Increasing Cultural Competence and Humility Amongst Behavioral Health Providers: A quality improvement project in a rural and urban behavioral health clinics

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Abstract

Background: Behavioral health professionals assessed their awareness, knowledge, and skills after attending a presentation that followed an 'Improving Cultural Competency for Behavioral Health Professionals' (ICC for BHP) training developed by the U.S. Department of Health & Human Services. The project aimed to increase awareness, knowledge, and skills in providing culturally sensitive care by 30%. This study was conducted in a rural and urban behavioral health clinic, from October 2022 to January 2023. Professionals included psychiatric mental health nurse practitioners, medical assistants, licensed vocational nurses, social workers, marriage family therapists, QMHPs, and QMHAs.

Methods: The IHI Model for Improvement, Plan-Do-Study-Act (PDSA), and the Cultural Competency Self-Assessment Checklist (CCSC) were methods used to guide this quality improvement project.

Intervention: The CCSC was administered prior and after attending a cultural competency presentation to evaluate improvement in awareness, knowledge, and skills amongst healthcare professionals. The training was provided by certified ICC for BHP facilitators.

Results: Both project sites had improvement in awareness, knowledge, and skills. The pre and post self-assessment checklist scores noted increases in awareness by 12%; knowledge by 10%; and skills by 21% for the rural site. For the urban site the self-assessment checklist surveys reflected an increase in awareness by 15%; knowledge by 13%; and skills by 4%.

Conclusion: Although the specific aim of 30% increase in awareness, knowledge, and skills was not met; the improvement project demonstrated significant potential for systemic change with continual implementation.

Keywords: Cultural humility, cultural competency, diversity training, behavioral health, quality improvement

Contents

Introduction

Problem Description

In the United States, racially and ethnically diverse individuals are less likely to use mental health services despite there being a need (NeMoyer et al., 2020). Data shows that in 2015, 31% of Hispanics, 31% of Blacks, 22% of Asians, and 48% of Whites sought mental healthcare (American Psychiatric Association [APA], 2017). Data also shows that when minorities receive care, further mental health treatment is often not be pursued (NeMoyer et al., 2020). Various factors have impacted ethnic and racial groups' decisions to use mental health care services. Some include a longstanding history of discrimination and mistreatment of minorities, language differences between providers and patients, a stigma for mental health held by some minorities, and costs (APA, 2017; McGuire, & Miranda, 2008). These factors result in health disparities for ethnic and racial groups that lead to poor health outcomes (IOM, 2003; McGuire, & Miranda, 2008).

The National Academy of Medicine identified how racially and ethnically diverse individuals often receive inadequate access to care that lead to adverse health outcomes (Alegría et al., 2021; Oregon Department of Corrections [ODC], 2018). Untreated mental illness in minorities worsens mental health, leading to unfortunate psychological and physical outcomes (Coombs et al., 2021). Studies have shown that mental illness in minorities that goes untreated is tied to distress, depression, anxiety, cancer, heart disease, diabetes, inflammation, and obesity (Williams, 2018). To reduce these health disparities, the Oregon Medical Board has developed a cultural competency guide "a practical guide for medical professionals." The guide aims to increase culturally responsive care; however, it is underutilized by providers as it is not enforced (SAMHSA, 2015; Stork, et al., 2001).

Oregon Health Authority (OHA) reports that racial and ethnic diversity has increased in Oregon from 19.6 in 2009 to 24% in 2019 (Oregon Health Authority [OHA], 2021). Though the demographics are changing in Oregon, the healthcare workforce does not reflect the population that it is serving. According to the Oregon Department of Health Services, there is an underrepresentation of diverse mental health care providers available to care for different ethnic and racial groups (Oregon Department of Human Services, 2021). The OHA states that of all behavioral health providers in the state, 87% are White compared to 13% non-White (OHA, 2021). This gap in Oregon creates ethnic and racial disparities that can impact people of color's care. Multiple approaches to improving health service quality for culturally and ethnically diverse groups have been implemented in healthcare to lessen the gap; yet, disparities in the United States continue to exist (Jongen et al., 2018).

In urban areas, such as Portland, Oregon, reliable and current data reflecting the race and ethnicity of mental health service providers in Multnomah County is unavailable (Multnomah County Mental Health System, 2018). Though the racial and ethnic background of behavioral health providers in Multnomah County is unclear, a survey conducted by the Mental Health and Addiction Services suggests a lack of staff diversity (Multnomah County Mental Health System, 2018). The lack of diversity is even more prevalent in rural areas. The Behavioral Health Workforce Report (2022) concluded Klamath County as one of Oregon's seven designated Health Professional Shortage Areas in 2021, specifically having the highest need for racial/ethnic diverse behavioral health practitioners (Zhu et al., 2022).

Along with a limited number of diverse providers in Multnomah County and Klamath County, all physicians, advanced practice nurses, and other health care professionals in Oregon must commit to two hours of cultural competency education (Oregon State Board of Nursing

2022). This requirement must be met at the initial application and each renewal; however, there is no need to submit proof of education to the board, making it easy for providers to overlook cultural competency training (Oregon State Board of Nursing, 2022).

Available Knowledge

Mental health care providers play a significant role in determining the nature of interactions and patient experiences when accessing health care (Jongen et al., 2018; Honavar, S. G. 2018). When healthcare providers do not understand clients' cultural differences, essential elements of effective relationship-building, including communication, trust, satisfaction, and empowerment, can be jeopardized (Jongen et al., 2018; Honavar, 2018). In addition, cultural differences can increase the risk of providers imposing cultural bias on their patients (Ogundare, 2019; Street et al., 2020).

