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Enhancing Cultural Humility for Sexual and Gender Minorities within an Inpatient Mental

Health Hospital: A Quality Improvement Project

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Abstract

Background: Sexual and gender minorities (SGM) are a population that experiences health disparities. Cultural competence among healthcare providers is one way to help reduce health disparities that is shown to be improved by educational interventions.

Purpose: The purpose was to enhance cultural humility among healthcare professionals in a mental health hospital to promote inclusivity especially as it pertains to SGM. The purpose was to shift a training model focused on cultural competence to one that incorporates concepts related to cultural humility by implementing a classroom-based training with a pre and posttest.

Methods: The design was non-experimental, using a convenience sample of twenty to forty healthcare professionals in a mental health hospital, and involved provision of two trainings containing content including concepts and practical interventions related to enhancing cultural humility and inclusivity. Learning was assessed through analysis of responses to the Cultural Humility scale, administered before and one month after the training, using descriptive statistics and paired t-tests. The ecological systems theory guided this project.

Results: Eight participants completed the pretest and training, and seven completed the posttest. The difference between the mean total pretest score ($M=43.14$, $SD=1.46$) and the mean total posttest score ($M=44.43$, $SD=4.93$) was not found to be significant, nor were the differences in means of the pretest and posttest scores for both the positive and negative subscales.

Conclusion: Qualitative reports from participants showed favorable results of the intervention and the project served as a model to create a cultural humility training for healthcare professionals specific to SGM.

Keywords: Cultural competency, sexual and gender minorities, and psychiatry

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Enhancing Cultural Humility for Sexual and Gender Minorities within an Inpatient Mental Health Hospital: A Quality Improvement Project

Introduction

It is well documented that sexual and gender minorities (SGM) experience health and health care disparities. The Department of Health and Human Services first included sexual minorities as a health disparity group in *Healthy People 2010* (Mayer, 2008) and *Healthy People 2020* further identifies gender minorities as a disparity group (Office of Disease Prevention and Health Promotion, 2014). Mental illness is one, among many, disparities faced by SGM. To reduce health and health care disparities in this group, healthcare professionals must be competent in the unique health care needs, aware of present and past social stigma, and familiar with barriers to current healthcare (Mayer, 2008). Cultural competence which focuses on the learning of belief systems, needs, and vulnerabilities of minority groups (Yeager & Bauer-Wu, 2013) traditionally has been the conceptual model used in training healthcare professionals to provide care to diverse populations. The term cultural competency has been utilized in both the organizational analysis of the project site and review of literature due to the terminology used in the setting and by its regulatory bodies, and in order to yield the most relevant interventions in regard to the setting and population being used. Though, the trend towards education focused on cultural humility (Hook et al., 2013) and structural competence was applied to the design of the intervention itself.

Background

Disparities are often considered to be in relation to race or ethnicity; over the past couple decades sexual and gender minorities have also been considered a disparity group. The initiative of Healthy People is to improve health outcomes in disparity populations. A report by the Gay

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and Lesbian Medical Association (2001) stressed the need for data collection specific to sexual and gender minorities. Given the lack of data collection measures and practices, lesbian, gay, bisexual, and transgender (LGBT) people are not accurately represented in terms of demographics. Therefore, it is not easy to determine the impact of social determinants on health given this demographic data is not routinely collected. In terms of current demographic information, Ward, Dahlhamer, Galinsky, and Joestl (2014) reported in their National Health Interview Survey, in a sample representative of U.S. civilians that were not institutionalized, identification of gay or lesbian made up 1.6% of sample, 0.7% identified as bisexual, and 1.1% identified as something else or did not know. Further, Flores, Herman, Gates, and Brown (2017) estimated, based on state specific population surveys, that 0.6% of U.S. adults identify as transgender. The Office of Disease Prevention and Health Promotion (2014) reported that in 2002, 4% of U.S. adults (age 18-44) identified as LGBT.

The burden of chronic illness carried by some groups under the LGBT umbrella is driven by structural determinants of health. Fredricksen-Goldsen et al. (2014) describe how ““social, economic, and environmental disadvantage...”” (para. 2) result in health disparities in this population. For example, the National LGBT Cancer Network (2020) discuss that LGB women are found to have increased rate of obesity, diabetes, asthma, and mental health concerns as well as increased alcohol use and smoking rates that stem from social, economic, and behavioral factors associated with stress of living as a minority. This, in turn, increases the risk of breast cancer and other cancers in this population. Another example of social determinants contributing to disproportionality is that sexual minorities in the U.S. have a higher incidence of tobacco use when compared to non-LGBT individuals in same age group (American Cancer Society, 2016). It is known that Big Tobacco has specifically targeted the LGBT community beginning in 1991

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at latest by means of advertising such as in strategies similar to Project SCUM, and also by large donations to AIDS research in return for support of tobacco company (Truth Initiative, 2018). Moreover, Blondeel (2016) indicates that mental health in this population is understudied but references one large scale study that showed an increase in certain mental health disorders and substance use disorders in sexual minorities. Further, violence was shown to be a burden on this population. Lastly, data on death by suicide in this population is not available due to failure to collect this data in death reports (National LGBT Health Education Center, 2018). However, the National LGBT Health Education Center reports that lesbian, gay, and bisexual (LGB) high school teens are 4.5 times more likely to have a suicide attempt compared to non-LGB high school teens; lesbian, gay, bisexual, and queer adults are twice as likely to have attempted suicide. There is a forty percent lifetime prevalence for suicide in transgender adults (National LGBT Health Education Center).

Moreover, there have been actions that have had a direct impact on sexual and gender minorities in the United States, with an overall intent to limit SGM rights and hinder social progress. For example, the Affordable Care Act requires data collection relevant to disparity groups for participants of federal health plans as deemed by the secretary. Sexual orientation and gender identity questions were removed from two federal surveys, the Center for Independent Living Annual Program Performance Report and the National Survey of Older American Act, despite sexual and gender minorities' status as a disparity group (American Psychological Association, 2017b). Questions specific to sexual orientation and gender identity were first proposed to be included in the 2020 U.S. Census, only to be removed as a proposed topic shortly after (Wang, 2017).

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The American Psychological Association Public Health Directorate (2018) reports there have been close to 125 anti-LGBT state bills initiated. Further, the American Civil Liberties Union (2019) specifically outlines these measures; anti- LGBT state bills are grouped into categories based on restrictions such as: “Single-Sex Facility Restrictions...Anti-Trans Religious Exemptions...Restrictions on Identification Documents...Restrictions on Access to Healthcare...” (para. 5). Providing a different point of view, the American Civil Liberties Union also details several bills that have been introduced to protect and expand the rights of sexual and gender minorities. Given recent public policy and politics regarding sexual and gender minorities, in addition to the initiative of HealthyPeople 2020 among other initiatives in improving health and healthcare for this population, this is a timely and needed project.

