consists of five constructs: cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire.
3. There is more variation within ethnic groups than across ethnic groups (intra-ethnic variation).
4. There is a direct relationship between the level of competence of health care providers and their ability to provide culturally responsive health care services.
5. Cultural competence is an essential component in rendering effective and culturally responsive services to culturally and ethnically diverse clients. (Campinha-Bacote, 2002)

Purnell's model draws on Leininger's (1991) definition of culture, which is a foundational cultural competency model. Her model theorizes culture as "learned, shared and transmitted values, beliefs, norms and lifeways of a particular group that guides their thinking, decisions and actions in patterned ways" (p. 47). Purnell recast patients' health within a broader context shaped by race, gender and class power relations (Botelho & Lima, 2020). Purnell's model depicts several assumptions. We have highlighted a few of them here, many of which are repeated throughout this article, creating some reoccurring themes. These assumptions include, but are not limited to:

Assumptions of the Model

1. There are core similarities across all cultures
2. There are differences within, between and among cultures.
3. Cultures are subject to change gradually in a stable society.
4. If patients are co-participants in health care and are given the choice in selecting health-related interventions, plans and goals, then, there will be an improvement in health outcomes.
5. Culture exerts a significant impact on a person's interpretation of health care and how he/she responds to care.
6. Families and individuals fit in numerous cultural groups.
7. Each person deserves to be respected for his/her cultural heritage and uniqueness.
8. Caregivers require both specific and general cultural information to offer care that is both culturally competent and sensitive.
9. Assessment plans and interventions that are culturally competent tend to improve patients' care.
10. Biases and prejudices can be lessened through cultural understanding.
11. Effectiveness of care can be improved through reflecting on a distinctive understanding of the lifeways, beliefs and values of individual acculturation patterns and diverse populations.
12. Cultural and racial differences need the adaptations of the standard interventions.

The dignity of all individuals is fostered through culturally competent care. Because cultural norms vary within populations and around the world, there are no absolute models or guidelines for providing culturally competent care to every population. Therefore, nurses need to seek knowledge of nursing models, guidelines and more, from available sources of literature to implement culturally competent care (Douglas et al., 2014).

DEFINITI ONS

Race- Merriam-Webster (2021) dictionary defines race as "any one of the groups that humans are often divided into based on physical traits regarded as common among people of shared ancestry." According to the US Census Bureau, there are five predominant races in the United States. Single racial groups can be divided into the following categories: White, Black or African-American, Asian, American Indian, Alaskan Native and Pacific Islander (United States Census Bureau, n.d). However, it is important to note that more and more Americans are identifying as belonging to two or more races. Whereas in the 2010 U.S. Census, 2.4% (approximately nine million people) of the population identified as belonging to two or more races, in the 2020 U.S. Census nearly 10% (33.8 million people) self-identified as belonging to two or more races (United States Census Bureau, n.d.).

Ethnicity- Ethnicity is defined as a group of people who identify with each other based on common ancestral, social, cultural, or national experiences (dailydot.com).

Diversity- "Diversity is a set of conscious practices that involve:

- Understanding and appreciating the interdependence of humanity, cultures and the natural environment;
- Practicing mutual respect for qualities and experiences that are different from our own;
- Understanding that diversity includes not only ways of being but also ways of knowing;
- Recognizing that personal, cultural, and institutionalized discrimination creates and sustains privileges for some while creating and sustaining disadvantages for others; and
- Building alliances across differences so that we can work together to eradicate all forms of discrimination" (Queensborough Community College, 2021, para 3).

Equity- Equity relates to providing support related to specific needs. It in turn "levels the playing field", for greater fairness.

Inclusion- Inclusion refers to how diversity is leveraged to create an equitable, fair, healthy and high-performing organization or community. In this community or organization, all individuals are respected, feel engaged and motivated and their contributions toward meeting organizational and societal goals are valued (O'Mara et al, 2014).

Bias- Bias is an inclination, prejudice or tendency toward or against something or someone. Biases are often based on stereotypes, rather than actual knowledge of an individual or circumstance. Such cognitive shortcuts can result in prejudgments that lead to rash decisions or discriminatory practices (Psychology Today Staff, 2021).

ELDERLY

Older adults or the elderly, persistently face health disparities. Especially those older adults who are from racial and ethnic minorities. Health disparities are defined as differences in treatment provided to members of different ethnic or racial groups that are not justified by treatment preferences or underlying health conditions. Older minority Americans have consistently been shown to have worse health than Whites of the same age group across, disability, disease and self-assessed health (Dilworth-Anderson, Pierre, & Hilliard, 2012).

There are clinical barriers to the elderly receiving adequate health care. One of these barriers is ageism, which is the specific use of negative language, inaccurate stereotypes and/or discriminatory practices toward a specific age group. Other clinical barriers may include conscious and unconscious bias, being deeply entrenched in the culture of biomedicine and the lack of training in the principles and practice of providing culturally respectful care (Periyakoi, 2019).