Implicit biases are stereotypes, attitudes, and prejudices unconsciously held about other people (FitzGerald & Hurst, 2017). Research shows implicit bias is prevalent among mental health professionals and can prevent access to care, clinical assessment and diagnosis, treatment, and crisis response (Merino et al., 2018). The data also indicates implicit biases among mental health providers can lead to inappropriate treatment associated with misinterpretation of emotional expression and high healthcare costs (Merino et al., 2018). Empirical evidence suggests that approximately 80% of medical errors involving miscommunication can be associated with cultural bias and misdiagnosis (Ogundare, 2019; Street et al., 2020). These effects decrease patients' quality of care and can perpetuate mental health disparities.

One way to reduce health disparities and improve the health of ethnic and cultural communities is to train health care providers to be culturally competent (Lin, et al., 2020; Harrison et al., 2019; Mollah et al., 2018; Jongen et al., 2018; Behavioral Health, n.d.; Merino, et

al., 2018). A barrier to this method is confusion around the concept of cultural competence and its definition. A definition often used to describe cultural competency is a learning process that impacts self-awareness, knowledge, and skills that allows for effective and efficient cultural services (Behavioral Health, n.d.; Jongen et al., 2018).

Various cultural competency trainings have been designed to expose providers to different cultures and expand their understanding of the beliefs, values, and behavior (Lekas et al., 2020; Brottman et al., 2020). Providers should be cautious about these trainings as the risk of stereotyping, stigmatizing, and othering patients can result if the concept of cultural humility is disregarded (Lekas et al., 2020). Cultural humility care is a reflective process that guides health care providers in becoming self-aware of biases and privileges, managing power imbalances, and continually learning from patients (Behavioral Health, n.d.; Lekas et al., 2020; SAMHSA, 2014).

Healthcare providers can make a difference in reducing health disparities by becoming culturally competent (Lekas et al., 2020; Behavioral Health, n.d.). Building a strong therapeutic alliance requires that healthcare staff adapt to the needs of patients during their healthcare visits (Liu et al., 2021). Research shows that culturally competent providers have less trouble garnering the trust of their patients, receive higher satisfaction scores from patients, more patients follow recommendations, and improve communication results between the providers and patients (Liu et al., 2021; Merino et al., 2018). Moreover, culturally competent providers seek to be fully informed by a patient's culture, understanding that beliefs and values can change over time (Lekas et al., 2020; Multnomah County Mental Health System, 2018). Therefore, becoming culturally competent requires that healthcare providers continually seek to grow in their ability to meet and respect the values and preferences of care for their patients (Harrison et al., 2019; Multnomah County Mental Health System, 2018; SAMHSA, 2014).

Rationale

The Institute of Medicine (IOM) identifies six aims to improve healthcare: safety, timeliness, effectiveness, efficiency, patient-centeredness, and equity (Gould, 2019). An online training titled "Improving Cultural Competency for Behavioral Health Professionals" (ICC) helps providers meet the six aims for improving health care quality. This training also follows a cultural humility approach so that providers are responsive to individual cultural health beliefs, preferred languages, health literacy levels, and communication needs (Behavioral Health, n.d.). Think Cultural Health is an online resource center that offers the ICC training for behavioral health providers (Jackson & Gracia, 2014). The National Standards for Cultural and Linguistically Appropriate Services structured the ICC training with the aim to achieve culturally appropriate care. Further, this cultural competency training was implemented as an evidence-based intervention for this project to improve the cultural competency of behavioral health providers.

The proposed improvement project was guided by the Institute for Healthcare Improvement Model for Improvement (MFI). The IHI MFI uses an evidence-based process for identifying, testing, and implementing quality improvement projects (IHI, 2020). The IHI MFI is based on three questions: "What are we trying to accomplish? How will we know that a change is an improvement? What changes can we make that will result in improvement?" (Langley, et al., 2014). Combined with these three questions and the Plan-Do-Study-Act (PDSA) cycle form the foundation of the MFI (Langley, et al., 2014). The model's approach is to spread change by developing, testing, and implementing. By doing so, it recognizes the fundamental relationship between improvement and change (Langley, et al., 2014; Staffileno, et al., 2021).

The MFI method is preferable over others because it is based on a scientific technique and has potential to accelerate improvement (IHI, 2020; Langley, et al., 2014). The MFI model guided the implementation of culturally competent training in two distinct settings, urban and rural behavioral health clinics.

Specific Aims

From November 2022 to January 2023, behavioral health providers in one urban and one rural community mental health facility will exhibit an average of 30% increase in communication, knowledge, skill, and comfort in providing culturally sensitive care for a culturally diverse population.

Methods

Context

This project was implemented at two behavioral health clinics in Portland, OR, and Klamath County, OR. The clinic in Portland is a Federally Qualified Health Center (FQHC) that is located in a large metropolitan urban setting. This clinic delivers routine health screenings, medication management, mental health support and counseling, and substance use disorder (SUD) treatment. This clinic also assists residents in recovery with housing and employment access. In 2021, the clinic delivered health care to 9,283 people, placed 3,896 residents in housing, served 509 people after incarceration, and supported 1,965 people in managing SUD through recovery housing. In addition, the clinic supported 8,791 people with a SUD, and 1,308 people were connected with employment. Costs are based on a sliding fee scale based on a client's ability to pay. Services are provided in-person, telephonically, or via video.