Problem Statement

The occurrence of health and health care disparities among sexual and gender minorities is indicated by increased prevalence of mental illness specifically anxiety, depression, and suicide attempts, higher rates of substance use, increased risk of cardiovascular disease and cancer types, and decreased access to appropriate medical care. These disparities result from historical stigmatization, lack of healthcare professionals who are knowledgeable in the unique health needs of sexual and gender minorities and aware of the social determinants that effect health and healthcare, lack of inclusive health care environments, and paucity of demographic data guiding evidence-based care.

Organizational “Gap” Analysis of Project Site

The Health Research and Educational Trust (2013) defines cultural competence specific to healthcare organizations as a system’s capacity “to provide care to patients with diverse values, beliefs and behaviors, including tailoring health care delivery to meet patients’ social,

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cultural, and linguistic needs” (p. 3). Best practice to increase cultural competence among healthcare professionals is by education. Literature shows that education in cross-cultural care to healthcare professionals increases knowledge, perspective, and skill (Betancourt, Green, and Carrillo, 2018). In regard to hospitals, Betancourt et al. report that the Joint Commission identifies cultural competence as a standard, and requires hospital staff to be trained. The Joint Commission (2010) recommends integrating cultural competence into care and recommends leadership to promote cultural competence organizationally.

In addition, the Joint Commission recommends that hospitals incorporate CLAS standards. Betancourt et al. (2018) describe Cultural and Linguistically Appropriate Services, or CLAS standards, as standards for cultural competence in health care that were developed by the U.S. Department of Health and Human Services. The U.S. Department of Health and Human Services Office of Minority Health (n.d.) details that CLAS standards are intended to help to abolish health disparities. Two of the most relevant standards include: ongoing training related to policies and practices that promote culturally and linguistically appropriate services, and ongoing assessments of organizations opportunities for improvement of culturally and linguistically appropriate services (U.S. Department of Health and Human Services Office of Minority Health, n.d.). No standards are specific to sexual and gender minorities. However, the standards do speak to conducting assessments of the needs of cultural and linguistic minorities in the given service area and developing interventions to address those needs accordingly.

Practice at the project site at the time of the organizational analysis included cultural competence training upon hire and yearly thereafter through classroom-based training. No sexual and gender specific cultural competence training was conducted. There were no known ongoing cultural competence quality improvement activities. Barriers to implementing practice of sexual

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and gender minority specific cultural competence training may include: lack of support, lack of opportunity to use alternate approaches, time constraints, cost associated with training, and lack of education/experience.

Review of the Literature

The purpose of this review of the literature was to explore interventions that improve cultural competence specific to SGM among mental healthcare professionals.

Search Methods

The following databases were searched for literature published in English within five years related to enhancing cultural competence specific to SGM among mental health care organizations: PubMed, Cochrane Library, and Web of Science. PubMed was searched for literature published using the Medical Subject Heading (MeSH) terms *Cultural competency*, *Education*, and *Psychiatry*. This search yielded 100 results; titles and abstracts were reviewed for relevancy to topic.

Abstracts were reviewed to include articles with highest level of evidence available; qualitative studies and opinion articles were excluded. This yielded four relevant studies. Cochrane Library was searched utilizing the same MeSH terms which yielded no results. MeSH terms were decreased to search this database using only *Cultural competency* and *Education* which yielded six results. Titles and abstracts were reviewed for relevancy which produced one result. Finally, Web of Science was searched using all three MeSH terms with publications in English in the past five years which yielded nine results, eight which were not relevant and one which was duplicate from PubMed search.

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The MeSH terms were then decreased to only *Cultural competency* and *Education* in this database which yielded 763 articles. This was further refined to include articles relevant to nursing or psychiatry which decreased the results to 85 articles. The titles and abstracts were reviewed for relevancy. Qualitative studies and opinion articles were excluded to include articles with highest level of evidence available, ten studies were obtained and reviewed. Four studies from PubMed, two studies from Cochrane Library, and ten studies from Web of Science make a total of 15 studies that were reviewed completely. After review of the 15 studies, one was excluded as it pertained to cultural competence enhancement by international immersion experience which is irrelevant, another was excluded because of qualitative design, one was excluded as it studied cultural competence of faculty in relation to students, and one was excluded as the intervention strictly pertained to end of life care. Ultimately, 11 studies were included in the review of literature.

Search Results

Purposes of reviewed studies. The purpose of four studies included evaluating the effectiveness of web-based training programs on cultural competence of health care providers by means of self-report on questionnaires and data collected from surveys completed by participants. Similarly, Perry, Woodland, and Brunero (2015) developed and evaluated an e-simulation module's effectiveness of improving cultural competence and Bhat, Wehbe-Alamah, McFarland, Filter, and Kaiser (2015) assessed the effectiveness of three online modules in increasing cultural knowledge, sensitivity, and behaviors. Chang, Guo, and Lin (2017) also developed a web-based training and their purpose was to assess for effects of training on cultural competence domains, in addition to assess for changes in cultural competence of students after graduation. Opposed to the other studies, Chang, Guo, and Lin used social media platform

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Facebook to develop web-based training. Instead of assessing for effectiveness of web-based training program only, Carpenter, Estrada, Medrano, Smith, and Massie's (2015) purpose was to evaluate the effectiveness of web based cultural competence training versus traditional training of medical students.

Six studies intended to evaluate the effectiveness of instructor-led or classroom-based training on cultural competence of healthcare providers. Horvat, Horey, Romios, and Kis-Rigo (2014) aimed to evaluate the effect of training in cultural competence on providers, patients, and organizations. Most studies had similar purposes, but the setting and population varied. For example, Bäärnhielm, Edlund, Ioannou, and Dahlin's (2014) also evaluated the outcome of cross-cultural training program, specifically between refugees and refugee reception workers, primary care providers, and psychiatric providers. Steinke, Riner, and Shieh (2015) had a similar purpose but the population included health care providers prior to a medical mission to Haiti. Two studies also assessed for effectiveness of training program, but used content specific to a particular minority group: Bristol, Kostelec, and MacDonald's (2018) used content specific to sexual and gender minorities in emergency room setting and Sempertegui, Knipscheer, and Bekker (2018) used content specific to Turkish and Moroccan-Dutch minority groups. In contrast, Aggarwal et al. (2016) intended to analyze teaching methods in relation to the DSM-5 cultural formulation interview while Mills, Xiao, Wolitzky-Taylor, Lim, and Lu (2017) looked to evaluate resident's cultural competency following a one-hour training on the cultural formulation interview.

