Elevating Cultural Humility in Practice: Perspectives From Hispanic/ Latino RDNs

ELEVATING CULTURAL HUMILITY IN PRACTICE: PERSPECTIVES FROM HISPANIC/ LATINO RDNS

By

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Abstract

Objective:
To assess the experiences of Hispanic/Latino Registered Dietitian Nutritionists (RDNs) in serving Hispanic/Latino communities and translate these insights into culturally humble strategies for non-Hispanic/Latino RDNs.

Background:
As the Hispanic/ Latino population grows, so does the prevalence of nutrition related chronic diseases. Research suggests that these disparities are linked to dietary acculturation, limited healthcare access, and family dynamics. Cultural humility—a lifelong commitment to self-evaluation and learning—offers a approach to improving care.

Methods:
A 16-question qualitative and quantitative online- anonymous survey was distributed to practicing RDNs who identify as Hispanic/Latino within the member interest group (MIG) for Latinos and Hispanics in Nutrition and Dietetics (LAHIDAN) of The Academy of Nutrition and Dietetics (AND). A total of 30 participated in the voluntary survey via Qualtrics. The responses were analyzed to identify common themes in patient challenges, provider barriers, and effective counseling strategies. Frequencies and thematic coding were used to summarize findings.

Results:
Obesity (81.8%) and type 2 diabetes (77.3%) were the most commonly seen conditions. Major patient barriers included socioeconomic challenges (66.6%) and cultural beliefs (61.1%). RDNs cited limited health literacy (61.1%) and a lack of culturally appropriate resources (61.1%) as top challenges. Participants emphasized the importance of patient-centered care, cultural humility, and bilingual, tailored education materials.

Conclusion:
Findings highlight the need for cultural humility training that moves beyond translated materials to address nuanced social, linguistic, and cultural dynamics.

Introduction

The US Census Bureau defines “Hispanic or Latino” as an individual of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture of origin, regardless of race.[1] According to the American Community Survey (ACS) of the US census Bureau, in 2022 the Hispanic/Latino population in the US was nearly 64 million, about 19% of the US population. The states with the highest population of Hispanics/Latinos were Puerto Rico, New Mexico, California, Texas, Arizona, Nevada, Florida, New Jersey, and New York.[2] The ACS also reports that Hispanics/ Latinos are the second largest ethnic group in the US with the largest subgroups being Mexican, Central American, Puerto Rican, South American, Cuban, and Dominican.[2] In fact, it is predicted that by 2060 the Hispanic/Latino population of the US is expected to reach about 28% of the total population.[3] Similarly, in the state of Georgia, Hispanics/Latinos are the third largest population (approximately 10%), with Mexican being the largest subgroup (more than half) followed by Puerto Rican, South American, Guatemalan, and Salvadorian.[4] As the Hispanic/Latino population in the US increases, there also seems to be an increased prevalence of

rates of nutrition related chronic diseases.[3,5,6] The current research suggests that these disparities are exacerbated by multiple factors such as dietary acculturation to the westernized diet, barriers to access to healthcare, and influence of family dynamics.[5,7] These disparities underscore the need for culturally responsive healthcare interventions and dietary recommendations tailored to their unique cultural, social, and economic contexts. This literature review intends to summarize the prevalence of nutrition related chronic illnesses in Hispanic/Latino Americans, barriers to health care, challenges in applying generalized dietary guidelines, and the role of cultural humility in fostering effective nutrition interventions.

Increased Prevalence of Nutrition-Related Chronic Illnesses in Hispanic/ Latino Americans

Within the Hispanic/Latino population there has been an increased prevalence of noncommunicable chronic diseases such as obesity, type 2 diabetes (T2DM), prediabetes, metabolic associated steatotic liver disease (MASLD), cardiovascular disease (CVD), and dyslipidemia.[2,8-11] Statistically, in Georgia, the leading chronic nutrition related illnesses among Hispanics/Latinos are obesity, MASLD, hypertension (HTN), and T2DM.[4] These non-communicable diseases are some of the leading causes of death worldwide, accounting for about 60% of deaths.[12] This is important to note since the modifiable factors that can prevent or manage these conditions are lifestyle change and diet.[12] The etiology of these non-communicable chronic diseases is multifactorial and intricate.[13] Potential and researched factors include age, family history, genetic predisposition, current weight, physical activity, lifestyle habits (such as smoking or drinking alcohol), and diet.[13] For instance, the pathogenesis of MASLD is associated with increased intakes of calorically dense foods, saturated fats, and trans fats as these foods contribute to lipid accumulation in the liver.[14] Increased intake of added sugars also plays a role in the pathogenesis of MASLD because there is an association with insulin resistance and lipogenesis in the liver.[14] Statistically, Hispanics/Latinos of Mexican descent may be at a greater risk for MASLD because of their reported increased intakes of sugar sweetened beverages and processed meats.[14]

Studies suggest that the dietary acculturation of Hispanics/Latinos in the US plays a role in their increased rates of chronic illness.[3,7] Dietary acculturation is a factor that has been associated with a decrease in dietary quality. In the US, dietary acculturation is defined as the process of individuals adopting diet related values, practices, and beliefs associated with the US.[15] For instance, Wang et al. used data from the Hispanic Community Health Study/Study of Latinos (HCHS/SOL) to develop a dietary acculturation pattern from 14,172 participants based on two 24-hour dietary recalls.[16] The study examined the association between dietary acculturation with incidence of CVD and the gut microbiota. Wang et al. found that higher dietary acculturation was associated with an increased risk of CVD, possibly due to changes in the gut microbiota, as a westernized diet is generally lower in whole grains, beans, fruits, beans and higher in refined grains. The typical western diet or standard American diet (SAD) is high in saturated fat, red or processed meats, processed and refined carbohydrates, sugar sweetened beverages, and low in fiber rich foods such as fruits and vegetables.[17,18] In comparison traditional Hispanic/Latino Mesoamerican diets (present day central Mexico, Belize, Guatemala, parts of Honduras, El Salvador, Nicaragua, Costa Rica, and Panama) are seen as “healthy,” as they are generally rich in plant-based foods like grains, legumes, vegetables, fruits, tubers, and minimal amounts of animal-based foods.[19,20] An ancillary study to an observational cross sectional study observed the 24-hour dietary recalls of 280 Hispanic adults (Mexican descent) and investigated the association between

the traditional Mexican diet and risk of hepatic steatosis, finding that the more the individual adhered to a Mexican diet, the risk of developing of hepatic steatosis decreased.[19]

