Improving Equity in Behavioral Health through Cultural Competence Training and Humility for Healthcare Providers: A Quality Improvement Project

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Abstract

Background: Despite ongoing efforts to improve healthcare access and quality for minority groups in the United States, disparities based on race and ethnicity persist, affecting African Americans, Latinos, and the LGBTQ community. A one-hour training session on Embracing Cultural Humility, aligned with the 'Improving Cultural Competency for Behavioral Health Professionals' (ICC for BHP) training developed by the U.S. Department of Health & Human Services, targeted behavioral health professionals. Implemented in three Oregon behavioral health clinics from June 2023 to March 2024, the project involved psychiatric mental health nurse practitioners (PMHNPs), Transcranial Magnetic Stimulation (TMS) technicians, and administrative staff. Focusing on awareness, knowledge, and skills, the project aimed to enhance cultural sensitivity by 25%. This quality improvement project strives to address persistent disparities in healthcare.

Methods: The quality improvement project was guided by methodologies including the IHI Model for improvement, the Plan-Do-Study-Act (PDSA) Cycle, and the Cultural Competency Self-Assessment Checklist (CCSC).

Intervention: A certified facilitator delivered a presentation based on the ICC for BHP tailored for behavioral health providers. The CCSC was administered both prior and after the presentation to evaluate advancements in awareness, knowledge, and skills related to delivering culturally sensitive care for minorities.

Results: Key findings from the pre- and post- self-assessment checklist indicate an average perceived percentage increase in awareness of 16.5%, knowledge by 7.1%, and skills by 8%.

Conclusion: Despite not reaching the 25% aim, the project exhibited considerable potential for systemic improvement through continuous implementation.

Keywords: Cultural competence, cultural competency, cultural humility, behavioral health, quality improvement

Contents

Problem Description

In the United States (U.S), racial and ethnic disparities in healthcare persist despite ongoing efforts to improve access and quality of care for marginalized populations such as African Americans and Latinos (Yearby, et al., 2022). According to the U.S. Census Bureau, it is projected that racial minorities will comprise over 50% of the country's population, and by 2060, the U.S. will become a minority-majority country (Renteria et al., 2020; U.S. Census Bureau, 2019). Data shows that Oregon's population is becoming increasingly diverse, with a higher rate of growth in racial and ethnic populations compared to the national average (Oregon Health Authority [OHA], 2023). According to the OHA, the racial and ethnic diversity in Oregon was reported as 24% in 2019 (OHA, 2021).

Health disparities are systematic differences that affect the health, access, and quality of care among population groups defined by race, ethnicity, gender, sexual orientation, and socioeconomic status (Moreno & Chhatwal, 2020). Racial, ethnic minorities, and lesbian, gay, bisexual, transgender, queer and questioning (LGBTQ) individuals encounter obstacles in accessing mental health care, including insurance gaps, limited provider diversity, financial barriers, and stigma (CDC, 2022; McGregor et al., 2019; Rice & Harris, 2021; Thomeer et al., 2023). LGBTQ individuals experience unique disparities, facing dual stigma from healthcare providers (Canady, 2021; Choukas & Thoma, 2022; Rice & Harris, 2021).

Despite mental health promotion efforts in Oregon, diverse individuals face disparities in receiving appropriate mental health services (MHRA, 2022). Oregon's mental health professional diversity falls below national averages and the state's population, leading to limited access to culturally humble mental health care services (McGregor et al., 2019; Oregon Mental Health Regulatory Agency [MHRA], 2022). The Multnomah County Board of County Commissioners recognized racism as an Oregon public health crisis (Hunter & Lawton, 2022).

Available Knowledge

Research has shown the role of inadequate cultural sensitivity training among healthcare providers as a primary factor contributing to the underutilization of mental health resources within underrepresented minority communities (Rice & Harris, 2021). The lack of cultural humility may lead to misdiagnosis and ineffective treatment, impacting diverse individuals' health outcomes (Novacek et al., 2020). Therefore, it is critical for behavioral health professionals in the diverse state of Oregon to enhance their cultural humility to effectively address the current healthcare disparities and inequities.