The other clinic is also a FQHC in Klamath County, Southcentral, Oregon. The clinic is the largest non-profit community mental health facility that provides a wide array of mental health and addiction services to people of all ages. This clinic serves a rural population with a median household income of 36% below the federal poverty level (Klamath Family Head Start [KFHS], 2020). From 2017 to 2018, the clinic served over 10,600 new clients (Klamath Family Head Start [KFHS], 2020). Like the clinic in Portland, services in the Klamath clinic are provided in person, via telehealth, and by telephone.

Interventions

To increase cultural competence, we sent three email reminders to all behavioral health care staff at both outpatient mental health clinics to attend a cultural competency presentation following the ICC for BHP content. Additionally, we presented via Zoom and Microsoft Teams to introduce content from the ICC for BHP training and emphasized that the training aimed to expand cultural and linguistic competency. Two presentations took place, the rural took two hours scheduled for October 5, 2022, and the urban took an hour scheduled for November 16, 2022.

The presentation emphasized the importance of cultural humility and culturally competent care, including the implications of receiving the ICC training on quality of care (Harrison et al., 2019). During the Zoom and Microsoft Teams meeting, staff became aware of the two to one-hour commitment to complete the entire presentation and the continuing education credits they received for their time. Additionally, ten minutes were reserved for staff to fill out the pre-survey questions during both presentations.

After completing the ICC for BHP training, staff understood how culture identity and intersectionality are essential to providing culturally competent care for all clients. Behavioral health providers and advanced practice nurses understood how reflective practice helps identify bias and strategies to reduce bias in assessment and diagnosis. Additionally, staff learned how culture influences communication and gained insight into what is most important to the client.

Study of the Intervention

The study of intervention included an assessment called "Cultural Competence Self-Assessment Checklist" that was sent out prior to attending the cultural competency presentation. This checklist evaluated providers skills, knowledge and awareness in their interactions with culturally and linguistically diverse populations. The self-assessment tool was adapted from the Central Vancouver Island Multicultural Society. A self-assessment followed the completion of the cultural competency presentation. In addition to the pre and post self-assessments, the study monitored any local, state, and national cultural competency initiatives that may impact the outcome.

Measures

The primary outcome measure for this project was the percentage of behavioral health professionals who attended the ICC for BHP presentation out of the total number of staff who completed the survey at each clinic between November 2022 and January 2023. A secondary outcome measure was the comparison between pre and post-self-assessments. These measures allowed us to determine if the intervention increased perceived knowledge, awareness, and skills in providing culturally sensitive care, which was the project's primary aim. The process measures include the number of behavioral health professionals who attended the ICC for BHP presentation, the number of staff who completed the pre- and post-self-assessments, emails sent,

and emails not sent due to a lack of access to staff emails. Balancing measures included the average time spent attending the presentation and qualitative data obtained from interactive discussions during the presentation to allow staff to engage in reflective questions from the ICC for BHP training.

Analysis

We provided a pre- and post-Cultural Competence Self-Assessment Checklist to collect qualitative data over the period of three days for the rural setting and a month for the urban setting. The assessment measured providers' knowledge and awareness in their interactions with culturally and linguistically diverse populations. Scores were compared to identify the impact that the introductory presentation to the ICC for BHP training had on behavioral health providers. Lastly, scores were noted on a bar chart to analyze survey comparison scores prior and after the presentation.

Ethical Considerations

At both clinics, staff were informed about the project as well as how participation is on a voluntary basis. Both clinics consented to the implementation of this project and signed their letter of support. Participant responses and pre- and post-self-assessment scores were kept confidential by removing any individual identities from collected quantitative and qualitative data and staff adhered to HIPPA guidelines. This project did not involve human subjects and there is no conflict of interests. Finally, applied to the Oregon Health & Science University Investigational Review Board to receive approval for this quality improvement project.

Results

Implementation of the projects was developed, revised, and executed over three PDSA cycles with an additional month difference in the timeline for the urban setting compared to the rural setting (see Appendix A & B). The rural setting occurred between June 2022 and October 2022, while the urban setting occurred between June 2022 and November 2022.

The "Plan" series of the PDSA cycle that guided the project's development included researching data on the efficacy of cultural competency training and researching cultural competency self-evaluation tools. The evidence-based cultural competency self-assessment checklist chosen was created by the Central Vancouver Island Multicultural Society and aided in evaluating the efficiency of the cultural competency presentation. The "Do" stage of the PDSA cycle consisted of completing the online ICC for BHP training to become facilitators, creating a one and two hour presentation that extracted content from the ThinkCultural Health ICC for BHP training, and collaborating with organizational leadership to adopt the cultural competence presentation as staff training. The “Study” cycle reviewed data collected from the pre- and post-surveys to evaluate progress towards that project aim of an average of 30% increase in perceived knowledge, self-awareness, and skills when providing culturally competent care. The “Act” phase consisted of utilizing organizational leaders' constructive feedback to make adjustments and start another cycle.

At the end of the first PDSA cycle, the original 36 self-assessment cultural competence checklist was translated into SurveyMonkey questionnaire. After receiving feedback from healthcare staff from both the rural and urban clinical sites, the SurveyMonkey format transitioned to a 16 questionnaire using Google Forms. The brief cultural competence self-assessment Google Forms survey was free and had no question limit compared to the

SurveyMonkey version. The "Act" phase was considered to address the low pre-survey response rates in the rural setting by sending increased email reminders in the urban setting due to a potential increase in participation rates.