Research also indicates that Hispanics/Latinos who stay longer in the US are at higher risk of developing a chronic illness, indicating that they may have more exposure to an obesogenic environment and food.[3,5,7,21] For instance, in the HCHS/SOL, a cohort study of 14,099 US Hispanics/ Latinos ages 18-74 years, observed the dietary patterns (DPs) of these groups to identify overarching dietary patterns based on length of stay in the US.[5] The results of the study found an association between years living in the US and DPs, particularly "Burgers, Fries, & Soft Drinks and White Rice, Beans, & Red Meats." For example, individuals of Mexican origin had similar DPs as seen in previous studies (consuming more traditional foods such as rice, beans, and red meats), individuals of Puerto Rican origin, however, were seen to have increased DPs for "Burgers, Fries, and Soft Drinks," which differed from the results from the previous Boston Puerto Rican Health Study.[22] A few other studies proposed that these inconsistencies between Puerto Ricans and Mexicans could be due to factors such as age and nativity.[22-24] The results of the study may have reflected that older Hispanic/Latino immigrant individuals, compared to younger immigrants, may be more likely to adhere to a traditional diet of white rice, beans, & red meats, whereas Hispanics/Latinos born in the US may have dietary profiles with higher intakes of foods known to be related to chronic disease.[7,24] Compared to findings from the Boston Puerto Rican Health Study, individuals that identified as Puerto Rican in the HCHS/SOL were relatively younger and mostly US born.[5,22] In general, the study found that greater length of stay in the US was associated with lower DP healthfulness across all heritage groups which was reflected by lower adherence to traditional DPs ("Rice, Beans, and Red Meats") and higher correspondence to unhealthier western DPs ("Burgers, Fries, and Soft Drinks").[5]

Barriers to Accessing Healthcare

There are also many barriers that the Hispanic/Latino community face to have access to adequate health care. These factors can be categorized into groups such as environmental, cultural, and economic.[25,26] These barriers can be further subdivided into language barriers, geographical barriers, socioeconomic challenges, and health literacy. Language barriers significantly hinder effective communication between healthcare providers and Hispanic/ Latino patients, leading to poorer health outcomes.[27] Health literacy is also a critical factor; bilingual programs for patients, meaning the use of bilingual providers or educators, have shown promising improvements in health literacy and engagement among Latino communities, yet gaps remain in their implementation and effectiveness.[27]

Environmental barriers

Environmental barriers include factors such as household responsibilities, lack of childcare, insufficient free time, lack of social support, living in unsafe neighborhoods, and inaccessibility to exercise facilities or adequate nutrition sources.[28,29] For example, a qualitative assessment conducted with ten focus groups for seventy-five Latina women (forty years or older) residing in low-income communities of Houston, Texas aimed to assess their nutrition related-knowledge, attitudes, and behaviors to determine the possible effectiveness of a church program to promote healthy energy balance.[29] The results of this study noted that the top barriers keeping Latina women

from being more physically active were safety concerns, limited access to resources, expenses for purchasing exercises programs, lack of motivation, cultural norms, and not wanting to miss novelas. Despite this study being small and involving mainly older Latina women, its findings are important to consider when determining interventions to promote physical activity amongst the Latino population. Similar themes, such as lack of community support and inaccessibility to safe exercise facilities, may be more common, therefore more research should be completed to generalize the findings. Other research has highlighted the fact that Latina women have expressed their desire for educational/ motivational support groups and a need for easily accessible exercise facilities and childcare.[30] A similar study reported that social support is very effective in promoting lifestyle changes amongst Latinas. The study found that Latina women were 2.5 times more likely to participate in physical activity if they observed a member of their community participating in exercise.[30]

Physical barriers

Other studies have also suggested that the physical environment of Hispanics/Latinos is a notable barrier when it comes to accessing health care or fostering healthy environments. For instance, in the HCHS/SOL, Hispanics/Latinos from San Diego, California were surveyed twice over the span of six years to investigate the association between health inequities and physical activity with neighborhood environments compared to other populations.[31] The results of this study reflected that for individuals that were residing in more developed neighborhoods (more retail density or recreation activity) had higher rates of moderate to vigorous physical activity (MVPA) and participated in more physically active transportation such as walking by 12-22%. Additionally, those individuals that resided in areas with more green space or recreational parks were 14-16% more engaged in recreational MVPA. Overall, the study found that Hispanic/Latino adults that resided in neighborhoods with physically active built environments were more likely to engaged in MVPA. Since the participants of this study were mainly of Mexican descent this does not guarantee that the results are generalizable to other Hispanic/Latino subgroups, however the findings may suggest a need to consider physical environment of Hispanics/Latinos as a significant barrier that hinders them from accessing health care or practicing healthful habits, such as physical activity.

Another physical barrier that hinders access to adequate nutrition and health care is limited transportation, such as: lack of resources (public transportation or personal vehicles) and far proximity of nutrition sources.[32,33] Additionally, according to the Pew Research Center, about 48% of Hispanic/Latinos in the US claim to have inadequate access to quality medical services due to their geographical standing which is a main reason for their worse health outcomes.[34]

Food Insecurity

The status of food security is also another barrier that the Hispanic/Latino population encounters trying to maintain adequate nutrition status.[35] According to the US Department of Agriculture (USDA), food insecurity is a term used to describe areas that have limited or uncertain availability of nutritionally adequate and safe food or limited or uncertain abilities to acquire acceptable food in socially acceptable manners.[36] Food insecurity has affected Hispanic/Latinos disproportionately, as of 2020 food insecurity was higher in the Hispanic/ Latino population than

in those who identified as White, non-Hispanic/Latino, affecting 7.1% and 2.2% of the population, respectively.[37]

Minimal research has been performed to assess the social determinants of health (SDOH) associated with food insecurity among Hispanics/Latinos. According to Healthy People 2030, SDOH are factors in the environment of where individuals are born, live, work, play, worship, and age that affect their health risks, health outcomes, and quality of life (QoL).[38] These SDOH are grouped into 5 domains of economic stability, educational access and quality, health care access and quality, neighborhood and built environment, and social and community context. Food insecurity overlaps many categories of the SDOH, such as economic stability and health care access and quality, making it challenging to pinpoint one single intervention to approach this problem as it is multifaceted. The socio-ecological model (SEM) is a theoretical model that focuses on making the individual the center focus of the environment to better observe how multiple factors (such as sociocultural environment) contribute to issues such as food insecurity.[39] A narrative review including Hispanic/Latino households with children less than three years of age used the SEM and reported that proximity to food purchasing and distribution locations (such as supermarkets, grocery stores, SNAP and WIC-eligible stores) have an influence on the healthy food availability and dietary intake.[40] Additionally, the authors highlighted that their findings aligned with previous studies that suggested that areas with predominately racial minorities had lower socioeconomics and less accessibility to supermarkets than predominately white neighborhoods.[34,41]

