

## Cultural Competence: Where Are We as Athletic Training Educators?

Destinee H. Grove, MS, LAT, ATC\*; Jamie Mansell, PhD, LAT, ATC†

\*Athletico Physical Therapy, Ballwin, MO; †Department of Kinesiology, Temple University, Philadelphia, PA

**Context:** Cultural competence is the ability of health care professionals to investigate and incorporate the cultural needs of patients into care and clinical decisions. Research shows that athletic training students and certified athletic trainers possess moderate to high levels of cultural competence yet struggle exhibiting culturally competent behaviors. Therefore, an exploration of athletic training educator cultural competence and preparedness to teach cultural competence concepts is warranted.

**Objective:** The study sought to assess the cultural competence of athletic training educators and how prepared, comfortable, and confident they feel teaching cultural competence and related concepts.

**Design:** Cross-sectional survey.

**Setting:** Online.

**Patients or Other Participants:** Ninety professional-level athletic training educators (60 women, 30 men).

**Data Collection and Analysis:** Cultural competence scores were collected using a previously validated survey tool. The remaining survey items collected information about participants' self-reported cultural competence teaching efficacy. All responses were collected through Qualtrics and analyzed using SPSS version 25. Frequency counts and percentages were determined. Measures of central tendencies were calculated for continuous variables. A paired-samples *t* test was used to determine if cultural competence knowledge and exhibition of culturally competent behaviors differed significantly.

**Results:** Athletic training educators identified mostly as white women ( $n = 59/90$ , 65.56%) and had high levels of self-reported cultural competence ( $5.33/7.00 \pm 0.66$ ). However, half of respondents (50.56%,  $n = 45/89$ ) believed they do not possess adequate knowledge of cultural competence concepts, and a majority of respondents were not taught cultural competence concepts during professional education (78.89%,  $n = 71/90$ ) nor during athletic training-specific continuing education opportunities (54.44%,  $n = 49/90$ ).

**Conclusion(s):** Further investigation regarding athletic training educator cultural competence education is warranted. Additionally, barriers to recruitment and retention of underrepresented athletic training faculty should be explored to increase diversity within athletic training programs. Finally, an athletic training-specific cultural competence assessment may more accurately measure cultural competence in this population.

**Key Words:** Culture, diversity, higher education, inclusion

---

*Ms Grove is currently an Athletic Trainer at Athletico Physical Therapy and Head Athletic Trainer at East St. Louis Senior High School. Please address correspondence to Destinee H. Grove, MS, LAT, ATC, Athletico Physical Therapy, 13537 Barrett Parkway Drive, Suite 105, Ballwin, MO 63021. destineegrove@gmail.com.*

---

**Full Citation:**

Grove DH, Mansell J. Cultural competence: where are we as athletic training educators? *Athl Train Educ J.* 2020;15(1):49–54.

# Cultural Competence: Where Are We as Athletic Training Educators?

Destinee H. Grove, MS, LAT, ATC; Jamie Mansell, PhD, LAT, ATC

## KEY POINTS

- The United States is becoming increasingly diverse. Therefore, there is a need for culturally competent athletic trainers to adequately care for and meet the needs of diverse patient populations.
- Despite little formal educational training, athletic training educators exhibited moderate to high levels of cultural competence and self-reported teaching efficacy.
- Athletic training educators may not be adequately prepared to teach cultural competence in athletic training programs, so further investigation of nondidactic cultural competence education avenues is needed.
- Further, barriers to the recruitment and retention of diverse athletic training faculty should be examined.