Methods used in studies. One study by Carpenter et al. (2015) used randomized control study design; the Health Belief Attitudes Survey was used to compare the outcome of a training for 180 medical students who were randomized into experimental and control groups where the

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experimental group partook in four case studies presented in online modules and the control group received one-hour lecture using PowerPoint and usual curriculum. Two studies used mixed methods research design. Bäärnhielm et al. (2014) analyzed results from 5-point Likert scale surveys given before and after training modules to a sample of 278 participants including members from reception areas, primary care and psychiatric care, and employment agency with varying educational levels. Content from focus group interviews were also transcribed and analyzed. Similarly, Aggarwal et. al (2016) used a mixed methods approach using questionnaires from 75 clinicians before and after training, in addition to clinician interviews.

Four studies used pretest-posttest design, all of which used standardized measures to analyze effectiveness of intervention. Bhat et al. (2015) used the Cultural Competence Assessment (CCA) survey before and after three training modules on 15 registered nurses from palliative and hospice care unit. Mills et al. (2017) used an adapted version of the Cultural Competence Assessment tool after a one- hour training on the Cultural Formulation Interview. Further, Steinke et al.'s analyzed effectiveness of multimodal training of 11 health professionals scheduled to embark on Haiti medical mission using Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-Revised. Bristol et al. (2018) administered the Ally Identity Measure to health care team members including nurses, secretaries, nurse practitioners, and physicians before and after a two-hour training on lesbian, gay, bisexual, and transgender (LGBT) specific cultural competence. Paired samples t-tests were used in all studies to analyze difference in scores of standardized testing, except Bristol et al. used independent sample t-tests.

In comparison, two studies used a time series design. Sempertegui et al. (2018) utilized measures at three different intervals before and immediately after training, and again three

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months after training, whereas Chang et al. (2017) evaluated measures using Cultural Competence Scale for Pre-Graduates Students to Licensed Professionals twice before start of work, and three months after beginning job. Alternatively, Perry, Woodland, and Brunero (2015) used a posttest only design. Perry, Woodland, and Brunero as well as Sempertegui et al. used self-developed measures for data collection following their trainings. Only Carpenter et al. and Chang et al. used both experimental and control groups.

Lastly, only one systematic review was retrieved; Horvat et al. (2014) developed a conceptual framework for cultural competence and included four domains: content, teaching approach, intervention structure, and sample characteristics. The data was extracted by two separate authors based on these four domains of the conceptual framework. To sum up, most study designs were pretest- posttest design using a standardized measure of provider knowledge and attitudes. The most compelling evidence found was a systematic review, as well as two studies using both an experimental and control group.

Results of studies. All studies evaluating effectiveness of training on domains of cultural competence had statistically significant improvement in scores of measures used. Bäärnhielm (2014) found knowledge about support and community resources, as well as knowledge about health problems and treatment were shown to increase from baseline after training. Similarly, Perry et al. reported an increase in confidence in communication, knowledge regarding culture and language and health, understanding of benefit of interpreter, and consideration of cultural needs in preparation for discharge. Likewise, Steinke et al. (2015) reported that overall scores for the Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals -Revised, as well as scores for four out of five subscales including awareness, knowledge, encounters, and desire increased significantly after intervention.

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Mills et al. (2017) and Bhat et al. (2015) had similar results including significant increase in total scores of Cultural Competence Assessment Tool, as well as Bristol et al. (2018) using the Ally Identity Measure. Sempertequi et al. (2018) also reported there was a significant change in scores between groups in the following scales: knowledge test, attitude and awareness, knowledge, and diversity competence. Also, to note, this study repeated measure at multiple intervals and reported no significant mean changes at three-month follow up which per report may indicate stability. Moreover, Chang et al. (2017) found cultural awareness to have a statistically significant change in intervention group, but Chang et al. did not report significant change in other measures including knowledge, perception of own ability, and skill.

Moreover, Aggarwal et al. (2016) reported that behavioral simulation accounted for most helpful intervention (33%) in training of the Cultural Formulation Interview, followed by video demonstration (14.7%), and then mixed methods (33%), 16% of which reported video and behavioral simulation. Carpenter et al. (2015) showed no difference in median score on their measure, the Health Belief Attitudes Survey (HBAS), in regard to differences between web-based training versus traditional training. Lastly, in their systematic review, Horvat et al. (2014) reported there was one individual RCT and four cluster RCTs which evaluated the effect of cultural competence training to no training. It is reported that there is low quality of evidence overall for all outcomes. Participants were healthcare professionals. Studies differed in their purpose, content, and length of intervention. No evidence related to patient treatment outcomes were noted. There was one low quality study showing improved client health behavior. One RCT showed improved involvement of care by client but this was low quality. In regard to evaluation of care, two RCTs showed no difference and one study showed improvement in client experiences of women; all three were considered low quality.

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Discussion of Search Evidence

The Oxford Centre for Evidence-based Medicine-Levels of Evidence (Centre for Evidence-Based Medicine, 2019) was used to assess the quality and strength of the evidence. The Cochrane review by Horvat et al. (2014) was the highest level of evidence found in this review. Per Horvat et al., quality of evidence of RCTs reviewed were low which was also observed in this review of literature. The majority of studies, nine out of eleven, offered a pretest-posttest research design. Three studies had a randomized sample, but one was not truly randomized as Sempertegui et al. (2018) reported randomized participants by groups working in specific institutions. All studies with pretest-posttest design showed a significant change in total scores of measures after intervention, along with change in multiple subscales in various studies. The RCT by Carpenter et al. (2015) was the only study to show no median score change, and this was in relation to web-based training versus traditional training.

Despite the limitations of scant literature on interventions to improve cultural competence of healthcare providers, there were several studies, albeit low quality studies, that indicated effectiveness of training on improvement in several domains of cultural competence. In this review, there was only one study specific to the population of sexual and gender minorities. Given the paradigm shift from singular minority group competence to multiculturalism and cultural humility, it was fair to generalize interventions used specific to one minority group to another minority group. Further, Carpenter et al. (2015) showed no difference in median scores on HBAS with use of web-based training compared to traditional training. With this consideration and in regard to cost, the intervention of web-based learning could be considered as an effective form of training for cultural competence of health care providers.

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Further, the majority of studies focused on cultural competence of health care providers, though specific specialties were indicated in some studies (i.e. palliative care nurses, refugee workers, psychiatric providers). For this project, the intervention group was health care workers in a mental health setting. Only Mills et al. (2017) showed a significant change in measures after cultural competence training using a specific population of psychiatric providers. The evidence regarding similar healthcare professional groups was generalized to support the intervention of training to increase cultural competence.

This review of literature focused primarily on interventions to improve cultural competence of mental healthcare professionals as cultural competency continues to be the term used by U.S. Department of Health and Human Services, the Joint Commission, and the Centers for Medicaid and Medicare Services. As the regulatory bodies for the project setting, the term cultural competency was explored to yield the most relevant interventions in regard to the setting and population being used. Though, the trend towards education focused on cultural humility (Hook et al., 2013) and structural competence will be applied to the design of the intervention itself.