One thing that it is important to address is how to communicate with older patients. The National Institute on Aging (n.d.) lists several tips to consider when communicating with older patients. The first is the use of a proper form of address. Establish respect at the onset of your interactions by using formal language. Use Mr., Mrs. Ms. Etc. and the patient's last name. If the patient wishes for you to address them differently, let them take the lead and inform you as such. Do not use patronizing terms such as "dear", "sweetie" or "honey". Other tips include: making the patient feel comfortable, taking the time to establish rapport, not rushing, avoiding interrupting, using active listening skills, demonstrating empathy, avoiding medical jargon, being careful about language (some words may have different meanings to older patients or may have different connotations based on the patient's cultural or ethnic background), writing down take-away points, ensuring an understanding of the health information (what the main health issue is, what the patient needs to do and why it is important to act), being sure to compensate for hearing deficits (avoid high-pitched voice, talk slowly, as if they have a working hearing aid, face the person directly, be aware of background noise, keep a notepad handy) and compensating for visual deficits (make sure there is adequate lighting, make sure the patient has their glasses if worn, make sure font is large enough on written material).

There are both state and federal laws in place to protect the elderly.

- The Elder Justice Act helps draw funds from the government to combat elder abuse across the country. This money typically funds government-run programs that investigate and prosecute criminals guilty of elder abuse.
- The Older American Act refers to a variety of bills that provide certain standards for care facilities and supports the National Long-Term Care Ombudsman Resource Center (NORC), the Administration on Aging and the National Association of States United for Aging and Disabilities all of which protect against elder abuse (Elder Abuse, 2021).

CHILDREN

There are cultural considerations when it comes to children which extend beyond race, ethnicity, gender and religion. Keep in mind that the race, ethnicity and religion of the custodial parent do directly impact the culture of the child. There are still things to consider when addressing the health care needs of children that directly relate to them being children. This brings to mind the granddaughter of my next-door neighbor. Her parents were Jehovah's Witnesses. The child had sickle cell anemia. The child had a severe sickle cell crisis and required a blood transfusion. The parents refused. The little girl later died. About 10 years later, I was a pediatric nurse practitioner in a Comprehensive Pediatric Sickle Cell Center. We too had a patient whose parents were Jehovah's Witnesses, and the child required a blood transfusion. In the latter case, the medical director obtained a court order, and the child received a blood transfusion. I cannot speak to why one situation resulted in obtaining a court order and the other did not. However, I can address that while parents' beliefs must be respected, when dealing with the pediatric population, the child is your patient. Health care providers have an obligation to their pediatric patients to deliver optimum care, just as they do all other patients. Sometimes that means being an advocate for the patient when they cannot be advocates for themselves.

"Cultural and linguistic issues affect multiple aspects of pediatric care, including outcomes, quality, costs and satisfaction with care" (Flores, 2003, p. 1). Anticipatory guidance materials need to be available in multiple languages at basic literacy levels. This helps to educate families on key health issues.

It is also important to understand when caring for children, that family is defined differently by different cultures. Generally, the family is what the family says it is. Who comprises the family, the roles that each member has and how the system (family) functions can be defined by culture, society and the family itself.

Do not assume that children and youth from a particular ethnic or cultural group are culturally the same. Youths want to be seen as individuals. Asking questions about preferences is paramount. Understanding developmental stages in the pediatric population is also very relevant.

"The National Health Law Program protects the rights of children and adolescents to receive the health care they need in Medicaid and the Children's Health Insurance Program (CHIP). Medicaid provides quality coverage for more than 30 million children, including essential medical, vision, hearing and dental screenings and services under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit" (National Health Law Program, 2021, Introduction). In the fall of 2019, the U.S. Census Bureau released a report sharing that approximately 425,000 more children were uninsured in 2018 than in 2017. There has been a decline in public coverage, specifically Medicaid and the Children's Health Insurance Program (CHIP) (National Institute for Children's Health Quality, 2019).

There is a direct relationship between racism and maternal-child health.

- Infant mortality rates for America's Black babies are more than twice the rate of White babies.
- Black babies are more than three times as likely to die from complications related to low birth weight as compared to White babies in the U.S.

"Embedded within these persistent disparities are the ongoing effects of institutional racism—racism that began with the enslavement of Black people was embedded in our earliest institutions, and has continued to influence policies and practices ever since" (National Institute for Children's Health Quality, 2021, para 1).

