

**Improving Health Disparities Through Implicit Bias Training in the Community Mental  
Health Setting**

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## **Abstract**

### **Background**

The purpose of this quality improvement project aims to increase Licensed Medical Provider (LMP) training on implicit bias by 80%. The project will utilize the Transformative Learning Theory, incorporating a disruptive experience, critical reflection, and an acquisition of skills in the form of two synchronous training sessions.

### **Methods**

Participants providing psychiatric care at a local community mental health center will be recruited to participate in two online synchronous trainings, along with the completion of the Harvard Implicit Bias Association Test. Participants will then reflect on training contents over two directed discussions. Participants will then complete a post-intervention survey.

### **Participants**

Licensed Medical Providers within the community mental health discipline have been recruited to participate. All providers meeting these criteria who were willing to participate were included, with no exclusion for exposure or demographic status of clients.

### **Results**

A total of 25 individuals were recruited, with a final 13 participants included in the training. Of the 13 participants, a total of 10 participants (76.9%) completed the post-intervention survey. Overall, the final aim was not met, with a 52 % increase in provider training. A total of 50% of

respondents were found to “strongly agree” that knowledge gained during the training will impact future practice; 40% were found to “agree” with this statement, while 10% chose “neither agree nor disagree.”

### **Introduction:**

Racism is thought to impact every area of life for individuals of minority status. It is known to be woven into the very fabric of society, often disguised in the systemic frameworks that enable us to function as we are. Yet, health care for individuals who do not identify as the majority are often most impacted. This disparity is not a recent development. Historically, race and health care have been more interrelated than is often understood and acknowledged.

Disparities in care have led to the development of three health care improvement aims: the first being to improve patient experience, improve overall health of the population, and lastly, to reduce per capita cost of health care (Whittington, et al., 2015). The presence and impact of racism, although controversial, is in fact a public health crisis that impacts all three previously mentioned aims. With the hopes of addressing these aims, the implementation of implicit bias training should be incorporated and mandated for all eligible providers.

### **Review of the Literature**

Current evidence suggests that racial disparities within psychiatry still exist. When looking at the diagnosis of schizophrenia, African American individuals are more likely to be diagnosed with the disorder compared to their white counterparts, despite evidence indicative of other possible disorders. It has also been found that when comparing the medical records of African American and non-Latino whites’ screening scores for both schizophrenia and depression, African-American individuals are more likely to have screened positive for both

depression and schizophrenia, compared to non-Latino whites who screened for depression only, suggesting mood symptoms among African American psychiatric patients may be under or misdiagnosed (Gara, et al.,2018). Some suggest that this is indeed a form of bias, which has led to poorer mental health outcomes in this population.

A meta-analysis by Olbert, et al. (2018) also look at racial disparities within schizophrenia diagnoses. After looking at 52 studies, they identify African Americans as diagnosed with schizophrenia at a rate 2.4 times higher than that of their white counterparts. The analysis finds higher rates of diagnostic disparities within communities showing a higher percentage of whites, which they believe may be due to less familiarity in understanding cultural variances in the display of psychotic symptoms, as well as variances in symptom criteria used (Olbert,et al., 2018; Neighbors, et al., 2003). As suggested, these variances in criteria often lead to inaccurate diagnoses and thus, a potential for poorer outcomes, increased cost, and a greater distrust of the healthcare system for these clients.

When looking at post-traumatic stress disorder (PTSD), Seng, et al. (2005) find that African American women with equal rates of hospitalization for battering and rape were less likely to be diagnosed with PTSD compared to white counterparts, despite gender and class controls. In addition, they found that these individuals were less likely to be diagnosed with dissociative disorder and borderline personality disorder, but equally likely to be diagnosed with schizophrenia, conduct disorder, or substance abuse (Seng, et al., 2005). Although cultural variances may have contributed to these outcomes in some form, one should question the present-day impact of systemic bias as a contributory factor.

Unconscious bias, or the bias acted upon outside of our conscious awareness, is known to impact views, actions, decisions, and judgments, despite an individual's awareness of such views

(Gawronski & Bodenhausen, 2006). Much of psychiatric clinical practice operates based upon a sense of individual awareness, subjective judgments, and intuition (Kerner et al., 2019).

Therefore, the potential consequences of unchecked bias in regards to diagnosis and treatment are unparalleled.

### **Rationale**

In order to truly enact change, the Transformative Learning Theory suggests that a disruptive experience, critical reflection, the acquisition of skills, and dialog are all necessary. It is theorized that this disruption, followed by skill building, reflection, and dialogue work together to challenge previously held ideals, and replace them with a more holistic, integrated, view (Sukhera, et al., 2020).