Evidence Based Practice: Verification of Chosen Option

A multi-method classroom-based training focused on enhancing cultural humility among healthcare professionals, especially as it relates to sexual and gender minorities was implemented and effectiveness was evaluated using self-report, including a cultural humility scale with previously-established validity and reliability. This quality improvement project addressed the problem by promoting inclusivity by means of an educational intervention to enhance cultural humility among healthcare professionals.

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Theoretical Framework

The theoretical framework used in this project was Bronfenbrenner's ecological systems theory. The model involves five systems that interact with one another over time (Clauss-Ehlers et al., 2019). Bronfenbrenner (1994) suggests that one must consider the ecological forces that have an influence on human development in order to understand human development. The model served as a framework for healthcare professionals to consider multiple systems that impact an individual's development and experience.

The model outlines five systems: microsystems comprised of inner most experiences and interpersonal experiences, mesosystems comprised of interactions between two settings that directly involve the individual, exosystems comprised of at least two settings where at least one setting does not directly involve the individual, macrosystems comprised of larger societal culture and influential social and economic forces, and chronosystems which considers the influence of time (Bronfenbrenner, 1994). Bronfenbrenner uses these subsystems to illustrate nests in which one lays inside the next in directly influencing the development of the individual.

Clauss-Ehlers et al. (2019) integrate Bronfenbrenner's ecological systems theory to design their "Multicultural Guidelines task force model, *a layered ecological model of the Multicultural Guidelines...*" (p. 233) which can be directly applied to this project. The task force model illustrates how in the microsystem, relationships and definition of self are interrelated. Further, the model depicts how settings in the mesosystem such as school or work can have a direct impact on the components in the microsystem. Systems in the exosystem are explored where the views of the psychologist and client regarding the impact of institutions can have an impact on the individual's direct experience. Macrosystems, specifically the domestic and international climates, influence the entire model including individual experiences.

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Clauss-Ehlers et al. (2019) include the concepts of power-privilege, tensions, and fluidity as considerations to their model. The American Psychological Association (2017a) suggests the psychologist consider the inherent power-privilege relationship between the provider and patient and strategize to level this dynamic. Further, it is prudent to learn and consider other power-privilege dynamics that patients currently experience or have historically experienced. In regard to tensions, the American Psychological Association recommends exploring tensions in the context of interacting systems, rather than tensions exclusively developing at an individual level. The concept of fluidity suggests that there is constant movement among and between the systems and this may manifest as “...relationship patterns, life events and transitions, contextual influences, the passage of time, and the influence of the internal experience on themselves...” (American Psychological Association, p.12). The encompassing goal as depicted in this model is to build resilience and decrease trauma; positive interactions between provider and patient is a channel in which this goal can be achieved. The model’s constructs were used to develop content for the intervention in this project, specifically as it applies in enhancing perspectives of how social forces have an impact on healthcare encounters. Refer to Appendix A for diagram.

Methods

Project Design

This quality improvement project consisted of an educational intervention. A series of two trainings using multimodal classroom-based training techniques was conducted. A pretest-posttest research design was used. Data was collected by self-report scales administered before and after intervention.

Goals, Objectives and Expected Outcomes

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The overall goal was to help eliminate health and healthcare disparities faced by sexual and gender minorities by promotion of inclusivity. In relation to the task force model described by Clauss-Ehlers et al. (2019), the goal was to incorporate measures directly at the microsystem level by providing education to healthcare professionals to have an effect on individual interactions between health care professionals and patients; positive and therapeutic interactions and relationships can reduce trauma and build resilience. By modifying the microsystem, the mesosystem, exosystem, and macrosystem levels will ultimately be affected as the systems are interrelated.

Specifically, one goal was to perform a pre-test measure of mental healthcare professionals' cultural humility using the Cultural Humility scale (Hook et al., 2013). The objective was to administer the Cultural Humility Scale in November of 2019 to more than 33% of all healthcare professionals meeting inclusion criteria prior to the intervention phase. The expected outcome was that 90% of participants who attended the training would complete the Cultural Humility scale prior to the intervention phase in November 2019.

Furthermore, the goal was to deliver a multi method classroom-based training that would enhance cultural humility among healthcare professionals, especially as it relates to sexual and gender minorities, and deepen perspectives of how social forces have an impact on healthcare encounters. The objective was to conduct a multi method classroom-based training to all participants who completed the initial Cultural Humility scale in November 2019. The expected outcome was that 90% of participants would complete the training.

Next, the third goal was the participants' positive subscale scores on the Cultural Humility scale would increase by 30% or greater one month after the training was completed. The objective was to evaluate the effect of a classroom-based training by participants'

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completion of the Cultural Humility scale one month after the training in December 2019.

Expected outcomes included: 50% of participants would complete the post intervention Cultural Humility scale and a 30% or greater increase in postintervention Cultural Humility positive subscale scores compared to preintervention Cultural Humility positive subscale scores for all participants would be observed.

Lastly, the fourth goal was to evaluate the effectiveness of the training in meeting its outlined objectives. The objective was to evaluate the training by means of participants' completion of the post training evaluation in November 2019. The expected outcome was 50% of participants who attended training would complete post training evaluation.

Project Site and Population

The project site was an inpatient behavioral health hospital in central Massachusetts that provides care in mental health and co-occurring substance use disorders. The hospital is composed of three adult units, one transitional age unit (adolescent/young adult), and one child unit. The hospital also has an intake unit. The hospital opened in 2016 as a response to limited inpatient psychiatric beds in the area. Kowalczyk (2017) reports there has been an addition of 576 new inpatient beds in Massachusetts since 2009, with a sum of 2776 beds in the state in August of 2017.

The population consisted of health care professionals employed at the hospital including psychiatrists, psychiatric-mental health advanced practice nurses, staff nurses, mental health counselors, and unit coordinators. After meeting with the key stakeholders at the facility, it was suggested to narrow the population to one specific unit in the hospital. The rationale was for ease of scheduling trainings, and increased feasibility in obtaining post training data. With these considerations, the population was changed to health care professionals on the transitional age

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unit (a unit designated for patients aged 16-24) including psychiatrists, psychiatric-mental health advanced practice nurses, staff nurses, mental health counselors, and unit coordinators. Inclusion criteria included current employment at the hospital on the transitional age unit in any of the outlined positions. Exclusion criteria included employees in positions that were not outlined. Potential participants were notified of training dates via email two weeks prior to project implementation. The training details were outlined in the email calling for volunteers to participate in training. One week prior to the intervention, staff on the transitional age unit were reminded of the training each day during morning, evening, and night report. With two trainings, and likely ten to fifteen attendees per training capping at twenty attendees per training, approximately twenty to forty total participants were originally anticipated. Given the reduction in total possible participants due to restricting training to one unit only, a decreased number was anticipated after notification of training narrowed to one unit.

