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KIND Communication: An Educational Intervention to Raise Nurse Resident's Awareness Towards Decreasing Implicit Bias Through Effective Communication Strategies

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Abstract

Background: There is an increasing need for healthcare institutions to become more aware of how provider biases can affect patient outcomes and contribute to health care disparities for Black and other diverse populations. Implicit biases can result in poor patient outcomes and a breakdown in trust between patients and health care providers.

Purpose: To educate nurse residents on the use of the Kinesics, Inclusive, Non-biased and Deliverable KIND, Communications technique to decrease biases during interactions.

Methods: Nurses enrolled in the institutions Nurse Residency program participated in the training session during their monthly educational meeting. Education was provided using a power-point presentation which included videos and open-dialogue discussions. The nurses were administered the Cultural Assessment Screening tool and asked about the trainings effect.

Results: A total of 32 nurse residents attended the programming with a yield of 19 paired pre and post-tests for cultural awareness. Although scores for culture awareness increased the change was not significant (p-.551). Open ended responses were positive including that hearing the personal experiences of others aided in their ability to reflect on their own biases was valuable and that the film shared on the experience of being Black was eye opening.

Discussion: The modest changes on cultural awareness and written responses to the open-ended question may indicate benefits in utilizing KIND communication in practice. Increasing awareness of unconscious attitudes towards racial groups through storytelling and gaining understanding of one's own biases by hearing the lived experiences of others.

Keywords: *cultural competence, cultural humility, training, communication, workplace incivility, intercultural communication, implicit bias*

Introduction

Many health care facilities are becoming more attentive of the need to increase cultural awareness within their institutions. Black individuals and other diverse groups have been negatively impacted by racism in healthcare and evidence suggests that racism is a social determinant of health (Gonzalez et al., 2018). Institutionalized racism impacts the structures, policies, practices, and norms resulting in variances in access to the goods, services, and opportunities of society by race (King, 2016).

Black Americans have distinct trauma in relation to atrocities committed against them, which deeply impacts trust within the healthcare system, and they are more likely to prefer concordant providers (King, 2016). This can be problematic for Black patients as nearly 80% see non-Black physicians and there are a limited number of Black providers, approximately 5% in the U. S., (Hagiwara, Slatcher, Eggly, & Penner, 2017). According to Minority Nurse, approximately 9.9% of RNs identify as Black/African American in comparison to 75.4% of nurses that identify as White/Caucasian (Minority Nurse, 2020).

Negative health outcomes for minority patients has been directly linked to racism at both the individual and institutional level leading to increased research on implicit bias amongst healthcare providers (Gatewood et al., 2019). Few studies have explored the role of Black patients' perceptions of discrimination in understanding the quality of racially discordant medical interaction and how non-Black physicians' implicit and racial bias affect medical interactions and outcomes of Black patients (Hagiwara, Dovidio, Eggly, & Penner, 2016). In addition, despite the growing amount of literature addressing implicit bias there is little research addressing the effects of implicit bias on nursing (Gatewood et al., 2019).

Institutions have begun to address this by using cultural competency trainings to improve communication between members of the healthcare team and to improve patient outcomes. Unfortunately, cultural competency may have created a bigger problem by teaching cultural generalizations that increase biases and stereotypes as individuals are often clustered into groups rather than being viewed as complex and unique individuals (Malat, 2013). It is human nature to have assumptions, but often these assumptions may have a negative impact on patient and provider relationships.

Implicit bias refers to the unconscious and unintentional assumptions people make about each other and is related to poor health outcomes and negative patient perceptions during healthcare encounters (Gonzalez et al., 2018). Decreased cultural responsiveness can create a power dynamic in which one individual may make false assumptions based on race and other characteristics, which can create barriers to communication, nurse retention, and safety (Green, 2019). Recognizing implicit biases and learning effective communication skills such as intercultural communication is critical for care and safety and can be a powerful tool to decrease bias and stigma by reducing tendencies of generalizations and assumptions (Henderson, Barker, & Mak, 2016).

Problem statement

The risk of cultural and implicit bias among health care workers in the medical setting is indicted by poor patient outcomes towards Black individuals and other diverse patients creating health care disparities resulting from a lack of culturally responsive training. Poor cultural awareness of health professionals affects both staff and patients' experiences and satisfaction. Cultural awareness training is associated with both improved patient outcomes and patient and staff satisfaction (Hall, Chapman, Lee, Merino, Thomas, Day & Coyne-Beaseley, 2015).

The purpose of this capstone project was to use the KIND (Knowledgeable Kinetics, Inclusive Language, Non-biased, Deliverable) Communication technique developed by the author, to build cultural connections and gain understanding and acknowledgment of cultural diversity and personal views, perceptions and biases towards it. The goal of KIND is to become aware of individual biases and use self-reflection and self-critique to address these biases by recognizing non-verbal and para-verbal communication along with feelings that arise from discomfort when interacting with Black individuals and individuals from other diverse populations. KIND seeks to detect perceptions and feelings of bias during patient-provider encounters. It is a technique that can be used across practice settings to enhance communication.