## INTRODUCTION

The United States is growing increasingly diverse. In 2018, minorities accounted for 39.30% of the population.<sup>1</sup> On a smaller scale, the National Collegiate Athletic Association (NCAA) reported that 32.84% of its student-athletes identified as ethnic minorities during the 2017–2018 academic year.<sup>2</sup> In comparison, diversity within the athletic training profession is lacking, with only 16.85% of total National Athletic Trainers' Association (NATA) membership identifying as ethnically diverse.<sup>3</sup> It is important to note that these statistics also include Hispanic or Latinx persons, which members of any race can identify as. Despite the diversity gap, the NATA has recently acted to reinforce diversity's professional importance and acknowledged it as essential to providing patient-centered care. These actions include publishing germane articles in the *NATA News*,<sup>4,5</sup> theming National Athletic Training Month 2018 as "Compassionate Care for All," and including culture-related mandates in the 2020 Curricular Content.<sup>6</sup>

*Cultural competence*, the process in which clinicians investigate and incorporate the cultural needs of the patient during all facets of care, is necessary to better care for diverse patients.<sup>7,8</sup> Further, it is crucial to understand that cultural competence is a journey. One does not reach a final state of unequivocal competence. In fact, by understanding that it is impossible to know all there is to know about different persons and cultures, one realizes and accepts that cultural competence is a continuum and requires continuous personal growth.<sup>8</sup> It is also necessary to note that culture is a broad term and encompasses far more than race and ethnicity. Other identities such as sexuality, geographic location, religion, language, and ability constitute a person's cultural identity. Thus, it is important to understand how these factors affect patient needs and inform our clinical decisions.

Athletic training has begun to realize the importance of diversity and inclusion to patient-centered care, yet athletic trainers may not be as culturally competent as those in comparable professions like nursing<sup>9</sup> and occupational therapy.<sup>10</sup> Because the athletic training profession acknowledges that cultural competence allows for the provision of

equitable, patient-centered care, athletic training educators must also value diversity and inclusion within their athletic training programs to prepare culturally competent clinicians.

In summary, athletic training programs are where most clinical skills are imparted. Skills that the Commission on Accreditation of Athletic Training Education (CAATE) mandates should include cultural competence. However, such skills may be ignored as evidence suggests that athletic trainers<sup>11</sup> and athletic training students<sup>12</sup> lack high levels of cultural competence and experience incongruence between perceived cultural competence and exhibited culturally competent behaviors. Although barriers to cultural competence have not yet been examined in athletic training, nursing research indicates they include lack of knowledge and educational preparation,<sup>13–15</sup> overt racism,<sup>15,16</sup> organizational climate,<sup>14,16</sup> and limited experience with diverse populations.<sup>17,18</sup> Though all barriers warrant further investigation, the focus of this study pertains to the lack of knowledge and educational preparation. Considering athletic training educators are the bedrock of athletic training programs and are responsible for teaching concepts like cultural competence, the purpose of this study was to investigate the cultural competence of athletic training educators and their preparedness to teach cultural competence concepts.

## METHODS

### Study Design

We used a cross-sectional survey design to collect data. The survey consisted of 7 sections and had 65 items in total.

### Procedures

Program director information from CAATE-accredited athletic training programs was collected from publicly accessible databases and compiled into a single spreadsheet (Microsoft Excel, Redmond, WA). The primary investigator e-mailed program directors with information regarding the study background and purpose. The e-mail also included a link to the survey and a request asking participants to forward the e-mail to others meeting the inclusion criteria. Follow-up e-mails were sent 4 and 8 weeks after the initial e-mail to remind prospective participants to complete the survey and recruit others who fit the inclusion criteria.

### Participants

Participants must have been the primary instructor of at least 1 CAATE-accredited entry-level athletic training program course within the last 12 months (ie, past academic year) to be included in the study. There were no exclusionary factors. The final study sample included 90 participants (women = 60 and men = 30); no participants identified as transgender, gender-fluid or gender nonconforming, or other. Nearly 6% (n = 5/90, 5.56%) identified as LGBTQIA+ (lesbian, gay, bisexual, transgender, queer, intersex, or asexual). All districts were represented in the sample. Table 1 illustrates participants'

**Table 1. Participant Years Teaching in Athletic Training Programs, Certified as an Athletic Trainer, and Practicing as an Athletic Trainer**

Category	Mean ± SD	Range
Teaching	11.80 ± 7.08	1.00–30.00
Certified	19.08 ± 8.04	5.00–41.00
Practicing	13.25 ± 8.29	2.00–40.00

teaching, certification, and practice history; Tables 2 and 3 list participants' races and ethnicities, respectively. Due to the nature of our sampling methods (ie, asking participants to recruit other participants), it is impossible to calculate a response rate.