RELIGION

RELIGION	ORIGINS & HISTORY	ADHERENTS (APPROX.)	GOD(S) AND UNIVERSE	HUMAN SITUATION AND LIFE'S PURPOSE	AFTERLIFE	PRACTICES	TEXTS
BAHA'I FAITH	Founded by Bahá'u'lláh, 1863. Tehran, Iran	5-7 million	One God, who has revealed himself progressively through major world religions.	The soul is eternal and essentially good. Purpose of life is to develop spiritually and draw closer to God.	Soul separates from the body and begins a journey towards or away from God. Heaven and hell are states of being.	Daily prayer, avoidance of intoxicants, scripture reading, hard work, education, work for social justice and equality.	Writings of Bahá'u'lláh, and oter Bahá'í leaders.
BUDDHISM	Founded by Siddharta Bautama (the Buddha) in c. 520BC. NE India	360 million	Varies: Theravada atheistic; Mahayana more polytheistic Buddha taught nothing is permanent.	Purpose is to avoid suffering and gain enlightenment and release from cycle of rebirth, or at leas arrain a better rebirth by gaining merit.	Reincarnation (understood differently than in Hinduism, with no surviving soul) until gain enlightenment	Meditation, mantras, devotion to deities (in some sects), mandalas (Tibetan)	Tripitaka (Paki Canon); Mahayana sutras like the Lotus Sutra; others.
CHRISTIANITY (CATHOLIC, PROTESTANT, ORTHODOX)	Founded by Jesus Christ in c. 30 AD, Israel	2 billion	One God who is a Trinity of Father, Son, and Holy Spirit.	All have sinned and are thereby separated from God. Salvation is through faith in Christ and, for some, sacraments and good works.	Eternal heaven or hell (or temporary purgatory).	Prayer, Bible study, baptism, Eucharist (Communion), church on Sundays, numerous holidays.	The Bible (Old and New Testaments)
CONFUSCIANISM	Founded by Confucious (551-479BC), China	5-6 million	Not addressed	Purpose of life is to fullfill one's role in society with propriety, honor, and loyalty.	Not addressed	Honesty, politness, propriety, humaneness, perform correct role in society, loyalty to family, nation	Analects
HINDUISM	Indigenous religion of India as developed to present day.	900 million	One Supreme Reality (Brahman) manifested in many gods and goddesses	Humans are in bondage to ignorance and illusion, but are able to escape. Purpose is to gain release from rebirth, or at least a better rebirth.	Recarnation until gain enlightenment.	Yoga, meditation, worship (puja), devotion to a god or goddess, pilgrimage to holy cities, live according to one's dharma (purpose/ role).	The Vedas, Upanishads, Bhagavad Gita, Ramayana, etc.
ISLAM	Muhammad, 622 AD, Saudi, Arabia	1.3 billion (Sunni: 940 million)	One God (Allah in Arabic)	Humans must submit (Islam) to the will of God to gain Paradise after death.	Paradise or Hell	Five Pillars: Faith, Prayer, Alms, Pilgrimage, Fasting. Mosque services on Fridays. Ablutions before prayer. No alcohol or pork. Holidays related to the pilgrimage and fast of Ramadan.	Quran (Scripture); Hadith (tradition)
JAINISM	Mahavira, c 550 BC. eastern India	4 million	The universe is eternal; many gods exist. Gods, humans and all living things are classiefied in a complex hierarchy.	The soul is uncreated and eternal and can attain perfect divinity. Purpose is to gain liberation from cycle of rebirth, by avoiding all bad karma, especially by causing no harm to any.	Reincarnation until liberation.	Monasiticism under the Five Great Vows (non-violence, Truth, Celibacy, Non-Stealing, Non-possessiveness); worship at temples and at home. Meditations and mantras	The teachings of Mahavira in various collections.

(America's Most Common Religions By State (Besides Christianity) (boston.com)

"The Joint Commission (TJC) requires hospitals to be accountable for maintaining patient rights, including accommodating for cultural, religious and spiritual values" (Swihart, Yarrahapu, & Martin, 2021, para 1). Therefore, being able to deliver health care services that meet the religious needs of patients is a component of cultural competency. Health care providers do need to consider how religion impacts health care practices. Although all health care providers may not know all the religious practices and rituals of every religion, respecting the fact that they have an impact is the first step. Inquiring about one's religion is a part of patient intake forms and is not only collected for statistical purposes.

Swihart, Yarrahapu and Martin (2021) explored religious competency in clinical practice. In their publication, they discussed several religions and listed some important key points that may be necessary for developing cultural competency in a health care setting.