Background

Implicit bias contributes to the increased health disparity for Black Americans and other diverse groups (Hall et al., 2015). Compared with Whites, Black individuals have greater difficulty accessing care, are generally less satisfied with their interactions with providers, and receive worse care than White individuals due to dominant communication styles, limited demonstrations of positive emotions by providers to Black patients, and reduced patient input and inclusion from the patient in their treatment decisions (Hall et al., 2015).

Regardless of the advancements in health care over the past century, Black Americans continue to face barriers to quality health care due to blockades related to race and ethnicity (Hall et al., 2015). Implicit biases are thoughts and attitudes that are often outside of conscious awareness and can be difficult to intentionally acknowledge and control. They are often subtle expressions and can occur unintentionally, whereas explicit biases are thoughts and feelings that are more deliberate and can be more readily controlled (Hall et al., 2015).

Implicit biases play a strong role in non-verbal (e.g. eye contact, posture) and paraverbal

behaviors (speech, tone) which can be difficult to monitor and self-regulate (Hagiwara et al., 2017). As Black individuals are often the target of this behavior, they are attuned to the subtle biases which critically mold their impressions of intergroup interactions. Black patients reported decreased trust and poor treatment by individuals with high levels of implicit bias (Hagiwara et al., 2017). This subtle form of bias is known as aversive racism and it can have a negative effect on interracial interactions.

Aversive racism occurs when a person is low in explicit bias, but who harbors implicit racial bias against Black individuals. Although aversive racism research primarily focuses on White individuals, it also applies to the orientation of members from other diverse groups towards Black individuals (Penner et al., 2010) thus highlighting the importance of understanding implicit bias and the deleterious effects on the Black population in healthcare.

Cultural competency was initially characterized as a "set of congruent behaviors, attitudes and policies that come together in a healthcare system, agency or among professionals that enable that system, agency or professions to work effectively in cross- cultural situations" (McCalman, Jongen, & Bainbridge, 2017, p. 2). It was later redefined by the by the United States (US) National Quality Forum as the "ongoing capacity of healthcare systems, organizations and professions to provide for diverse client populations high quality care that is safe, client and family-centered, evidence-based and equitable" (McCalman et al., 2017, p. 2).

In comparison to cultural competence, cultural humility requires self-reflection and self-critique during multicultural encounters leading to the acceptance and respect of other cultural backgrounds (Abdul-Raheem, 2018). According to Gonzalez et al., (2018) there are no published interventions that exist to help providers at any stage of training develop the skills that are necessary to recognize and manage their implicit bias when encountering patients clinically. The

ability to self-reflect and self-critique are necessary skills in being open to understanding and correcting behavior associated with implicit bias (Gonzalez et al., 2018).

In relation to cultural competence and cultural humility, cultural intelligence provides appropriate verbal and non-verbal cues to coordinate application of cultural knowledge when interacting with Black lives and other diverse populations. Cultural intelligence can be beneficial to strengthening communication. Individuals with high cultural intelligence not only enjoy encountering new cultures, they are also more creative and flexible, and have a clearer viewpoint related to diverse cultural environments (Rahimaghaee & Mozdbar, 2017). To rise to this challenge nursing leaders and institutions began implementing cultural competence policies, practices, and educational training sessions to aid health care workers into being more aware of culturally diverse situations.

The position statement of the American Association of Colleges of Nursing (AACN) recognizes the importance of addressing prevalent and persistent inequities in health care by preparing nurses and other healthcare professionals to meet the needs of an increasing diverse American society ("AACN Position Statement," 2017). One barrier to cultural competence training is that it often increases an individual's awareness towards cultural biases, but it can potentially leave individuals feeling as though they have been either the victim or the perpetrator of racial inequity and prejudices with little skill set to acknowledge, address, and move beyond cultural blockades. This can cause deterioration of effective communication amongst team members and between health care providers and their patients.

Another concern that has been voiced by Clinical Nurse Executives aside from cultural competence training being insufficient, was the lack of cost effectiveness and the lack of opportunities for safe and practical learning. These nursing leaders also articulated the need to

create opportunities for organizations and healthcare workers to safely discuss and address knowledge gaps without fear of offending others and creating cultural dissonance (Ogbolu, Scrandis, Fitzpatrick, & Newhouse, 2016).

The Joint Commission (TJC) encourages hospitals to integrate concepts from communication, cultural competence, and patient- and family-centered care fields into their organizations. They can also impose financial penalties if institutions fail to provide patient-centered, safe, equitable, and culturally appropriate care ("The Joint Commission," n.d.). The Association of American Medical Colleges (AMCC) recognizes and supports the development of culturally competent curricula to eliminate biases in health care and to meet the needs of an increasingly more diverse country as more than half of the US population will consist of non-White racial groups and non-European ethnicities by 2043 (Jernigan, Hearod, Tran, Norris, & Buchwald, 2016).