### Instrument Description and Validation

The Cultural Competence Assessment (CCA) is an instrument designed to measure cultural competence levels across various professions and educational achievement.<sup>19</sup> Consisting of 30 questions, the CCA has 3 subscales: cultural diversity experience (CDE), cultural awareness and sensitivity (CAS), and cultural competence behaviors (CCB). The CDE subscale assesses how many different racial, ethnic, and special population groups with which the participant has interacted in the past year. The goal of the CAS subscale is to assess the participant's attitudes toward and sensitivity of different cultures encountered while teaching or providing care or both. To this end, participants are given statements and asked to rate their agreement with each statement on a 7-item Likert scale from *strongly agree* to *strongly disagree*. An example of statements in the CAS subscale include, "Race is the most important factor in determining a person's culture." The CCB subscale is meant to assess how often a participant performs various culturally competent behaviors such as, "I use a variety of sources to learn about the cultural heritage of other people." The CCB is also scored using a 7-item Likert scale ranging from *always* to *never*. The CCA and each of its subscales have high internal consistency with an overall Cronbach  $\alpha = 0.89$  and CAS and CCB Cronbach  $\alpha = 0.75$  and  $0.91$ , respectively.<sup>19</sup> The authors received permission to use the CCA in this study.

In addition to assessing athletic training educators' cultural competence, the survey had 4 additional subsections: consent, demographics, barriers, and self-efficacy. The consent subsection consisted of a single question confirming participants' consent to enroll in the study and complete the survey. The demographics subsection contained 21 questions that gathered information regarding participant race, eth-

**Table 2. Participant Race**

Race	Frequency (%)
Asian	1 (1.11)
Black	1 (1.11)
White	86 (95.56)
American Indian	0 (0.00)
Hawaiian or Pacific Islander	0 (0.00)
Other	0 (0.00)
Two or more races	2 (2.22)

**Table 3. Participant Ethnicity**

Ethnicity	Frequency (%)
Hispanic or Latinx <sup>a</sup>	1 (1.11)
Non-Hispanic or Latinx	79 (87.78)
Prefer not to answer	2 (2.22)
Two or more ethnicities	1 (1.11)

<sup>a</sup> Latinx is a gender-neutral term that encompasses all persons who identify as being of Latin descent.

nicity, gender, NATA district, teaching and clinical experience, institution and program characteristics, and cultural competence educational background. Not all participants were asked all demographic questions. For example, participants were only asked to provide the religious or spiritual affiliation of their teaching institution if they previously affirmed their institution had such an affiliation. Three questions comprised the barriers subsection, which asked participants what barriers they think contribute to the prevention of athletic training students and certified athletic trainers from becoming culturally competent and providing culturally competent care and whether their athletic training students are required to demonstrate foreign language competency. Foreign language competency was investigated as communication barriers contribute to health disparities and negatively affect patient-provider interactions.<sup>7,20</sup> The last subsection of the instrument was the self-efficacy subsection, which consisted of 10 questions and provided information about participants' preparedness to teach and effectiveness at teaching cultural competence and related concepts to athletic training students. Information gleaned in this subsection included participants' feelings toward teaching cultural competence (ie, preparation, comfort, confidence, possession of adequate knowledge), if they have sufficiently prepared their students to practice cultural competence and provide culturally competent care upon graduation and certification, and ways they incorporate and teach cultural competence and related concepts (ie, diversity, inclusion, and equity) in their classrooms. Educator preparedness was defined as the extent to which educators possess the proper self-reported educational background (eg, training), confidence, and comfort teaching cultural competence concepts.

