Implementing Cultural Competency Training for Behavioral Health Professionals: A Quality Improvement Project

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Abstract

Background: Behavioral Health Care Providers (BHPs) can assess their cultural and linguistic competence through the National CLAS Standards framework that was developed by the Office of Minority Health as a part of an initiative to improve health equity. This study aims to increase cultural humility, knowledge, and comfort in providing culturally sensitive care for clients with diverse cultural backgrounds by implementing the U.S. Department of Health & Human Services' 'Improving Cultural Competency for Behavioral Health Professionals' online educational training for behavioral health providers. This study was conducted across three different behavioral health organizations, two community mental health clinics located in Oregon and one private practice located in Washington. Participants included psychiatric nurse practitioners, psychiatrists, psychologists, registered nurses, licensed social workers, QMHPs, QMHA's, and licensed mental health counselors (LMHC).

Methods: The Plan-Do-Study-Act (PDSA) method of quality improvement was used for this project. Baseline assessment included the "Self-Assessment of Perceived Level of Cultural Competence (SAPLCC)" questionnaire. The SAPLCC was utilized post-intervention and the percent change in perceived level of knowledge, skill, and comfort for caring for culturally diverse clients was reviewed.

Intervention: The SAPLCC questionnaire was conducted to evaluate healthcare providers' knowledge, skill, and comfort as related to providing culturally sensitive care for clients with diverse backgrounds. The U.S Department of HHS' sponsored online educational training, the ICC for BHP, was chosen for implementation.

Results: All three project sites had 50% or less participation due to barriers relating to participant buy-in. The average percent change between pre- and post-SAPLCC scores across the three project sites was 17.92%, not meeting the project aim.

Conclusion: Although the specific aim was not met, the impact of the quality improvement project includes an increased awareness of culturally sensitive care for each participant. Further renditions of the project should consider integrating the ICC for BHP as a formal system training for all behavioral health professionals as well as measuring direct impact on patient outcomes.

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

Contents

Introduction …… 4

Problem Description …… 4

Available Knowledge …… 5

Rationale …… 6

Specific Aim (s) …… 7

Methodology …… 7

Context …… 7

Interventions …… 8

Study of the Interventions …… 9

Measures …… 11

Analysis …… 12

Ethical Considerations …… 12

Results …… 12

Interpretation …… 16

Reference List …… 20

Appendix A. Project Timeline Seattle location …… 23

Appendix B. Project Timeline SE Location …… 24

Appendix C. Project Timeline NE Location …… 25

Appendix D. Multidimensional Model …… 26

Appendix E. Process Map …… 27

Appendix F. Cause & Effect Diagram …… 28

Appendix G. Self-Assessment of Perceived Level of Cultural Competence (SAPLCC) …… 29

Implementing Cultural Competency Training for Behavioral Health Professionals

According to the US census, by 2044, racial minorities will account for more than 50% of the country's population (U.S. Census Bureau, 2019). As the United States becomes more diverse, the need for culturally sensitive mental healthcare providers will continue to increase (Rice & Harris, 2021). Research suggests that a healthcare provider's ability to practice culturally competent care is essential for bridging mental health access to patients with culturally diverse backgrounds (Hughes et al., 2020; Jongen et al., 2018; McGregor et al., 2019). Currently, Spanish speakers make up 10% of licensed mental health providers in Oregon, and Latino providers make up only 3% (HSRI, 2017). In King County, Washington, there is a lack of culturally competent providers who are aware of the specific mental health conditions and disparities of its refugee residents, which make up 10-23% of its population (Jorgenson & Nilsson, 2021). Both Oregon and Washington's mental healthcare systems indicate the need for solutions to address the barriers to accessing mental healthcare services. The release of *Unequal Treatment* in 2002 by the United States Institute of Medicine (IOM) revealed critical health disparities for racial and ethnic minorities. It emphasized the necessity for organizations to establish cultural competence training for healthcare providers to address the inequities in the quality of care received by these patient populations (McGregor et al., 2019). The report also highlighted the importance of the patient-provider relationship in mitigating the health disparities in healthcare quality (Nelson, 2002). Unfortunately, there are many barriers to accessing and utilizing mental health services for racial and ethnic minorities, immigrants, and refugee populations. Current barriers include language differences, acculturative stress, differences in the cultural conceptualization of mental illness, miscommunication and mistrust, stigma, and fear (Jorgenson & Nilsson, 2021, Salami et. al., 2019, Stepanikova & Oates, 2017).

Available Knowledge

A patient's experience in accessing health care is directly impacted by their healthcare professional's ability to practice in a culturally competent manner (Jongen et al., 2018; McGregor et al., 2019; Hughes et al., 2020, Parra-Cardona & DeAndrea, 2016). Cultural and linguistic differences between providers and patients can result in significant miscommunication, mistrust, decreased service satisfaction, and overall feelings of disempowerment. In contrast, a provider's increased cultural competence has been associated with improved patient satisfaction with their care and increased adherence to their treatment (Jongen, McCalman, & Bainbridge, 2018; McGregor et al., 2019; Hughes et al., 2020). The cultural competence of mental health professionals is imperative when formulating interventions for mental health clients. Since culture plays a vital role in the manifestation of psychopathology, expression of symptoms, and help-seeking behaviors, cultural competence becomes necessary for mental health providers to ensure quality care (Parra-Cardona & DeAndrea, 2016; Venkataramu et al., 2020).

Current evidence shows that Cultural Competency Training (CCT), in addition to patient education, increasing the number of mental services, and incorporating culturally formulated interviews, will help improve patient experience, decrease misunderstanding and enhance diagnostic validity (Hughes et al., 2020; Rice & Harris., 2021). Cultural competency training "increases compassion, integrity, sensitivity, and respect" toward minority clients who receive mental health services (Hughes et al., 2020; Venkataramu et al., 2020, p. 6). One systematic review aimed to determine how useful CCT training was for mental health providers and found an overall improvement in both knowledge and attitude when addressing cultural aspects of mental health, as well as an improved level of comfort in using the Cultural Formulation Interview, found in the DSM V (Rice & Harris, 2021; Sue, 2001; Venkataramu et al., 2020).

Furthermore, recent literature recommends that CCTs include concepts of cultural humility, which is defined as having "traits of respect, empathy, and critical self-reflection at both intrapersonal and interpersonal levels" (Hughes et al., 2020, p. 29).