Cultural humility training in healthcare facilities has been identified as effective in addressing disparities (Handtke et al., 2019). Empirical data shows that patients receiving mental health care from culturally and aware sensitive providers are more likely to sustain engagement in ongoing care (Rice & Harris, 2021). A systematic review showed that cultural competence trainings provide a highly effective approach for transforming attitudes, enhancing knowledge, and fostering the development of skills among mental health providers (Chu et al., 2022). A retrospective population-based cross-sectional study found racial and ethnic disparities in how individuals perceive the cultural competence of their healthcare providers (Eken et al., 2021).

Cultural competency training encompasses sensitive communication to avoid stigma and improve access to care (McGregor et al., 2019). This ensures the provision of high-quality care to patients from diverse cultural backgrounds and contributes to the reduction of healthcare disparities (Handtke et al., 2019; McGregor et al., 2019; Rice & Harris, 2021). Cultural humility prioritizes self-assessment, interpersonal sensitivity, and addressing power disparities, aiming to prevent stereotyping (Stubbe, 2020). Cultural humility training prompts providers to introspectively examine their beliefs, values, and biases—both explicit and implicit—revealing the influence of their culture on patient interactions (Lekas, 2020).

Rationale

The clinical site lacked established guidelines and training programs fostering cultural humility among staff, leading to uncertainty regarding the cultural responsiveness of behavioral health providers in delivering appropriate care for clients from diverse backgrounds (see Appendix B). The U.S. Department of Health and Human Services Office of Minority Health (DHHS) has established the National Standards for Culturally and Linguistically Appropriate Services (CLAS) (Stubbe, 2020). The "Think Cultural Health Program" promotes the adoption of these standards, including the online training course "Improving Cultural Competence for Behavioral Health Professionals (ICC)." The ICC aims to enhance healthcare quality and equity by providing a framework for behavioral health professionals to increase cultural and linguistic competency (Moreno & Chhatwal, 2020). The principal standard requires healthcare providers to deliver "effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs" (Moreno & Chhatwal, 2020; Stubbe, 2020).

As an evidence-based intervention, this project incorporated cultural humility training to enhance the cultural sensitivity of behavioral health providers. This quality improvement project followed the Model for Improvement Framework (MFI) by the Institute for Healthcare Improvement (IHI). The MFI model offers a foundational approach that serves as a prominent tool in the field of quality improvement. The model is centered around three fundamental questions that serve to set the objective of the project (see Appendix C) (Langley et al., 2009). Subsequently, these questions are complemented by the Plan-Do-Study-Act (PDSA), which employs rapid cycles of change to assess impact, measure outcomes, and iterate through successive testing. The integration of the MFI model in the implementation of the ICC training provides a scientific approach for driving clinical change and fostering continuous improvement.

Specific Aims

The project aimed to implement cultural competency and humility training to enhance equity in behavioral health care services. From June 2023 to March 2024, behavioral health professionals in three private mental health clinics were projected to exhibit a 25% average increase in self-perceived knowledge, skills, and awareness in providing culturally sensitive care to clients from diverse cultural backgrounds.

Methods

Context

The quality improvement project was implemented at three behavioral health clinics located in Bend, Portland, and Salem, in the state of Oregon. The three clinics offer both in-person and telehealth outpatient psychiatric services that cater to individuals of all age groups and serve 27 counties in Oregon with approximately 26,360 annual patient visits. These clinics provide diverse outpatient psychiatric interventions and treatment modalities to meet community demands. Committed to enhancing mental health services, the clinics utilize research-driven technologies within a therapeutic environment. The Portland location currently has seven Psychiatric Mental Health Nurse Practitioners (PMHNPs), one TMS technician, and one administrative staff. The location in Bend counts with five PMHNPs, and the Salem clinic includes three PMHNPs, two TMS technicians, and one administrative staff. The overall remote administrative staff includes seventeen (scribes, billing, and administrative team).

Intervention

At each clinic, behavioral health professionals received invitations through email to participate in the Embracing Cultural Humility presentation. A comprehensive one-hour presentation derived from the ICC for BHP program by the DHHS was developed to enhance the

knowledge, skills, and awareness of behavioral health providers at these three clinics. The details of the training are available at https://thinkculturalhealth.hhs.gov/education/nurses

During the monthly staff meeting, behavioral health providers had the opportunity to engage in a one-hour training for behavioral providers session dedicated to enhancing their cultural and linguistic responsive approach to care. This training was offered virtually. By participating in this training, behavioral health providers enhanced skills, knowledge, and awareness to provide culturally sensitive and inclusive care that meets the unique needs of individuals from different cultural and social contexts. This interactive presentation was designed to enhance health outcomes and promote equitable access to high-quality mental health services for all clients, irrespective of their diverse backgrounds. Providers were encouraged to actively participate, ask questions, and engage in meaningful discussions to further their cultural and linguistic humility.