Multicultural competencies (MCCs) “or the knowledge, skill, and awareness, when working with diverse clients” has been recognized as a critical professional competency when delivering care (Owen et al., 2016). Cultural competence training creates awareness of cultural differences however it can inadvertently have the negative effect of clustering individuals into groups based on physical differences. This can lead to false assumptions and micro-aggressions, which may further traumatize the person and lead to a breakdown in trust and communication.

Micro-aggressions are parts of an alliance rupture in which individuals align the offense to an aspect of their identity. They are subtle messages in communication that can be insensitive, disrespectful, and insulting to another person's culture (Davis et al., 2016). There is an increased need for formalized communication techniques that can be used to develop and increase rapport, reduce bias, and assist in providing culturally responsive care.

Review of the Literature

The following databases were included in the search for this project: Cumulative Index of Nursing and Allied Health Literature (CINAHL), PubMed, Google, The Joint Commission, and U.S. Department of Health and Human Services (HHS). Medical Subject Headings (MeSH) terms included the following: *cultural competence, cultural humility, communication, and training* yielding over 146 articles with these terms for the PubMed search. With the inclusion criteria of articles pertaining to training techniques, communication, published in the last five years, and in the English language were applied this search resulted in 25 articles. Several of the articles were excluded as they did not pertain to the topic or did not contain information on cultural humility and communication.

Boolean search term combinations in CINAHL included *cultural competence, cultural humility, data, implicit bias or unconscious bias, black, black Americans, or African American, healthcare, and communication* resulting in over 2000 articles. When the search terms "cultural humility" and "communication" were utilized together the search yielded 18 results. The terms "*implicit bias"* or "*unconscious bias"* and "*Black" or "Black Americans"* or "*African Americans"* and "*healthcare*" were utilized together the search yielded 273 articles. Articles that did not primarily focus on black populations, articles about implicit bias outside of the healthcare system, studies outside of the United States, and articles pertaining to children were excluded.

A total of 463 articles were extrapolated from the search, and after excluding for relevancy to topic, 36 articles remained, which were then critiqued for strength, quality, and level of evidence by Johns Hopkins Nursing Evidence- Based Practice appraisal tool; Synthesis and Recommendations Tool (Dearholt & Dang, 2012). For the purposes of this study, 24 articles

were utilized in which four were literature reviews, one was an RCT, two were quasi experimental, one was a meta-analysis, and three were qualitative.

A Google search was utilized for locating current cultural communication techniques and theories applicable to cultural communication and for information related to implicit bias and the Black population. Appreciated information was found on Project Implicit and the Implicit Association Test. Google also yielded excellent information about cultural competency and humility in healthcare. It also provided information on cross-cultural communication. The Joint Commission provided valuable information about advancing effective communication, cultural competence, and patient-and family-centered care.

Trainings that focus on culturally responsive care and communication have been proven to have better patient outcomes and improved communication amongst team members. Two Level I systemic review of reviews studies (Truong, Paradies, & Priest, 2014) (Hall et al., 2015), three-Level V literature review studies of high quality discuss best practices for incorporating cultural humility and understanding implicit bias (Shen, 2015), (Jernigan et al., 2016), (McCalman et al., 2017). The Level I systemic review supports the findings that cultural competency can improve healthcare outcomes. The literature review revealed that there was moderate improvement in provider outcomes and healthcare utilization outcomes, however there was weaker evidence for improvements in patient and client outcomes (Truong et al., 2014).

A Level I systemic review evaluated evidence on implicit racial/ethnic bias among health care providers and the connection between the provider's implicit attitudes regarding racial/ethnic groups and healthcare outcomes (Hall et al., 2015). The study concluded that most health care providers have implicit bias with positive attitudes favored more towards White individuals and negative attitudes towards people of color and that implicit bias was strongly

connected to patient-provider interactions, treatment decisions, treatment adherence, and patient health outcomes (Hall et al., 2015).

The three-Level V literature reviews supported evidence that there are a variety of tools and methods to improve cultural awareness in the health care setting (Shen, 2015), (Jernigan et al., 2016), (McCalman et al., 2017). One literature review supports findings that cultural competency trainings can advance the skills, attitudes, and knowledge of medical students (Jernigan et al., 2016).

A Level I meta-analysis found that the experiences and racial attitudes of students in medical school were influenced by negative role model behavior and limited or negative interactions which increased a student's implicit racial bias (Van Ryn et al., 2015). A level II RCT examined biases against African Americans from medical students and also corroborates the importance of informal and experiential elements in training to help positively shape racial bias by medical providers however the study was limited as it did not directly measure discriminatory behavior and the study relied on self-reported measures (Burke et al., 2017). The literature validates that a variety of tools, scales, and questionnaires are designed to measure cultural competency; however, not many tests for psychometric evaluation and there are concerns about the reliability, utility, and validity of existing instruments (Shen, 2015). Key areas in implementing cultural competency in health care organizations include user engagement in the development and/or implementation of strategies, organizational readiness, and delivery across multiple sites (McCalman et al., 2017).