Training that encompasses cultural humility includes, understanding the role of culture and how it shapes behavior, learning to utilize culturally adaptive practice, and developing one's awareness of personal cultural influences, prejudices, and biases (Hughes et al., 2020; McGregor et al., 2019). Despite the acknowledgment of the importance of cultural competency by the American Psychological Association and the Association of Multicultural Counseling and Development, previous trend studies have shown little to no progress towards reducing mental health disparities for racial-ethnic minority groups (Cooks et al., 2017) and there is limited evidence on how to develop culturally competent guidelines (Rice & Harris, 2021, Sue, 2001; Venkataramu et al., 2020). Continued access disparities are of high clinical and public health significance, given that minorities with serious mental illness get sick and die much younger than other adults compared to whites with serious mental illness (Corrigan et al., 2017). Even in the age of internet-based health promotion, its associated benefits continue to be beyond the reach of a vast majority of the minority population (Parra-Cardona & DeAndrea, 2016). Still, Cultural Competency Training is considered a crucial strategy in addressing racial and ethnic disparities across the United States.

Rationale

The National Academy of Medicine's 2001 report identified six overarching "Aims for Improvement" for healthcare. One of the stated aims includes increasing equitable care by closing the racial and ethnic gaps in health status, which organizations can accomplish through the implementation of CCTs. The National Standards for Cultural and Linguistically Appropriate

Services (CLAS) by the Office of Minority Health aims to advance health equity, improve quality and eliminate health disparities by establishing guidelines for healthcare organizations in achieving effective, equitable, and culturally responsive care (U.S. Department of Health & Human Services, n.d.) Providing culturally and linguistically competent care can help health professionals/organizations achieve health equity, increase their capacity to care for diverse clients, and reduce societal burdens due to health disparities. The National CLAS standard framework and Think Cultural Health website provides a program titled "Improving Cultural Competency for Behavioral Health Professionals (ICC for BHP)," which enabled the implementation of an evidence-based intervention for this project in improving providers' cultural and linguistic Competence (U.S. Department of Health & Human Services, n.d.).

This project is supported by Betancourt et al.'s (2005) proposed framework that reflects the representation of cultural competence throughout a healthcare organization on three different levels: organizational, structural, and clinical. By implementing Cultural Competency Training (CCTs), the existing disparities in racial and ethnic healthcare can fill the gaps towards equitable care as defined by one of these aims (Betancourt et al., 2005; IOM, 2001).

Similarly, a conceptual framework that helps understand cultural competence at an individual and organizational level is Sue's (2001) Multiple Dimensional Cultural Competence (MDCC). This model organizes three primary dimensions of multicultural competence: (a) specific racial/cultural group perspectives, b) components of cultural competence such as attitudes, skills, and knowledge, and (c) foci of cultural competence such as individual, clinical, and organizational (Sue, 2001). This framework helps identify the complex and dynamic nature of cultural competence and is helpful for providers and organizations to implement culturally responsive services. See Appendix D for the Multiple Dimensional Framework visual.

The Institute of Healthcare Improvement (IHI) utilizes the Model for Improvement (MFI) as a framework to help guide improvement work within healthcare organizations. The IHI and MFI were used in the development of this project. The IHI association designed the MFI tool in process improvement and consisted of two distinct phases. The two phases address three fundamental questions and implement the Plan-Do-Study-Act (PDSA) cycle (IHI, 2021).

The details of phase one incorporate setting a time-specific measurable aim in a defined population, establishing quantitative measures, and selecting time-specific ideas for change. Phase two is to test a change in the work setting by using action-oriented learning. After each test, the PDSA cycle is continually improved by refining the process and learning from each test. The selection of MFI as the methodology of choice is preferred for its partiality of small-scale changes before implementing a larger-scale change. If a successful implementation of this project occurs in these smaller clinic settings, the ICC for BHP could potentially be integrated into the system-level diversity training.

Specific Aims

From December 2021 to February 2022, Behavioral Health Professionals in these community mental health clinics will demonstrate an average of 20% increase in perceived knowledge, skill, and comfort in providing culturally sensitive care for clients with diverse cultural backgrounds.

Methods

The project was implemented at three different behavioral health clinics in Portland, OR, and King County, WA. Two behavioral health clinics were conducted at large community-based behavioral health clinics in NE and SE Portland. These clinics provide a variety of community-based mental health treatments such as medication management, counseling, substance misuse

treatment, and family support services. The SE behavioral health clinics were based at a culturally specific site that caters to the Latinx population of Portland, OR. Both clinics provide face-to-face or video conferences for initial client assessments, and the NE clinic provides telephone visits for subsequent follow-up appointments. The SE clinic offers all modes of communication for follow-up appointments during COVID-19 emergency measures in place. Both clinics require to conduct a yearly 1-hour diversity and inclusion training and participation in antiracist work. Both clinics for this project included participants employed at the clinics. At the NE location, there were eight participants, and at the SE site, there were five participants. The NE clinic's participants were 100% white and 100% female-identifying and have received their Master of Science in Nursing or Doctorate in Nursing Practice and specialize in psychiatric mental health. Of the total possible participants at the NE clinic in Portland, all LMP providers who were willing to participate were included. At the SE clinic, ten participants, one MD, two psychologists, four Qualified Mental Health Professionals (QMHP), and three Qualified Mental Health Associates (QMHA) participated in the project.

The third clinic is a private practice located in four Seattle area locations in the Pacific Northwest. This organization is one of the largest outpatient behavioral health providers for individually focused care and integrated treatment. They offer accessible and collaborative treatment, servicing over five hundred thousand people since 1995. They provide both in-person and telehealth services for their patient population. The majority of patient demographics are Caucasian and mainly have private insurance. This practice hopes to provide integrated and accessible mental health services in Washington State. They have two psychiatrists, four PMHNPs, three LMHCs, four SUDP, medical receptionists, and TMS technicians (Associated Behavioral Health Care, n.d.).

Interventions

Behavioral health professionals at each clinic were invited to complete an online training developed by the U.S Department of Health and Human Services (DHHS) as a strategy to improve the quality of care for clients from diverse backgrounds. The program titled 'Improving Cultural Competency for Behavioral Health Professionals (ICC for BHP) is a five-hour online educational training sponsored by DHHS Office of Minority Health and is approved by the National Association for Alcoholism and Drug Abuse Counselors (NAADAC). NAADAC approval ensures that learners receive a consistent, reliable, and quality learning experience that applies to their careers and advances their understanding of addiction and co-occurring disorders-related issues (NAADAC, n.d.).