Study of the Intervention

Prior to participating in the training, behavioral health providers completed an adapted version of the Cultural Competence Self-Assessment Checklist (see Appendix D). The tool incorporates a 4-point Likert-style rating scale to help participants recognize their strengths and areas requiring further improvement for attaining cultural humility (Argyriadis et al., 2022). This tool also emphasizes that the term “culture” encompasses not only race, ethnicity, and ancestry, but also the shared culture, including beliefs, and common experiences, among individuals with disabilities, and those who identify as members of the LGBTQ community, members of faith, and spiritual communities (Argyriadis et al., 2022). Upon completion of the training, providers filled out a post-training self-assessment checklist.

Measures

The primary outcome measure of this project entailed comparing pre- and post-training self-assessment checklists. This comparison focused on calculating the average percentage changes perceived by behavioral health providers. The project aimed to achieve a 25% average, and outcome tracking entailed measuring the average against this target. These results helped calculate the perceived changes in three main domains: knowledge, awareness, and skills acquired by behavioral health care providers through the Embracing Cultural Humility training. This measure facilitated the evaluation of whether the intervention led to improvements in these three domains, aligning with the primary objective of the project.

Process measures included tracking the engagement of staff members in pre- and post-training self-assessments, the number of emails sent to providers, and the overall count of participants in the training. These metrics helped identify improvement areas and ensured the training aligned with behavioral health providers' needs. Balancing measures involved assessing the average training duration, monitoring whether the ICC training was being delivered within the planned schedule, and time spent collecting data

Analysis

A 4-point Likert scale was utilized to analyze interval data. The qualitative data was recorded in Excel to evaluate shifts in three key domains related to the provider's knowledge, skills, and awareness. The mean scale score was employed to measure central tendency and outcomes through a pre-post comparison, utilizing ten questions derived from the Cultural Competence Self-Assessment Checklist before and after the implementation of the project.

Ethical Considerations

The project was disseminated to staff through meetings and emails, ensuring effective delivery of project details and emphasizing optional and voluntary participation. Staff members

consented by completing the pre- and post-self-assessment surveys. The clinical sites endorsed and supported the project by signing a letter of support. To uphold the principles of confidentiality, participant responses and scores were anonymized by removing individual identifiers from the collected quantitative and qualitative data. This process adhered to the Health Insurance Portability and Accountability Act (HIPPA) guidelines, guaranteeing the protection of sensitive information. This project did not involve human subjects, thereby any potential conflicts of interest that may arise during the course of the project was monitored. Efforts were made to ensure transparency and mitigate any conflicts that may emerge, aligning with ethical considerations. This quality improvement project received an Institutional Review Board (IRB) exemption from the Oregon Health & Science University.

Results

The project was implemented through three Plan-Do-Study-Act cycles from June 2023 to March 2024 (see Appendix A). The "Plan" stage involved extensive research on evidence-based cultural competency and humility training, as well as exploring tools to assess the effectiveness of training methodologies. The evidence-based Cultural Competence Self-Assessment Checklist, from the Greater Vancouver Island Multicultural Society was selected to appraise the effectiveness of the presentation. The "Do" phase involved completing the online ICC for BHP training to attain the role of a facilitator and developing a one-hour presentation. Four emails were sent to staff, including a pre-presentation survey, while the consecutive emails served as reminders to complete the pre- and post-surveys. The "Study" phase involved gathering data from surveys to assess progress toward the project's goal. The "Act" phase incorporated feedback from organizational leaders and behavioral health providers who emphasized on "cultural humility" rather than "cultural competence." Consequently, this project aimed to

cultivate the providers' humility by prompting them to acknowledge their own biases, privilege, and limitations of their knowledge (Lekas et al., 2020).

