

PERSPECTIVES OF REGISTERED NURSE CULTURAL COMPETENCE IN A RURAL STATE - PART I

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ABSTRACT

Inferences have been made from recent research that there is a correlation between lack of cultural competence and the incidence of health disparity. As our society becomes more global and more diverse, it is apparent that culture can no longer be considered as solely associated with ethnic/racial/cultural groups. Nurses permeate all areas of health care and are therefore in a position to have positive impact on cultural competency. This paper describes the 5 constructs of cultural competence as described by Dr. Josepha Campinha-Bacote: cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire. She emphasizes, as do others in the literature, that cultural desire and awareness are antecedents to knowledge acquisition and skill. Is mere cultural awareness enough? How do healthcare providers in homogenous rural states attain cultural competence when cultural encounters and cultural knowledge may not be readily accessible? This is the first in a series of two articles which explores Cultural Competence of health care providers in a rural state. The first article in the series provides literature review and definitions related to cultural competence as well as the impact of cultural competence. The second article reveal results of a cultural competence self-assessment survey of registered nurses in North Dakota, a sprawling rural state described as 9th in the union for percentage of caucasians and 5th in rank for the most American Indians.

OVERVIEW OF CULTURAL COMPETENCE

In March of 2002, the Institute of Medicine (IOM) released the report, *Unequal Treatment: Confronting Racial Disparities in Health Care*. The IOM report concluded that evidence suggests that bias, prejudice, and stereotyping on the part of health care providers may contribute to differences in health care (Institute of Medicine, March 2002). While the IOM's report focused on racial and ethnical diversity, the American Psychological Association (APA) defined ten groups of persons in their ethics code. These included persons of differing age, gender, race, ethnicity, national origin, religion, sexual orientation, disability, language and socioeconomic status (APA Code of Ethics, 2002). Logically, nurses can expect to care for patients that identify with the disenfranchised segment of one or more of these groups. Culture can no longer be seen as solely associated with distinct ethnic/racial/cultural groups. Nurses who are able to operate from a perspective of cultural competence will rapidly learn that culture is a component of all human life, including health and illness, and not something that mainly affects persons who are ethnically, racially or socio-economically different from them (Desantis, 1994).

Diversity in North Dakota

US Census data from 2003 revealed, not surprisingly, that the majority of the state of North Dakota is Caucasian (North Dakota Fact Sheet, 2005). North Dakota ranked as the 9th most white, or Caucasian state in our union. It was fifth in rank for the state with the most American Indians or Alaskan Indians (AI/AI). American Indians and Hispanics made up the

largest population of diverse cultures in our state of 609,691 (North Dakota Fact Sheet, 2005). Of the American Indians living in North Dakota, 40.2% of them did not live on reservations (North Dakota Indian Affairs Commission, 2005).

Census demographic data may not have included some groups living in our state, for example the data did not accurately account for the number of migrant workers in our state. The numbers of non-white races residing in our state may have been under represented on U.S. Census polls as this data was limited to household populations and excluded those living in institutions, college dormitories, and other group quarters. It has been reported that over 22 languages are spoken in the North Eastern part of the state where there has been a steady influx of refugees over the past 2 decades. They come from several international hot spots: Kurdistan, Haiti, Russia, Bosnia, Zaire, Vietnam, Somalia, Sudan, Cuba, Armenia, and Iraq.

CULTURAL COMPETENCY AND NURSING CARE IN NORTH DAKOTA

Health care providers have received criticism about an overall lack of cultural competence, which may be linked to health disparities, decreased patient satisfaction, and decreased patient compliance. As research begins to tie health disparities to cultural diversity, the mandate for professional cultural competency strengthens. The Commission on Collegiate Nursing Education, the National League for Nursing, most State Boards of Nursing, and other accrediting and certification bodies required or strongly encouraged the inclusion of the aspects of cultural care in nursing curricula and health care provider competencies (Andrews and Boyle, 2002). Diversity training and cultural competency educational courses have been included in university and hospital educational programs around the country. The impact of these programs remains to be seen. The National Mental Health Association made a strong statement that supports this thought: “many health systems simply pay lip service to this concept. Some organizations claim to be culturally competent, but don’t have appropriate procedures in place to address diversity” (as quoted in Meadows, 2000). There were not standard guidelines in place to help educators effectively design, evaluate, or report the interventions used to increase cultural competence (Price et al. 2005).