Though the CCA has been previously validated and was not edited for use in this study, we felt it important to establish the face validity of the instrument in its entirety. Therefore, we sent the complete instrument, including the prevalidated CCA and author-created consent, demographic, barrier, and self-efficacy sections to 4 athletic training educators meeting the inclusion criteria for validation. These individuals were chosen as pilot participants because they met the inclusion criteria and had various amounts of experience with both cultural competence and qualitative research. Pilot participants completed the survey and returned suggestions that were reviewed by the authors; no changes were adopted because participants' suggestions pertained to the CCA, which we were not able to edit. The final survey was disseminated using Qualtrics (Provo, UT), and all data were collected anonymously. This study was approved by the Temple University Institutional Review Board prior to data collection.



**Table 4. Participant Cultural Competence Assessment Scores and Comparison with Certified Athletic Trainers and Athletic Training Students**

Sample	Dimension, Mean ± SD		
	Overall <sup>a</sup>	CAS	CCB
Educators	5.33 ± 0.66	6.08 ± 0.58	4.58 ± 1.00
Certified <sup>b</sup>	4.80 ± 1.51	5.65 ± 0.52	3.95 ± 1.51
Students	NP	5.66 ± NP	3.76 ± NP

Abbreviations: CAS, cultural awareness and sensitivity; CCB, cultural competence behaviors; NP, not provided.

<sup>a</sup> Scores range from 1 to 7, with a higher score designating higher levels of cultural competence.

<sup>b</sup> Certified athletic trainers, which may encompass athletic training educators.<sup>11</sup>

### Data Analysis

Prior to analysis, survey submissions were examined and data from submissions not reaching 50% completion were removed. These participants would not have completed the CCA, barriers, or self-efficacy subsections in any capacity. Thus, their limited responses did not contribute to the objectives of the study and resulted in their removal prior to analysis. One hundred one submissions were submitted and included in data cleaning. Data cleaning consisted of removing 1 submission due to failure to consent and 10 submissions for not meeting completion criteria. Ninety survey submissions were included in final analysis, yielding a completion rate of 89.11% (n = 90/101), though some analyses may not have responses from all 90 participants. SPSS version 25 (IBM Corp., Armonk, NY) was used for all analyses.

We used descriptive statistics to calculate CAS and CCB scores by averaging participants' responses to items in those domains. This resulted in individual CAS and CCB scores ranging from 1 to 7, with the higher score designating higher levels of cultural competence. We then calculated overall cultural competence scores by averaging each participant's CAS and CCB scores. Additionally, we used a paired-samples *t* test to determine if CAS and CCB scores differed significantly.

Frequencies were used to describe the number of faculty who have had general or athletic training-specific diversity or cultural competence training; feel prepared, comfortable, and confident teaching cultural competence concepts; and believe they possess adequate knowledge about cultural competence (Table 4).

### RESULTS

Cultural competence assessment survey scores—both overall and within the individual subscales—ranged from 2.29 to 7.00 on a 7.00 scale, with higher scores indicating greater cultural competence. Athletic training educators' overall cultural competence score was 5.33/7.00 ± 0.66, whereas their CAS and CCB subscale scores were 6.08/7.00 ± 0.58 and 4.58/7.00 ± 1.00, respectively. A paired-samples *t* test indicated athletic training educator CAS scores were significantly different from CCB dimension scores ( $t(89) = 14.59, P < .001$ ). From the CDE subscale, when asked, "How competent do you feel

working with people who are from cultures different from your own," 30.33% (n = 27/89) of participants felt very competent and 64.04% (n = 57/89) felt somewhat competent.

Eighty percent of participants (n = 72/90) reported having participated in general (ie, nonathletic training specific) diversity or cultural competence training. However, only 45.56% (n = 41/90) of participants have participated in athletic training-specific diversity or cultural competence training. An even smaller minority (n = 19/90, 21.11%) reported being taught cultural competence concepts during their professional education.

A small majority of participants (n = 51/90, 56.67%) reported feeling prepared to teach cultural competence concepts. Slightly more participants (n = 52/90, 57.78%) reported feeling confident teaching cultural competence concepts, and 74.44% (n = 67/90) reported feeling comfortable teaching cultural concepts. Of note was that less than half of participants (n = 44/89, 49.44%) thought they possessed adequate knowledge of cultural competence concepts.