Cultural Barriers

Cultural factors also play a role in management of chronic illness for this population, especially obesity.[7,25,42] In a 2021 cross sectional analysis that used data from NHANES (2011-2016), including surveys and 24-hour dietary recalls for 1,039 Hispanic/Latino adults with children (ages 6-17 years), Overcash et al. examined the dietary patterns and dietary quality between males and females.[17] Although the data from this study was mostly self-reported, such as dietary intakes and Healthy Eating Index (HEI) scores, it supported the concept that parental dietary practices and habits had a heavy influence on the health and dietary practices of their children. Notably, gender norms played a big role in the dietary practices for both men and women, with women having higher intakes of total vegetables and lower intakes of protein in comparison to men.[17] Traditionally, amongst the Hispanic/ Latino population, societal gender norms encourage women to consume more fruits and vegetables, while men are encouraged to consume more meat and fat.[43] Another similar study, looked at the parental perspectives about factors that influenced how and what they fed their children. This study consisted of four focus groups (n=36), mostly mothers of Mexican descent, reporting that their husbands and grandparents had strong influences on the dietary choices of their children and were also more likely to indulge their children with unhealthy foods, which counteracted the mothers' goals of healthy eating.[44] In another study, Mena et al observed the influence father figures in Hispanic/Latino families had on dietary choices and practices, which have previously been seen to have significant impact on nutrition choices in these families.[44] This study composed of twenty-six fathers (primarily of Mexican origin) participating in focus groups, to obtain their perspectives of the role of fathers in modeling and parenting healthy food and eating behaviors.[45] The findings highlighted that Mexican American fathers' agreed on the importance of nutrition and physical activity on their children's growth. Mena et al. reported

that fathers had supportive and unsupportive involvement when it came to reinforcing healthy eating and lifestyle changes. The parenting practices from fathers were reported as setting expectations and limits, role modeling, and managing food and activity opportunities. The results from both studies support the concept of gender norms potentially affecting how each parent models dietary behaviors for their children.[17,45] This is important for future practice and implications for RDNs to consider when facilitating nutrition interventions for Hispanic/Latino patients, such as by providing resources and suggestions that consider both father figure and mother figures roles.

Family and community are another significant cultural influence on this population as family values and opinions are often considered when making individual health decisions.[46] This societal norm, that is practiced in many Hispanic/Latino population, is known as "familismo" which emphasized the importance of family connectedness.[26] Parental influence has also been found to have a strong impact on the management of children with obesity; these influences include feeding practices, parenting style, and modeling healthy eating behaviors.[25] To effectively educate this population on health management, a family approach is very important in the treatment process.

Another common cultural tradition that may hinder access to health care is the practice of "machismo," a common gender/ societal standard in many Hispanic/Latino cultures. "Machismo" describes the role of men in society to be focused on masculinity, bravery, dominance, aggression, sexism, and reserved emotions.[47] Although, in recent research, the negative shift of masculinity has moved in a positive direction known as "caballerismo" where the male gender role is depicted with characteristics such as chivalry, bravery, and as a family provider.[47] However, "Machismo" may be more expressed in individuals with less US acculturation. On the other hand, "Marianismo" is used to describe the societal norms for female identifying individuals.[46] The role of the female in society is family/home centered, and encourages females to be passive and nurturing to respect patriarchal values.[47] The health and wellbeing of many Hispanic/Latino women is heavily influenced by the influence of male figure affecting their health outcome and access to care. In a small study that consisted of 15 in-depth interviews with health care providers who care for indigenous Hispanic/ Latina pregnant women, Carpio-Arias et al. reported that the pregnant women would only receive care if their partner (male) gave consent or was present.[48] These findings on the Hispanic/Latino cultural influence access to health care show that it is an important topic that should not be overlooked when working with this population.

Healthcare provider barriers

Other barriers limiting access to health care include health care provider related factors such as language barriers, lack of Hispanic health care providers and lack of culturally appropriate health guidelines and assessment tools. In 2013, about 4.4% of healthcare providers reported as identifying as Hispanic/Latino and in 2021, according to the Pew Research center, about 7% of US physicians identified as Hispanic/Latino.[34,49] In 2020, about 6% of the active registered dietitians (RDs) reported as identifying as Hispanic/Latino and in 2022 about 10% of working RDs in the US identified as Hispanic/Latino.[50,51] Despite the increased numbers of Hispanics/Latinos in healthcare, the numbers are still a very small percentage of the healthcare force.[50,51] The lack of Hispanic/Latino health care providers is an additional barrier in care because it may discourage

Hispanics/Latinos from receiving care or adhering to guidelines provided by non-Hispanic/Latino providers.[34,49,52]

A few studies found that when a bicultural RD gave nutrition education to lower income Latinos, the participants improved their dietary and healthy food purchasing habits.[53,54] Additionally, according to the Pew Research Center Poll, 44% of Hispanics/ Latinos surveyed, find that a major obstacle to navigating the health care system is a language barrier or cultural differences.[34] Other than reports of difficulties from being culturally different, Hispanic/Latino Americans also report feelings of not receiving the most advanced care or that their wellbeing being a low priority to health care providers.[34] This demonstrates that many Hispanics/ Latinos feel a lack of trust or support from health care providers. The lack of trust that Hispanic/ Latino individuals feel for medical providers may also stem from previous negative experiences. In fact, one third of Hispanic/ Latino adults claim they have had to speak up to receive adequate care.[34] Furthermore, about a one third of Hispanics/ Latinos also claim that they prefer receiving care from a Spanish speaking provider and about two-thirds prefer receiving care from a Hispanic/ Latino provider.[34] This dissatisfaction with current health care may hinder some individuals from actively engaging in advocating for their own health in fear of not accessing adequate care from a trusting provider, especially among Hispanic/Latinos with lower English proficiency.[26]

Economic Barriers

Another evident barrier in accessing health care for the Hispanic/ Latino population is affordability. According to the Pew Research Center, 29% of Latinos in Georgia have no health insurance and Hispanics/ Latinos are less likely than non-Hispanic/ Latino adults to receive preventative care.[4,34] In fact, Hispanics/ Latinos are more than twice as likely to be uninsured than White, non- Hispanic/ Latinos. Additionally, the rates of non-elderly Hispanics/ Latinos having health insurance has decreased from 32.7 percent in 2010 to 18.0 percent in 2022.[55] Furthermore, Hispanics/ Latinos are also less likely to use anti-obesity medications due to high costs and lack of insurance coverage.[56] This may suggests that due to a lack of health insurance coverage, the Hispanic/ Latino population is less likely to receive treatments for preventing and managing obesity related comorbidities. Socioeconomics further plays a role in hindering access to care. This may be highlighted by the observation that Hispanics/ Latinos with greater household incomes and higher educational attainment have lower rates of obesity and greater chances of weight loss success.[56,57]

The current literature suggests that there are a variety of barriers that interfere with access to health services for the Hispanic/ Latino population. Although it may be challenging to overcome every barrier above to ensure adequate care for this population, a possible route for intervention would be for healthcare providers to acknowledge these barriers, collaborate with this population, and be more culturally aware of differing situations.