The ICC for BHP is an accredited program approved for five continuing education (CE) credit hours. The main objective of this program is for behavioral health professionals to increase their cultural and linguistic competency in four courses totaling between 4-5.5 hours (Behavioral Health, n.d). Learning objectives of this course include describing the principles of cultural humility, discussing how provider bias can affect therapeutic relationships, and identifying strategies to reduce bias during assessment and diagnosis. A detailed description of all curricular elements and materials is freely available at https://thinkculturalhealth.hhs.gov/education/behavioral-health.

Participants were recruited through email and encouraged to complete the ICC for BHP training during non-clinic hours within one month. Prior to implementing the training, a pre-intervention questionnaire titled "Self-Assessment of Perceived Level of Cultural Competence (SAPLCC)" was emailed to the participants. This questionnaire, developed by Echeverri et al. (2013), is a tool for assessing knowledge, skills, and attitudes relating to the provision of

culturally competent health care to diverse patient populations (see Appendix G for complete questionnaire). Differences between pre-and post-questionnaire answers were used to measure the impact of the ICC for BHP training. Implementing the Plan-Do-Study-Act (PDSA) model, the improvement project was reviewed at one, two, three, and four months. The SAPLCC was utilized as a post-questionnaire and was sent to only medical providers who completed both the pre-questionnaire and ICC for BHP training.

Measures

The outcome measure for this project was the average percent change in perceived knowledge, skill, and comfort in providing culturally competent care after the ICC for BHP intervention. Outcome tracking included measuring this percent average versus the 20% threshold indicated as the project aim. This project's process measures included monitoring pre-and-post-SAPLCC questionnaire responses and ICC for BHP training completion rates. Another process measure included the number of staff with access to the ICC for BHP intervention. As an approach to monitor these processes, a reminder email was sent out to the participants at the beginning of each week, containing the SAPLCC questionnaire and the ICC for BHP training link (see references in Appendix D). The completion of each process marked the end of a single PDSA cycle, at which point evaluation and remediation were considered to create more ways of communicating with providers, fostering engagement, and solving time constraints for providers. Balancing measures included the time that providers were unable to direct toward client care and increased work burden. Brief surveys were sent at the end of each PDSA cycle to measure the perceived increased work burden. See Appendix E for the project's process map.

Analysis

Data collection occurred over four months using the SAPLCC pre- and post-questionnaire scores. An average of each total score on the following sections comfort, skill, and knowledge were used to determine a significant difference between pre-and post-questionnaires. The data was analyzed using a run chart at the end of each PDSA cycle month.

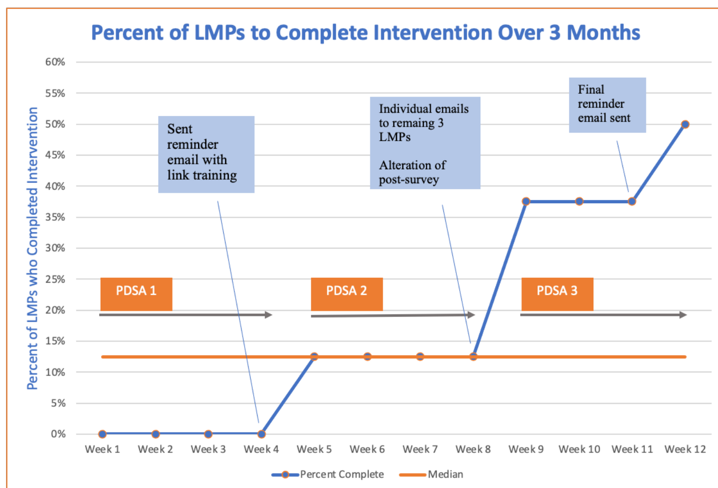
Ethical considerations

At each project site, leadership and participants were informed of the project and given updates either through email or during interdisciplinary team (IDT) meetings. Participation in this improvement project was voluntary, and results from all findings, including survey responses, remained confidential. Participants could choose to withdraw their participation at any point. All the clinics gave consent to implementing this project by signing a letter of support. The Participant's staff were informed to adhere to HIPPA standards and refrain from disclosing client names or identifiers in their responses. An Institutional Review Board request for determination was completed and was given a non-human research determination prior to the implementation of the project.

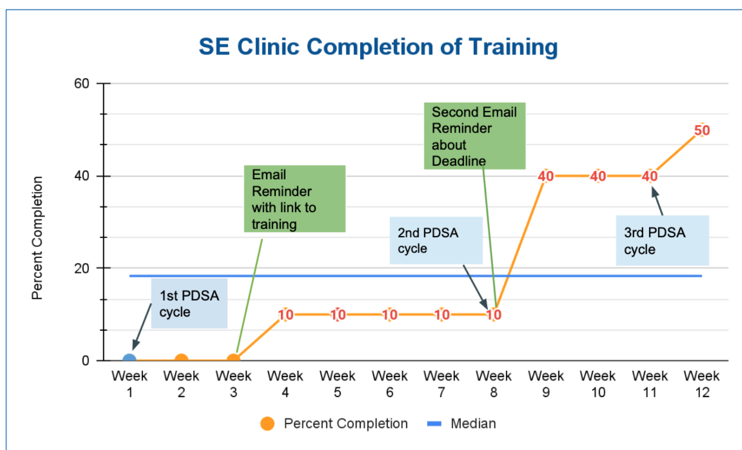
Results

Implementation of the projects was developed over three monthly PDSA cycles with slight variation in the timeline (see Appendix A, B, and C).

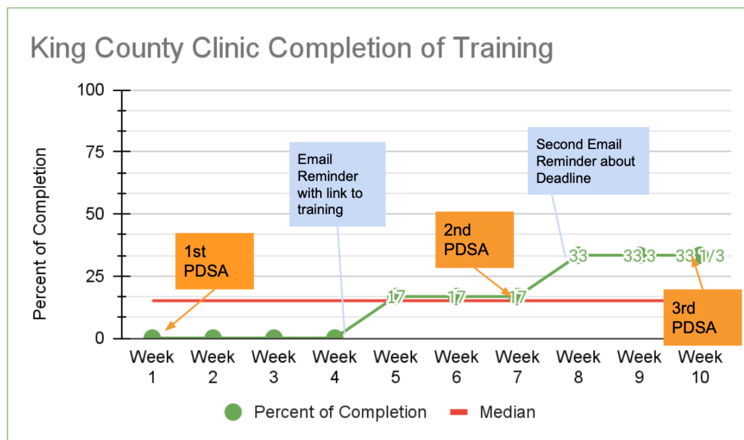
The Portland, NE location took place between November 2021 and February 2022.