- **Buddhism** - Buddhists are usually vegetarian and avoid alcohol, tobacco and coffee. Artificial insemination and birth control are acceptable. Blood products are acceptable, but patients may avoid mind-altering drugs. Unexpected death may require special rituals.
- **Christian Science**- They avoid food or drink which contains alcohol and sometimes caffeine. They avoid tobacco. The church does not dictate individual health care choices. Christian Scientists generally choose spiritual means for preventing and healing disease. They usually do not immediately seek immediate medical care. However, once in medical care, they do not normally second-guess medical expertise but may prefer minimal interventions where that is an option. During pregnancy, labor and delivery they may request a midwife.
- **Church of Jesus Christ of Latter-day Saints (Mormon)**- Mormon garments, also referred to as Mormon undergarments or Mormon underwear, are undergarments worn by members of The Church of Jesus Christ of Latter-day Saints as a symbol of sacred covenants made with God. For most people who wear them, the Mormon garments take the place of regular underwear and are worn both day and night (Mormon Beliefs, 2021). Alcohol, coffee, tea and tobacco are discouraged and drugs containing any of these may be avoided. Fasting is required once each month. Fasting is not required if the person is ill. Blood and blood products are accepted. Abortion is forbidden except in the case of rape and when the mother's life is in jeopardy (Swihart, Yarrahapu, & Martin, 2021). In death autopsy is permitted, organ donation is permitted and euthanasia is not allowed.
- **Eastern Orthodox**- Holy Unction anointing is administered to the sick on the Wednesday between Palm Sunday and Easter. Fasting from meat, dairy and oil for 40-days beginning seven weeks before Easter, and November 15-December 24 and on Wednesdays and Fridays is a component of their religious practices. Fasting is flexible if pregnant and for those with health conditions. Blood transfusions and blood products are allowed. Traditional medical interventions are accepted.
- **Islam**- Pork, shellfish and alcohol are prohibited. Only vegetable oil can be used. Eat with the right hand and only eat food that is clean, good, pure, nourishing, pleasant, tasteful and wholesome. Custom prohibits handshakes or any contact between genders. Thus, female patients may require female health providers (especially doctors and nurses). Blood and products are permitted. An autopsy can only be performed for legal or medical reasons. Organ donation is accepted. Abortion is forbidden except in the case of rape and when the mother's life is in jeopardy. Some women are required to wear a burqa, covering the head, face and entire body, including hands and feet. A hajib, which is a veil covering the head, may be required. Prayers for the deceased led by a male must be performed within 72 hours after death.
- **Jehovah's Witness**- Avoid any food that contains blood and thus meat products must be properly drained of blood. They refuse blood or blood products. Abortion is forbidden and artificial insemination by donors is forbidden. An autopsy is accepted if legally required.
- **Judaism**- There are Orthodox Jews who strictly interpret the Torah. There are Conservative Jews who are conservative but are not as strict as orthodox Jews. They observe both modern and traditional religious observances and practices. Whereas Reform Jews choose religious observances and have the freedom to interpret the Torah. They may request kosher-certified food. An amputated limb must be buried in consecrated ground, blood and blood products are accepted. They may consult a Rabbi regarding the decision to be tube-fed or to be placed on life-support. Birth control is prohibited and abortion is allowed to save the mother. The yarmulke may be worn at special times by many Jewish men or at all times by devout Orthodox Jews. Jews may also wear the tzitzit, an undergarment with fringes tied in 613 knots symbolic of the laws of Moses (Mormon beliefs, 2021). Many married Orthodox Jewish women observe the modesty code known as sniut, which requires married women to cover their hair. Hats, scarves and wigs are often referred to as sheitels. Most Conservative and Reform women do not cover their heads daily (Salzberg, 2002: Wikipedia, 2021). Autopsy and organ donation are acceptable. Burial is required as soon as possible, cremation is discouraged or prohibited. The family may stay with the body until it is moved by the funeral home (Swihart, Yarrahapu, & Martin, 2021).
- **Protestant** (Amish, Anglican, Baptist, Christian, Church of Christ, Disciplines of Christ, Episcopalian, Lutheran, Mennonites, Methodist, Presbyterian and United Church of Christ)- There are generally no dietary restrictions based on religion. Blood and blood products are an individual choice. There are no issues that inhibit health care.
- **Roman Catholicism**- Avoid meat on Fridays, fast and sacramental confession before receiving Eucharist (holy communion). Generally, no dietary restriction is related to religion. Blood and blood products are accepted. Abortion is prohibited. Only natural birth control is permitted. Sacrament of the Sick by a priest is important (Last Rites). Autopsy and organ donation are accepted.

DISABLED

Under the context of the Americans with Disabilities Act (ADA) "disability" is a legal term and not a medical term. Therefore, ADA's definition of disability is different from some other laws, like Social Security Disability-related benefits (ADA National Network, 2021). "The ADA defines a person with a disability as a person who has a physical or mental impairment that substantially limits one or more major life activity" (para 2).

"Over 1 billion people are estimated to experience disability. This corresponds to about 15% of the world's population, with up to 190 million (3.8%) people aged 15 years and older having significant difficulties in functioning, often requiring health care services" (World Health Organization [WHO], 2021, para 2). 26% of the US population has a disability (Slayter, 2021). Physical, developmental and intellectual disabilities and levels of impairment vary greatly. However, regardless of the type of disability or level of impairment, barriers to health care do exist and can greatly impact one's quality of life. According to WHO, people with disability encounter a range of barriers when they attempt to access health care including:

Attitudinal barriers

- People with disability commonly report experiences of prejudice, stigma and discrimination by health service providers and other staff at health facilities.
- Many service providers have limited knowledge and understanding of the rights of people with disability and their health needs. Service providers have inadequate training and professional development about disability.
- Many health services do not have policies in place to accommodate the needs of people with disability. Such policies could include allowing longer and flexible appointment times, providing outreach services and reducing costs for people with disability.
- Women with disability face particular barriers to sexual and reproductive health services and information. Health workers often make the inaccurate assumption that women with disability are asexual or are unfit to be mothers.
- People with disability are rarely asked for their opinion or involved in decision-making about the provision of health services to people with disability.

Lyndsey Ingram is a recent high school graduate.
She has down syndrome. She continues to thrive.

Physical barriers

- Health services and activities are often located far away from where most people live or in an area not serviced by accessible transport options.
- Stairs at the entrance to buildings or services and activities located on floors that do not have elevator access are inaccessible.
- Inaccessible toilets, passages, doorways and rooms that do not accommodate wheelchair users, or are difficult to navigate for people with mobility impairments, are common.
- Fixed-height furniture, including examination beds and chairs, can be difficult for people with disabilities to use.
- Health facilities and other venues for activities are often poorly lit, do not have clear signage, or are laid out in a confusing way that makes it hard for people to find their way around.