Unintended consequences for the rural setting included having technical difficulties at the beginning of the presentation and not sending additional pre-survey reminders, while for the urban setting, included not allotting time during the presentation for staff to fill out the post-survey at the end of the presentation and not sending additional post-survey reminders.

Summary

There were 143 total participants at the rural clinic. Of these, 23 (16%) completed the pre-surveys, and 84 (58%) submitted their post-surveys. A few staff at the rural clinic had difficulty logging in telephonically, which might have influenced the low pre-survey response rate. By the end of the presentation, ten minutes were provided for staff to complete the post-survey, which may reflect the higher number of post-surveys compared to the pre-surveys.

There were 87 total participants at the urban clinic. Of these, 69 (79%) completed the pre-survey, while 14 (16%) submitted the post-survey. Factors that might have led to lower post-survey response rates for this site may have been impacted by a lack of time allotted for staff to fill out the post-survey on Microsoft Teams, staff needing to provide direct client care right after the presentation, and not sending out two additional post-survey email reminders as was the case for the pre-survey.

Key findings from this quality improvement project showed that obtaining organizational support from leadership was imperative for its implementation. Along with leadership buy-in, becoming facilitators helped reach a larger audience and increased staff engagement at both rural

and urban clinics. Lastly, we noted that participants who completed the surveys showed improved awareness, knowledge, and skills.

Interpretation

The project aim was a 30% increase in the average perceived level of awareness, knowledge, and skill evaluated by comparing the pre- and post- self-awareness cultural competency checklist scores. At the rural location, the perceived level of awareness increased by 12%, level of knowledge by 10%, and levels of skills by 21%, not meeting the project aim. At the urban clinic, the perceived level of awareness increased by 15%, level of knowledge by 13%, and level of skills by 4%, not meeting the project aim (see Appendix C).

The significant differences in the number of participants who completed the pre-survey compared to the post-survey at the rural and urban behavioral health clinical sites skewed the project results. For those who participated, data showed a net increase in participants' average percent level of awareness, knowledge, and skill. Though this project did not meet the specific aim, scores reflected a slight improvement in cultural competency at both clinics.

A strength of this project was that obtaining early organizational support was crucial for successfully implementing the presentation at both sites. Additionally, becoming facilitators allowed staff to have a platform where learning took place, along with interactive discussion regarding the material from the ICC for BHP content. Lastly, a virtual presentation reached a large rural and urban healthcare audience.

Limitations

Limitations for this project included that the virtual platform made it unclear whether everyone was engaged, as some participants had their cameras off. The different pre- and post-survey response rates also led to percentages that were imprecise used to assess awareness,

knowledge, and skill. Lastly, each site had a time limit, making it challenging to cover the entire ICC for BHP training material; the urban site allotted two hours, while the urban site designated one hour for the cultural competency presentation.

Conclusions & Next Steps

Though the survey scores in both rural and urban Oregon settings did not meet the project-specific aim percentage, increased awareness, knowledge, and skill resulted in healthcare professionals. More specifically, this quality improvement project can improve health outcomes and shows the potential to increase cultural competence and humility among healthcare professionals. Facilitating the ICC for BHP training in an introductory presentation increased outreach to a larger healthcare audience which may help reduce health disparities in Oregon. Ultimately, to directly impact patient outcomes, consideration of increasing facilitators to reach more healthcare staff should occur.

Furthermore, reaching cultural competency and cultural humility is lifelong, as the culture of clients is not fixated and can change over time. Therefore, healthcare organizational leaders can ensure that care is continually improved by supporting healthcare professionals in becoming culturally competent and practicing cultural humility on an annual basis. Overall, cultural competence training like the ICC for BHP can be utilized across multiple care settings to ensure culturally responsive care is provided at all healthcare system levels.

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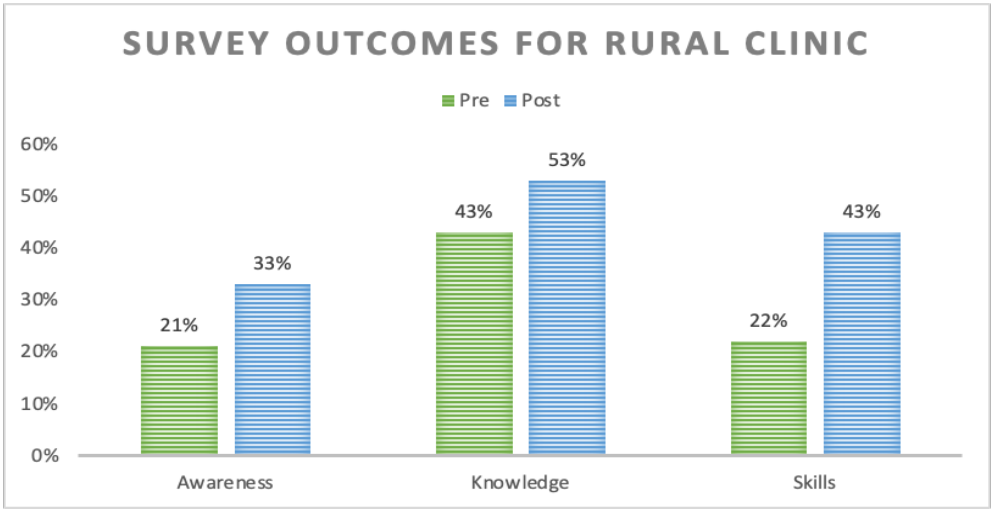
Appendix A. Project Timeline (Portland Location)