The Portland SE between December 2021 through February 2022



The King County, WA Location took Place between January 2021 through February 2022



Planning included collecting research on the efficacy of cultural competency training and deciding on the methods of training implementation. Additional research was conducted on self-assessment questionnaires relating to the provision of culturally competent care and deciding on the method of questionnaire implementation. The "Do" stage of the PDSA cycle consisted of behavioral health professional completion of the ICC for BHP online educational training and data collection of pre-and-post-SAPLCC survey responses. The "Study" stage reviewed the data collected and utilized data points to assess progress toward the project aim of an average 20% increase in perceived knowledge, skill, and comfort of providing culturally competent care. The "Act" stage was revisited at the end of every month between the designated dates at each site, resulting in adaptations, or eliminations of the postulated plan. At the end of PDSA Cycle 1, the original SAPLCC questionnaire in PDF format was translated to a shortened version at each designated site via Survey Monkey or google forms online format. The online shortened version of the SAPLCC was utilized due to the potential increase in the participation rate and the benefit of convenience compared to the original PDF SAPLCC questionnaire that required additional time to complete, print, scan, and email. The Survey Monkey template was free to use and there were no unanticipated costs. The Google forms template was free to use and there were also no costs associated with its use. The "Act" stage was also revisited to address the remote work environment and resulting communication barriers, with changes made in email frequency and specificity to participants and other behavioral health personnel. See Appendix F for the Cause & Effect diagram which highlights contributing factors to our project's aim.

Unintended Consequences & Missing Data

Unintended consequences include the addition of time spent on the completion of the training outside of normal office hours. Additional missing data can be explained by the lack of

completion of survey responses as well as participants at each of the locations not finishing the training.

Summary

A total of eight participants were recruited for the project in NE Portland, ten at the SE project site, and six at the King County, WA project site. A total of four (50%) participants completed the training at the NE location, five (50%) in the SE Portland location and two (33.3%) took part at the Seattle-based site. Key findings show that all participants who completed the survey at the NE Portland location were of white/Caucasian background and all who completed the survey at the SE Portland location were Hispanic/Latino. Those who took the training at the Seattle-based locations were of White/Armenian and Black/Somali descent. All who completed the training also completed the post-survey. Factors impacting participation rates include participant availability, work burden, personal views on the topic of culturally sensitive care, distance learning fatigue due to the COVID 19 pandemic, and finally COVID related illness and personal losses.

The project aim was a 20% increase in the average "perceived level of comfort, skill, and knowledge" scores between the pre-and-post-SAPLCC. At the NE community clinic, the perceived level of comfort scores increased by an average of 23.7%, level of skill by 7.95%, and level of knowledge by 20.8%, with a combined average percent change of 17.6%, not meeting the project aim. At the SE location, the perceived level of comfort scores increased by an average of 3.6%, the level of skill by 12.98%, and the level of knowledge by 7%, with a combined average percent change of 8.76%, not meeting the project aim. At the Seattle area location, the perceived level of comfort scores increased by an average of 26.69%, the level of skill by 29.41%, and level knowledge by 26.31%, with a combined average percent change of 27.5%,

meeting the project aim. Across all three sites, only an average of 44.43% of all possible participants completed the ICC for BHP and the overall combined aim at all three sites was 17.92% not meeting the aim.

A strength of this project was its accessibility due to the ICC for BHP online training allowing providers to register and complete the training at their convenience. The training was split into five user-friendly modules, allowing participants to pace themselves. Additionally, this quality improvement project was conducted at three different behavioral health clinics, allowing interpretation of results from each site to be used to direct further project implementation.

Interpretation

The increase in work burden and personal views on the topic of culturally sensitive care, distance learning fatigue due to the covid-19 pandemic, and covid related illness and losses could have impacted the buy-in from participants. Overall providers buy-in were challenging and the methods can be adjusted to encourage participation should future implementation occur. Possible adjustments include an additional increase in the time frame allotted for training completion as well as the implementation of reminders and incentives for participation.

There were fewer participant buy-ins from the Seattle-based clinic, at only two participants, and overall low participation rates might have had an impact on the results of this study. Of the three projects, the King County project implementer had the shortest amount of time implementing this intervention, indicating that rapport could be important for buy-in from participants. Additionally, it was found that the majority of participants were made up of providers who identified as a minority themselves, accounting for 54.5% of all participants. This could have impacted the results of this study as these participants may have already been informed or comfortable with culturally competent care prior to the intervention.

Additionally, survey length was reported at all sites as "too long" and "not specific to the training." This feedback indicates that there should be an adjustment to future pre- and post-intervention cultural competency questionnaires. Post-project implementation, it was discovered that a survey was developed through the 'Think Cultural Health' website for the 2022 training and is specific to measuring ICC for BHP efficacy. It was also discovered that the training includes the ability to be a facilitator who can implement the intervention and measure outcomes in person. Although the specific aim was not met for this project, data show a net increase in the average percent perceived level of knowledge, comfort, and skill for each participant as well as positive feedback from all participants regarding the training.

Limitations

Limitations identified that may have affected the internal validity of this project's key findings include the small sample size, potential provider bias or personal views on this topic, and imprecision in the measurement tools used to assess knowledge, skill, and comfort gained from this specific online training. Additionally, due to the small sample size at each clinic, the generalizability of the key findings may only be applicable to similar behavioral health settings and their populations.

This project made several attempts to minimize and adjust for limitations. Multiple emails were sent to participants in order to get full participation however only 44.43% of the data was collected based upon the total completion rate across the three sites. Recruitment attempts consisted of emails, meeting presentations, and one-on-one meetings. Other limitations included the inability to track those who have completed the training until they have completed the training and post-survey. In the future, efforts can be made in the future PDSA to be a facilitator

through the website located at Behavioral Health - Think Cultural Health and add participants into the training platform. Furthermore, the long-term impact of this five-hour training is unknown, the training was implemented over a short duration and overall had low completion rates; effective cultural competency is a lifelong process.

Conclusions & Next Steps

Although not all sites met the specific aim, the impact of the quality improvement project includes increased awareness of culturally sensitive care for each participant. With an accessible training format that addresses topics important for behavioral health providers to consider, this quality improvement project contributes to the secondary aim of encouraging culturally sensitive care towards clients from diverse backgrounds. Considering that the ICC for BHP training is updated yearly by the U.S Department of Health and Human Services, this training should continue to be implemented for behavioral health providers across all clinical settings and has the potential to spread to other behavioral health clinics in the surrounding area.