### DISCUSSION

Cultural competence is important to the delivery of equitable health care.<sup>7,13,21</sup> Thus, athletic training has slowly incorporated cultural competence into its professional standards and expectations. Despite this, athletic training students<sup>12</sup> and certified athletic trainers<sup>11</sup> may practice with lower levels of cultural competence than expected. Athletic training educator, athletic trainer, and athletic training student cultural competence scores are compared in Table 4. Nynas<sup>12</sup> did not report athletic training student overall cultural competence scores nor the standard deviations for the CAS and CCB subscale scores; therefore, that information is not included. Additionally, Marra<sup>11</sup> studied certified athletic trainers, which encompasses athletic training educators; therefore, there exists a possibility that our samples overlap. Regardless, we feel it beneficial to provide the information to afford the most robust comparison of available data.

Athletic training educators exhibited similar cultural competence patterns, meaning they scored significantly higher on the CAS subscale than the CCB subscale. This indicates greater cultural awareness but reduced capacity to use that awareness to inform clinical behaviors. Overall, athletic training educators self-reported moderate to high levels of cultural competence.

Only 21.11% (n = 19/90) of respondents reported being taught cultural competence during their professional education. Compared with nursing, a study of 170 nursing faculty from 25 states found that 83.53% (n = 142/170) were taught cultural content during their professional preparation.<sup>9</sup> Despite possessing less training than nursing faculty, athletic training educators have received more training than certified athletic trainers. A 2010 study of certified athletic trainers found that only 53.80% (n = 1576/2927) had previous diversity training and 89.70% (n = 1712/1908) reported that training was not specific to athletic training.<sup>11</sup>

Interesting enough, most athletic training educators felt prepared, comfortable, and confident teaching cultural competence concepts, yet less than half (n = 44/89, 49.44%)

felt they possessed adequate knowledge about cultural competence, were taught cultural competence during their professional education ( $n = 19/90$ , 21.11%), or received diversity/cultural competence training specific to athletic training ( $n = 41/90$ , 45.56%). These findings present a preparation or efficacy paradox that should be investigated to understand where participants' perceptions of preparedness originate since they do not appear to be rooted in formal or didactic education. This paradox is further supported by research that found nursing faculty had more transcultural nursing and cultural competence education than athletic training educators, yet they still felt unprepared,<sup>16,22</sup> unconfident,<sup>17</sup> and uncomfortable<sup>22</sup> teaching cultural competence concepts to nursing students.

Perhaps this paradox may be explained through other means such as exposure to and experience working with diverse groups, educational opportunities unrelated to athletic training or commitments relevant to cultural competence and pertinent topics. Further, some educators, noting their lack of formal education, may have chosen to investigate and learn about cultural competence on their own, resulting in what only appears to be unexplained self-efficacy. Moreover, some respondents may feel they will never possess adequate knowledge about cultural competence, even in possession of formal or informal education. Thus, they understand cultural competence to be a continuum with ever-present opportunity for knowledge expansion and personal improvement. Despite these valid alternative routes to cultural competence knowledge, there exists literature in support of formal cultural competence education (eg, didactic courses, professional development).<sup>12,23–25</sup> Thus, to better understand athletic training educators' teaching preparedness and efficacy, both formal and informal avenues should be examined.

Demographically, it is worth acknowledging that 66.67% of respondents ( $n = 60/90$ ) identified as women; 10.79% higher than the percentage of NATA members who identify as women (55.88%)<sup>3</sup> and 17.47% higher than the percentage of postsecondary American women faculty (49.20%).<sup>26</sup> The historical exclusion of women from the American professorial body may have made women more likely to complete the survey since they identify with and have traditionally been part of a minority culture, perhaps inflating the representation of women in the sample.