Challenges with Generalized Dietary Guidelines

In health research, Hispanic/ Latino individuals are often treated as a homogenous group, however, the subgroups of this population are quite different from one another, and they often adjust and assimilate to US culture in diverse patterns from one another in a process termed segmented

assimilation.[58,59] The current Dietary Guidelines for Americans (DGAs) suggest that following a diet with a variety of fruits and vegetables, whole grains, lean protein, and reducing consumption of sugar sweetened beverages, saturated fats, and high fat/sodium foods reduces risk of the aforementioned chronic illnesses.[60] Research gaps persist in applying dietary guidelines specifically tailored for Hispanic/ Latino populations, as existing guidelines often do not account for cultural dietary practices and preferences, which can lead to ineffective health interventions. While these general dietary guidelines, such as adhering to a low sodium diet (like DASH), have been studied and shown to benefit diverse populations{Dhillon, 2022 #73}, their application in real world settings must account for cultural and dietary nuances. Tailoring interventions to reflect traditional foods and cooking methods is critical for enhancing adherence and outcomes.

When looking at current literature, most of the current dietary interventions and recommendations for Hispanics/ Latinos in the US have been done on Mexican individuals, falsely grouping together all Hispanics/ Latinos into receiving the same recommendations. In a 2019, data from a study consisting of 15,633 Hispanic/ Latino adults (ages 18-74) was pulled from the HCHS/SOL to examine and compare the adherence to the 2010 DGAs amongst differing Hispanic/ Latino subgroups.[24] The data from this study focused on major subgroups of Hispanics /Latinos such as Cubans, Dominicans, Mexicans, Puerto Ricans, Central Americans and South Americans. The largest Hispanic/ Latino subgroup represented in the study was Mexican (39%), the other major subgroups were Cubans (21%) and Puerto Ricans (17%). The study highlighted the concept that prevalence of obesity was high in this population, however it did vary by heritage. South Americans reported having the lowest prevalence of obesity while Puerto Ricans had the highest. Furthermore, the prevalence of nutrition related chronic illnesses, such as T2DM (14.8%), HTN (22.1%), and hypercholesteremia (42.4%) were common among all subgroups.[24]

Siega Riz et al used the HEI score to measure adherence to a healthful diet based on the DGAs.[24] Interestingly, this study found that the overall mean HEI score was 63.8 (out of 100) with Mexicans having the highest HEI (71) and Puerto Ricans having the lowest HEI (56). Additionally, most participants (87%) were able to adhere to the protein recommendation and obtain a maximum score for this group.[24] Other food groups where one-fourth to three-fourths of the study population achieved maximum scores on the HEI were fruits, greens, and beans.[24] When looking at adherence to whole grain recommendations, Mexicans had higher adherence (45%) than other groups such as Puerto Ricans which had the lowest adherence rates (0.81%).[24] All subgroups adhered by less than ten percent to the DGAs for poly- and monounsaturated fatty acids, except for those of Cuban heritage.[24] The study reflected that a common dietary trend amongst the groups was low adherence (below 2%) to the sodium dietary guidelines. Overall, this large cohort study highlighted that not all subgroups of Hispanics/Latinos adhere to the DGAs equally suggesting there may be discrepancies in how the information is translated or received by differing subgroups of Hispanics/ Latinos. Notably, the study found factors such older age, greater than high school education, greater than $10,000 household income, being female, Spanish language preference, being born outside the 50 US states, and having diabetes, to increase adherence to the DGAs.[24]

These differences in DPs across Hispanic/Latino subgroups reflect their diverse demographic origins and cultures, highlighting the specific foods available in each region.[61] Some of the key foods common in most Latin American countries were corn (including corn products such as tortillas), legumes (black beans, lentils, fava beans) fruits, chili peppers, vegetables (potatoes,

carrots, zucchini), rice, animal proteins, and limited dairy.[62] It would not be accurate to assume that all Hispanics/ Latinos eat these common food groups since dietary practices are variable dependent on the individual origin; therefor there is an increased need for more personalized and adapted nutrition invention where the provider collaborates with the patient to ensure improved health outcomes. For example, dietary recommendations from providers advising Hispanic/ Latino patients to follow a Mediterranean style diet to control their nutrition related chronic illness, which has been seen to be effective in preventing and management of chronic diseases such as DM, HTN, and CVD, may not be well received since it is does not typically include culturally appropriate foods.[20]

These challenges to generalize DGs for Hispanics/ Latinos is evident and reflective in past research that over-represent Mexican Americans.[3] The over generalization of Hispanic/ Latino data to be reflective of Mexican Culture brought about the concept of the "Hispanic paradox," which describes lower rates of heart disease and mortality among Mexican immigrants in low socioeconomic conditions, does not apply equally across all Hispanic/Latino subgroups.[63] Puerto Ricans, for instance, exhibit significantly worse health outcomes than Mexican Americans.[20,64] A recent review found Puerto Ricans have a lower life expectancy due to CVD, compared to Mexican or Cuban Americans.[20,64] These statistics are important to take into consideration when developing or adapting nutrition interventions for this population.

Cultural Humility in Nutrition Interventions

Cultural humility is increasingly recognized as a vital component in designing effective health interventions for Hispanic/ Latino populations.[65] It emphasizes the importance of healthcare providers recognizing and respecting cultural differences and being open to learning from their patients.[66] Unlike cultural competence, which emphasizes acquiring knowledge about specific cultural practices, cultural humility focuses on self-reflection, ongoing learning, and a willingness to adapt to the unique needs of patients.[66] Training healthcare providers to acknowledge regional and cultural diversity can significantly improve the quality of care delivered to Latino patients.

Culturally tailored interventions for Hispanics/ Latinos have demonstrated the importance of addressing language, literacy, cultural food practices, and community involvement in achieving effective health outcomes. A systematic review of diabetes prevention programs for US Hispanic adults examined twelve studies that adapted interventions by delivering education in Spanish, addressing literacy levels, incorporating Hispanic foods and recipes, utilizing peer educators/ community health workers, and integrating community input.[49] The findings of this review found that the most successful interventions for improving weight and hemoglobin A1c (HbA1c), were culturally tailored for Hispanics/ Latinos, by targeting low-literacy populations, including culturally relevant foods, addressing cultural beliefs about diet and health, involving family and Friends, and using hands-on strategies such as community gardens.

Culturally tailored screening tools also play a vital role in nutrition interventions. A 2006 study developed a food frequency questionnaire (FFQ) specifically for Mexican Americans in California, highlighting discrepancies in general FFQs.[67] While traditional FFQs often assess beverages like soda, juice, and tea, they overlook culturally specific drinks like atole or horchata, which are high in sugar and could lead to underreporting of sugar intake. In a more recent 2022

study, a new short FFQ for Mexican American Adults was developed from drawing 100 participants from the Cameron County Hispanic Cohort.[68,69] The results of this study supported the that the short FFQ can be used as tool to quickly assess the dietary patterns for Mexican American Adults. Additionally, tools such as the Nutrition Environment Measures Survey for Stores (NEM-S) have been adapted to evaluate Latino-specific food environments.[68] The NEM-S, designed to assess the availability, quality, and pricing of foods in grocery stores, was modified for use in "tiendas," Latino-focused stores.[68] This adaptation included culturally relevant foods and assessed accessibility and affordability, offering a more accurate understanding of the food environment for Hispanic/ Latino communities.