Ethical Considerations/Protection of Human Subjects

The University of Massachusetts, Amherst (UMass) Internal Review Board (IRB) approval was obtained prior to initiating the DNP project. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 protects privacy of patient's health information, among other protections (U.S. Department of Health and Human Services, 2013). Further, the DNP student who conducted this project followed the *Standards of Care* for hospital setting. The information collected from this project did not include any patient identifiers.

The risk to healthcare professionals participating in this project was no different from the risk to healthcare professionals receiving standard training. Participant confidentiality was assured by coding the participants using individual identification numbers. The list of participants and their identifying numbers were kept in a locked filing cabinet, only accessible to

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the DNP student who conducted this project. All electronic files containing identifiable information were password protected and only the DNP student had access to the passwords.

Measurement Instruments

In order to measure the outcomes of this DNP project, the following instruments were used: a demographic survey, the Cultural Humility scale, and a post training evaluation. In terms of the Cultural Humility scale, Hook et al. (2013) tailored the tool as a client-rated scale in terms of rating their counselor. For this project, the healthcare professional used the scale as a self-rated measure preintervention and again postintervention. It consists of twelve 5-point Likert scale items; there are two subscales, one subscale including positive items and the other including negative items. It demonstrated an acceptable internal consistency measure with Cronbach's alphas from .86 to .93 (McElroy-Heltzel et al., 2018). Construct validity of the scale was noted by Franco and McElroy-Heltzel (2018) as the scale is "correlated with therapy working alliance ($r = .75$) and the cross-cultural counseling inventory ($r = .64$)" (p. 273). Refer to Appendix B. The demographic survey included questions regarding the following which had been adapted from the Cultural Competence Assessment tool (Balcazar et al., 2009): age, gender identity, race/ethnicity, highest level of education obtained, current position, years of experience in profession, prior cultural competency training on sexual and gender minorities. Refer to Appendix C. A three-point Likert scale survey adapted from Kuta (2017) was used for the post training evaluation in addition to open ended questions. Refer to Appendix D.

Data Collection Procedures

Preintervention. Initially, the stakeholders at the facility requested the training be conducted in a series of luncheon trainings during different shifts to increase participation. At that time, the training was being offered to the entire hospital. One of the key stakeholders, the

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quality assurance coordinator left her position and, so was no longer involved in the project. The chief medical officer requested the chief nursing officer get involved at this point. At this time, the chief nursing officer approved to have two trainings, each approximately one hour, for health care professionals working on the transitional age unit instead of using lunchtimes in order to facilitate trainings. She also approved that participants would receive pay for their time spent in the training. Two trainings were scheduled, one from 2:00-3:00 and one from 3:30-4:30 to better facilitate attendance from each shift. As stated previously, potential participants were notified of training times via email two weeks prior to project implementation. The training details were outlined in the email calling for volunteers to participate in training. One week prior to implementation, staff on the transitional age unit were reminded of the training each day during morning, evening, and night report.

Intervention. The intervention consisted of a pretest, educational intervention, posttest, and training evaluation. Participants completed the pretest consisting of a demographic survey and the modified Cultural Humility scale prior to the educational intervention. Once the pretest was completed, participants attended an hour-long educational intervention. The concepts of cultural humility and structural competence were reviewed, along with discussion of a shift in the training framework from cultural competence to cultural humility and structural competence. Specifically, a focus on self-awareness and reflection in relation to cultural humility (Yeager & Bauer-Wu, 2013), and a focus on social determinants that cause disparities and inequities (Metzl & Hansen, 2014) were reviewed. The majority of the curriculum was adapted from Acquaviva's (2017) *LGBTQ-Inclusive Hospice and Palliative Care: A Practical Guide to Transforming Professional Practice*. Refer to Appendix E for curriculum of the educational intervention.

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PowerPoint presentation, group discussion, and handouts including additional resources for more information were used for the educational intervention.

There were two sessions of the training conducted at strategic times of the workday to increase participation. A reminder email was sent to participants two weeks prior, and health care professionals were given reminders during morning, evening, and night report each day during the week prior to the training. Following the educational intervention, participants completed a post training evaluation. One month following the training, the participants completed the posttest consisting of a repeat modified Cultural Humility scale which was sent via email. This occurred the week of December 15, 2019. Reminders to complete the posttest were given via email to participants to increase response rate.

Post-intervention. Each participant received an identification number which was used to evaluate data. Pre- and post-tests were labeled with a unique identifier. A copy of identification numbers with respective identifying information was kept in locked filing cabinet. Demographic data was entered into SPSS using identification numbers. Preintervention Cultural Humility scale scores and postintervention Cultural Humility scale scores were entered into SPSS. All paper forms were kept secure and were disposed of by shredding after data was entered into SPSS.

Data Analysis

Descriptive analysis of demographic data of participants was completed. Paired sample t-tests were used to analyze pre and post test scores from Cultural Humility scales; total Cultural Humility scale scores and scores for subscales were analyzed. Analysis of post training evaluation responses was completed.

Results

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Two trainings took place in November 2019, and the posttest was completed one month after in December 2019. There was a total of eight participants who completed the pretest, training, and the post-training evaluation. Seven of the eight participants completed the posttest one month after the training. The one participant who did not complete the posttest had left their position at the facility and did not respond to reminder emails for completion of posttest. Therefore, 100% of participants who attended the training completed the pretest and 100% of participants who attended the training completed the post-training evaluation. 87.5% of participants who completed the training and pretest also completed the posttest one month after training. Table 1 shows the positions held by participants at the facility where the training was conducted. The mean number of months that people worked at the facility was 16.25 months.

Table 1

Frequency Table of Current Positions of Participants

Position	Frequency
Nurse	4
Mental health counselor	3
Management	1

In regard to demographics, 7 out of 8 participants reported that they were assigned female sex at birth, and 1 out of 8 participants reported male sex assigned at birth. All participants who reported female sex at birth reported they identify as female currently. Similarly, the one participant who reported male sex at birth reported identifying as male currently. Table 2 shows age groups of participants. Moreover, two participants identified as Black, one of which also identified as American Indian/Alaskan Native, and the remaining six participants identified as white. Only one participant of the 8 reported speaking another language other than English and the language was reported as Haitian Creole.

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Table 2

Age Group of Participants

Age group	Frequency	Percent
19-28	3	37.5
29-38	3	37.5
49-58	1	12.5
59-68	1	12.5
Total	8	100.0

In regard to highest level of education obtained, one participant reported they graduated high school or obtained GED, one participant reported some college with no degree, two participants reported associate degree, three participants reported bachelor's degree, and one participant reported master's degree. Table 3 indicates the participants' report on types of cultural competency training received in the past.