Communication barriers

- A key barrier to health services for people who have a hearing impairment is the limited availability of written material or sign language interpreters at health services.
- Health information or prescriptions may not be provided in accessible formats, including Braille or large print, which presents a barrier for people with vision impairment.
- Health information may be presented in complicated ways or use a lot of jargon. Making health information available in easy-to-follow formats – including plain language and pictures or other visual cues – can make it easier for people with cognitive impairments to follow.

Financial barriers

- Over half of all people with disability in low-income countries cannot afford proper health care.
- Many people with disability also report being unable to afford the costs associated with traveling to health services and paying for medicine, let alone the cost of paying to see a health service provider.

Language and terminology are paramount to changing attitudes. First, using the terms person with a disability, rather than a disabled person aids in seeing the person first. Focusing on what one can do rather than what one cannot do. Accentuating their strengths and their adaptabilities. As an aunt of a now young adult with down syndrome who has recently graduated high school, there has always been an emphasis on what she "can" do. Whether it was soccer and then Buddy Ball, her singing in the choir, acting in high school plays, to her being a member of a cheer and dance teams. Inclusion when at all possible is important to building self-esteem and confidence. Providing access helps to eliminate barriers and aid in providing optimum health outcomes.

GENDER AND LGBTQ

Gender and gender bias will be explored, both as it relates to health care providers and patients. Race and gender are important factors when examining the demographic make-up of health care providers. While males predominantly make up physicians in the US, nurses, nurse practitioners, PTs and OTs are predominantly females. "In the United States today, there is a persistent lack of diversity among health care professionals. It's critical that health care organizations improve diversity to ensure that people of all socioeconomic backgrounds, races, ethnicities, cultures, sexual orientations, religions and genders are represented in the health care workforce" (University of St. Augustine for Health Sciences, 2021, para 1).

"Where there is a lack of gender and ethnic representation, there is also a lack of diverse thought. This can limit the creativity and breadth of ideas and perspectives within organizations" (University of St. Augustine for Health Sciences, 2021, para 16). Therefore, representation matters.

Patients need to see themselves in their health care providers and feel that there is a connection between themselves and those who deliver their care. There must be a level of understanding, respect and empathy.

It is also important to be aware of gender bias. Gender bias is a preference or prejudice against one gender. As health care providers, we must not make assumptions based on traditional gender roles. Who does the shopping, who does the cooking, who is the primary caregiver for the children? All are questions that should be asked when relevant situations arise.

"About 3.5% Americans identify themselves as lesbian, gay, or bisexual while 0.3% identify themselves as transgender. The LGBT (lesbian, gay, bisexual and transgender) community belongs to almost every race, ethnicity, religion, age and socioeconomic group" (Hafeez, Zeshan, Tahir, Jahan, & Naveed, 2017, para 1). Lesbian, gay, bisexual, transexual, queer (or questioning) (LGBTQ) identified patients face various physical, behavioral and sexual health disparities. LGBTQ individuals often face discrimination, bias, stigmatization, maltreatment and lack of empathy both within and outside of health care settings. It is often the history of or fear of this maltreatment that can cause a delay in individuals seeking health care.

As many of us may know, the LGBTQ community and the acronym(s) or umbrella term that describe the community has varied from time to time and expanded to include other groups. One such varying acronym is LGBTQIA+. Some terms that may be helpful include:

L=Lesbian: A woman whose enduring physical, romantic and/or emotional attraction is to another woman.

G= Gay: People whose enduring physical, romantic and/or emotional attractions are to people of the same sex.

B= Bisexual: Person who has can form enduring physical, romantic and/or emotional attractions to those of the same gender or those of another gender.

T=Transgender: A wide-ranging term for people whose gender identity or gender expression differs from the biological sex they were assigned at birth.

Q= Queer: An adjective used by some people whose sexual orientation is not exclusively heterosexual.

Q=Questioning: Person who is questioning their sexual orientation or gender identity.

I=Intersex: A person born with biological sex characteristics that aren't traditionally associated with male or female bodies.

A= Allies: A person who is not LGBT but actively supports LGBT.

+=+: not just a mathematical symbol anymore, but a denotation of everything on the gender and sexuality spectrum that letters and words can't yet describe.

Other important terms to understand are:

Pansexual=Attracted to people of all gender identities.

Cisgender=Gender identity matches the sex they were assigned at birth.

Gender Nonconforming (G.N.C.)=Expression of gender outside traditional norms associated with masculinity or femininity.

Nonbinary=Identifies as neither male nor female and sees themselves outside the gender binary.

Genderqueer=Gender identity is outside the strict male/female binary.

Gender fluid=Identity shifts or fluctuates.

Gender-Neutral=Preference not to be described by a specific gender; prefers "they" as a singular pronoun. (LGBTQIA Resource Center, 2020).