These examples underscore the importance of cultural humility in designing and implementing nutrition interventions that respect and respond to the unique needs and preferences of Hispanic/ Latino populations. A narrative review on the barriers in healthcare for Hispanic/ Latino patients with limited English proficiency aimed to review the perspectives, beliefs, and experiences of in the US healthcare system.[26] The study noted that effects of limited English proficiency, when coupled with other factors such as immigration status, cultural traditions, and socioeconomic needs, affected how Hispanic/ Latino patients perceived their quality of care. In fact, the review highlighted that care was better received if a professional interpreter was used rather than an "ad hoc" interpreter, which is often family members or friends that are not trained or experts in health care possibly skewing health outcomes. The preferred medium in which the professional interpreter is used is not specified, however, it is noted the usage of an interpreter should be accompanied with increased time spent with the patient, and better physical communication cues such as eye contact and open body language.[70] By incorporating culturally relevant strategies, interventions can improve health outcomes and foster greater community engagement.

Conclusion

It is crucial that RDs who work with the Hispanic/ Latino population provide culturally appropriate nutrition inventions to best serve the needs of the population.[71] Based on the barriers discussed, it may be more appropriate to create and adapt current nutrition education materials specific to the Hispanic/Latino population. This does not suggest directly translating current materials since it would not be culturally appropriate to recommend general dietary guidelines as the diverse Latin American countries have varied dietary preferences and practices. Instead, strategies or guidelines for working with Hispanic/Latino patients may be beneficial in creating rapport and trust possibly improving dietary adherence to goals. Creating culturally appropriate nutrition education materials or improving practice guidelines for non-Hispanic/ Latino RDs when working with this population may be able to better address and prevent the rising rates of nutrition related chronic illness, such as T2DM, MASLD, HTN, and obesity.

Project Methodology

To investigate and gain input on guidelines for cultural humility and best practices for non-Hispanic/ Latino health care providers we developed an anonymous online survey for active Hispanic/ Latino RDs. The survey was created in Qualtrics (Appendix I) and sent to Latinos and Hispanics in Dietetic and Nutrition (LAHIDAN) members to gain information about working with Hispanic/ Latino communities. The survey also highlights which topics need specific attention when counseling or educating the Hispanic/Latino population. The survey will inform the

"*Elevating Cultural Humility in practice: Tips from Hispanic/Latino RDNs* " that will guide non-Hispanic/ Latino providers to better understand the culture of Hispanic/ Latino individuals, thus improving care. See Appendix II to reference the tip sheet.

Survey

The survey aimed to capture both qualitative and quantitative information from LAHIDAN members. It was sent out on the LAHIDAN discussion board from February 10-March 30, 2025 The discussion post board is open to members only. LAHIDAN currently has 484 members which consists of 278 active practicing RDs. Thirty participants agreed to participate in the survey, though eight did not answer any questions. Twenty-two members responded to the questions, though some of the surveys were not complete. Half of the respondents (N=24) reported Mexican heritage. See Table 1 for the ethnicity of the participants. The primary population served was Mexican (54.5%) followed by Puerto Rican (22.7%). See Table 2 for the population served.

Table 1: Ethnicity of LAHIDAN Participants

Ethnicity/Nationality	**N=24 (%)**
Mexican	12 (50)
Puerto Rican	4 (16.7)
Columbian	2 (8.3)
Central American	1 (4.2)
Other/undisclosed	5 (20.8)

Table 2: Main Hispanic/Latino population served (N=22)

Hispanic/Latino group served	**Frequency (%)**
Mexican	12 (54.5)
Puerto Rican	5 (22.7)
Central American	2 (9.0)
South American	1 ((4.5)
Multiple	2 (9.0)

Results

Practice information

The survey asked two questions pertaining to what types of disease states the RDs encountered and what types of education were provided. Table 3 shows the date from the most common disease state reported (N=22) was obesity (81.8), followed by T2DM (77.3%), HTN(45.4%), CVD (31.8%), MASLD (13.6%), eating disorders (4.5%) and NICU/type 1 diabetes (4.5%).

Table 3. Common disease state seen in Hispanic/Latino patients (N=22)

Disease state	**Frequency (%)**

Obesity	18 (81.8)
Type 2 Diabetes	17 (77.3)
Hypertension	10 (45.4)
Cardiovascular disease	7 (31.8)
Metabolic dysfunction associated steatotic liver disease	3 (13.6)
Eating disorder	1 (4.5)
NICU/Type 1 diabetes	1 (4.5)

The type of education requested by patients was also reflective of the types of disease states commonly encountered (N=21) with diabetes management (76.1%) and weight management (76.1%) being the most common education topics followed by hypertension (33.3%), healthy eating patterns (23.8%), maternal and child nutrition (23.8%), heart health (19.0%) and GI (4.8%). See table 4 for most common education provided.

Table 4: Most common education provided to Hispanic/Latino patients (N=21)

Education topic	**Frequency (%)**
Diabetes Management	16 (76.1)
Weight Management	16 (76.1)
Hypertension	7 (33.3)
Healthy Eating Patterns	5 (23.8)
Maternal and Child Nutrition	5 (23.8)
Heart Health	4 (19.0)
GI	1 (4.8)

Challenges

There were three questions in the survey to determine if there were any challenges or barriers encountered for providers or patients when receiving care. The results (N=18) indicates that the most commons challenges faced by Hispanics/Latino RDNs when working with the Hispanic/Latino population are limited health literacy (61.1%) and lack of culturally appropriate resources (61.1%), followed by limited access to health care (44.4%), language barriers (22.7%), and time constraints (16.7%). See table 5 for most common challenges.