Table 3

Frequency of Types of Previous Cultural Competency Training

Type of Cultural Competency Training	Frequency	Percent
Specific Required Class	4	50.0
Specific Elective Class	1	12.5
Various Classes in School	3	37.5
Fieldwork Experiences in School	3	37.5
Continuing Education Workshops or Courses	1	12.5
Supervision on the Job	3	37.5
Interactions with Professionals from other Disciplines	2	25.0
No formal training	1	12.5

The mean pretest and posttest scores from the modified Cultural Humility Scale are shown in Table 4, along with the paired t-test for total pretest and posttest scores shown in Table

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5. The tables omit the one participant who did not complete a post-test, so as to allow for a comparison of pretest and posttest scores. There was no significant difference between means for total pretest and total posttest scores.

Table 4

Mean Pretest and Posttest Scores from modified Cultural Humility Scale

	Mean	Range	Median	N	SD
Total Pretest Scores	43.1429	4.00	43.00	7	1.46385
Total Posttest Scores	44.4286	15.00	44.00	7	4.92805

Note. The maximum score is 60, indicating high levels of cultural humility.

Table 5

Paired Samples Test for Total Pretest and Posttest Scores

	Paired Difference		Std Error of Mean	95% Confidence Interval of Difference		t	df	Sig. (2 tailed)
	Mean	SD		Lower	Upper			
Pretest-Posttest	-1.28571	4.07080	1.53862	-5.05058	2.47915	-.836	6	.435

Moreover, positive subscale scores from pretest and posttest were compared. See Table 6 and Table 7. In addition, negative subscale scores from pretest and posttest were compared. See Table 8 and Table 9. There was no significant difference between means of positive subscale scores for pretest and positive subscale scores for posttest. There was no significant difference between means of negative subscale scores for pretest and negative subscale scores for posttest.

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Table 6

Mean Positive Subscale Scores for Pretest and Posttest from modified Cultural Humility Scale

	Mean	N	SD
Positive Subscale Pretest Scores	31.7143	7	2.13809
Positive Subscale Posttest Scores	31.7143	7	2.81154

Table 7

Paired Samples Test for Positive Subscale Scores for Pretest and Posttest

Positive Subscale	Paired Difference			95% Confidence Interval of Difference		t	df	Sig. (2 tailed)
	Mean	SD	Std Error of Mean	Lower	Upper			
Pretest-Posttest	.00000	2.00000	.75593	-1.84969	1.84969	.000	6	1.000

Table 8

Mean Negative Subscale Scores for Pretest and Posttest from modified Cultural Humility Scale

	Mean	N	SD
Negative Subscale Pretest Scores	11.4286	7	2.69921
Negative Subscale Posttest Scores	12.7143	7	4.60848

Table 9

Paired Samples Test for Negative Subscale Scores for Pretest and Posttest

Negative Subscale	Paired Difference			95% Confidence Interval of Difference		t	df	Sig. (2 tailed)
	Mean	SD	Std Error of Mean	Lower	Upper			
Pretest-Posttest	-1.28571	2.69037	1.01686	-3.77389	1.20246	-1.264	6	.253

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The post training evaluation asked participants to indicate “Yes,” “Needs Work”, or “No” to ten criteria which indicated the extent to which the presentation was effective, refer to Appendix D. For criteria 1-5 and 7-10, 8 participants out of 8 responded “Yes” to questions. For criterion 6 which indicated that time for presentation was used effectively, 7 out of 8 participants responded “Yes” and one participant responded “Needs Work.”

Two open ended questions were asked of participants on the evaluation. Participants offered comments on what was liked most about the presentation. The following comments were received: “It was an interesting topic,” “Well rounded presentation, very informative,” “I enjoyed being given questions to be able to use and follow up with in my care of work and with my patients,” “How she was able to into detail about all topics,” and “Learning a new perspective- method- when working with patients.” In addition, participants offered comments on suggestions for improvement. The following comments were received: “How to work with and build teams that encourage consistency with the subject and philosophy,” “Need more trainings like this,” and “Need more time.”

Discussion

The means of total scores on the pretest and posttest consisting of the modified Cultural Humility Scale were analyzed. It was found that the difference between the means from the pretest compared to the posttest was not significant. The modified Cultural Humility Scale included both a positive subscale and negative subscale, and the means of the subscales from the pretest and posttest were compared. Similar to the total score, the differences of means between both the positive subscale and negative subscale were not significant. Indeed, the difference in means for total score and both subscales were not found to be significant. However, qualitative

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data retrieved from participants' completion of post training evaluations showed that the intervention of a training had a positive effect. Participants reported gaining new perspectives, along with request for more time to cover the topic. This indicates that there is a gap in traditional training methods and material. Further, there is an opportunity to transform traditional cultural competence training for health care professionals to promote inclusivity and include modern perspectives.

The first expected outcome of completion of pre-test for more than 33% of all healthcare professionals meeting inclusion criteria was not met. Only eight healthcare professionals completed the pretest; barriers to this goal with recommendations to increase participation was previously indicated. Moreover, another expected outcome was that 90% of participants who complete the pretest will attend the training, as well as greater than 50% of participants who completed training will complete posttest. Both expected outcomes were met as 100% of participants who attended the training completed the pretest and 87.5% of participants who attended the training completed the posttest. The expected outcome that there will be a 30% or greater increase in postintervention positive subscale scores compared to preintervention positive subscale scores was not met. Likely, ceiling effects for the pretest contributed to this outcome. Also, social desirability biases and central tendency error probably played a part in this outcome by decreasing variability in range of scores and change in scores over time. The last expected outcome which aimed for 50% of participants who attended training to complete the post training evaluation was met; 100% of participants completed the evaluation.

Certainly, there were barriers to this quality improvement project. The small number of participants was a significant limitation. Barriers of participation included healthcare professionals perceived burden of attending training. Participants received work-pay for the time

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spent during the training and refreshments were offered at each training in order to overcome this barrier and to increase participation. Another barrier was the acuity of the unit. The acuity of the unit was relatively high on the day of the trainings, health care professionals may have opted to not attend training after work shift due to high stress level and fatigue. Further, a barrier was health care professionals not wanting to come to training on their scheduled day off. In the future, the training could be offered online or via videoconferencing in order to overcome this barrier and increase participation. As previously mentioned, Carpenter et al. (2015) showed no difference in median scores on HBAS with use of web-based training compared to traditional training. With this consideration and in regard to cost, the intervention of web-based learning could be considered as an effective form of training for cultural humility of health care providers. The discussion among participants and the question/answer portion complemented the didactic content of the training considerably. A disadvantage of a web-based, fully asynchronous training would be the incapacity to engage in discussion, though training via videoconferencing would be capable of supporting discussion. Due to multiple barriers of classroom- based training including coordination of staff attendance, motivation for attendance, and cost, a web-based training that has the capability of supporting discussion among participants may be effective in increasing attendance without significantly effecting the outcome of the intervention. In the future, the addition of process measures focused on what specific aspects of the training were delivered and which were most effective would be helpful in determining the most effective method to deliver the training.