The initial PDSA cycle incorporated feedback from clinical staff and leadership. The original 36-question Self-Assessment Cultural Competence Checklist was streamlined to 10 questions using Google Forms. In response to the "Act" phase, addressing the low pre-survey response rates involved expanding the training to the entire organization. To boost engagement, participants received extra time to complete the pre-survey before the presentation, with allocated time for the post-survey. The live presentation was recorded and uploaded to the organization's Psychiatry Shared Drive, offering staff convenient access to the content. Unintended consequences involved low participation in post-survey responses, leading to the need for an additional reminder, and the time spent analyzing the data.

Summary

Out of a sample of 41 staff members, 61% (25) completed the pre-survey, while 39% (16) completed the post-survey. Participation rates variations can be attributed to participant availability, work demands, and time constraints. Non-attendance of some administrative staff at monthly meetings contributed to participation disparity. The project aimed for a 25% increase in the average knowledge, skills, and awareness. However, key findings showed an average percentage increase of 16.5% in awareness, 7.1% in knowledge, and 8% in skills across all clinics. The overall average percentage change was 10.5% (see Appendix E).

Despite the project not meeting its initial aim, a notable strength lies in the fact that a concise one-hour training session resulted in improvements in cultural competency and humility. This highlights the project's efficacy in fostering positive change, emphasizing that even modest increases represent significant gains in this context. Another aspect is its accessibility, facilitated by the availability of the recorded presentation and the online platform of the ICC for BHP

training, enabling providers to further their training. Implementing this quality improvement project across three behavioral health clinic locations enhances the interpretability of results.

Interpretation

This project's outcomes revealed a significant percentage increase of 16.5% in awareness through a one-hour training based on the ICC for BHP. A prior quality improvement project by Toledo-Chavez and Gabriel (2023), aiming at enhancing awareness, skills, and knowledge showed similar outcomes. In their study, larger sample sizes in both urban (69 pre-survey responses and 14 post-survey responses) and rural clinics (23 pre-survey responses and 84 post-survey responses), revealed increase in awareness of 12% in the rural setting and a 15% increase in the urban clinic. While the current project revealed modest skill and knowledge increased of 8% and 7.1%, respectively, Toledo-Chavez and Gabriel (2023) observed more substantial gains. Knowledge increased by 13% in the urban clinic and by 10% in the rural clinic. Meanwhile, skills increased by 21% in the rural clinic, and by 4% in the urban clinic, representing the lowest increase and highlighting variations in the effectiveness of the training interventions.

Barriers, such as time constraints and busy schedules, affected robust training adoption of the current project. Despite these challenges, some providers expressed continued interest in further training. This project emphasizes the need for evidence on integrated care effectiveness for culturally diverse populations facing disparities. Another critical aspect of this project highlights the importance of addressing the challenges associated with integrating cultural humility training within busy practice environments with limited time resources. The literature suggests integrating cultural humility training across organizational, structural, and clinical levels (McGregor et al., 2019). Establishing organizational policies requiring cultural humility training should include adequate allocation of time and resources for effective implementation (McGregor et al., 2019).

Limitations

Limitations that could impact the generalizability of the project's main findings include a small sample size and the observed variability in response rates between the pre- and post-surveys. Factors that might have introduced confounding and limited internal validity include potential provider bias or personal perspectives on the subject, as well as imprecision in the measurement tool, given that it relied on self-assessment. Additional limitations include time constraints during the presentation and the virtual nature of the training for providers may have constrained their involvement and engagement. Efforts to mitigate and address limitations involved the distribution of a series of emails encouraging participation in both the pre- and post-surveys. Key support from leadership and administrative staff was instrumental, with emails sent and announcements made during staff meetings to promote engagement. Moving forward, a more effective approach could be to administer the pre-survey to participants before the presentation and collect post-survey responses after the presentation. This strategy aims to enhance data accuracy and reduce potential skewing results.

Conclusion

Within the context of this quality improvement project, the one-hour Embracing Cultural Humility training yielded an increase in behavioral health providers' perception of delivering culturally and linguistically sensitive care. While the project did not meet the aim, both pre- and post-surveys showed increased awareness, knowledge, and skills. These findings emphasize the importance of integrating such training programs to advance equity in behavioral health in Oregon, applicable across diverse care settings and addressing organizational, structural, and clinical levels. A deep understanding of these domains is crucial for guiding future interventions targeting behavioral health inequities. This may involve developing clinic policies for standardized staff training in cultural humility.