Table 5: Most common challenges faced by Hispanic/Latino RDNs when working with Hispanic/Latinos (N=18)

Challenge	**Frequency (%)**
Limited health literacy	11 (61.1)
Lack of culturally appropriate resources	11 (61.1)

Limited access to health care	8 (44.4)
Language barriers	5 (22.7)
Time constraints	3 (16.7)

Only five respondents answered "Yes" to facing challenges tailoring dietary recommendations to specific Hispanic/Latino populations. Based on the information provided from individuals that face difficulties tailoring nutrition recommendations for this population, the highlighted difficulties stem from:

1. **A lack of culturally relevant educational materials**
    - "*Educational materials reflect the Standard American Diet and do not include culturally appropriate food recommendations*."
    - *"In our bariatric program we ask patients to eliminate a variety of carbohydrate foods including bread, rice, tortillas so it can feel pretty limiting to some of these patients. I try to redirect them to continue using beans, root vegetables, plantains, and fruit."*
2. **Cultural and familial practices at home interfere with precision diets**
    - *"Individuals who didn't go to school past 5th grade really struggle, women with chronic health conditions especially if their husband doesn't have chronic health conditions as they usually have to prepare food based on their husbands expectations"*
3. **Lack of culturally appropriate community resources**
    - *"Would love more recipe software that was inclusive of Latino recipes"*
    - *"Difficulties tailoring materials and community resources culturally relevant"*

When discussing the barriers Hispanic/ Latino face when achieving goals the providers reported the greatest barrier was socioeconomic (66.6%) followed by cultural beliefs or practices (61.1%) and language barriers (38.9%). See Table 6 for all barriers.

Table 6: Greatest barriers Hispanic/Latino patients face when achieving goals (N=18)

Type of barrier	Frequency (%)
Socioeconomic challenges	12 (66.6)
Cultural beliefs or practices	11 (61.1)
Language barriers	7 (38.9)
Limited access to culturally appropriate foods	6 (33.3)
Distrust in health care	5 (27.8)
Access to health care	2 (11.1)

Addressing Barriers and challenges:

When asked what strategies or tools were most used (N=16), "modify recommendations on cultural preferences" by asking questions to better understand every individual needs were preferred (93.8). Other strategies are to encourage interpreters even when using peer educators that are Spanish speaking. See table 7 for strategies or tools used to navigate challenges.

Table 7: Strategies or tools used to navigate challenges (N=16)

Strategy/ tool used	Frequency (%)
Modifying recommendations based on cultural preference	15 (93.8)
Peer educators or community health workers (Spanish speaking and/or Hispanic/Latino Heritage)	7 (43.8)

Specifically, when working with the population and considering what types of food to recommend, the responses (N=15) all varied, from common foods like tortillas, tamales, beans, region specific fruits, rice, chiles, salsas, and traditional seasonings. However, most answers also state that the foods vary per patient either per nationality or what they grew up eating:

- **"***All foods that Hispanic or Latinos typically eat"*
- *"depends on their nationality, but definitely beans and avocado is part of the discussion"*
- *"Everything they describe when they answer "what are your go-to foods from your culture/country/household/growing up?"?"*

A common theme noted was that most nutrition recommendations focused around portion sizes and fat/fiber content of foods and not specific foods when counseling this population.

- *"It varies. I guide my recommendations based on what the patient is currently eating. Most foods stay. There may be modifications as far as portions (i.e. 2-3 tortillas vs 6), 1/2 cup of rice, add some meat if able to and not already including, alternative cooking methods to deep frying."*
- *"no particular food, more focus on portion size"*

When asked about how cultural differences are addressed during nutrition counseling (N=14) the common themes reported were collaborating with patients, listening by letting patients lead and letting them explain their backgrounds/upbringings, acknowledging their differences and emphasizing their desire to learn about their patient. This seems like the RDs try to use strategies rooted in motivational interviewing and empathy.

1. **Collaborating with patients:**
    - *"I ask them to lead with the foods they like to eat, prepare, purchase and then work from there"*
    - *"I ask patients what they eat at home and the foods they enjoy. At times we will go over a recipe and identify what ingredients fall into the different food groups"*
2. **Listening by letting patients lead and letting them explain their backgrounds/upbringings:**
    - *"I ask for examples of their favorite meals and ask for additional details about preparation, ingredients, and portions. I may ask if the meals are connected to cultural traditions."*
    - *"By asking for them to teach me about where they come from, integral aspects of their culture today, from their past. Showing willingness my willingness to learn about them*."
3. **Acknowledging their differences and emphasizing their desire to learn about their patient:**
    - *"Express that I am Mexican and may not know all of the Latin American cuisines but am willing to work with them to better support their needs."*
    - *"I just try to stay educated on possible differences, and adapt my approach to meet their needs."*
4. **Using motivational interviewing and behavior-based counseling:**
    - *"I first try to understand the why they follow specific behaviors: preference, culture, economy, family/peers, environment, then if barriers exist help overcome the barriers if that is something patient is ready for and desires."*
    - *"I listen and provide empathy. I am always open to learning their cultures and preferences and try to work with them from there."*

When asked what key practices non-Hispanic/ Latino RDNs should follow when working with Hispanic/ Latino populations (N=15) the RDNs reported using motivational interviewing skills like empathy, listening, being non-judgmental, and being collaborative. Being collaborative, which suggests being more curious and asking more questions about your patients to better understand their cultural upbringing (asking what they ate growing up) and adapting meal plans/ recommendations. Some RDs suggest learning Spanish if possible, if not feasible taking the time to wanting to learn about your patient's culture and practicing cultural sensitivity. When using translators, be careful of wording, speak slowly and clearly to allow interpreter to process, and avoid labeling foods as good and bad because interpreters are not always specifically trained in nutrition. Overall, they advise non-Hispanic RDs to avoid making blanket statements/ recommendations without listening to their patients first. This may mean setting aside more time for these patients.

1. **Practice Empathy, active listening, and cultural humility:**
    - *"Understanding the cultural reliance of foods like tamales and tortillas & different food holidays"*
    - *"Not being judgmental about cultural foods and practices"*
2. **Ask questions and be collaborative:**
    - *"ask about their favorite foods growing up, find a way to incorporate white rice into your recommendations, the RD is not just making a recommendation for the individual with most Hispanic/Latino patients - these recommendations will be implemented for the family so they need to be appropriate for that and think about changes that won't take out flavor and children, adult children, teens, and elderly will enjoy; don't just make a blanket recommendation like "don't eat any more canned fruits or vegetables" because you didn't take the time to find a way to communicate with your patient who is navigating life at a disadvantage, work with them, get an interpreter and schedule your appoint to be longer if needed"*
    - *"Motivational interviewing to allow the patient to participate in the planning process. This would increase the likelihood that the recommendations will more closely reflect the patient's food preferences."*
3. **Use inclusive and respectful language:**
    - *"Avoid labeling foods as good vs bad; if monolingual Spanish speakers refer to Spanish speakers RD colleagues/peers. I have found interpreter services are not usually trained to interpret for RD visits. I have been present during visits where my interns use interpreters and the translations are often not accurate."*
4. **Prioritize language access and improve interpreter use:**
    - *"Utilize culturally relevant education and talk as easy to understand as possible for the interpreter to translate"*

Four common misconceptions non-Hispanic/Latino RDNs have about Hispanic/Latino population (N=15) were found in the responses:

1. **Hispanic/Latino foods are unhealthy:**
    - *"That our food is unhealthy. It's not! It's the lack of access to affordable food to most immigrant and refugee individuals who then have to learn to prepare food with ultra-processed and cheap foods."*
2. **Hispanic/Latinos are uneducated and do not care about their health:**
    - *"That are not educated"*
    - *"That many have low health literacy due to language barrier"*
    - *"That they won't make changes"*
    - *"That Hispanics/Latinos don't value their health, nutrition, physical activity."*
3. **Hispanic/Latinos cannot afford things:**
    - *"They can't afford things"*
4. **All Hispanic/Latinos eat the same foods:**
    - *"That all Hispanic/Latino cultures are the same. For example assuming all Hispanic/Latinos eat mexican food. Or that traditional foods are unhealthy."*

To address the gaps in cultural humility, the RDNs were asked to share what resources or trainings they recommend to non-Hispanic /Latinos (N=13). Some common resources suggested for non-Hispanic/Latino RDs include:

1. **Expanding cultural practice/ food knowledge**
    - *"cultural foods from the patient perspective not the perspective of "western" diet"*
    - *"Training on culturally appropriate foods."*
    - *"Grocery tours in Hispanic/Latino stores, making cultural dishes, trying different foods."*
2. **Enhance Spanish language skills**
    - *"Spanish language resources"*
    - *"They need to learn to speak Spanish and have good written materials en Español"*
3. **Encourage collaborating with Hispanic/Latino RDs**
    - *"Work with a native speaker RDN as mentor"*
    - *"Find Hispanic/Latino dietitians in social media for resources and to learn as much as possible about the cultural practices of the biggest Hispanic population around them."*
4. **Understanding the social, political, and economic factors that impact Latino communities.**
    - *"Learn about authentic Latino/Hispanic diets, learn the resources patients can use to access nutritious foods at a reasonable cost; if you can, attend a SNAP-ed class in a high Latino area, connect with your local food bank to learn about what foods and nutrition quality your patients may be accessing."*
    - *"Basic understanding of varied immigrant experiences depending on the politics, social, and economic stressors back at home"*

In terms of resources, when asked what resources would help when working with Hispanic/ Latinos (N=12) Some common themes in resources included:

1. **Higher quality and updated culturally relevant and evidence based resources:**
    - *"More information about indigenous languages and food customs among indigenous people of Latin America"*
    - *"More relevant and culturally appropriate Spanish language resources"*
2. **Need for more community based resources:**
    - *"Community support for myself or my patients."*
    - *"Social media networks that the families can go to with Spanish speaking RDs."*
    - *"The creation of local support groups en Español"*
3. **Need for assistance with creating resources:**
    - *"More nutrition content in Spanish. When I was a 1099 employee, I could usually go to a nutrition content website and find a mass of nutrition resources that I could refer patients to but unfortunately, only 10% of the materials were in Spanish. I have started creating my own but it's not enough and there is not enough of an effort for materials to be translated to Spanish or other languages (Vitenamese, Arabic, and other)"*

- *"maybe translation services to get hospital wide educational handouts translated appropriately."*

Some common themes the respondents (N=11) felt should be emphasized in training programs about cultural humility include:

1. **Individualized, patient-centered care:**
   - *"Every person we come in contact has information that we can learn from. Listen actively and modify your guidance to the individual not the "population"*
2. **Recognition of cultural diversity within cultures:**
   - *"Yes! that not all Hispanic families eat tortillas and not everyone that speaks Spanish is Mexican."*
3. **Respect for traditional and cultural foods:**
   - *"All foods can be part of a healthy diet. Just because something isn't broccoli or kale doesn't mean it's any less nutritious than other produce."*
   - *"Stop pushing a westernized diet."*
4. **Humility/ openness to learn and compassion:**
   - *"Understanding that heritage and culture influence how patients relate to their food choices. Their may be underlying subtext to eating behaviors that stem from how someone was brought up."*
   - *"Tell your patient about your limited knowledge in their culture, often times, patients want to share help you learn what their life and food preferences are and they are almost always happy to share"*
   - *"Be kind ! You never know what issues are facing in their lives"*
   - *"Be humble"*
   - *"Leave assumptions at the door; be open to learning from your patients"*

Conclusion

Based on the survey results, the type of education provided to Hispanic/Latino population is dependent on the disease state, with main education topics focused on diabetes management, weight management, and hypertension. When it comes to addressing cultural differences and tailoring dietary recommendations, while most of the RDs face no problems, a few report that some problems may stem from a lack of culturally relevant educational materials, cultural and familial practices at home interfere with precision diets, and a lack of culturally appropriate community resources. Overall, the results highlight the importance of culturally appropriate and need for cultural humility practices.

Additionally, common challenges faced by Hispanics/ Latino RDNs when working with the Hispanic/ Latino population were limited health literacy (61.1%) and a lack of culturally appropriate resources (61.1%). Similarly, barriers Hispanic /Latino patients faced when managing nutrition related conditions were socioeconomics (66.6%), cultural beliefs or practices (61.1%) and language barriers (38.9%). To address and accommodate for these challenges, Hispanic/ Latino RDs report that using techniques routed in motivational interviewing, such as listening, being collaborative, and empathetic, has been successful when working with the Hispanic/Latino population. Since being Hispanic/Latino does not guarantee that one will be competent in every

Hispanic/Latino culture, it is important to acknowledge differences and be open to learning and collaborating.

Furthermore, non-Hispanic/ Latino RDNs may also have misconceptions about Hispanic/ Latino patients. These misconceptions may interfere with patient care; to account for the misconceptions, Hispanic/ Latino RDNs have provided key practices that they believe will assist these practitioners in optimizing their care. Some suggestions for non-Hispanic/ Latino RDs include expanding cultural food knowledge, being immersed in culture, enhancing Spanish language skills (either by practicing Spanish or finding reputable translators), encourage collaborating with Hispanic/ Latino RDs or referencing RDs of that shared culture, understanding the social, political, and economic factors that impact Hispanic/Latino communities. Additionally, non-Hispanic/ Latino RDNs should practice using motivational interviewing skills like empathy, listening, being non-judgmental, and being collaborative. Overall, they advise non-Hispanic/ Latino RDs to avoid making blanket statements/recommendations without listening to their patients first.

As it has been addressed previously, not all Hispanic/ Latino cultures are the same and therefore, translating materials into Spanish does not "solve the problem" and may actually come across as culturally inappropriate. Using the findings from this survey, the goal is to create a tip sheet with guiding questions that may be appropriate when working with Hispanic/Latino patients. The questions are tailored, not to get a concrete answer from patients, but instead to help non-Hispanic/ Latino RDs to be more collaborative and curious when working with Hispanic/Latino populations. The purpose of this tool is to help increase patient satisfaction when collaborating with RDs that are from different cultural backgrounds.