Although the majority of our state’s population is white, nurses cannot be excused from accountability in providing culturally safe and congruent care. The process of becoming culturally competent takes time and commitment. An ongoing nursing education program must focus on developing the knowledge and skill required to evolve along the continuum of cultural competence (Salimbene, 1999).

An informal telephone survey of the staff education coordinators of 6 urban hospitals in North Dakota on June 28, 2005 revealed that all six facilities had training on cultural competency/diversity in place. The types of training and the frequency with which the programs were held varied from facility to facility. None of the hospitals surveyed reported a mechanism for evaluating the effect of these programs.

CULTURAL COMPETENCE: A REVIEW OF THE LITERATURE

The concept of cultural competence has become a dominant force not only in health care, but also in Business (Hampden and Tropenaars, 1997; Trompenaars and Wooliams, 2004), Social Work (Patti, 2000), Education (Silverman, 2005), and Psychiatry (Green, 1997). The United States Department of Health recognized the impact of cultural competency as it related to

health disparity as outlined in their publication, *The Problem of Accessing Health Care*, (Meadows, 1999). The web site for the Bureau of Primary Health Care (BPHC) (2005) described cultural competence as a journey. The BPHC has partnered with the National Center for Cultural Competence (NCCC) as a part of a strategic plan to enhance culturally competent services.

Leininger claimed to be the first to have coined the term cultural competence (Burcham, 2002). A search of her books through 2002, elicited a definition of culturally competent nursing care as “the explicit use of culturally based care and health knowledge in sensitive, creative, and meaningful ways to fit the general lifeways and needs of individuals or groups for beneficial and meaningful health and well-being or to face illness, disabilities, or death” (2002, p. 84). Leininger otherwise used the term cultural congruence when describing culture specific care that is safe and appropriate.

Spector (2004) defined cultural competence as an ability by health care providers and health care organizations to understand and respond effectively to the cultural and linguistic needs brought to the health care experience; a complex combination of knowledge, attributes and skill. Paulanka and Purnell (1998) emphasized the importance of self-awareness, respect and conscientious thought processes in their definition. Andrews and Boyle (1999) qualified cultural competence as a process as opposed to an end point.

Campinha-Bacote (2003) also de-emphasized the idea of an end point in reaching cultural competence. She defined cultural competence as a process in which the nurse continuously strives to achieve the availability to effectively work within the cultural context of a client, individual, family or community.

Bell and Evans, as quoted in Campinha-Bacote (2003), caution against cultural blindness when one is progressing through the stages of cultural competence: “in this interacting style, the health care professional has made a decision that he/she is committed to equality for all people and therefore treats all people alike, regardless of cultural background” (p. 23). This type of interacting style lends to misinterpretation of verbal and physical cues made by the patient and ignores the fact that there are variations within cultural groups.

ATTRIBUTES AND ANTECEDENTS OF CULTURAL COMPETENCE

A literature search of nursing publications yielded a fair amount of consistency in definitions and attributes of cultural competency (Table 1). Awareness can be counted not only as an attribute, but also as an antecedent. The health care provider must first be aware of the need for knowledge and of one’s own competency level pre-education before a quest for competency can begin. Burcham (2002) mentioned cultural awareness as an attribute and as an antecedent. Leininger (2002), Purnell (1998), and Spector (2004) all described awareness of one’s own beliefs and values as one of the first steps in achieving cultural competency. The NCCC conducted a number of activities to meet its goal of assuring high quality healthcare that is culturally and linguistically competent (NCCC, 2005). Some of those activities included provisions for self-assessment for both individual providers and organizations (NCCC). In this way, health care providers can gauge their needs and plan pertinent educational activities.