LGBTQ youth are an exceptionally vulnerable population and their fear of coming out can lead to depression, post-traumatic stress disorder, isolation, acting out, substance abuse and suicidal behavior. "LGBT youth represent up to 40% of all young people experiencing homelessness" (Hafeez, Zeshan, Tahir, Jahan, & Naveed, 2017, para 3).

There are also health risks to consider. Gay men have an increased risk of various cancers including prostate, testicular, anal and colon, which might be related to limited culturally sensitive screening services. There is also an increased risk of STDs like syphilis, human papillomavirus (HPV) infections and hepatitis in MSM (Men who have Sex with Men). There is also a possible increased risk of breast, ovarian and endometrial cancers in lesbians and bisexual women due to fewer full-term pregnancies, fewer mammograms and obesity (Hafeez, Zeshan, Tahir, Jahan, & Naveed, 2017).

The three takeaways from the presented information include:

1. Eliminate bias.
2. Develop an understanding of proper terminology and use it appropriately.
3. Increase the existence of culturally sensitive screening services.

All three of these takeaways not only develop cultural awareness and sensitivity but can save lives.

MENTAL ILLNESS

The culture of the patient influences many aspects of mental health, mental illness and patterns of health care utilization. It is important to note that general statements about the cultural characteristics of a given group may invite stereotyping of individuals based on their appearance or affiliation. There is usually more diversity within a population than there is between populations (e.g., in terms of the level of acculturation, age, income, health status and social class) (U.S. Department of Health and Human Services [DHHS], 1999).

Also, "when clinician and patient do not come from the same ethnic or cultural background, there is greater potential for cultural differences to emerge. Clinicians may be more likely to ignore symptoms that the patient deems important, or less likely to understand the patient's fears, concerns and needs. The clinician and the patient also may harbor different assumptions about what a clinician is supposed to do, how a patient should act, what causes the illness and what treatments are available. For these reasons, DSM-IV exhorts clinicians to understand how their relationship with the patient is affected by cultural differences" (U.S. Department of Health and Human Services [DHHS], 1999, Chapter 2, Culture of Clinician, para 6).

The UPenn Collaborative on Community Integration (2006) discusses disparities in behavioral health services for members of racial and ethnic minority populations. People in these populations:

- are less likely to have access to available mental health services;
- are less likely to receive necessary mental health care;
- often receive a poorer quality of treatment; and
- are significantly underrepresented in mental health research.

Furthermore, cultural barriers that exist that potentially limit access to care include:

- mistrust and fear of treatment;
- alternative ideas about what constitutes illness and health;
- language barriers and ineffective communication;
- access barriers, such as inadequate insurance coverage; and
- a lack of diversity in the mental health workforce.

The UPenn Collaborative on Community Integration (2006) recommends that mental health care providers take the following steps to improve their cultural competency:

- Use open-ended questions to identify each person's unique cultural outlook.
- Re-evaluate intake and assessment documentation, as well as policies and procedures, to be more inclusive.
- Employ qualified mental health workers who are fluent in the languages of the groups being served.
- Understand the cultural biases of staff and provide training to address educational needs.
- Understand the cultural biases in program design.
- Identify resources, such as natural supports, within the community that will help an individual recover.
- Design and implement culturally sensitive treatment plans.
- Evaluate procedures and programs for cultural sensitivity and effectiveness.
- Survey clients and workers to elicit their understanding of cultural competence and culturally competent practice.

VETERANS

Veterans, specifically those who have served in combat and/or in situations that were psychologically and physically challenging, have unique backgrounds. Because of their experiences, it is a common belief that health care workers, including nurses and providers, with no military background, do not understand their needs. This leads to the underutilization of health care by Veterans. It is difficult for nurses to understand the culture of the military if they have never been exposed to it. With more Veteran's seeking nonmilitary health care, civilian nurses need to increase their knowledge of Veteran' culture. This section will discuss Veterans and the importance of understanding their unique circumstances and health care issues such as PTSD and depression (Sever, Fall 2020).

Each branch of the military is unique with its own core values and mission. To decrease cultural barriers and provide the best possible care to Veterans, non-military nurses should make it a priority to learn about the differences in branches of the military (Sever, Fall 2020). Health issues among Veterans vary depending on the era and the role they served. Here are a few of the health issues:

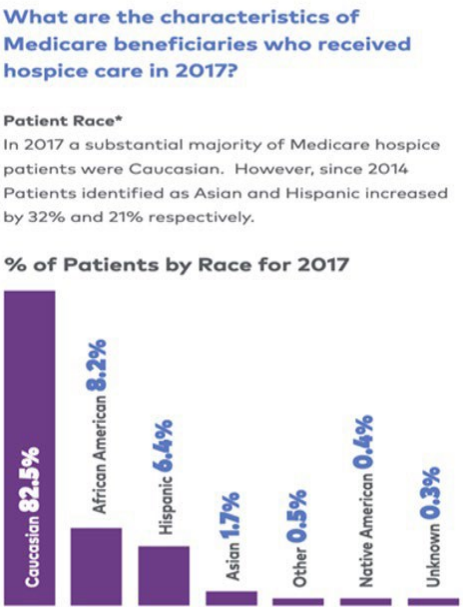
- Infectious diseases: Those who served in foreign countries were vaccinated; nevertheless, some contracted life-threatening infections. For example, small sandflies found in the Middle East can cause Leishmaniasis which can cause mild symptoms such as fever or more life-threatening issues such as an enlarged spleen and liver.
- Musculoskeletal injuries and pain: the vigorous duties for military personnel commonly lead to chronic shoulder, knee, back and leg pain.
- Noise and vibration exposure: hearing loss and ringing in the ears are a result of exposure to extremely loud noises such as gunfire and aircraft noise. Further damage such as numbness and pain result from prolonged exposure to heavy vibrations.
- Chemical exposure: Veterans who were exposed to chemical agents, such as Agent Orange, sarin gas and Gulf War nerve agent sarin from the Vietnam era and Gulf War era, have lifelong damaging effects.
- Traumatic brain injury (TBI): Some Veterans endure emotional and behavioral fluctuations, cognitive damage and physical symptoms due to irreversible brain damage. A variety of symptoms may arise including seizures, memory loss, inability to concentrate, anxiety and depression. This type of damage is a result of head injuries during combat or combat training.

- Mental health issues: Psychological damage often results from trauma due to military service in a war zone. Veterans diagnosed with PTSD or depression may also suffer from secondary problems such as violent behaviors, paranoia, alcohol and drug abuse and more. Veterans are twice as likely as civilians to die of suicide. Statistics show 14% of suicides in the US are Veterans; yet only 8% of the US population are Veterans (Sever, Fall 2020).

The Army is the largest and oldest of the US military branches. Their core values are integrity, selflessness, duty, loyalty, personal courage and honor (Sever, Fall 2020, p. 7). The Navy is the second-largest U.S. military branch. Their core values are "commitment, honor and courage" (Sever, Fall 2020, p. 8). Their mission is to "recruit, train, equip and organize to deliver combat-ready Naval forces to win conflicts and wars while maintaining security and deterrence through sustained forward presence" (RFI | U.S. Navy, n.d., p. 1). The Marine Corps is the smallest of US military branches, and "their mission is to conduct amphibious operations and develop amphibious doctrine" (Sever, Fall 2020, p. 8). Their core values are also commitment, honor and courage (Marine Corps Values | Marines, n.d.). The youngest of the military branches is the Air Force (Sever, Fall 2020). Their core values are "integrity first, service before self and excellence in all we do" (U.S. Air Force - Vision, n.d., p. 1). Their mission is to "fly, fight and win airpower anytime, anywhere" (U.S. Air Force - Mission, n.d., p. 1). Devotion of duty, respect and honor are the Coast Guard's core values (Sever, Fall 2020,). "The U.S. Coast Guard has several missions which encompass "securing the extensive interests in the seas which surround the U.S. and far beyond thereby ensuring the safety, security and stewardship of our nations waters" (Coast Guard Roles and Missions, n.d., p. 1).

Health care workers need to understand the impact the military culture has on the Veterans' conduct and how they manage their health care. Keeping in mind accepting treatment may be seen as accepting defeat. Nurses need to understand Veterans are trained to be proud of overcoming challenges and this thought process may interfere with seeking health care. This leads to the underutilization of health care by Veterans, especially those with unique circumstances and health care issues such as PTSD and depression (Sever, Fall 2020).

HOSPICE



(2018_nhpco_facts_figures, 2019)

Hospice care is a model for quality, compassionate care provided to those with terminal illnesses and approaching end-of-life regardless of age, race, religion, etc. (2018_nhpco_facts_figures, 2019, Introduction section). Patients, families and caregivers increased satisfaction with the quality of care with hospice, better quality of life and reduced health care expenses are benefits directly correlated with hospice enrollment during the final stages of life (Dillon & Roscoe, 2015). Pain management, superb medical care, along with spiritual and emotional care are patient-centered. Patients' families are also provided support with hospice care (2018_nhpco_facts_figures, 2019, Introduction section). With hospice, the focus switches from curing to caring. Hospice services are provided where the patient lives such as a home, long-term care facility or hospice facility, hospital, nursing home, or any other place where a patient resides; and most hospice costs are paid by Medicare (2018_nhpco_facts_figures, 2019). Although there is documentation of the known benefits of hospice care there are certain populations who underutilize hospice services which leads to further health disparities (Dillon & Roscoe, 2015).

The most up-to-date information on Medicare decedents shows Native Americans, Asians, African Americans and Hispanics are the racial/ethnic populations of minorities who underutilized Hospice services most (2018_nhpco_facts_figures, 2019). Additionally, studies have shown Hispanics and African Americans who do utilize hospice services receive a poorer quality of care compared to Whites. Research also shows African Americans received fewer visits, during their final days from hospice staff and revoked services more frequently compared to Whites (Boucher & Johnson, 2020). Both student nurses and nurses have exhibited ratings of African Americans pain lower than Whites (Aronowitz et al., 2019). It is important to understand that providing equal care can still be unequal for certain populations. Ethnic minorities receiving hospice care were disproportionally affected by COVID-19 due to existing disparities in health care, structural racism and other factors furthering the vulnerability of these populations. Early in the pandemic, people with dying loved ones in health care facilities were unable to spend time with them before they passed away. This policy restriction on visiting was equal but had a disproportionate impact on minorities. Certain minority populations were left unable to fulfill certain cultural or traditional rituals. For example, Muslim culture belief is the quality of the afterlife is determined by the greater number of visitors when you die. Therefore, the visitor restriction left Muslim families in great distress (Bajwah et al., 2021). Visiting restrictions and mandatory face-covering led to further communication issues for those in need of interpreters. Patients were left without family to interpret for them in person and translators were not readily available in facilities. Wearing masks increased difficulty talking on the phone to interpreting services which caused frustration for patients, families and health care workers. Many health care workers believe providing equal treatment is best for the patient. This one size fits all mentality leads to inequality in caring for ethnic minority patients (Bajwah et al., 2021).