A Level I mixed-methods exploratory study looked at qualitative and quantitative data from focus groups regarding culturally competent communication in mental health settings with results showing varying stakeholder perceptions on the feasibility of clinicians implementing

cross-cultural communication strategies. In contrast, patients reacted positively to all strategies for improving cultural communication (Aggarwal et al., 2018).

A Level II RCT study (Hagiwara et al., 2017) and a Level II meta-analysis (Hagiwara et al., 2016) evaluated communication and investigated how non-Black physicians' racial bias influence communication and patient outcomes during racially discordant medical care with findings suggesting that non-Black providers with higher levels of implicit bias used first person plural pronouns and anxiety-related words. The study provides insight into physicians' actions that may be contributing to negative patient outcomes (Hagiwara et al., 2017). One Level II mixed-methods design study reported on the effects of micro-aggressions and a Level V qualitative design study (Gonzalez et al., 2018) focused on patient outcomes and the effects of cultural humility on mediating relationships affected by micro-aggressions. The study supports findings that less culturally humble individuals damage working alliances (Davis et al., 2016).

A level III study by Owen et al., 2016 assessed for the effects of cultural competency training, patient and student satisfaction, and outcomes related to culturally responsive care. A Level III mixed methods design confirmed that cultural competency training improved nurse practitioners' ability to provide culturally responsive care. Although all the participants of the study felt that the cultural assessment tool that was used was helpful, they also felt that a live session would have been more desirable (Debiasi & Selleck, 2017).

A Level III descriptive correlational studied the effects of student satisfaction when nurse educators use cultural humility. Nursing students were more satisfied when educators were more culturally humble (Abdul-Raheem, 2018). Another Level III study took a retrospective examination between client's ratings of their therapists' cultural humility and the degree to which clients are affected negatively by a therapist's missed cultural opportunities. Clients

reported therapists that took the opportunity to have cultural discussions also had better treatment outcomes (Owen et al., 2016).

A Level II d cross-sectional correlational study evaluated the relationship between cultural intelligence and professional competency. There was a positive correlation between increased cultural intelligence and increased competency indicating cultural intelligence could be a predictor for professional competency. Limitations included limited methods to collect data (Rahimaghaee & Mozdbar, 2017).

Evidenced Based Practice

There is a robust amount of literature about cultural competency and humility providing research on the effects of poor cultural awareness in the healthcare setting. Research also supports the effects of cultural humility and intelligence when delivering culturally responsive care. The literature supports using a variety of training methods and tools when teaching cultural awareness and when increasing awareness around implicit biases.

Project Implicit is a non-profit organization, which collaborates internationally between researchers. They have a shared goal of understanding implicit social cognition and educating the public about hidden biases (https://implicit.harvard.edu/implicit/). Project Implicit uses the Implicit Association Test (IAT) to measure attitudes or beliefs that people may be reluctant or incapable of reporting (https://implicit.harvard.edu/implicit/). Although the IAT provides valuable information for increasing awareness that there is a bias, it does little to guide the individual on recognizing the feelings associated with the bias and offers little direction on what to do when such bias arises.

Organizational Gap Analysis

All members of the organization are provided with cultural competence training through

seminars and online training, however, there have been no trainings on how to communicate through cultural differences. Organizational management including the Chief of Diversity, Presidents Council, and the Workplace Incivility Council have noted a decrease in staff job satisfaction and morale and were highly motivated to improve cultural humility and decrease implicit bias.

Theoretical Framework

The Critical Race Theory (CRT) movement was initiated by a group of lawyers, activists, and scholars in the 1970's who were interested in studying and altering the relationship between race, racism, and power and considers many of the same issues as the civil rights movement, however looks more broadly at the economics, history, context, group-and self-interest, and even feeling and the unconscious (Delgado & Stefancic, 2001). This theory holds aspects of activism and works to not only understand social situations, but to discover how society structures itself around issues of race and then attempts to change it for the better. The movement was initially rooted in law and is now being utilized across a multitude of disciplines (Delgado & Stefancic, 2001).

Critical race theory understands that color blindness reduces or alleviates the role in racial issues and in the empathy towards the life outcomes for different racial groups. This theory offers a framework that aligns with multicultural psychology and is beneficial in the conceptualization in practice of psychotherapy and counseling in cross-cultural situations ("Psychology," n.d.). (See Appendix A) Critical race theorists subscribe to a series of propositions. First, most critical race theorist believed that racism has the sense of ordinariness and normality thus making it different to address in cure. Secondly, they also believe that our society has a system of interest convergence or material determinism that materially advances

white elites and advances the working class psychically. Due to this, large portions of society are unmotivated to change (Delgado & Stefancic, 2001).