In order to meet the attribute of cultural respect/sensitivity, the nurse must operate from an attitude of respect. There is no room for ethnocentricity on the part of health care providers. Galanti (1991) supported this thought, stating that viewing the health behavior of others from a perspective that is culturally relativistic can only help us achieve our goals of providing safe, meaningful and appropriate care. While some in health care may argue that “they should learn

Table 1

Attributes of Cultural Competence

CULTURAL AWARENESS	
The ability to analyze one's own biases and prejudices towards other groups	Andrews and Boyle (1999)
Awareness of one's own existence, sensations, thoughts, and environment without letting it has undue influence on those other backgrounds. Self examination and in-depth exploration of one's own cultural and professional back ground	Paulanka and Purnell (1998, p. 2) Campinha-Bacote (2003)
Understanding of one's own cultural values, biases, and traditional health/belief practices	Spector (2004, p. 325)
CULTURAL KNOWLEDGE	
Acquiring knowledge of cultures other than one's own	Andrews and Boyle (1999)
Achieving sound educational foundation regarding a variety of cultural races/world views	Campinha-Bacote (2003)
Demonstration of understanding of the client's culture	Paulanka and Purnell
The nurse remains alert to using nursing, medical, and humanistic knowledge to understand the client	Leininger (2002, p. 123)
CULTURAL SKILL	
Process that is greater than just fact gathering-it is focused, systematic, reflective and evaluative	Smith (1998)
Sensitive, creative and meaningful care practices [adapted to] fit with the general values, beliefs, lifeways of clients for beneficial health care. The ability to collect relevant cultural data regarding the client's presenting problem as well as accurately performing a culturally based physical assessment	Leininger (2002, p. 12) Campinha-Bacote (2003)
CULTURAL ENCOUNTERS	
Culture care is focused on discovery and learning about the meanings, patterns and uses of care within cultures	Leininger (2002, p. 57)
The process that encourages the health care provider to directly engage in cross-cultural interactions with clients from culturally diverse backgrounds.	Campinha-Bacote (2003)
Development of mutually satisfying relationships with diverse cultural groups involves good interpersonal skills and the application of knowledge	Spector (2004)
If all cultures could study each other's techniques with a culturally relativistic perspective, the cause of modern medicine would be greatly advanced	Galanti (1991, p. 9)
When individuals of dissimilar cultural orientations meet, the likelihood for developing a mutually satisfying relationship is improved if both parties attempt to learn about each other's culture	Paulanka and Purnell (1998, p. 2)
CULTURAL RESPECT/SENSITIVITY	
It is imperative for those of us who deliver health care to be understanding/sensitive to cultural differences..."	Spector (2004, p.30)
Cultural respect implies that the provider possesses some basic knowledge of and constructive attitudes toward the traditions observed among the diverse cultural groups found in the setting in which they practice	Spector (2004, p. 8)
CULTURAL PROFICIENCY/DEVELOPMENT	
Represents a commitment to change and is evidenced by demonstration of new knowledge and cultural skill and information sharing. Cultural competency is a process.	Burcham (2002, p. 10) Campinha-Bacote (2003)
To be even minimally effective, culturally competent care must have the assurance of continuation after the original impetus is withdrawn	Paulanka and Purnell
The nurse assesses his/her competencies and areas that need to be strengthened or modified.	Leininger (2002, p.28)

our ways”, this attitude is not helpful. What better way to advocate for a patient than to exhibit an understanding of where he/she is coming from? This truly is patient advocacy and is key to effective nursing (DeVries, 1999).

Acquisition of knowledge and skills pertinent to the culture or cultures for which the nurse is caring is an essential antecedent as well. There were many texts, web sites, videos and journal publications found on the topic of cultural competency. Most of these described not only the concept of cultural care and or competency, but also described cultural characteristics and health habits of specific cultural and ethnic groups. Texts utilized for this literature search included those by Spector, Campinha-Bacote, Leininger, Purnell, Andrews & Boyle, and Galanti. As these authors note within their texts, the nurse/health care provider must be alert to stereotyping and must understand that within cultures, variations do exist. These authors defined cultural competency as being on a continuum with emphasis on the need for constant re-evaluation.