Furthermore, the ICC for BHP now has the capability to be conducted by an in-person facilitator. This option should be considered for future renditions of this project to streamline the training further and for the potential to complete this training in person, avoiding the limitations that resulted from the online-training format. The ICC for BHP training also includes pre- and post-survey, which facilitators can unlock for the participants, eliminating the need for the SAPLACC pre- and post-survey used in this project. Attention should focus on encouraging participant buy-in by increasing opportunities for educational exposure to the training. This can be done by scheduling additional meetings where information is disseminated or by sending additional reminder emails to participants to complete the post-intervention responses.

Additionally, further renditions of this project could consider the direct impact on patient outcomes. As the United States continues to have a diverse population, adhering to the National CLAS standards will ensure that healthcare providers/organizations achieve effective, equitable, and culturally responsive care**.** The multidimensional cultural competence framework model identifies cultural competence's complex and dynamic nature. Providers and organizations must mind the multiple foci of cultural competence (individual, clinical, and organizational) and the various cultural constructs such as attitudes, skills, and knowledge. Effective cultural competence requires investment and involvement at all levels of organizational infrastructure to provide policies, programs, and providers that can provide equitable and culturally responsive care to all the patients.

References

Behavioral Health. (n.d.). *Think cultural health*. Retrieved May 27, 2021, from https://thinkculturalhealth.hhs.gov/

Betancourt, J. R., Green, A. R., Carrillo, J. E., & Park, E. R. (2005). Cultural competence and health care disparities: key perspectives and trends. *Health Affairs (Project Hope)*, *24*(2), 499–505. https://doi-org.liboff.ohsu.edu/10.1377/hlthaff.24.2.499

Corrigan, P. W., Torres, A., Lara, J. L., Sheehan, L., & Larson, J. E. (2016). The healthcare needs of latinos with serious mental illness and the potential of peer navigators. *Administration and Policy in Mental Health and Mental Health Services Research*, *44*(4), 547–557. https://doi.org/10.1007/s10488-016-0737-2

Cook, B. L., Doksum, T., Chen, C.-n., Carle, A., & Alegría, M. (2013). The role of provider supply and organization in reducing racial/ethnic disparities in mental health care in the U.S. *Social Science & Medicine, 84*, 102-109.https://doi.org/10.1016/j. socscimed.2013.02.006

Cook, B. L., Trinh, N.-H., Li, Z., Hou, S. S.-Y., & Progovac, A. M. (2017). Trends in racial-ethnic disparities in access to mental health care, 2004–2012. *Psychiatric Services*, *68*(1), 9–16. https://doi.org/10.1176/appi.ps.201500453

Hughes, V., Delva, S., Nkimbeng, M., Spaulding, E., Turkson-Ocran, R. A., Cudjoe, J., Ford, A., Rushton, C., D'Aoust, R., & Han, H. R. (2020). Not missing the opportunity: Strategies to promote cultural humility among future nursing faculty. *Journal of Professional Nursing: Official Journal of the American Association of Colleges of Nursing, 36*(1), 28–33. https://doi-org.liboff.ohsu.edu/10.1016/j.profnurs.2019.06.005

Institute of Medicine [IOM] (U.S.) Committee on Quality of Health Care in America. (2001).

Crossing the Quality Chasm: A New Health System for the 21st Century. National Academies Press (U.S.).

Jorgenson, K. C., & Nilsson, J. E. (2021). The relationship among trauma, acculturation, and mental health symptoms in Somali refugees. *The Counseling Psychologist, 49*(2), 196-232.

Jongen, C., McCalman, J., & Bainbridge, R. (2018). Health workforce cultural competency interventions: a systematic scoping review. *BMC Health Services Research, 18*(1), 232. https://doi-org.liboff.ohsu.edu/10.1186/s12913-018-3001-5

McGregor, B., Belton, A., Henry, T. L., Wrenn, G., & Holden, K. B. (2019). Improving behavioral health equity through cultural competence training of health care providers. *Ethnicity & Disease, 29* (Suppl 2), 359–364. https://doi-org.liboff.ohsu.edu/10.18865/ed.29.S2.359

Nelson, A. (2002). Unequal treatment: Confronting racial and ethnic disparities in health care. *Journal of the National Medical Association, 94*(8), 666.

Parra-Cardona, J. R., & DeAndrea, D. C. (2016). Latinos' access to online and formal mental health support. *The Journal of Behavioral Health Services & Research, 43*(2), 281–292. https://doi.org/10.1007/s11414-014-9420-0

Rice, A. N., & Harris, S. C. (2021). Issues of cultural competence in mental health care. *Journal of the American Pharmacists Association, 61*(1), e65-e68.

Salami, B., Salma, J., & Hegadoren, K. (2019). Access and utilization of mental health services for immigrants and refugees: Perspectives of immigrant service providers. International *Journal of Mental Health Nursing, 28*(1), 152-161.

Stepanikova, I., Oates, G. R. (2017). Perceived discrimination and privilege in health care: The

role of socioeconomic status and race. *American Journal of Preventive Medicine, 52*(1). https://doi.org/10.1016/j.amepre.2016.09.024

Sue, D. W. (2001). Multidimensional facets of cultural competence. *The Counseling Psychologist, 29*(6), 790-821.

U.S. Census Bureau (2019, July 2). *Projections of the size and composition of the U.S: 2014-2060*. The United States Census Bureau. https://www.census.gov/library/publications/2015/demo/p25-1143.html.

U.S. Department of Health & Human Services (2019). *Think cultural health: Improving cultural competency for behavioral health professionals.* Retrieved from: https://thinkculturalhealth.hhs.gov/behavioral-health/default.asp?id=709512&LinkToken=vwHYZESzmGzGdJYtctNmgltrMb8uCqvTHBoexMd%2FxcA%3D

U.S. Department of Health & Human Services (n.d). *National culturally and linguistically appropriate services standards.* Retrieved from https://thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedNationalCLASStandards.pdf

Venkataramu, V. N., Vajawat, B., Raghuraman, B. S., & Chaturvedi, S. K. (2020). Cultural competency training for psychiatry residents and mental health professionals: A systematic review. *International Journal of Social Psychiatry*, https://doi.org/10.1177/0020764020981610.