Another belief by CRT theorists is the notion that race and races are the products of social thoughts and relations that categorize people based on specific physical traits, and then construct thoughts based on those traits which are then either manipulated or withdrawn when discussing things such as personality, intelligence, and moral behavior. The differential racialization is not scientifically based and is used by dominant groups in response to the shifting needs of society, such as the labor market (Delgado & Stefancic, 2001, p. 8).

Lastly, a tenant of CRT is regard for the unique voice of color in understanding that minorities have a level of competence about race and racism because of their direct experiences with oppression that their white counterparts may not know, and through legal storytelling and narrative analysis the lived experiences of people of color can be expressed. Storytelling can occur in the context of a person's family history, biographies, scenarios and narratives. It is hypothesized that dominant racial groups struggle to understand what it is like to be non-white and through storytelling they may be able to bridge the gap in thinking between persons of goodwill whose experiences, perspectives, and backgrounds differ (Delgado & Stefancic, 2001).

This theoretical framework will be used for this project to bring light to current racial phenomena, develop the discourse about complex racial concepts that occur in both verbal and non-verbal communication and challenges racial hierarchies that may implicitly be affecting patient care and outcomes. Critical Race Theory places race at the center rather than the periphery of science and medicine (Bridges, Keel, & Obsaogie, 2017) and as with KIND Communication, looks to consciously bring race to the forefront of care. Understanding each one of these facets can assist in building rapport and simultaneously can decrease the risk of

stereotyping.

KIND Communication

The "*K" in KIND* Communication, which stands for Knowledgeable Kinesics, looks to remove the ordinariness and normality of race by cuing healthcare providers on their own body language and subconscious feelings that arise when caring for Black individuals and individuals from diverse backgrounds. Nonverbal communication is a significant factor for interpersonal communication however regrettably is often on the periphery of therapeutic interactions. Nonverbal cues given by the provider or perpetuated by the client can offer critical clues to the comfort level between individuals during certain topics of discussion (Foley & Gentile, 2010).

The *"I" in KIND* Communication refers to Inclusive Language, which challenges innate beliefs and thoughts that automatically assign traits to dominant groups.

The "*N" in KIND Communication* speaks to Non-biased communication' which seeks to increase individuation during encounters to avoid stereotypes, generalizations and categorization. Individuation and categorization exist on a continuum with individuation occurring as a desirable and wanted outcome (Lucas, Creery, Hu, & Paller, 2019). There is still a society of separate and unequal that can largely be attributed to the pervasive discrimination and segregation that is known to Blacks but unknown to Whites (Borrell, 2018).

The *"D" in KIND* aims to deliver non-biased care when cultural underpinnings are being assessed, to carefully avoid stereotypes and discrimination based on biological variations and implicit biases, and to evaluate patient and provider outcomes. Outcomes can include but is not limited to patient satisfaction, provider satisfaction, and patient adherence to treatment.

This DNP project was a quality improvement design incorporating evidence through an educational intervention with the use of CRT and KIND to evaluate the effects of cultural

communication using pre-assessment screening and the KIND technique, ideally to increase awareness towards the effects of cultural and implicit bias on communication. This communication technique aims to move individuals beyond awareness into a higher level of understanding and conscious application. The KIND technique is an acronym that stands for Knowledgeable Kinesics, Inclusive language, Non-biased, and Deliverable Communication; and was created to increase conscious awareness of biases, assumptions, and beliefs that influence behaviors and drive outcomes during interactions with Black individuals and individuals from other diverse populations. Underpinnings of the Critical Race Theory helps to reduce ordinariness that makes racism hard to recognize and attempts to decrease differential rationalization through storytelling and narrative analysis to improve outcomes in a commitment to social justice.

The KIND communication was developed by this DNP student to help individuals become more comfortable with culturally responsive communication and gears individuals towards being more present and aware of their feelings and biases. Many white Americans have limited interactions with Black Americans due to unwavering residential segregation and majority status and at times will avoid contact because of anxiety or negative assumptions (Burke et al., 2017). Reducing these negative interactions requires one to be more inquisitive about what they don't know, and not what they assume (Borden, 2018) (see Appendix C).

Knowledgeable Kinesics draws immediate attention towards one's self-awareness towards their own body language with approximately 60-65 percent of interpersonal communication conveyed through non-verbal communication (Foley & Gentile, 2010). Non-verbal communication plays a substantial role in establishing rapport and building a therapeutic alliance. Without rapport, the therapeutic alliance will be broken. Rapport is built upon three

non-verbal behavioral elements, which include attentiveness, positivity-negativity, and coordination (Foley & Gentile, 2010).

Attentiveness requires one to stay in the present and to not be distracted or lose interest in what the patient is saying as it undermines rapport. It can be conveyed by giving undivided attention and by making eye contact and nodding to encourage further communication. Positivity-negativity refers to how the patient and provider are responding to one another and can be relayed with non-verbal cues such as smiling, laughing, or leaning in while sitting during conversations. Coordination is the concept of similarity in the non-verbal behavior between individuals who are communicating. Taking cues by mirroring behavior such as making eye contact at the same moment, returning a smile, or changing position at the same time as the patient can help to build comfort when communicating. Lack of awareness towards these cues can hinder therapeutic relationships (Foley & Gentile, 2010).