Appendix I:

Survey questions: Barriers, Strategies, and Recommendations: Latino/Hispanic RDNs on Serving Hispanic/Latino Patients

Introduction:
This survey aims to investigate the cultural humility and best practices for non- Hispanic/Latino health care providers when working with Hispanic/Latino population.

The survey is for LAHIDAN practicing members to complete to provide tips, opinions, and awareness on best practice for working with Latino/Hispanic communities. The survey will also highlight which topics need specific attention when counseling or educating Latino/Hispanic population. The survey will help be the basis for creating educational resources and counseling tips for non-Hispanic dietitians/health care providers to use when working with Hispanic/ Latino individuals. The goal of the resources is to increase provider cultural humility and to provide more specialized/ culturally appropriate nutrition services.

The goal is for the resources created to not just be translated recommendations, but instead culturally appropriate nutrition recommendations.

Consent and agreement
Your responses will remain anonymous, please check the box below if you consent to participating in this survey.

[ ] I agree and consent to participate in this survey.

Part 1: demographics and practice information

1. What is your ethnic background?
   [ ] Mexican
   [ ] Puerto Rican
   [ ] Cuban
   [ ] Dominican
   [ ] Central American
   [ ] Other, Please specify

2. What geographic region of the US do you primarily work in?
   [ ] Northeast
   [ ] Midwest
   [ ] South
   [ ] West
   [ ] Other, Please specify

3. Which Hispanic/Latino subgroup do you primarily work with in your practice?
   [ ] Mexican
   [ ] Puerto Rican

[ ] Cuban
[ ] Dominican
[ ] Central American
[ ] South American
[ ] If multiple, please specify proportions or frequency:

4. What is the most common disease state you encounter when working with Hispanic/ Latino patients?
   [ ] Obesity
   [ ] Type 2 Diabetes
   [ ] Hypertension
   [ ] Cardiovascular Disease
   [ ] MASLD
   [ ] If other, Please specify:

5. What type of nutrition education do Hispanic/ Latino patients most frequently request or need?
   [ ] Diabetes management
   [ ] Weight management
   [ ] Heart health
   [ ] Hypertension
   [ ] Maternal and child nutritin
   [ ] Healthy eating patterns
   [ ] If "other" please specify

Part 2: Challenges and Barriers

6. What are the biggest challenges you face when working with Hispanic/Latino patients? (Select all that apply)

   [ ] Language barriers
   [ ] Limited health literacy
   [ ] Lack of culturally appropriate resources
   [ ] Time constraints during appointments
   [ ] Limited access to health care
   [ ] If Other, Please specify:

7. Have you encountered difficulties tailoring dietary recommendations to specific Hispanic/Latino subgroups?
   [ ] Yes (If yes, please specify the challenges you face:)
   [ ] No

8. What are the greatest barriers do you think Hispanic/Latino patients face in achieving their health goals? (Select all that apply)
   [ ] Language barriers
   [ ] Socioeconomic challenges
   [ ] Cultural beliefs or practices
   [ ] Limited access to culturally appropriate foods
   [ ] Distrust in the healthcare system
   [ ] If Other, Please specify:

Part 3: Strategies and Practices

9. What strategies or tools do you use to navigate challenges when working with Hispanic/Latino patients?
   [ ] Modifying recommendations based on cultural food preferences
   [ ] Peer educators or community health workers (Spanish speaking and/or Hispanic/ Latino heritage)
   [ ] If Other, Please specify:

10. What traditional or culturally significant foods do you most often incorporate into your recommendations for Hispanic/Latino patients?

11. How do you address cultural differences when providing nutrition counseling to Hispanic/Latino patients?

Part 4: Recommendations for Non- Hispanic/ Latino RDNs

12. What is one key practice you believe non-Hispanic/Latino RDNs should adopt when working with Hispanic/Latino patients?

13. What do you think is the most common misconception non-Hispanic/Latino RDNs have about the Hispanic/Latino population?

14. What resources or training would you recommend for non-Hispanic/Latino RDNs to better serve Hispanic/Latino patients?

Part 5: Suggestions and Insights

15. What additional support or resources would help you as an RDN working with Hispanic/Latino populations?

16. Are there specific aspects of cultural humility you believe should be emphasized in training programs for RDNs?

Thank you for your feedback. We know that your time is valuable, and we appreciate you taking a moment to help us develop this preceptor appreciation event.

Appendix II: Tip Sheet

Name: | Course: | Date:

ELEVATING CULTURAL HUMILITY IN PRACTICE: TIPS FROM HISPANIC/LATINO RDNS

Reflection questions to ask yourself before & after sessions with Hispanic/Latino patients

1. Communication & Trust (Before a session)
   - How may you ask about traditional or cultural food practices without appearing judgmental?
   - If the client prefers to speak Spanish, what are your options for ensuring clear, respectful communication?
   - What are some ways you could build rapport and trust with this client or family?

2. Cultural Practices & Food Beliefs (Before a session)
   - How could you learn more about the client's use of traditional remedies or food beliefs?
   - If the family is using remedies or food traditions that you're unfamiliar with, how might you respond?
   - In what ways could you incorporate their cultural food preferences into a health-supportive eating plan?

3. Family Dynamics & Decision-Making (Before a session)
   - How did the role of extended family (e.g., grandparents, older siblings) show up in this scenario?
   - Who appears to be the decision-maker in the household, and how would you adjust your approach accordingly?
   - How would you navigate a situation where the client's family influences choices that conflict with your recommendations?

4. Self-Reflection & Bias Awareness (Post session reflection)
   - What assumptions might you be making about this client or their family?
   - How might your cultural background or training influence the way you're approaching this situation?
   - Is there anything in this scenario that makes you feel uncomfortable or uncertain? Why?

Name: | Course: | Date:

ELEVATING CULTURAL HUMILITY IN PRACTICE: TIPS FROM HISPANIC/LATINO RDNS

SUGGESTED TOPICS TO ASK DURING NUTRITION CONSULTS

1

Communication & Trust

- What types of foods do you enjoy eating?
- Does what you eat hold a special meaning to you?
- What barriers do you face when preparing meals? Feeding difficulties?
- Get in the routine of asking EVERY patient if they prefer an interpreter.
  - When using an interpreter, Speak to the patient (not the interpreter) and make sure to speak slowly and clearly.
- Maintain good eye contact and open body language when listening to your patients.

2

Cultural Practices & Food Beliefs

- What types of foods do you cook?
- What type of spices do you cook with? What are you familiar with?
- What type of utensils do you use when you cook?

3

Family Dynamics & Decision-Making

- Who cooks at home?
- Who or what decides what food is prepared for the day?

4

Action & Adaptation

- I am so interested, I'd love to learn more about X,Y,Z
- I am not familiar with this. Can you tell me more about it?
- What are your non-negotiables? I am ready to collaborate with you.
- What things have you tried in the past that worked? What did not work?
- What does success look like for you?
- What do you think is affecting your nutrition the most? Either positively or negatively?

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