Appendix A. Projected Timeline (Seattle-area Location)

Task Description	Au g	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Finalize project design and approach (703A)	X							
Complete IRB determination or approval (703A)		X	X	X	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 the final paper (703B)								X
Prepare for project dissemination (703B)								X

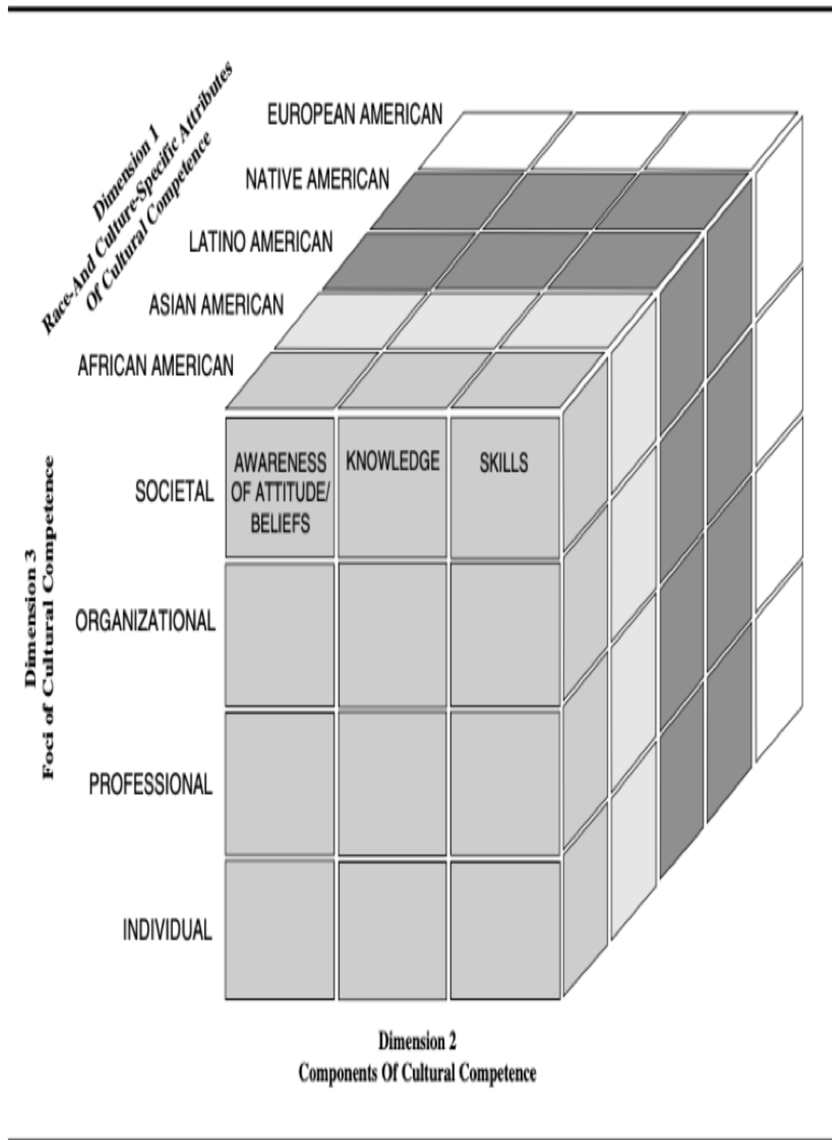
Appendix B. Projected Timeline (SE Location)

	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Finalize project design and approach (703A)	X										
Complete IRB determination or approval (703A)			X								
IRB Approval						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 the final paper (703B)										X	
Prepare for project dissemination (703B)											X

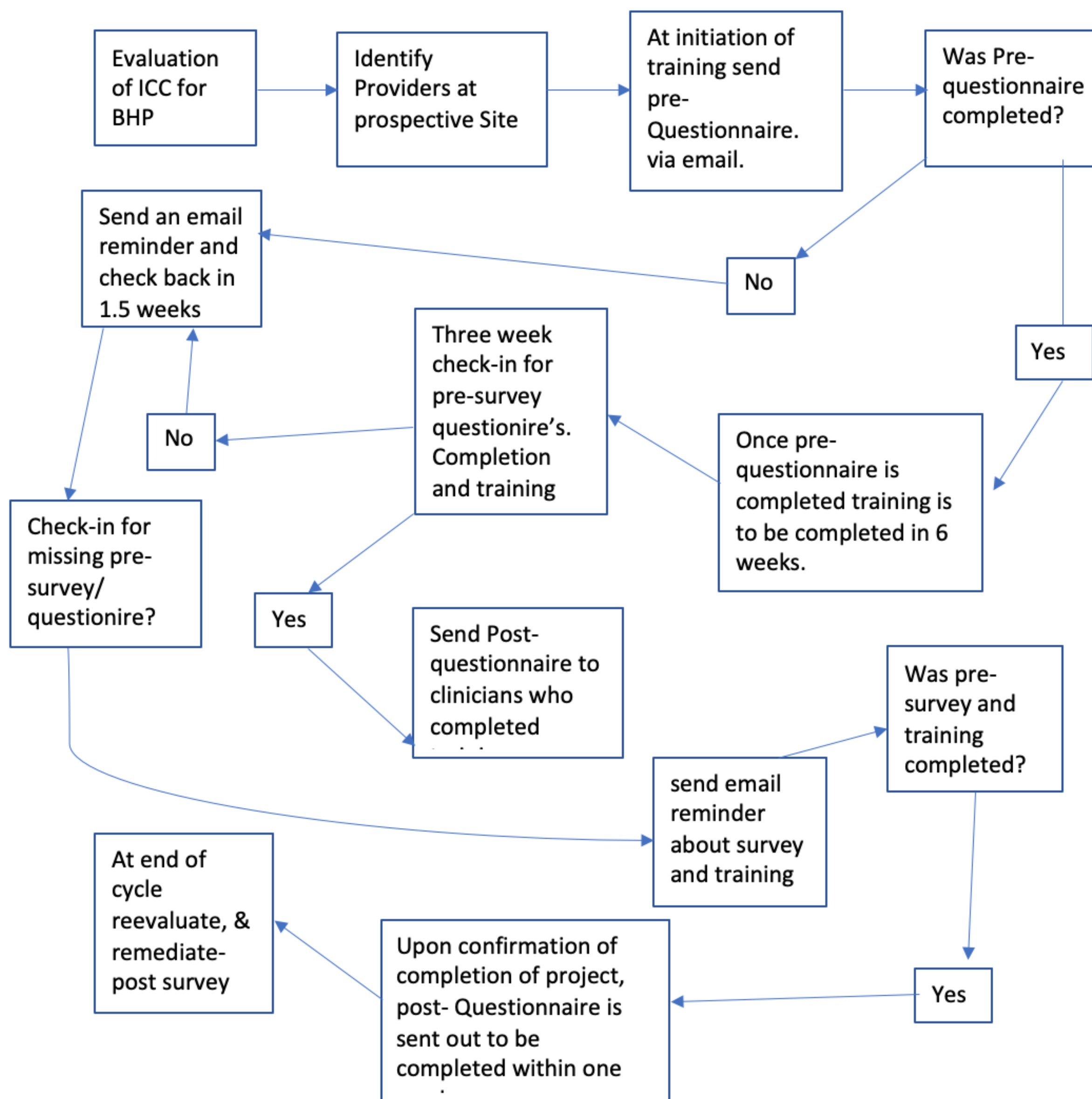
Appendix C. Projected Timeline (NE Location)