To improve the quality-of-care minority populations receive at the end of life, inequalities in hospice must be addressed (National Hospice and Palliative Care Organization [NHPCO], 2020). More research is needed to show the impact cultural competency training has on increased utilization of hospice services by racial/ethnic populations; however, cultural competency training has shown promises of addressing disparities in the quality of hospice care. One strategy to decrease disparities in health care, which includes hospice care, is cultural competency training (Boucher & Johnson, 2020). Lack of cultural competence can be associated with the underutilization of hospice for minority patients (Dillon & Basu, 2016; Haines et al., 2018). With the continued growth of the extremely sick among these populations, the relevance of understanding end-of-life preferences, cultural beliefs and the provision of culturally competent care increases (Boucher & Johnson, 2020).

CONCLUSION

Cultural competency is essential to diminishing health disparities. "Cultural competence is widely seen as a foundational pillar for reducing disparities through culturally sensitive and unbiased quality care" (Agency for Healthcare Research and Quality [AHRQ], 2019, para 1). Building cultural competency is an ongoing process. This article aimed to provide foundational information for nurses and other health care professionals as they continue to develop cultural competency to deliver the highest quality of care to their patients. The populations explored are those who are considered the most vulnerable. Those who are most likely to be subjected to discrimination, inadequate care and marginalization. These factors directly impact these populations' access to care and can cause patients to seek care late in a disease process or not seek care at all. Furthermore, prejudice, bias and a lack of understanding can lead to misdiagnosis and even death.

"Cultural competence is often seen as encompassing only racial and ethnic differences, omitting other marginalized population groups who are ethnically and racially similar to a provider but who are at risk for stigmatization or discrimination, are different in other identities, or have differences in health care needs that result in health disparities" (Agency for Healthcare Research and Quality [AHRQ], 2019, para 2). We hope that our exploration of multiple populations can assist you in a comprehensive approach to your quest to build cultural competence.

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Please answer the following questions. You must earn a minimum of 70% out of 100% in order to earn **2 CEUs**.

Please include your name, Nevada RN/LPN/CNA#, and valid e-mail address with your answers:

NAME: _____

RN/LPN/CNA#: _____

E-MAIL: _____

1. According to the most recent U.S. Census, those who identify themselves as multiracial is:
   a. Decreasing
   b. Increasing
   c. Staying the same
   d. Data not a part of the census
2. The cultural competency models discussed in the article are:
   a. Widely used in nursing
   b. Not applicable to present day nursing care
   c. Should be exclusively used in nursing practice
   d. Not absolute models or guidelines for providing culturally competent care to every population
3. Ageism:
   a. Involves use of negative language
   b. Is a barrier to receiving adequate healthcare
   c. Involves discriminatory practice toward a specific age group
   d. All of the above
4. Infant mortality rates for America's Black babies are more than twice the rate of white babies
   a. True
   b. False
5. The Nevada State Board of Nursing requires hospitals to be accountable for maintaining patient rights, including accommodating for cultural, religious, and spiritual values
   a. True
   b. False
6. A financial barrier mentioned in the article for a person with a disability can include paying for:
   a. Travel to receive healthcare services
   b. Caregivers
   c. Accommodations such as wheelchair ramp
   d. Wheelchair accessible housing
7. When clinician and patient do not come from the same ethnic or cultural background,
   a. They have a greater chance at have an understanding relationship
   b. There is never an impact on patient care
   c. There is greater potential for cultural differences to emerge
   d. They do not have assumptions about each other
8. Veterans commonly believe
   a. That healthcare workers with no military background do not understand their needs
   b. Their care is not impacted by provider's military experience
   c. Only those who served in the same branch of service can understand their needs
   d. All providers are ill equipped to deal with PTSD and depression
9. Native Americans, Asians, African Americans (AAs), and Hispanics overutilize hospice care.
   a. True
   b. False
10. Cultural competency continuing education (4 CEUs) must be completed:
    a. One-time only
    b. Every 5 years
    c. Every 2 years
    d. Every year

Once completed, please e-mail to arvasquez@nsbn.state.nv.us, with the subject line "Cultural Competency". Please allow a minimum of **7-14 business days** from the date received for processing once received. Certificates will be sent via your **Nevada Nurse Portal account**.

You can also mail it to the **Nevada State Board of Nursing**

ATTN: Education Department 5820 S. Eastern Ave., Suite 200 Las Vegas, NV 89119