To note, many might consider concepts like sexual orientation and/or gender identity as part of a patient's cultural background hence, the use of this particular scale for this project. Alternatively, some might not consider facets of one's identity such as sexual orientation and/or

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gender identity as part of a patient's cultural background. A consideration is the extent to which any given participant associated the concepts of sexual orientation and/or gender identity as part of a patient's cultural background. This gap may explain a lack of sensitivity in this scale to the outcomes of the project's intervention, given that the participants were asked to complete a scale that inquired about cultural humility to measure the outcomes of the educational intervention specifically related to SGM. Moreover, participants' identification within the sexual and gender minority group is unknown in this project, and this could be considered in future projects. Participants' perception/awareness of working with sexual and gender minority patients, as well as the frequency they perceive provide care to this population could also be a consideration for future projects.

Another limitation was the re-purposing of the Cultural Humility Scale, as this had a direct impact on the tool's validity and reliability. Most scales found were focused on assessing provider's knowledge and attitudes similar to the focus of the Cultural Humility Scale. For instance, Bhat et al. (2015) and Mills et al. (2017) used the Cultural Competence Assessment, Steinke et al. (2015) used the Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals- Revised, and Bristol et al. (2018) used the Ally Identity Measure, all of which measure provider attitudes. One consideration would be to use the unmodified version of the Cultural Humility Scale, which is a patient/consumer report, in order to assess patient attitudes regarding their providers after the providers have completed cultural humility training. Further, future projects could be focused on measuring patient outcomes after provider training.

Bronfenbrenner's ecological systems theory was used as the theoretical framework in this project. Bronfenbrenner (1994) stresses that consideration of the ecological forces that have an

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influence on human development is necessary in order to understand human development. The model served as a framework for healthcare professionals to consider multiple systems that impact an individual's development and experience. Specific to this quality improvement project, one should consider structural determinants that have an impact on disparities for sexual and gender minorities. The overall goal of the project was to help eliminate health and healthcare disparities faced by sexual and gender minorities. The intervention used to reach the goal incorporated measures directly at the microsystem level, by providing education to healthcare professionals to have an effect on individual interactions between healthcare professionals and patients (Clauss-Ehlers et al., 2019).

Conclusion

Cultural competence which focuses on the learning of belief systems, needs, and vulnerabilities of minority groups (Yeager & Bauer-Wu, 2013) traditionally has been the conceptual model used in training healthcare professionals to provide care to diverse populations. Antiquated perspectives and methods of training cultural competence to healthcare professionals are not sufficient, and in fact may lead to inaccurate assumptions and stereotyping of patients. In light of multiculturalism, training specific to certain groups is overwhelming, unrealistic, and not sustainable. In terms of training on disparity groups and health and healthcare inequities, the more modern perspectives of cultural humility and structural competence are more relevant. A focus on self-awareness and reflection as emphasized in the concept of cultural humility (Yeager & Bauer-Wu) allow healthcare professionals to continually develop competence in providing sensitive care to all patients. A focus on social determinants that cause disparities and inequities as in a focus on structural competence can equip healthcare professionals with more accurate viewpoints, in order to better foster empathy and promote

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change. Trainings with these perspectives promote inclusivity for SGM; and more, they promote inclusivity for all patients, not only those identifying within a specific group or groups.

With that being said, the quality improvement project had several impacts. For one, both the healthcare professionals and administration gained new perspectives regarding cultural humility training and inclusivity of their own practice and of the institution. For one, the participants identified the concepts of cultural humility and structural competence related to training opposed to cultural competence as new and instructive. Further, the training propelled conversation about what measures at the institutional level were or were not in place to promote inclusivity. This project served as a model to not only create a cultural humility training for healthcare professionals specific to sexual and gender minorities, but a model that promotes inclusivity to all people.

The key findings in literature show that training is an effective intervention to enhance cultural competence in healthcare professionals. All studies in review of literature with a pretest-posttest design showed a significant change in total scores of measures after intervention, along with change in multiple subscales in various studies. Though this quality improvement project did not show significant results when comparing means of scores on pretest and posttest, it is important as qualitative reports from participants showed favorable results. The scores rated on the modified scale used in this project may have been influenced by social desirability biases and central tendency error; future trainings that use alternative scales to measure the outcome with less likelihood for these tendencies may be considered. Future actions needed include integrating this model focused on cultural humility and including sexual and gender minorities as a disparity group into the cultural competence training that is already established at the institution for new employees and continued education. This would generate sustainability of this model as it would

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incorporate the model into the already established training regimen of the institution. Another consideration to increase participation and sustainability is to develop a web-based training to offer to healthcare professionals. Successful integration at this institution could then serve as a model for other healthcare institutions who would like to modernize perspectives and methods of training for cultural competence and promote inclusivity.

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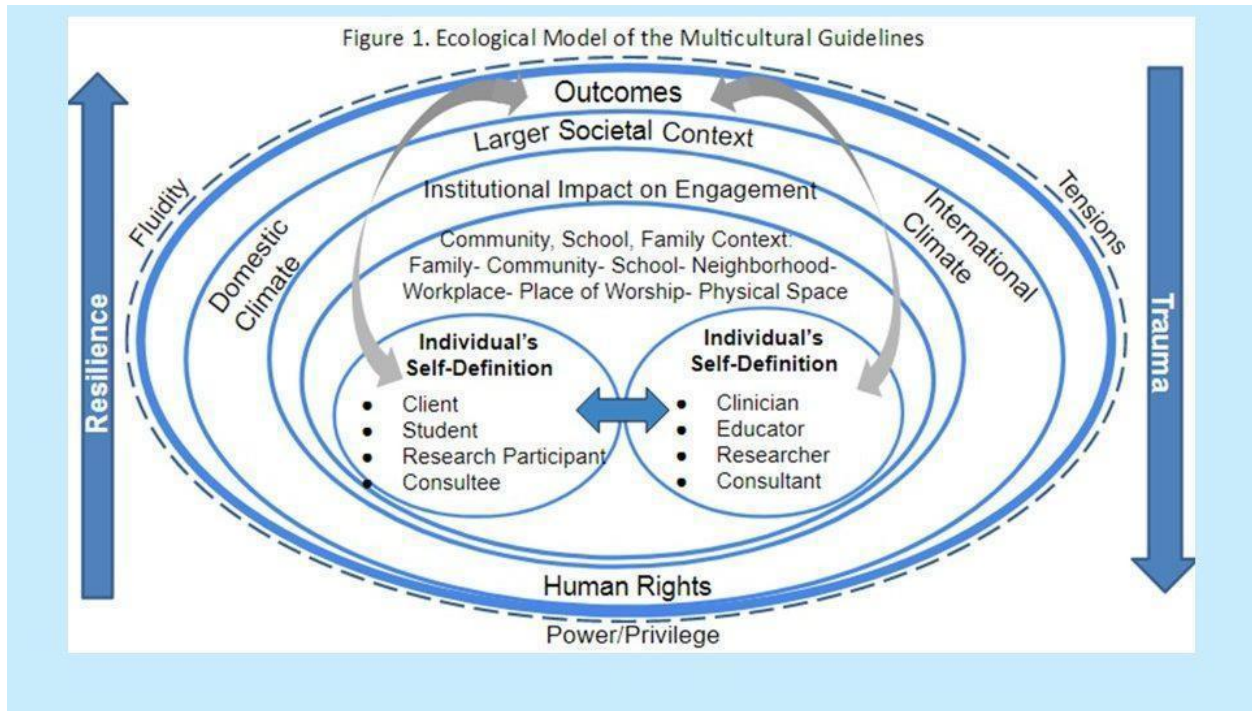
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Appendix A