	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	March
Finalize project design and approach (703A)	X									
Complete IRB determination or approval (703A)		X								
PDSA Cycle 1 (703B)				X						
PDSA Cycle 2 (703B)					X					
PDSA Cycle 3 (703B)						X				
Final data analysis (703B)							X			
Write sections 13-17 of final paper (703B)									X	X
Prepare for project dissemination (703B)										X

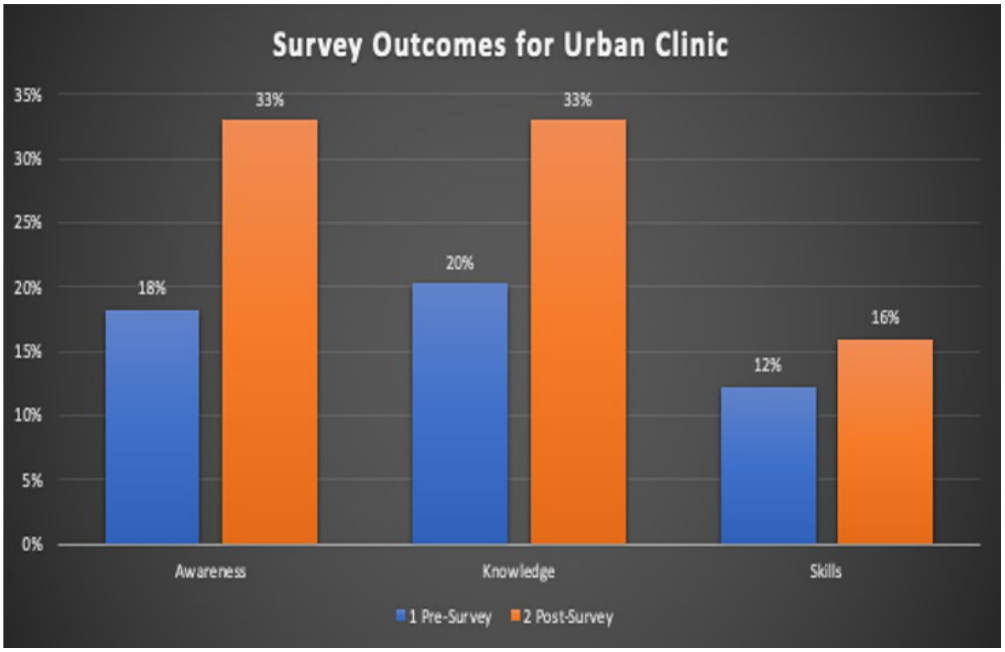
Appendix B. Project Timeline (Klamath Location)

	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	March
Finalize project design and approach (703A)	X									
Complete IRB determination or approval (703A)		X								
PDSA Cycle 1 (703B)						X				
PDSA Cycle 2 (703B)							X			
PDSA Cycle 3 (703B)								X		
Final data analysis (703B)									X	
Write sections 13-17 of final paper (703B)									X	X
Prepare for project dissemination (703B)										X

Appendix C. Survey Outcomes (Klamath & Portland Location)