This project utilized aspects of the Transformative Learning Theory framework with all prescribing mental health Licensed Medical Providers (LMPs) at a local prominent community mental health center. In this case, the completion of the Harvard University Implicit Association Test acted as the disorienting experience. This test measures the strength of associations between concepts and stereotyped evaluations (Project Implicit, 2011). The participants then completed two synchronous education modules, followed by a brief discussion. The education module provided a scientific underpinning to the concept of implicit bias, case studies and group discussion. Lastly, participants completed a post-measure evaluation survey with the aim of providing an opportunity to self-reflect on the Implicit Association Test, overall knowledge gained, potential shifts in awareness of personal bias, and how these shifts may impact future patient interactions. With the help of such trainings, this quality improvement project hopes to decrease instances of implicit bias among providers, thus improving minority patient outcomes,

decreasing erroneous costs, and impacting patient-provider relationships among minority communities.

### **Specific Aims**

This quality improvement project aims to increase implicit bias training for licensed medical providers by 80%, over a 12-week period, through the utilization of online education modules from January 2021 to March 2021.

## **II. Approach to the Conduct of the Project**

### **Setting**

This project took place at an outpatient community mental health clinic based in Portland, Oregon. This center specializes in community focused mental health treatment for clients of all demographics, including treatment for the family, older adults, urgent walk-in, and those in need of substance abuse treatment. The organization does not currently require unconscious bias training for all employees but does support this development through hosting diversity focused organizations.

### **Participants**

Participants included Licensed Medical Providers (LMPs) from clinic locations within the psychiatric discipline, for a total of 25 possible participants. Of these, all LMP providers willing to participate were included, with no exclusion for exposure or demographic status of clients. Future developments will aim to include all clinic staff regardless of discipline. Recruitment was implemented through both email and weekly provider meetings.

### **III. Project Implementation**

Project intervention included provider education on implicit bias in the health care setting. The goal of this education was to increase awareness of implicit bias, its impact on patient relationship and outcomes, as well as provide an opportunity to reflect on potential personal biases held toward the population served. This intervention involved the completion of the Harvard University Implicit Association Test, followed by two synchronous online education modules. Participants then completed a short 7 question online survey, which extracted each participants' views on the usefulness of training, its impact, either personal or professional, and the expected impact on future practice.

This project was completed with assistance from the People & Culture department. Both the Senior Director of Equity & Inclusion and Chief People Officer implemented each implicit bias training, provided the original training content, and assisted in coordinating trainings. Additional assistance was provided by a site medical director who provided resources and connected participants to the training and survey responses.

#### **Measures**

Process tracking included the monitoring of training completion rates and survey responses. Training attendance was tracked during each training session by training coordinators, while survey responses were tracked via SurveyMonkey. Survey Monkey analysis tool was utilized to calculate survey response data.

Outcome tracking included measuring the percentage of completed trainings versus the 80% threshold indicated as the project aim. A total of 25 LMPs were included in the trainings.

Balancing measures included the cost of utilizing the Survey Monkey tool; \$70.00, along with the time that providers were unable to direct toward client care. Provider schedules were blocked for a total of two days over a two-week time frame, for a total of 2 hours over each training.

Ethical considerations include the potential for participants to interpret the Implicit Association Test results as diagnostic, as well as the potential for emotional upheaval resulting in cognitive dissonance, and fears around the implications of any personal bias held. Results from all findings, including survey responses, have remained confidential. An Institutional Review Board request for determination was also completed, with a determination of non-human research granted prior to the implementation of the quality improvement project.

#### **IV. Implementation & Evolution of the Project**

Implementation of the project was developed over several PDSA cycles. Planning included collecting research, creating training goals, deciding on the training implementation methods. The planning stage was revisited several times, originally planning to utilize the Stanford School of Medicine online asynchronous implicit bias training module. An alternative training method through the site's People & Culture department was then made available. The site's synchronous training method was utilized due to the potential benefits in peer feedback, dialogue, and reflection. The Stanford School of Medicine online training was not chosen due to limitations in these areas. Updates in the use of this synchronous training were made prior to training implementation, including adding implications of implicit bias on clinical practice, relevant history, case studies, and current trends in practice. Unanticipated costs included the utilization of the full-access Survey Monkey tool.



The Do stage of the PDSA cycle involved two training sessions completed by the People & Culture department training instructors, with data collected after the completion of the survey responses. The Study stage involved the review of this data and utilization of data points to assess progress toward the project aim of an 80% training completion rate. The Act stage was revisited as new project developments were adopted. The use of a site-directed training prompted changes in planning, utilization, and access to training; changes in the providers' schedules were also made.