(Clauss et al., 2019, p. 234)

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Appendix B**PART 2: CULTURAL HUMILITY SCALE (ADAPTED VERSION)**

Directions: There are several different aspects of one's cultural background that may be important to a person, including (but not limited to) race, ethnicity, nationality, gender, age, sexual orientation, religion, disability, socioeconomic status, and size. Some things may be more central or important to one's identity as a person, whereas other things may be less central or important.

Please identify the aspect of your cultural background that is most central or important to you:

How important is this aspect of your cultural background?

Not at all important			Somewhat important		Very important
1	2	3	4	5	

If there is a second aspect of your background that is important to you, please list:

How important is this aspect of your cultural background?

Not at all important			Somewhat important		Very important
1	2	3	4	5	

If there is a third aspect of your background that is important to you, please list:

How important is this aspect of your cultural background?

Not at all important			Somewhat important		Very important
1	2	3	4	5	

Please think about your interactions with your patients and how your patients may perceive the interactions. Using the scale below, please indicate the extent to which you agree or disagree with the following statements about yourself.

Regarding the core aspect(s) of my patient's cultural background, I ...	Strongly disagree (1)	Mildly disagree (2)	Neutral (3)	Mildly agree (4)	Strongly agree (5)
1. Am respectful.	1	2	3	4	5

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2. Am open to explore.	1	2	3	4	5
3. Assume I already know a lot.	1	2	3	4	5
4. Am considerate.	1	2	3	4	5
5. Am genuinely interested in learning more.	1	2	3	4	5
6. Act superior.	1	2	3	4	5
7. Am open to seeing things from the patient's perspective.	1	2	3	4	5
8. Make assumptions about the patient.	1	2	3	4	5
9. Am open-minded.	1	2	3	4	5
10. Am a know-it-all.	1	2	3	4	5
11. Think I understand more than I actually do.	1	2	3	4	5
12. Ask questions when I am uncertain.	1	2	3	4	5

(Hook et al., 2013, p. 12-13, modified Dalton)

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Appendix C

PART 1: ABOUT YOU

Please circle the numbers or complete the correct response(s) to the following questions.

1. What sex were you assigned at birth? _____ What gender do you identify as now? _____
2. How old are you? _____ Years
3. What is your race/ethnicity? (Select ALL applicable):

(1) African American/Black	(2) Asian
(3) Hawaiian/Pacific Islander	(4) American Indian/Alaskan Native
(5) Hispanic/Latino(a)	(6) White
(7) Other. Please specify _____	
4. Do you speak any language(s) other than English when providing services? (1) Yes (2) No
5. If Yes, what are these languages? _____
6. What is the highest level of education you have obtained?

(1) Less than high school	(2) High school graduate/ GED
(3) Some college, no degree	(4) Associate degree
(5) Bachelor's degree	(6) Master's degree (MA, MS)
(7) Professional Degree (MD, JD, PsyD)	(8) Doctorate Degree (Ph.D./ Ed.D)
7. What is your current position?

(1) Executive position	(2) Volunteer
(3) Administrative (e.g., unit coordinator)	(4) Social worker
(5) Mental health counselor	(6) Managerial (e.g., project director, supervisor)
(7) Nurse	(8) Provider
(9) Other. Please specify _____	
8. How many years have you been working in your current position? _____ Months
9. Which of the following types of training did you receive on cultural competency, if any?
Circle ALL the responses that apply.

(1) I took a <u>required</u> class that focused SPECIFICALLY on this topic in school
(1) I took an <u>elective</u> class that focused SPECIFICALLY on this topic in school

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- (2) This topic was covered in various classes in school
- (3) I learned about this during my fieldwork experience in school
- (4) I took continuing education (CE) workshops or CE courses on this topic
- (5) I gained knowledge from reading about this topic on my own
- (6) I learned about it through supervision on the job
- (7) I learned about it through interaction with professionals from other disciplines at my workplace
- (8) I have had no formal training on cultural competency

(Balcazar et al., 2009, modified Dalton)

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Appendix D

Post-Presentation Evaluation

Presenter: _____

Date: _____

Topic: _____

Presentation Effectiveness Criteria

<i>To what extent did the presentation represent the following features?</i>	Yes	Needs Work	No	Comments
1. Purpose communicated clearly.				
2. Organized and easy to follow.				
3. Presenter exhibited a good understanding of topic.				
4. Presenter was well-prepared.				
5. Presenter spoke clearly/effectively				
6. Time for presentation used effectively.				
7. Data in slides was informative.				
8. Presenter responded effectively to audience questions and comments.				
9. Presentation was done in a way that engaged audience.				
10. Presentation enhanced understanding and knowledge about this topic.				

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Post-Presentation Evaluation (Cont.)

11. What did you like most about the presentation?

12. What areas might you suggest for improvement not listed above?

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(Kuta, 2017, modified Dalton)

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Appendix E

Curriculum for Educational Intervention

Minutes	Content
0-3	Complete pre-test
3-15	What is cultural humility, structural competence? Goal: Shifting training framework from cultural competence to cultural humility/structural competence. Goal: Shift care focused on special population to inclusive care to all patients. Goal: Identify practical strategies that can be done individually in shifting care and identify institutional wide strategies.
15-20	Self-awareness, CAMPERS
20-25	Sex and Gender
25-30	Sexual Orientation and Sexual Behavior
30-40	Perceptual, financial, and institutional barriers
40-45	History and Assessment
45-50	Institutional Inclusiveness
50-55	Question and answer
55-60	Complete evaluation

Content for curriculum adapted from Acquaviva (2017).