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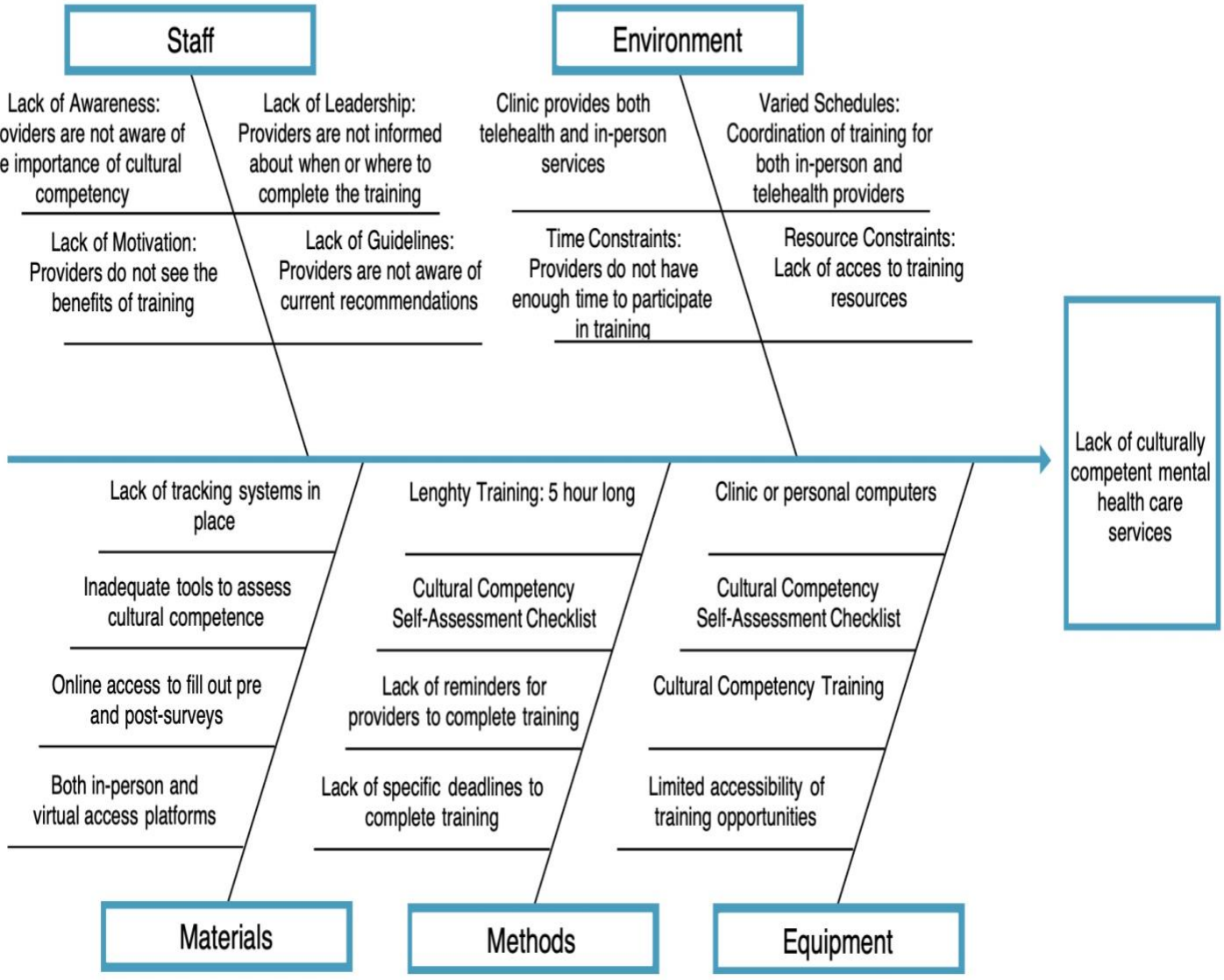