### **Unintended Consequences & Missing Data**

Unintended consequences & missing data included unforeseen technological complications during the second training session. This caused some training content to be missed due to time spent correcting technological shortages. Missing data is due to lack of completion of survey responses by all participants and lack of data showcasing the impact of the disruptive experience.

### **Key Findings & Outcomes**

Implicit bias training was provided for Licensed Medical Providers (LMP) at a community mental health center. The project aim was to increase the number of mental health LMPs by 80%. A total of 25 individuals were recruited, with a final 13 participants included in the training. Of the 13 participants, a total of 10 participants (76.9%) completed the post-intervention survey. Overall, the final aim was not met, with a 52 % increase in provider training, missing the 80% goal.

Although implicit bias training has not been made mandatory at this clinic, some states have required implicit bias training for all health care providers (Hagiwara, 2020). It is expected

that this type of training will be made mandatory at this site in upcoming years, so an expected increase in training is anticipated. Yet, until this requirement is made, the increase to an 80% enrollment in training may continue to fall short.

Key findings show that all participants who completed the survey were of White/Caucasian background. Individuals were invited to complete the survey responses despite training completion rate, with all respondents completing both the first and second training, and the Harvard Implicit Bias Association Test. Of the participants 90% were aware of implicit bias prior to completing the training session. A Likert scale including “strongly agree” “agree” “neither agree nor disagree” and “disagree” and “strongly disagree” was included in the survey. A total of 50% of respondents were found to “strongly agree” that knowledge gained during the training will impact future practice; 40% were found to “agree” to this statement, while 10% chose “neither agree nor disagree”. Lastly, participants were asked to share opinions on any additional trainings. Participants were given the option to choose “online modules” “group discussions” “workshops” “debriefings” “lectures” and “other.” Participants were shown to prefer group discussions (22.2%), workshops (22.2%), debriefing (22.2%) and lectures (33.3%); (Appendix).

Several factors may have impacted participation rates, including participant availability, awareness of the training, personal views on the topic, and aspects of remote work and distance learning due to the COVID 19 pandemic.

The impact of this quality improvement project on the system includes heightened awareness of implicit bias, historical racism, patient outcomes and disparities in care. With heightened awareness and reflection, the secondary aim is to encourage racially aware, equitable care for all mental health patients.

## **VI. Summary and Next Steps**

Going forward, further trainings on implicit bias should be implemented, with acknowledgement of participant preferences in lectures, workshops, debriefing opportunities and discussions. Attention should also be paid to minority representation within hiring. With 100 % of participants in this quality improvement project identifying as White/Caucasian background, further renditions of this project might aim to look at the impact of diversity in care, along with patient perceived impact. The inclusion of all licensed medical providers, despite discipline, and all staff interacting with patients are possible future developments.

## Appendix

Table 1: Race/Ethnic Identity

Cascadia Behavioral Healthcare

**What is your race/ethnic identity?**

| Answer Choices                            | Responses       |           |
|---|-----------------|-----------|
| American Indian or Alaska Native          | 0.00%           | 0         |
| Asian                                     | 0.00%           | 0         |
| Black or African American                 | 0.00%           | 0         |
| Native Hawaiian or Other Pacific Islander | 0.00%           | 0         |
| White/Caucasian                           | 100.00%         | 10        |
| Hispanic                                  | 0.00%           | 0         |
| Other (please specify)                    | 0.00%           | 0         |
|   | <b>Answered</b> | <b>10</b> |
|   | <b>Skipped</b>  | <b>0</b>  |

Table 2: Completion of Training

Cascadia Behavioral Healthcare

**Have you completed the Unconscious Bias training?**

| Answer Choices | Responses       |           |
|----------------|-----------------|-----------|
| Yes            | 100.00%         | 10        |
| No             | 0.00%           | 0         |
|                | <b>Answered</b> | <b>10</b> |
|                | <b>Skipped</b>  | <b>0</b>  |

Table 3: Completion of Parts 1, 2

Cascadia Behavioral Healthcare

**If so, were parts 1 & 2 completed?**

| Answer Choices  | Responses       |           |
|-----------------|-----------------|-----------|
| Yes             | 100.00%         | 10        |
| No, Only Part 1 | 0.00%           | 0         |
| No, Only Part 2 | 0.00%           | 0         |
|                 | <b>Answered</b> | <b>10</b> |
|                 | <b>Skipped</b>  | <b>0</b>  |

Table 4: Completion of Harvard Implicit Association Test

Cascadia Behavioral Healthcare

**I completed the Harvard Implicit Association Test**

| Answer Choices | Responses       |           |
|----------------|-----------------|-----------|
| Yes            | 100.00%         | 10        |
| No             | 0.00%           | 0         |
|                | <b>Answered</b> | <b>10</b> |
|                | <b>Skipped</b>  | <b>0</b>  |