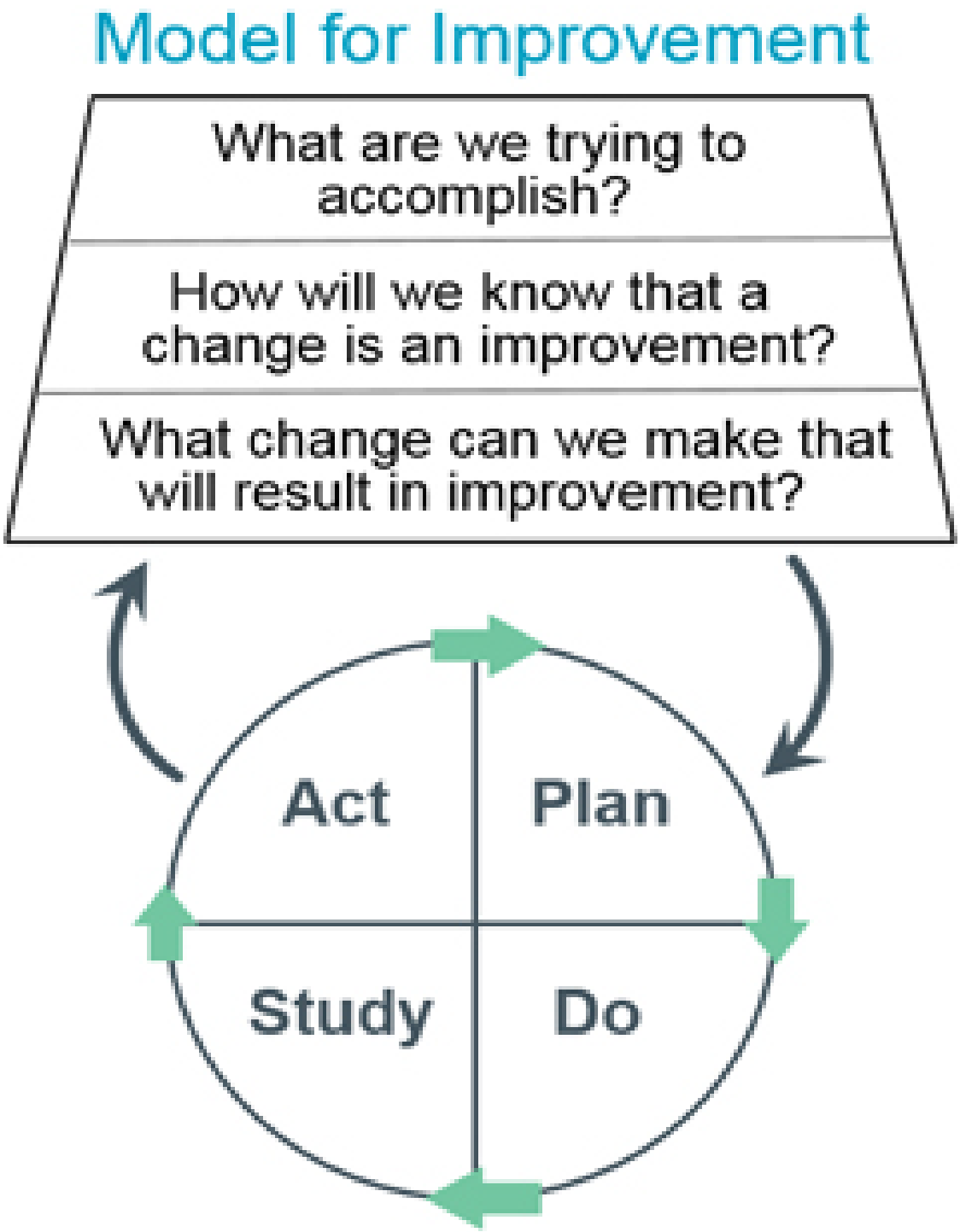


Rural Site Outcomes



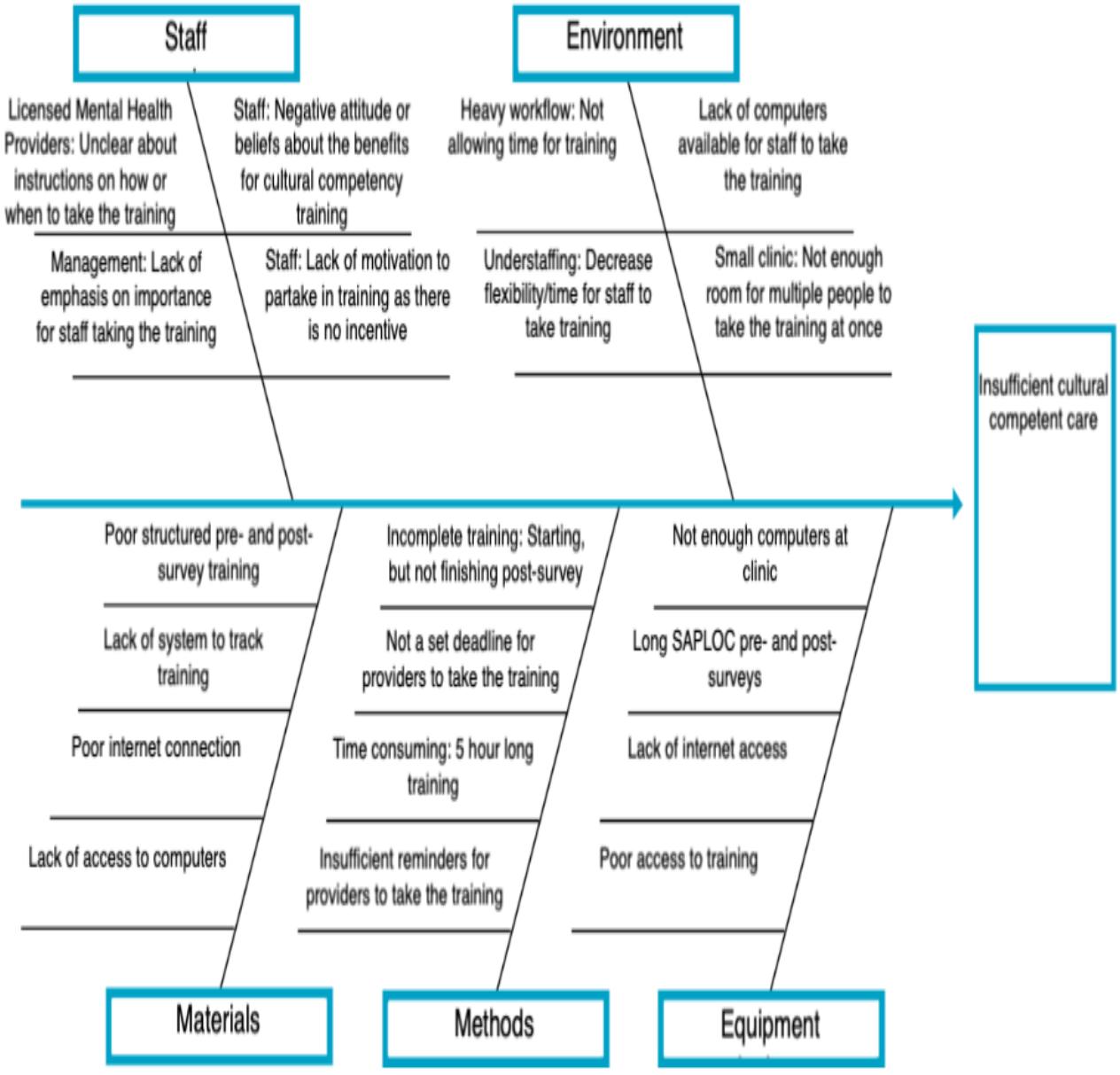
Urban Site Outcomes

Appendix D. IHI Model for Improvement

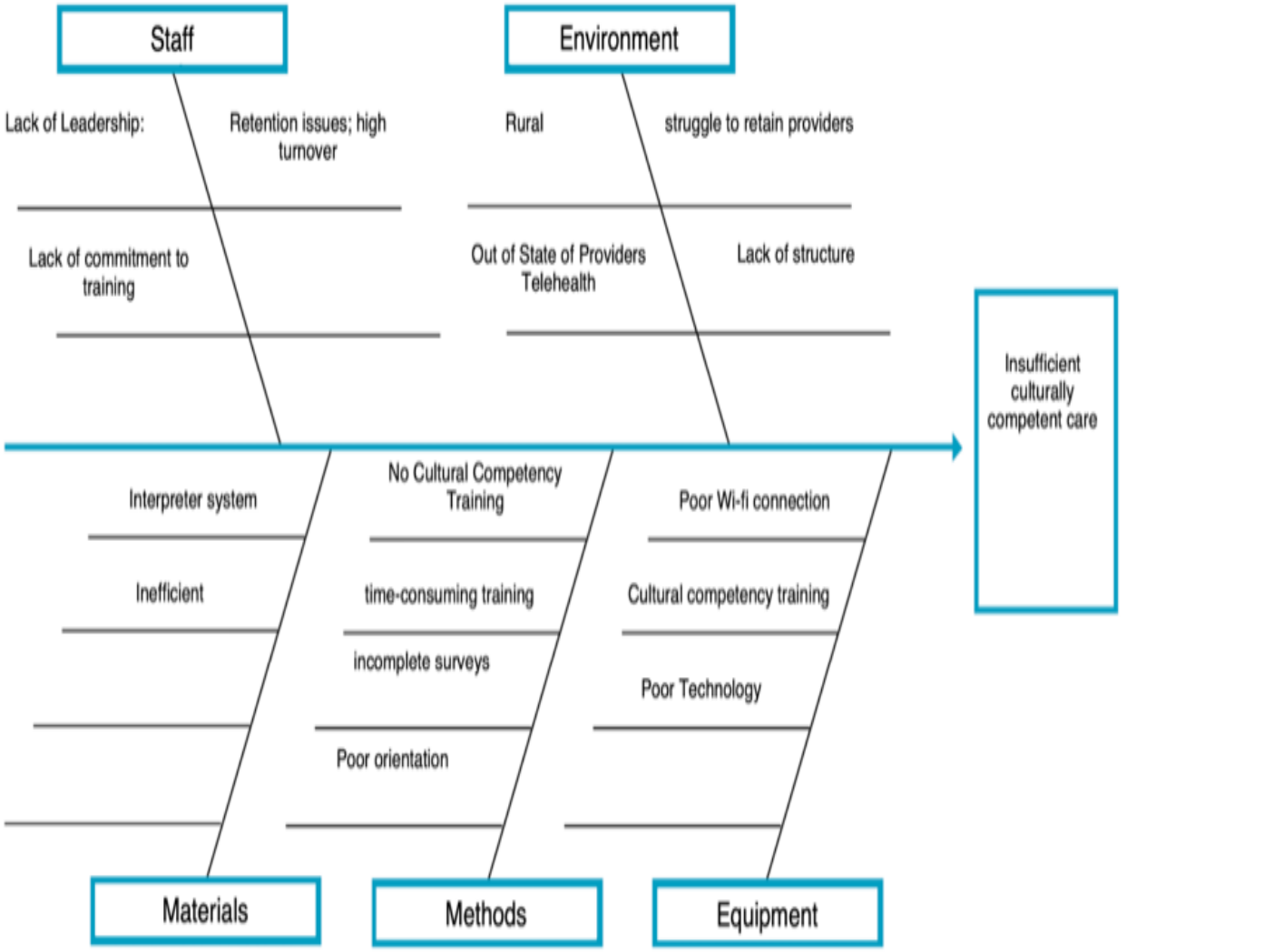


http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx

Appendix E. Cause & Effect Diagram (Portland Location)



Cause and Effect Diagram Rural Behavioral Health Facility



Appendix G. Cultural Competence Self-Assessment Checklist

CULTURAL COMPETENCE SELF-ASSESSMENT CHECKLIST

This self-assessment tool is designed to help you explore your individual cultural competence. Its purpose is to help you consider your own skills, knowledge, and awareness in your interactions with others, and recognize what you can do to become more effective working and living in diverse environments.

The term "culture" includes not only race, ethnicity, and ancestry, but also the culture (e.g. beliefs, common experiences and ways of being in the world) shared by people with characteristics in common, including, but not limited to: people who are Lesbian, Bisexual, Gay and Transgender (LGBT), people with disabilities, members of faith and spiritual communities, and people within various socio-economic classes. For this tool, the focus is primarily on race and ethnicity.

Read each entry in the **Awareness**, **Knowledge**, and **Skills** sections. Place a check mark in the appropriate column which follows. At the end of each section add up the number of times you have checked that column. Multiply the number of times you have checked "Never" by 1, "Sometimes/Occasionally" by 2, "Fairly Often/Pretty Well" by 3 and "Always/Very Well" by 4. The more points you have, the more culturally competent you are becoming.

This is simply a tool. This is not a test. The rating scale is intended to help you identify areas of strength and opportunities for ongoing personal and professional development.