CONSEQUENCES OF CULTURAL COMPETENCE

If cultural competency is on a continuum, then proficiency could be considered an outcome or consequence of cultural competency. Burcham (2002), Purnell (1998), Campinha-Bacote (2003), and Leininger (2002) supported this concept. The BPHC (2005) measures the following outcomes:

- Improved diagnoses and treatment plans
- Development of treatment plans that are followed by the patient and supported by the family
- Reduction in delays seeking care
- Enhanced overall communication
- Enhanced compatibility between Western and traditional cultural health practices

The Quality and Culture website (2005) contained commentary on the research to date which, summarized, explains that culturally competent health care practices could have an impact on disparities. For example, Spanish-speaking emergency department patients who spoke through an interpreter were more satisfied than those who said an interpreter should have been used.

Patient satisfaction, then, is a consequence of culturally competent care. Practitioner satisfaction, logically, would also increase as patient compliance with plans of treatment increased. This could mean fewer return visits by the patient and hopefully attainment of optimal health.

Leininger made mention of safe and appropriate care as a consequence of culturally congruent care. Indeed, regulatory agencies such as the Office of Minority Health (OMH) and the Joint Commission on Accreditation of Health Care Organizations (JCAHO) promoted cultural competency as a means of providing safe patient care. JCAHO supported *Hospitals, Language, and Culture: A Snapshot of the Nation*, which was a 30 month project designed to gather data on a sample of hospitals to assess their capacity to address language and culture issues as they impact the quality and safety of patient care (JCAHO, 2005). In December of 2000, the OMH published the final recommendations on national standards for culturally and

linguistically appropriate services in health care (CLAS) (Ross, 2001). The first standard listed was a mandate that health care organizations should ensure that all staff members are providing care that is compatible with the cultural health beliefs, practices, and language of their customers (Ross, 2001). JCAHO required hospitals to assess patient's learning needs. Part of this assessment involved evaluating cultural beliefs as they might impact learning. During informal discussions with health care providers in one North Dakota acute care facility, it was revealed that some nurses were not sure what to do if cultural barriers were defined in the assessment. Some of these nurses offered up the idea that they would use an interpretation service that was offered through a phone company, or would draw from a list of local interpreters if there were a language barrier, but none were able to list other possible interventions or assessment techniques.

CONCEPTUAL DEFINITION OF CULTURAL COMPETENCE

Cultural Competency can be conceptually defined as a referent to an individual who demonstrates cultural awareness, knowledge and skill and applies these components as he/she interacts with patients, co-workers, and customers. Further, the culturally competent individual operates from a platform of respect for others. He/She continuously self-assesses and adjusts to the dynamic and challenging opportunities in remaining culturally aware and effective.

REVIEW OF RELATED STUDIES

A review of scholarly publications revealed that there are few published correlational studies on cultural competence specific to nurses in health care settings. In June of 2005, Price, et al published a review of the published studies that evaluate cultural competence training of health care professionals. Under their eligibility criteria, only 64 articles were suitable for review. Of those, most all measured provider outcomes (Price, et al., 2005).

A study published by Narayanasamy (2003) explored qualitatively how nurses respond to their patients' cultural needs. The findings from this study reveal that while this sample of 126 nurses were able to give accounts of ways in which they responded to their patients' cultural needs, the nurses may have been operating from assumptions and stereotypes rather than from a culturally competent platform. Narayanasamy (2003) also noted that the study might have implications for nurse education in that the participants expressed a need for further professional development in cultural knowledge and skills.