Inclusive Language is the second component of KIND communication and requires one to be mindful and purposeful when communicating with others, with a goal of communicating dignity, respect, and impartiality ("Linguistic Society of America," 2016). This increased awareness requires one to be conscious of the ways in which language can make unintentional assumptions about people while simultaneously reinforcing dominant norms surrounding gender, sexual orientation, race, class, ability/disability, age, and other identities and experiences (Linguistic Society of America, 2016). Use people-first language, which keeps the individual as the primary element. Descriptors should only be used when relevant. It is always best to follow the patient's lead and ask what the patient prefers when you are not sure and to avoid idioms, jargons, and acronyms as some are rooted in negative connotations and stereotypes (Seiter, 2018).

The third tenet of KIND communication is Non-biased communication, which seeks to increase individuation during encounters to avoid stereotypes, generalizations and categorization. Individuation and categorization exist on a continuum with individuation occurring as a desirable and wanted outcome (Lucas, Creery, Hu, & Paller, 2019). Individuation entails focusing on the unique qualities of each individual, to decrease the amount of stereotypical information that can overshadow a person's memory or perception. Stereotypes can lead to interpersonal judgments and have subtle negative effects on interactions which can lead to undesirable effect on patient outcomes (Lucas, Creery, Hu, & Paller, 2019).

The last aspect of KIND communication is Deliverable outcomes, which ensures that care and communication was effective. Positive connections between the provider and the patient can help to improve provider comfort with future engagements with individuals of different backgrounds. It also strengthens the alliance and rapport between provider and patient, which can improve patient outcomes (Foley & Gentile, 2010). Outcomes can include but are not limited to patient satisfaction, provider satisfaction, and patient adherence to treatment.

Cultural awareness programs maintain a set of both individual and organizational attitudes, perspectives, behaviors and policies that promote and support effective interactions with diverse cultures. Practicing culturally responsive care to honor diversity means understanding the fundamental needs of your target audience and creating services and materials to meet those needs strategically ("HHS.gov," 2018).

Cultural training can help healthcare workers to become aware of their use of generalizations about clients and gives them the motivation to decrease the frequency with which they make stereotypical assumptions about patients (Debiasi & Selleck, 2017).

Methods

The first step of the project was for the DNP student to meet with the magnet nursing program director to discuss the project and to inquire about biases that nursing student may have encountered. Concerns and goals for the facility were discussed. The DNP students provided the director with a copy of the cultural assessment tool for review prior to administering to the participants in the nurse residency program. A date was then set to present the educational intervention in February.

The next step was for the DNP student to obtain consent and administer the pre-screen along with education on KIND communication. At the start of the in-service there was an introduction and discussion of the training purpose, which was for nurses to gain an understanding of KIND communication and to improve healthcare outcomes by increasing awareness of personal biases. Education was delivered through a power point presentation with video content and open-dialogue discussions (See Appendix D).

The final step was for the DNP student to re-administer the screening tool and assess for improvements of cultural awareness in communication. Participants had the opportunity to participate in open dialogue discussions to address cultural concerns, personal views and perspectives towards the culture of the institution and its members. Opportunity was provided for validation and feedback. Both DNP students participated in the presentation and collected and compiled the qualitative data from the group for later analysis.

The nursing residents were re-administered the survey through Survey Monkey after the brief intervention. The Cultural Awareness Assessment Tools reliability analysis was computed with a Cronbach's alpha of .734. An alpha of .700 or greater is considered appropriate in social science research (Anitori, 2014, p. 309). Nurse residents were also provided comment cards for

qualitative feedback. The DNP students collected and compiled quantitative and qualitative data for analysis and the results were given to the magnet nursing program director to review with the members of the team.

Project Site and Population

The setting where the project took place was in an urban not for profit hospital. The project took place with the nurse residents who were enrolled in the hospitals Nurse Residency Program. The location of the facility is centered in a primarily Hispanic, impoverished, and underserved community. The project site was at a 716-bed independent academic medical center and is the community's major referral hospitals and employs over 1100 medical staff and physicians. The hospital has 10 residency training programs, over 500 volunteers, and is the regions only Level I trauma center and pediatric trauma center. They also have a pharmacy on site, which fills over 218,000 prescriptions each year. The facility provides the highest level of care for conditions such as cancer, acute and chronic cardiovascular illness, nervous system illness, digestive illness, and other diseases that affect the major organ systems of the body (https://www.baystatehealth.org/locations/baystate-medical-center).

This project was carried out by two DNP students, both in the Psychiatric Mental Health Nurse Practitioner track with over 10 years of nursing experience. One DNP student provided the pre and post assessments and education to the nursing residents while the second DNP student provided the educational toolkit that can be utilized by all staff. The participants included approximately 32 new nurses enrolled in the hospitals nurse residency program.