Similarly, 95.56% ( $n = 86/90$ ) of participants identified as white, whereas a 2016 national survey of the race and ethnicity of full-time, postsecondary faculty found only 76% of respondents identified as white.<sup>27</sup> Although white-identifying persons may be overrepresented in our sample, it is difficult to draw conclusions and make comparisons due to the various definitions and classifications of race and ethnicity. For example, CAATE collects and reports both race and ethnicity,<sup>28</sup> whereas the NATA reports only ethnicity.<sup>3</sup> Further, the ethnicity options are different in both organizations. We collected race and ethnicity in accordance with CAATE reporting standards. However, moving forward, it may be beneficial to consider redefining race, ethnicity, and gender standards to align with contemporary definitions and allow for a more robust representation of organization membership and research samples.

## LIMITATIONS

Although our study extends current knowledge about cultural competence in athletic training and serves to inform future research germane to athletic training cultural competence curricula, it is not without its limitations. Caution should be taken when generalizing results due to the small sample size. Further, the CCA is not specific to athletic training; therefore, it may not be the best instrument to measure and assess athletic training cultural competence. This is especially evident since participants reported moderate to high levels of cultural competence but lacked proper training and felt they did not possess adequate knowledge about cultural competence. Additionally, as with most survey methods, social desirability may have affected participants' ability to answer honestly.

## CONCLUSIONS

Though athletic training as a profession has begun to recognize and appreciate cultural competence as an asset to care, little research exists examining the cultural competence of stakeholders and how cultural competence has been incorporated into athletic training curricula. Our study is the first, to our knowledge, to investigate the self-perceived cultural competence levels and instructional efficacy of athletic training educators. The results of this study indicate that athletic training educators are mostly white women with moderate to high levels of cultural competence and greater cultural competence than certified athletic trainers and athletic training students. Additionally, the findings suggest a need for inquiry into the informal avenues through which athletic training educators gain cultural competence as a means of explaining the preparation or efficacy paradox.

Future research should include efforts to develop and validate a cultural competence instrument specific to athletic training. Further, the paradox found in this study, and other avenues to cultural competence including clinical education, necessitates further investigation. Additionally, exploring barriers to persons of marginalized groups, including racial, ethnic, nationality, religious, and sexuality (ie, LGBTQIA+) minorities from obtaining faculty positions is warranted given the lack of diversity within the professoriate.

## Acknowledgments

We would like to thank and acknowledge Dr Ardith Door-enbos for allowing us to use the Cultural Competence Assessment Survey for this study.

## REFERENCES

1. Quick facts: United States. United States Census Bureau Web site. <https://www.census.gov/quickfacts/fact/table/US/PST045218>. Published 2018. Accessed January 27, 2020.
2. Student-athletes: 2017–2018 overall figures. National Collegiate Athletic Association Web site. <http://web1.ncaa.org/rgdSearch/exec/saSearch>. Published 2018. Accessed January 27, 2020.
3. Ethnicity demographic data—9/14/2018. National Athletic Trainers' Association Web site. <https://www.nata.org/sites/default/files/ethnicity-demographic-data-sept-2018.pdf>. Published September 14, 2018. Accessed January 27, 2020.
4. Grantham J. Cultural competence and diversity in athletic training. *NATA News*. 2015;27(2):10–12.