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Awareness		Never	Sometimes/ Occasionally	Fairly Often/ Pretty Well	Always/ Very Well
Value diversity	I view human difference as positive and a cause for celebration.				
Know myself	I have a clear sense of my own ethnic, cultural, and racial identity and how that is viewed by others with whom I differ.				
Share my culture	I am aware that in order to learn more about others I need to understand and be prepared to share my own culture.				
Be aware of areas of discomfort	I am aware of my discomfort when I encounter differences in race, religion, sexual orientation, language, and/or ethnicity.				
Check my assumptions	I am aware of the assumptions that I hold about people of cultures different from my own.				
Challenge my stereotypes	I am aware of the stereotypes I hold as they arise and have developed personal strategies for reducing the harm they cause.				
Reflect on how my culture informs my judgement	I am aware of how my cultural perspective influences my judgement about what I deem to be 'appropriate', 'normal', or 'superior' behaviors, values, and communication styles.				
Accept ambiguity	I accept that in cross-cultural situations there can be uncertainty and that I might feel uncomfortable as a result. I accept that discomfort is part of my growth process				
Be curious	I intentionally make opportunities to put myself in places where I can learn about difference and establish diverse connections.				
Be aware of my privilege	If I am a white person working with members of BIPOC communities, I recognize that I have inherently benefited from racial privilege, and may not be seen as safe, 'unbiased,' or as an ally.				
Be aware of social justice issues	I'm aware of the impact of social context on the lives of culturally diverse populations, and how power, privilege, and social oppression influence their lives.				
		1 pt x	**2 pt x**	**3 pt x**	**4 pt x**

Knowledge		Never	Sometimes/ Occasionally	Fairly Often/ Pretty Well	Always/ Very Well
Gain from my mistakes	I make mistakes and choose to learn from them.				
Assess the limits of my knowledge	I recognize that my knowledge of certain cultural groups is limited. I make an ongoing commitment to learn more through the lens of cultural groups that differ from my own.				
Ask questions	I listen fully to answers and make the time to advance my knowledge from a variety of existing culturally diverse resources before asking additional questions. I do this so that I don't unduly burden members of marginalized communities with addressing gaps in my cultural knowledge.				
Acknowledge the importance of difference	I know that differences in race, culture, ethnicity etc. are important and valued parts of an individual's identity—I do not hide behind the claim of "color blindness."				
Know the historical and current experiences of those I label as 'others'	I am knowledgeable about historical incidents and current day practices that demonstrate racism and exclusion towards those I label as 'others.'				
Understand the influence culture can have	I recognize that cultures change over time and can vary from person to person, as does attachment to culture.				
Commit to life-long learning	I recognize that achieving cultural competence and cultural humility involves a commitment to learning over a lifetime. I consistently demonstrate my commitment to this process.				
Understand the impact of racism, sexism, homophobia, and other prejudices	I recognize that stereotypical attitudes and discriminatory actions can dehumanize, even encourage violence against individuals because of their membership in groups that are different from mine.				
Know my own family history	I know my family's story of immigration and assimilation.				
Know my limitations	I continue to develop my capacity for assessing areas where there are gaps in my knowledge.				

Knowledge continued		Never	Sometimes/ Occasionally	Fairly Often/ Pretty Well	Always/ Very Well
Be aware of multiple social identities	I recognize that people have intersecting multiple identities drawn from race, gender identity, sexual orientation, religion, ethnicity, etc., and the potential influence of each of these identities varies from person to person.				
Acknowledge inter-cultural and intracultural differences	I acknowledge both inter-cultural and intracultural differences.				
Understand point of reference to assess appropriate behavior	I'm aware that everyone has a "culture" and my own "culture" is not to be regarded as the singular or best point of reference to assess which behaviors are appropriate or inappropriate.				
		1 pt x	**2 pt x**	**3 pt x**	**4 pt x**

Skills		Never	Sometimes/ Occasionally	Fairly Often/ Pretty Well	Always/ Very Well
Adapt to different situations	I develop ways to interact respectfully and effectively with individuals and groups that may differ from me.				
Challenge discriminatory and/or racist behavior	I effectively and consistently intervene when I observe others behaving in a racist and/or discriminatory manner.				
Communicate across cultures	I adapt my communication style to effectively interact with people who communicate in ways that are different from my own.				
Seek out situations to expand my skills	I consistently seek out people who challenge me to increase my cross-cultural skills.				
Become engaged	I am actively involved in initiatives, small or big, that promote interaction and understanding among members of diverse groups.				
Act respectfully in cross-cultural situations	I consistently act in ways that demonstrate respect for the culture and beliefs of others.				
Practice cultural protocols	I learn about and put into practice the specific cultural protocols and practices that make me more effective in my work with diverse individuals and groups.				
Act as an ally	My colleagues who are Black, Asian, Latinx, and Indigenous consider me an ally and know that I will support them in culturally appropriate ways.				
Be flexible	I work hard to understand the perspectives of others and consult with diverse colleagues and diverse resources about culturally respectful and appropriate courses of action.				
Be adaptive	I know and use a variety of relationship building skills to create connections with people from whom I differ.				
Recognize my own cultural biases	I recognize my own cultural biases in a given situation and I'm aware not to act out based on my biases.				
Be aware of within-group differences	I'm aware of within-group differences and I do not generalize a specific behavior presented by an individual to the entire cultural community.				
		1 pt x	2 pt x	3 pt x	4 pt x