Coffman, Shellman, and Bernal (2004) reviewed the use of the Cultural Self-Efficacy Scale (CSES) that had been developed by Bernal and Froman in 1987. They analyzed the use of the CSES from 1987 to 2002. Their method of survey and literature search revealed 26 known uses of the scale (Coffman et al. 2004). The authors eliminated 11 studies and reduced the pool of eligible studies to 15. These authors reported that the cultural self-efficacy literature indicated that the "samples of American nurses and students perceived a lack of self-efficacy in caring for culturally diverse populations" (Coffman et al. 2004). Their findings also showed that ethnicity, previous coursework and educational experiences can increase nurses' self-efficacy in delivering culturally competent care.

Doutrich and Storey (2004) reported on a collaborative project designed to improve the cultural competence and public health skills of registered nurses who are baccalaureate students. The students studied in this project completed pre- and post-tests on the Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals- Revised (IAPCC-R)

(Doutrich & Storey, 2004). A repeated measures analysis using SPSS software found that the students' IAPCC-R scores improved significantly after workshop interventions and student experiences with public health nurse mentors (Doutrich & Storey, 2004). From this project came changes in the academic practices related to links between nursing students and public health nurses. Among these changes was the inclusion of Campinha-Bacote's model of the process of cultural competence (Doutrich & Storey, 2004).

Campinha-Bacote field-tested her first tool, the IAPCC, for construct validity on 200 registered nurses who participated in an all-day workshop on cultural competence in health care (Campinha-Bacote, 1999). It should be explained here that the IAPCC-R version was developed in 2002 when Campinha-Bacote added the fifth construct of cultural desire to the tool (Campinha-Bacote, April, 2005). Each subject's pretest score on the IAPCC served as the control. Post-test scores revealed an increase in the level of cultural competence after attending the workshop on cultural competence (Campinha-Bacote, 1999).

Smith (2001) reported on a quasi-experimental design in a two-group repeated measure format in which 94 registered nurses participated. Forty eight of the nurses participated in a "culture school" while the other forty six received cultural training via nursing informatics (Smith, 2001). The CSES was used in pre-testing/post-testing. Both groups benefited from education, however, the nurses who participated in the 8.5 hour culture school rated themselves higher post education on the CSES than did the nurses who participated in the informatics course (Smith, 2001). Smith (2001) reports that a nursing education intervention could significantly increase cultural competence, as measured on the CSES and on knowledge based questions.

Perez (2005) described a study that assessed the level of cultural competence among professional health educators using the IAPCC-R. A review of the abstract of this study reveals that a series of analysis of a variance showed significant difference on cultural competency mean scores between health education setting and number of cultural/diversity education programs attended in the last 3 years.

The research articles described here had one theme in common in the summation of findings: education impacted self-reported cultural competency. Some of the authors discussed qualitative data in which study participants revealed a desire to learn more about other cultures in order to increase their cultural competency. The research for these articles was conducted in mainly urban areas where there would be an increased opportunity for cultural encounters.

IS CULTURAL COMPETENCE IMPORTANT IN A RURAL STATE?

Rural states, especially those in the Midwest and North Central areas of the United States, do not contain particularly diverse populations at first glance. Culture and cultural diversity, however, encompass much more than one's ethnicity. Culture is integral to each of our identities. It is our political affiliations; our gender; our occupation; socio-economic status; disabilities and abilities. Even within ethnic groups there are cultural variations which, until explored further may not be apparent. If we as health care providers harbor preconceived notions and prejudices about other groups of persons, even if those assumptions seem harmless, we may poison the opportunity to effectively and safely care for our patients.