	September 2021	October 2021	November 2021	December 2021	January 2021	February 2021	March 2021
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
Prepare for project dissemination (703B)							X

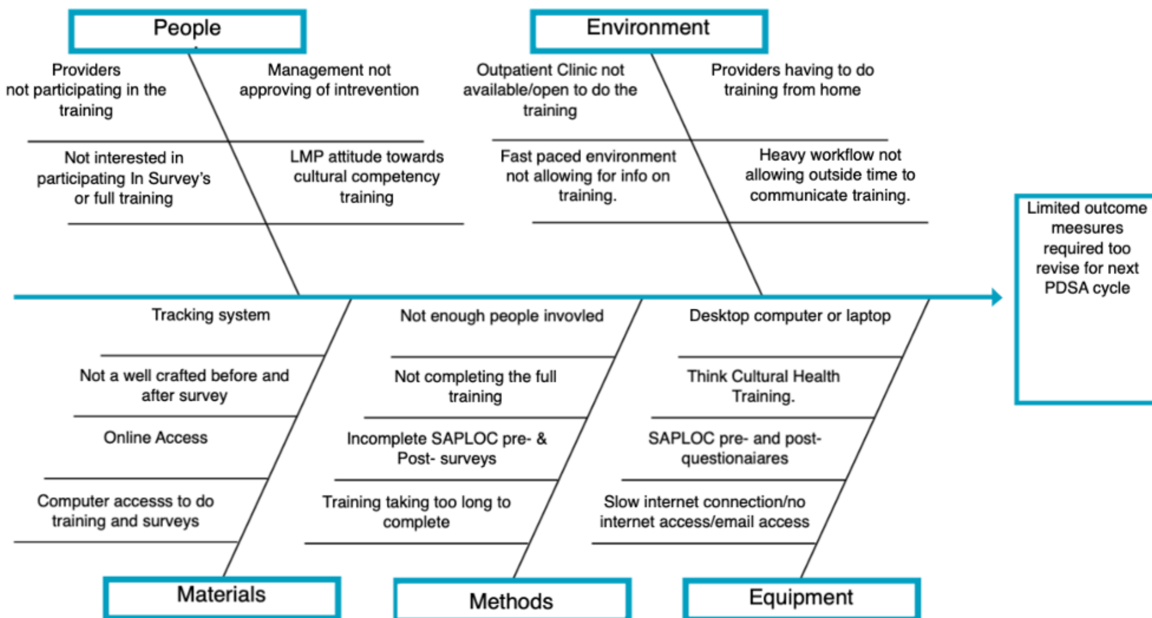
Appendix D. Multidimensional Model for Developing Cultural Competence



Appendix E. Process Map



Appendix F. Cause & Effect



Appendix G: SAPLCC Questionnaire

Self-Assessment of Perceived Level of Cultural Competence (SAPLCC)*

This questionnaire is a tool for assessing knowledge, skills, and attitudes relating to the provision of culturally competent health care to diverse patient populations. The results will assist us in planning future cultural diversity educational programs and will be used to validate the questionnaire and as a baseline assessment of your perceived cultural competence. Your individual responses to this questionnaire will remain confidential. Filling out the questionnaire is your implicit consent to participate. You may leave any question blank and stop participating at any time.**

A. Personal Characteristics

1. Race/Ethnicity: ______________________________ Gender: __________ Age: ___
2. Spoken language(s) other than English: ____
3. Highest academic degree obtained: ____
4. What is your academic year in the program: Didactic Year___ Clinical Year___
5. Previous training in cultural competence (mark all that apply)

None ____ Workshop ___ Conference ____ Job____

Within a class in physician assistant school _____ During undergraduate coursework____

6. Countries you have lived other than the United States: ______________________________

   ____

7. Experience you have working with diverse racial, ethnic or cultural groups:

Years of experience: one or less ___ one to three years ___ more than three years

Please describe the different backgrounds (culture, race, ethnicity, religion, sexual orientation, economic status, gender, age, language, disability, etc.) of the population groups you have experience working with

____

(*) The Self-assessment of Perceived Level of Cultural Competence (SAPLCC) questionnaire has been adapted with permission from two instruments: Parts B, C, D and E were taken from the Clinical Cultural Competency Questionnaire (CCCQ: Like, 2001) and part F from The California Brief Multicultural Competency Scale (CBMCS: Gamst, 2004). Please do not duplicate, quote from, or circulate without permission of the authors. **Contact:** Margarita Echeverri, PhD, MS, Center for Minority Health and Health Disparities Research and Education, Xavier University of Louisiana, College of Pharmacy, mechever@xula.edu

(**) This questionnaire was converted to an online format for this study.

B. KNOWLEDGE (1)						
How **KNOWLEDGEABLE** are you about the following subject areas?		**Not at all**	**Slightly**	**Mod**	**Very**	**Extremely**
1	Demographics of diverse racial, and ethnic groups	1	2	3	4	5
2	Socio-cultural characteristics of diverse racial and ethnic groups	1	2	3	4	5
3	Health risks experienced by diverse racial and ethnic groups	1	2	3	4	5
4	Health disparities experienced by diverse racial and ethnic groups	1	2	3	4	5
5	Socio-cultural issues in:					
A.	Health Promotion/Disease Prevention	1	2	3	4	5
B.	Reproductive Health/Pregnancy	1	2	3	4	5
C.	Child Health	1	2	3	4	5
D.	Adolescent Health	1	2	3	4	5
E.	Adult Health	1	2	3	4	5
F.	Geriatrics	1	2	3	4	5
G.	Women's Health	1	2	3	4	5
6	Ethnopharmacology (i.e., variations in medication responses in diverse ethnic populations)	1	2	3	4	5
7	Different Healing Traditions (e.g., Ayurvedic Medicine, Traditional Chinese Medicine)	1	2	3	4	5
8	Historical and contemporary impact of discrimination (i.e., racism, bias, prejudice) in health care experienced by various population groups	1	2	3	4	5
9	Office for Civil Rights August 30, 2000 Policy Guidance on the Title VI Prohibition Against National Origin Discrimination as it affects person with Limited English Proficiency	1	2	3	4	5
1	Office of Minority Health's National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care	1	2	3	4	5
C. SKILLS						
How **SKILLED** are you in dealing with socio-cultural issues in the following areas of patient care?		**Not at all**	**Slightly**	**Mode**	**Very**	**Extremely**
1	Greeting patients in a culturally sensitive manner	1	2	3	4	5
2	Eliciting the patient's perspective about:					
A.	Health and illness (e.g., its etiology, name, treatment, course, prognosis)	1	2	3	4	5
B.	Use of folk remedies and/or other alternative healing modalities	1	2	3	4	5
C.	Use of folk healers and/or other alternative practitioners	1	2	3	4	5
3	Performing culturally sensitive:					
A.	Physical examination	1	2	3	4	5
B.	Treatment plan	1	2	3	4	5
C.	Patient education and counseling	1	2	3	4	5
D.	Clinical preventive services	1	2	3	4	5
E.	End of life care	1	2	3	4	5