For this project the Cultural Awareness Assessment tool was utilized to measure staff's multicultural awareness in five categories, which included general education experience, cognitive awareness, research issues, behaviors/comfort with interactions, and patient

care/clinical issues (Shen, 2015). (See Appendix B) As the IAT increases awareness that everyone has a bias (https://implicit.harvard.edu/implicit/)the Critical Race Theory, the Cultural Awareness Assessment tool, and the use of KIND Communication technique aim for individuals to begin to move past awareness and shift into a higher level of understanding and application. (See Appendix E) Educating staff on how to utilize the KIND Communication technique occurred through power point presentation, open-dialogue discussions, and group activities.

The cultural awareness assessment tool is a 17-item questionnaire that has five components of cultural competence, (See Appendix F) (1) cultural awareness, (2) cultural knowledge, (3) cultural skill, (4) cultural encounter, and (5) cultural desire (Flowers, 2004). "Reliability analysis of the Cultural Awareness Assessment Tool was computed, and a Cronbach's alpha of .734 was obtained, indicating that the 17 items for this scale measured a similar construct: cultural awareness. An alpha of .700 or better is considered acceptable in social science research" (Anitori, 2014, p. 309). This tool will be used pre-intervention and will be re-administered post presentation.

Staff demographics, assessment scores, and personal statements/quotes were collected by the DNP students who kept the data secured in a private locker. The data was collected immediately after the session. Study participants were assigned a number that the DNP students put into an Excel spreadsheet with a key kept in a password protected computer.

The data collection and analysis process took 1 month which was ample time given the small numbers of participants (n=32). Once all the data from the session was collected, data analysis was completed using the Statistical Package for the Social Sciences software (SPSS) program through Survey Monkey.

The survey results were analyzed using descriptive and inferential statistics for measurement of demographics, screening scores, and subjective statements through a Survey Monkey. A t-test inferential statistic was used, and results were entered and analyzed in the SPSS statistical software. The variables of interest were assessment scores and subjective statements.

Protection of Human Subjects

The University of Massachusetts, Amherst (UMass) Internal Review Board (IRB) approval was obtained prior to initiating the DNP Project. The IRB and institutional approval to proceed with the project was obtained in the fall of 2019 from the hospitals IRB committee. (See Appendix G). All data collected as a part of the project had no protected patient information. The screening and survey results were secured in the DNP student's private locker with no patient or participants identifiers. The DNP student had completed CITI training and was knowledgeable about Health Insurance Portability and Accountability Act (HIPPA) procedures due to working as a psychiatric nurse in the hospital. In addition to the consent process, the use of no personal information and the right to not participate and stop the study at any time were explained. The consent, assessment tool, brief intervention, and wrap up took approximately 90 minutes. (See Appendix D)

Results

There were 32 nurses that participated in the project with ages ranging from 21-48. The timeframe in which the project occurred was 6 months from initiation to project completion. The expected outcomes for this quality improvement project were for the DNP student to educate 100% of the nursing residents on the overall project and expected outcome and to have 100% of nursing residents completed the cultural assessment screening tool (see Appendix B) by February

2020 which was accomplished. The pre-test and post-test samples were matched after the study was completed. Due to attrition only 19 participants were able to complete both the pre- and the post-test for cultural awareness. The age range and mean of those who completed both is presented in Table1 below.

Table 1

Age Range of those Nurse residents Completing Both Pre and Post Test

	N	Minimum	Maximum	Mean	Std. Deviation
Age	19	22.00	48.00	29.4737	7.62575

Of those who completed the paired tests, the youngest was 22 and the oldest was 48 with mean age increase of 29.5. Comparing this to the ages of all nurse residents who took the original cultural awareness test it became apparent that the attrition primarily happened in the younger age groups.

The table below presents the ethnic background of the 19 participating Nurse Residents who took both the pre and post tests on cultural awareness.

Table 2

Racial identity of Nurse Residents Completing both the Pre and Post Test

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	White	13	68.4	68.4	68.4
	Hispanic	3	15.8	15.8	84.2
	Other	2	10.5	10.5	94.7
	Black	1	5.3	5.3	100.0
	Total	19	100.0	100.0	

Compared to the initial sample, the paired race distribution remains similar in structure. Most participants were White (13. 68.4%), and the remaining 6 were Hispanic, Black, and Other.

Table 3. presents the religious distribution of the nurse residents that completed both the pre and post tests on cultural awareness.

Table 3

Religions of Nurse Residents Completing both the Pre and Post Test

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	None	9	47.4	47.4	47.4
	Christian	4	21.1	21.1	68.4
	Catholic	3	15.8	15.8	84.2
	Other	3	15.8	15.8	100.0
	Total	19	100.0	100.0	

Of the paired sample, there were 47% identified as non-religious with the remaining identified as being Christian (21%), Catholic (16%), and other (16%). This distribution structure also remained similar to the initial sample (Table 3).