Inhabitants of rural states are often described by visitors as friendly; willing to help a stranger. Communities in the state of North Dakota have become home to immigrants who have come from diverse countries; speaking no English at times. More American Indians are living in the communities surrounding their reservations rather than on the reservations. Health care

providers may recognize the ethical obligations to treat these patients regardless of race, creed, religious or political affiliations. These providers must recognize the dangers of approaching care as though all persons should be treated equally, however. The *outcomes* of care should be equal. That is, all patients should be able to hold the expectation that their care will follow recognized and accepted standards of care. The approach to the care, however, may vary based on the patient's needs. Cultural variations will impact those needs. In states where ethnic diversity is minimal, the cultural assessment tools available to nursing staff, may be sparse in content. For example, a single-question assessment such as, "are there any cultural or religious preferences you would like to discuss with me" may seem like a very pertinent open-ended question. This question may be met with a "no" from the patient who is not sure what this question means or who feels that his/her desires might really not be important to the nurse. This can put nurses in an awkward position when attempting to assess for cultural variations that would impact care. It also may place patients at risk for suboptimal care and discharge planning. The IOM report revealed several health care disparities amongst minorities which included:

- Inappropriate cardiac care, including medication prescriptions and surgical procedures
- Decreased incidence of appropriate cancer diagnosis and treatments
- Increased incidence of amputations for diabetic and peripheral vascular disease conditions

A thorough cultural assessment may not only reveal patient beliefs that would impact the approach to care, but would also be important to establishing a trusting relationship with the patient. In order to avoid cultural blindness, health care providers should provide patients with a cultural assessment whether they look like they need one or not (Campinha-Bacote, 2003). This becomes particularly important for health care providers who practice in geographical areas which are not ethnically and culturally diverse.

The first step toward achieving cultural competence is to assess one's own awareness, feelings, skills, and knowledge. In the next article in this series, the author will share results of a cultural competency self-assessment survey completed by North Dakota registered nurses.

REFERENCES

- Adams, D. (2000). *Making cultural competency work. Closing the Gap news letter*. Retrieved April 23, 2005, from <http://www.omhrc.gov/OMH?sidebar?archiveddctg.htm#11>
- Andrews, M., & Boyle, J. (1999). *Transcultural Concepts in nursing care*. Philadelphia: Lippincot, Williams & Wilkins.
- Andrews, M., & Boyle, J. (2002). Transcultural Concepts in nursing care. *Journal of Transcultural Nursing, 13*, 178-180. [MEDLINE]
- APA Ethical Principles of Psychologists Code of Conduct (2002). Retrieved on April 20, 2005, from <http://www.apa.org/ethics/code2002.html>
- Burchum, J. (2002). Cultural competence: An evolutionary perspective. *Nursing Forum, 137*(4), 5-15. [MEDLINE]
- Bureau of Primary Health Care. (n.d.). Retrieved April 1, 2005, from <http://bphc.hrsa.gov/culturalcompetence/default.htm>