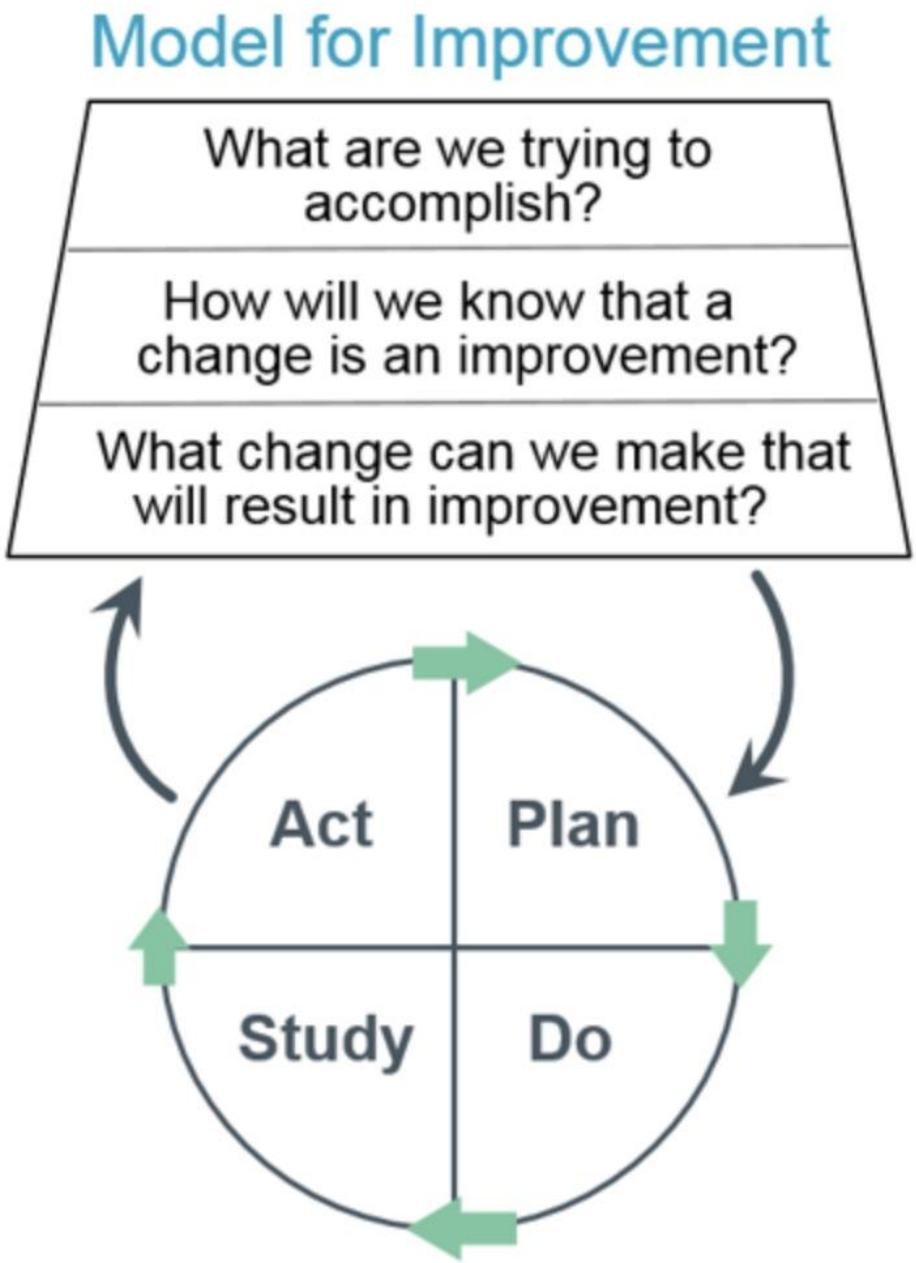
Appendix A. Project Timeline (Bend, Portland, and Salem, OR Locations)