5. Volberding J, Meyer C, Wilcoxson A, Moffit D, Harriell K, Nguyen Y. Why patient values matter in clinical decision making. *NATA News*. 2017;29(9):22–23.
6. 2020 standards for accreditation of professional athletic training programs. Commission on Accreditation of Athletic Training Education Web site. <https://caate.net/wp-content/uploads/2019/02/2020-Standards-Final-2-20-2019.pdf>. Published January 9, 2018. Accessed January 27, 2020.
7. Brach C, Fraser I. Can cultural competence reduce racial and ethnic health disparities? A review and conceptual model. *Med Care Res Rev*. 2000;57(Suppl 1):181–217.
8. Campinha-Bacote J. The process of cultural competence in the delivery of healthcare services: a model of care. *J Transcult Nurs*. 2002;13(3):181–184.
9. Kardong-Edgren S. Cultural competence of baccalaureate nursing faculty. *J Nurs Educ*. 2007;46(8):360–366.
10. Suarez-Balcazar Y, Rodawoski J, Balcazar F, et al. Perceived levels of cultural competence among occupational therapists. *Am J Occup Ther*. 2009;63(4):498–505.
11. Marra J, Covassin T, Shingles RR, Canady RB, Mackowiak T. Assessment of certified athletic trainers' levels of cultural competence in the delivery of health care. *J Athl Train*. 2010;45(4):380–385.
12. Nynas SM. The assessment of athletic training students' knowledge and behavior to provide culturally competent care. *Athl Train Educ J*. 2015;10(1):82–90.
13. Betancourt JR, Green AR, Carillo JE, Owusu Ananeh-Firemping II. Defining cultural competence: a practice framework for addressing racial/ethnic disparities in health and healthcare. *Public Health Rep*. 2003;118:293–302.
14. Reese DJ, Beckwith SK. Organizational barriers to cultural competence in hospice. *Am J Palliat Care*. 2015;32(7):685–694.
15. Taylor R. Addressing barriers to cultural competence. *J Nurses Staff Dev*. 2005;21(4):135–142.
16. Nairn S, Hardy C, Harling M, Parumal L, Narayanasamy M. Diversity and ethnicity in nurse education: the perspective of nurse lecturers. *Nurse Educ Today*. 2012;32(3):203–207.
17. Holland AE. The lived experience of teaching about race in cultural nursing education. *J Transcult Nurs*. 2015;26(1):92–100.
18. Montenery SM, Jones AD, Perry N, Ross D, Zoucha R. Cultural competence in nursing faculty: a journey, not a destination. *J Prof Nurs*. 2013;29(6):e51–e57.
19. Doorenbos AZ, Schim SM, Benkert R, Borse NN. Psychometric evaluation of the cultural competence assessment instrument among healthcare providers. *Nurs Res*. 2005;54(5):324–331.
20. Mazor SS, Hampers LC, Chande VT, Krug SE. Teaching Spanish to pediatric emergency physicians: effects on patient satisfaction. *Arch Pediatr Adolesc Med*. 2002;156(7):693–695.
21. Khoury A, Mendoza A, Charles A. Cultural competence: why surgeons should care. *Bull Am Coll Surg*. 2012;97(3):13–18.
22. Starr S, Shattell MM, Gonzales C. Do nurse educators feel competent to teach cultural competency concepts? *Teach Learn Nurse*. 2011;6(2):84–88.
23. Singleton JK. An enhanced cultural competence curriculum and changes in transcultural self-efficacy in Doctor of Nursing Practice students. *J Transcult Nurs*. 2017;28(5):516–522.
24. Majumdar B, Browne G, Roberts J, Carpio B. Effects of cultural sensitivity training on health care provider and patient outcomes. *J Nurs Scholarsh*. 2004;36(2):161–166.
25. Hawala-Drury S, Hill MH. Interdisciplinary: cultural competency and culturally congruent education for millennials in health professions. *Nurse Educ Today*. 2012;32(7):772–778.
26. Finkelstein MJ, Conley VM, Schuster JH. Taking the measure of faculty diversity. [https://www.tiaainstitute.org/sites/default/files/presentations/2017-02/taking\\_the\\_measure\\_of\\_faculty\\_diversity.pdf](https://www.tiaainstitute.org/sites/default/files/presentations/2017-02/taking_the_measure_of_faculty_diversity.pdf). Published April 2016. Accessed June 18, 2019.
27. Characteristics of postsecondary faculty. U.S. Department of Education, National Center for Education Statistics Web site. <https://nces.ed.gov/fastfacts/display.asp?id=61>. Published 2018. Accessed April 30, 2019.
28. 2015–2016 CAATE Analytics Report. Commission on Accreditation of Athletic Training Education Web site. [https://caate.net/wp-content/uploads/2017/09/2015-16-CAATE-Analytics-Report\\_VF.pdf](https://caate.net/wp-content/uploads/2017/09/2015-16-CAATE-Analytics-Report_VF.pdf). Published 2017. Accessed April 1, 2019.