- Campinha-Bacote, J. (1999). A model and instrument for addressing cultural competence in health care. *Journal of Nursing Education*, 38, 203-207. [MEDLINE]
- Campinha-Bacote, J. (2003). Many faces: Addressing diversity in health care. *Online Journal of Issues in Nursing*, 8(1), 3. [MEDLINE]
- Campinha-Bacote, J. (2003). *The process of cultural competence in the delivery of health care services: A culturally competent model of care*. Transcultural C.A.R.E Associates.
- Campinha-Bacote, J. (2005). Inventory for assessing the process of cultural competence among healthcare professionals-revised. Fact Sheet. Retrieved June 6, 2005, from <http://www.transculturalcare.net/services.htm>
- Coffman, M., Shellman, J., & Bernal, H. (2004). An integrative review of American nurses' perceived cultural self-efficacy. *Journal of Nursing Scholarship*, 2004, 36(2), 180-185. [MEDLINE]
- DeSantis, L. (1994). Making anthropology clinically relevant to nursing care. *Journal of Advanced Nursing* 20, 707-715. [MEDLINE]
- DeVries, C. (1999, October). Continued competence: Assuring quality health care. *American Journal of Nursing*, 99(10), 60-61. [MEDLINE]
- Doutrich, D., & Storey, M. (2004). Education and practice: dynamic partners for improving cultural competence in public health. *Family Community Health*, 27, 298-307. [MEDLINE]
- Galanti, G. (1991). *Caring for patients from different cultures. Case studies from American hospitals*. Philadelphia: University of Pennsylvania Press.
- Green, J.W. (1997). *Cultural responsiveness in family services*. Arch Fact Sheet number 50. Retrieved April 2, 2005, from <http://www.archrespice.org/FS50.pdf>
- Hampden-Turner, C., & Troupenaars, F. (1997). *Riding the waves of culture: Understanding diversity in global business* (2nd ed.). New York: McGraw-Hill.
- Institute of Medicine. (2002). Unequal treatment: What health care providers need to know about Racial and ethnic disparities in health care. Retrieved April 4, 2005, from <http://www.iom.edu>
- Joint Commission on Accreditation of Healthcare Organizations. (2005). Hospital, language, and culture. Retrieved July 8, 2005, from http://www.jointcommission.org/HLC/about_hlc.htm
- Leininger, M., & McFarland, M. (2002). *Transcultural nursing: Concepts, theories, research and practice*. New York: McGraw-Hill.
- Meadows, M. (1999). The problem of accessing health care. Closing the Gap, January 2000. Retrieved April 3, 2005, from <http://www.omhrc.gov/OMH/sidebar/archivedctg.htm>
- Meadows, M. (2000). Moving toward consensus on cultural competency in health care. Retrieved April 23, 2005, from <http://www.omhrc.gov/OMH/sidebar/archivedctg.htm>
- National Center for Cultural Competence. (n.d.). [Website.]. Retrieved April 18, 2005, from <http://www.gucchhd.georgetown.edu/ncc/ncc.html>
- Narayanasamy, A. (2003). Transcultural nursing: How do nurses respond to cultural needs? *British Journal of Nursing*, 12, 185-194. [MEDLINE]
- North Dakota Fact Sheet. (n.d.). Retrieved June 28, 2005, from <http://factfinder.census.gov/servlet/SAFFFACT>
- North Dakota Indian Affairs Commission (n.d.). Demographic information. Retrieved June 28, 2005 from <http://www.health.state.nd.us/ndiac/statistics.htm>

- Patti, R. (2000). *Social welfare management*. Thousand Oaks, CA: Sage.
- Purnell, L., & Paulanka, B. (1998). *Transcultural health care: A culturally competent approach*. Philadelphia: F. A. Davis.
- Perez, M (n.d.). Cultural competency among health educators. Retrieved June 28, 2005, from <http://www.aaahperd.org/2005/preliminaryprogram/abstract>
- Pollit, D., & Beck, C. (2004). *Nursing research: Principles and methods* (7th ed.). Philadelphia: Lippincott Williams & Wilkins.
- Price, E.G., Beach, M.C., Gary, T.L., Robinson, K.A., Gozu, A., Palacio, A., et al. (2005). A systematic review of the methodological rigor of studies evaluating cultural competence training of health professionals. *Academic Medicine*, 80, 578-586. [MEDLINE]
- Quality and Culture. (n.d.). [Website.]. Retrieved April 2, 2005, from <http://www.erc.msh.org>
- Ross, H. (2001, February/March). Office of minority health publishes final standards for cultural and linguistic competence. Closing the gap. Retrieved April 17, 2005, from <http://www.omhrc.gov/assets/pdf/checked/Final%20Standards%20for%20Cultural%20and%20Linguistic%20Competence.pdf>
- Salimbene, S. (1999). Cultural competence: A priority for performance improvement action. *Journal of Nursing Care Quality*, 13(3), 23-35. [MEDLINE]
- Silverman, J. (2005, March 31). House republicans may scuttle state's cultural competency efforts. Retrieved April 2, 2005, from <http://www.oregonlive.com/printer>
- Smith, L. (2001). Evaluation of an educational intervention to increase cultural competence among registered nurses. *Journal of Cultural Diversity*, 8(2), 50-63. [MEDLINE]
- Spector, R. (2004). *Cultural diversity in health and illness*. Upper Saddle River, NJ: Pearson Prentice Hall.
- Trompenaars, F., & Wooliams, P. (2004) *Business across cultures*. Chichester, UK: Capstone.