	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
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. Cause and Effect Diagram



Appendix C. IHI Model for Improvement



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

Appendix D. Cultural Competence Self-Assessment Checklist

Cultural Competence Self-assessment Checklist

Adapted from the Greater Vancouver Island Multicultural Society Cultural Competence Self-assessment Checklist. That checklist was created with funding from the Government of Canada and the Province of British Columbia.

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

The term 'culture' includes not only culture related to 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, such as people with disabilities, people who are Lesbian Bisexual, Gay and Transgender (LGBT), people who are deaf, members of faith and spiritual communities, people of various socio- economic classes, etc.) In this tool, we are focusing on race, ethnicity and ancestry. However, remember that much of the awareness, knowledge and skills which you have gained from past relationships with people who are different from you are transferable and can help you in your future relationships across difference.

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. Multiple 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 there to help you identify areas of strength and areas that need further development in order to help you reach your goal of cultural competence.

Remember that cultural competence is a process, and that learning occurs on a continuum and over a life time. You will not be asked to show anyone your answers unless you choose to do so.

While you complete this assessment, stay in touch with your emotions and remind yourself that learning is a journey.

Western
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Financé par : Citoyenneté et Immigration Canada

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				
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, colour, religion, sexual orientation, language, and 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 my stereotypes 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 are 'appropriate', 'normal', or 'superior' behaviours, values, and communication styles.				
Accept ambiguity	I accept that in cross cultural situations there can be uncertainty and that uncertainty can make me anxious. It can also mean that I do not respond quickly and take the time needed to get more information.				
Be curious	I take any opportunity to put myself in places where I can learn about difference and create relationships.				
Aware of my privilege if I am White	If I am a White person working with an Aboriginal person or Person of Colour, I understand that I will likely be perceived as a person with power and racial privilege, and that I may not be seen as 'unbiased' or as an ally.				
Aware of social justice issues	I'm aware of the impact of the social context on the lives of culturally diverse population, and how power, privilege and social oppression influence their lives.				
		1 pt x	2 pt x	3 pt x	4 pt x

Knowledge					
Gain from my mistakes	I will make mistakes and will learn from them				
Assess the limits of my knowledge	I will recognize that my knowledge of certain cultural groups is limited and commit to creating opportunities to learn more				
Ask questions	I will really listen to the answers before asking another question				
Acknowledge the importance of difference	I know that differences in colour, culture, ethnicity etc. are important parts of an individual's identity which they value and so do I. I will not hide behind the claim of "colour blindness".				
Know the historical experiences of non-European Canadians	I am knowledgeable about historical incidents in Canada's past that demonstrate racism and exclusion towards Canadians of non-European heritage (e.g. the Chinese Head Tax, the Komagata Maru, Indian Act and Japanese internment).				
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 involves a commitment to learning over a life-time				
Understand the impact of racism, sexism, homophobia ...	I recognize that stereotypical attitudes and discriminatory actions can dehumanize, even encourage violence against individuals because of their membership in groups which are different from myself				
Know my own family history	I know my family's story of immigration and assimilation into Canada				
Know my limitations	I continue to develop my capacity for assessing areas where there are gaps in my knowledge				
Awareness of multiple social identities	I recognize that people have intersecting multiple identities drawn from race, sex, religion, ethnicity, etc and the importance of each of these identities vary from person to person				

Knowledge					
Inter-cultural and intracultural differences	I acknowledge both inter-cultural and intracultural differences				
Point of reference to assess appropriate behaviour	I'm aware that everyone has a "culture" and my own "culture" should not be regarded as a point of reference to assess which behavior is appropriate or inappropriate				
		1 pt x	2 pt x	3 pt x	4 pt x

Skills					
Adapt to different situations	I am developing ways to interact respectfully and effectively with individuals and groups				
Challenge discriminatory and/ or racist behaviour	I can effectively intervene when I observe others behaving in racist and/or discriminatory manner.				
Communicate across cultures	I am able to adapt my communication style to effectively communicate with people who communicate in ways that are different from my own.				
Seek out situations to expand my skills	I seek out people who challenge me to maintain and increase the cross-cultural skills I have.				
Become engaged	I am actively involved in initiatives, small or big, that promote understanding among members of diverse groups.				
Act respectfully in cross-cultural situations	I can act in ways that demonstrate respect for the culture and beliefs of others.				
Practice cultural protocols	I am learning about and put into practice the specific cultural protocols and practices which necessary for my work.				
Act as an ally	My colleagues who are Aboriginal, immigrants or People of Colour consider me an ally and know that I will support them with culturally appropriate ways.				
Be flexible	I work hard to understand the perspectives of others and consult with my diverse colleagues 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 who are different from me.				
Recognize my own cultural biases	I can 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 would 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

Appendix E. Survey Outcomes