		Not at all	Slightly	Mod	Very	Extremely
4	Assessing health literacy	1	2	3	4	5
5	Working with medical interpreters	1	2	3	4	5
6	Dealing with cross-cultural conflicts relating to:					
	A. Informed consent	1	2	3	4	5
	B. Diagnosis or treatment	1	2	3	4	5
	C. Adherence/compliance problems	1	2	3	4	5
	D. Ethical conflicts	1	2	3	4	5
7	Apologizing for cross-cultural misunderstandings or errors	1	2	3	4	5

D. ENCOUNTERS/SITUATIONS

	How **COMFORTABLE** do you feel in dealing with the following cross-cultural situations?	Not at all	Slightly	Mod	Very	Extremely
1	Caring for patients:					
	A. From culturally diverse backgrounds	1	2	3	4	5
	B. With limited English proficiency	1	2	3	4	5
	C. Who insists on using or seeking folk healers or alternative therapies	1	2	3	4	5
2	Identifying beliefs that are not expressed by a patient or caregiver but might interfere with the treatment	1	2	3	4	5
3	Being attentive to nonverbal cues or the use of culturally specific gestures that might have different meanings in different cultures	1	2	3	4	5
4	Interpreting different cultural expressions of pain, distress, and suffering	1	2	3	4	5
5	Advising a patient to change behaviors or practices related to cultural beliefs that impair one's health	1	2	3	4	5
6	Speaking in an indirect rather than a direct way to a patient about his/her illness if this is culturally appropriate	1	2	3	4	5
7	Breaking "bad news" to a patient's family first rather than to the patient if this is more culturally appropriate	1	2	3	4	5
8	Working with health care professionals from culturally diverse backgrounds	1	2	3	4	5
9	Working with a colleague who makes derogatory remarks about patients from a particular ethnic group	1	2	3	4	5
1	Treating a patient who makes derogatory comments about your racial or ethnic background	1	2	3	4	5

E. ATTITUDES

		Not at all	Slightly	Mod	Very	Extremely
1	How **IMPORTANT** are each of the following factors in contributing to health disparities?					
	A. Genetics	1	2	3	4	5
	B. Lifestyle	1	2	3	4	5
	C. Environment	1	2	3	4	5
	D. Poverty	1	2	3	4	5
	E. Educational Status	1	2	3	4	5

	F. Illiteracy	1	2	3	4	5
	G. Ageism (prejudice based on age)	1	2	3	4	5
	H. Sexism (prejudice based on sex)	1	2	3	4	5
	I. Racism (prejudice based on race)	1	2	3	4	5
	J. Classism (privilege based on economical status)	1	2	3	4	5
	K. Ableism (prejudice against disabled people)	1	2	3	4	5
	L. Homophobia (prejudice against homosexuals)	1	2	3	4	5
2	How **IMPORTANT** do you believe socio-cultural issues are in your interactions with:	**Not at all**	**Slightly**	**Mod**	**Very**	**Extremely**
	A. Patients	1	2	3	4	5
	B. Health Professional Colleagues	1	2	3	4	5
	C. Residents, Medical/Pharmacy Students	1	2	3	4	5
	D. Staff	1	2	3	4	5
3	How **AWARE** are you of your own?	**Not at all**	**Slightly**	**Mod**	**Very**	**Extremely**
	A. Racial, ethnic, or cultural identity	1	2	3	4	5
	B. Racial, ethnic, or cultural stereotypes	1	2	3	4	5
	C. Biases and prejudices	1	2	3	4	5
4	How **IMPORTANT** do you feel it is for health professionals to receive training in cultural diversity and/or multicultural health care?	1	2	3	4	5

F. AWARENESS AND ABILITIES

Below it is a list of statements dealing with multicultural issues within a health care context. Please indicate the degree to which you agree with each statement by circling the appropriate number

1	I am aware that:	**Strongly Disagree**	**Disagree**	**Somewhat**	**Agree**	**Strongly agree**
	Being born a minority in this society brings with it certain challenges that White people do not have to face.	1	2	3	4	5
	I frequently impose my own cultural values upon the others.	1	2	3	4	5
	Being born a White person in this society carries with it certain advantages.	1	2	3	4	5
2	I am aware of:	**Strongly Disagree**	**Disagree**	**Somewhat**	**Agree**	**Strongly agree**
	How my own values might affect my patient	1	2	3	4	5
	Institutional barriers that affect the patient	1	2	3	4	5
	How my cultural background and experiences have influenced my attitudes and beliefs about other cultural and diverse groups	1	2	3	4	5
	Institutional barriers that may inhibit minorities from using health services	1	2	3	4	5
3	I have an excellent ability to assess, accurately, the health needs of:	**Strongly Disagree**	**Disagree**	**Somewhat**	**Agree**	**Strongly agree**
	Persons with disabilities	1	2	3	4	5
	Children and adolescents	1	2	3	4	5
	Older adults	1	2	3	4	5
	Men	1	2	3	4	5
	Lesbians/ Gays/Bisexuals/Transsexuals/Queers	1	2	3	4	5
	Women	1	2	3	4	5
	Persons who come from very poor socioeconomic backgrounds	1	2	3	4	5

	F. Illiteracy	1	2	3	4	5
	G. Ageism (prejudice based on age)	1	2	3	4	5
	H. Sexism (prejudice based on sex)	1	2	3	4	5
	I. Racism (prejudice based on race)	1	2	3	4	5
	J. Classism (privilege based on economical status)	1	2	3	4	5
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	L. Homophobia (prejudice against homosexuals)	1	2	3	4	5
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	D. Staff	1	2	3	4	5
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	How my cultural background and experiences have influenced my attitudes and beliefs about other cultural and diverse groups	1	2	3	4	5
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	Persons who come from very poor socioeconomic backgrounds	1	2	3	4	5