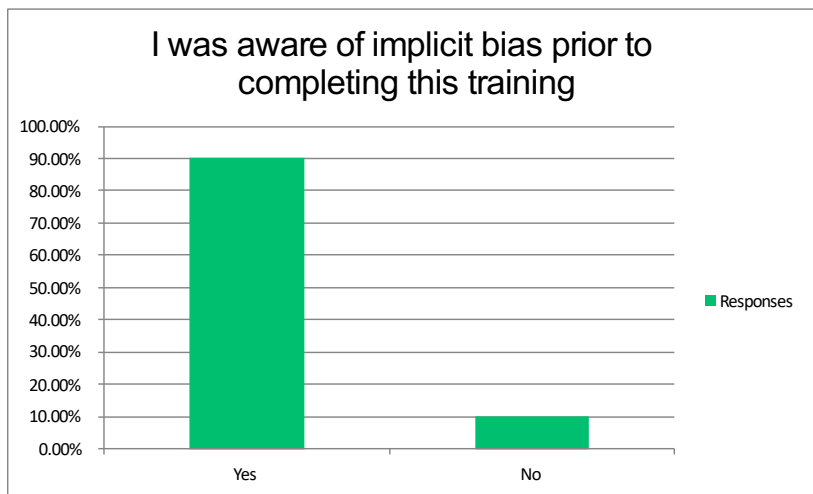


Figure 1: Provider Awareness

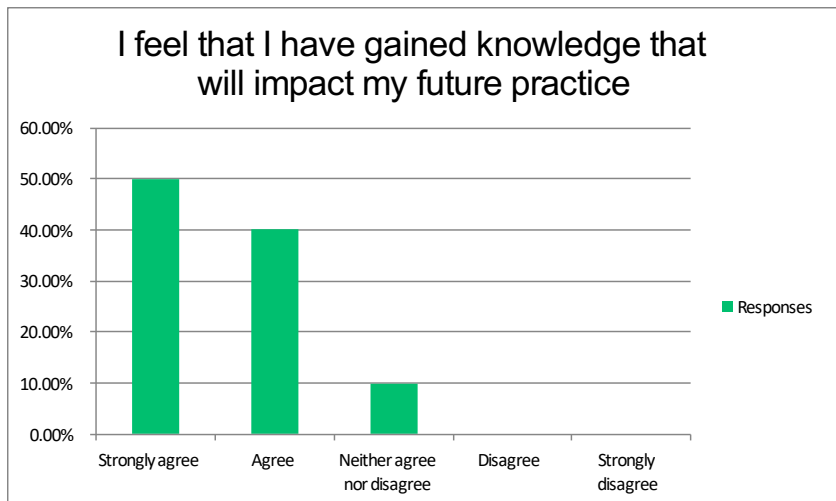


Figure 2: Impact on Future Practice

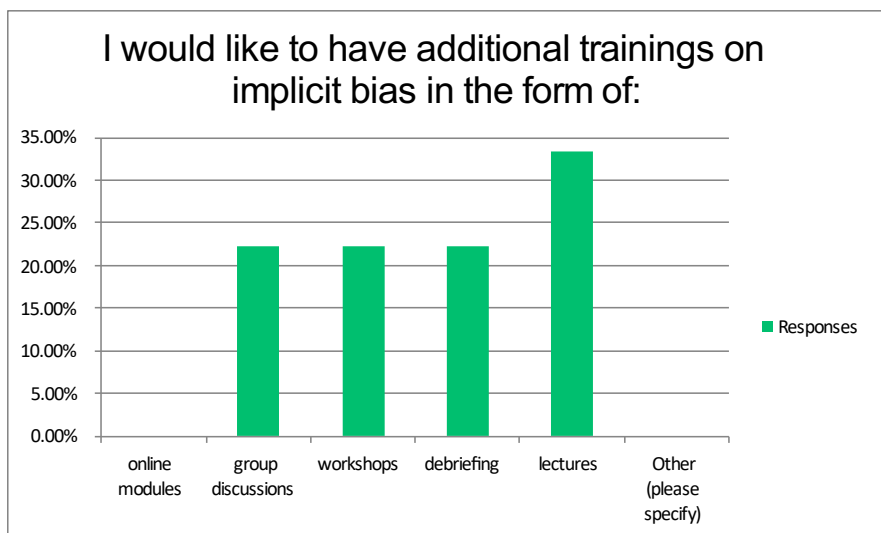


Figure 3: Additional Trainings

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