Table 4 presents the average pre and post-test score on the cultural assessment screening tool of those nurse residents who completed both the pre and post-test for cultural awareness.

Table 4

Pre- and post-test score for cultural awareness

	N	Minimum	Maximum	Mean	Std. Deviation
CA Total Pre	19	17.00	31.00	24.4211	4.16754
CA Total Post	19	18.00	35.00	25.1053	4.16193
Valid N (listwise)	19				

Participants were asked to answer questions regarding cultural awareness before the presentation and after with the scores range between 17 and 31 in the pre-test and afterwards the ranges were 18 to 35 in the post-test. So there was some modest improvement in the cultural assessment skill after the presentation.

For reference, the highest possible score for the cultural awareness test is 51, and the lowest possible score is 17. To be considered a high degree of cultural awareness, one needs to score 40 points and up. Between 30 and 39 points, a participant is considered to have average cultural awareness. Between 17 and 29 points, a participant is considered to have low degree of cultural awareness. The mean awareness score in both tests fell under the average awareness range.

To test whether the scores on the cultural awareness test significantly increased before and after the intervention, a paired samples t-test was utilized. Using a paired samples t-test allows evaluation within subject factors. The results are presented in Table 5.

Table 5

Paired samples t-test on Difference in scores on Cultural Awareness test

	Paired Differences							
			S.D.	95% CI Difference				Sig. (2-
	Mean	S. D.	Mean	Lower	Upper	t	df	tailed)
Pre-Post	-.68421	4.91090	1.12664	-3.05119	1.68277	-.607	18	.551

These results demonstrate that although the range of scores increased between pre- and post-tests, the difference was not significant indicating no difference between the two time periods. The mean difference between the two times was -.684, and the t score was -.607 (p=.551).

Participants were also given individual comment cards for feedback to the DNP students. The 5 themes were: *Understanding Implicit Bias, Video Reflections, Personal Reflections, Importance of Focusing on Black Populations, KIND Education.* Table 6 illustrates some participant thoughts and insights related to the educational intervention by theme.

Table 6
Narrative Themes

Understanding Implicit Bias
"Inclusion does not and is usually not comfortable, but it has to be respectable regardless of our own bias that we cannot control. Sometimes I felt uncomfortable and didn't know how I was supposed to feel when watching and talking about how black people grow up in today's society."
"Implicit bias- understanding that everyone has it instead of denying it, recognize it exists, learn from it, ask questions, & be mindful."
"I found myself recognizing my biases in the videos."
"I learned that even if you are unaware of your biases, you can still have racist behavior implicitly."
Video Reflections
"I really appreciated the video because it showed these young men's perspectives in their own words and with their emotions apparent which I found more impactful than when a teacher lectures about the perspectives of people of color."
"Excellent presentation!!! Growing up Black video brought tears to my eyes, it's sad that we've come so far, yet we are still so far from where we need to be.
"I think your presentation should be seen by everyone hospital wide." *"Really appreciated being able to hear the perspectives of young Black men…left a strong impression."*
"I appreciated the video because hearing the actual experiences and stories of young Black men really illustrated how adverse their lives had been due to their skin color-something other people that aren't Black will never experience."
"The more you act like someone else, the less authentic you are"-love this quote."

Personal Reflections

"My husband does not believe in white privilege and it bothers me because I see it every day- I'm White. My parents were very racist growing up. I became best friends with a Black girl in high school. I felt like I was doing something wrong by my parents."

"I have experienced racism at work toward my Black coworker, I backed her up. White woman asked my coworker If her hair was real. I don't know why White people ask this; it bothers me."

"My White manager asked my White assistant manager if she felt "safe" talking to my black coworker alone we talked about it and she cried but I supported her."

"I appreciate you talking about the negativity with saying "I'm colorblind" and how you need to see it to validate that person, which impacts patient care."

"I like calling out micro-invalidations as a bad thing. I think they mostly come out of a good place but it's going too far to the other end of the spectrum, so it becomes invalidating."

Importance of Focusing on Black Populations

"Homing in on the Black population will benefit all races. All races have prejudices and biases against Black people, so it is a good place to focus in on. The disability act is a really great example to explain the idea."

"By focusing on helping one race, all races can benefit. I think that fact should be expanded upon when trying to convince those who are opposed to interventions like these. I think some people refuse to validate that as a problem because they either haven't experienced or were taught that people should "just suck it up and deal with it" which is a toxic way to think and teach young people."

"Going forward I think people just need to learn to validate people and listen to their stories."

KIND Education

"Usage of KIND is important and a great teachable approach. I feel this needs to be implemented everywhere."

"I think it is important that we all know we have implicit biases, but a lot of people are quick to be defensive and say that "I am not racist." We all grew up differently with different ideas of the world."

"Important to think About how before you even see or meet a patient, you're already formulating a picture of them in your mind just by hearing or seeing their name."

Discussion

Organizational management of the facility were highly motivated to improve cultural outcomes and health care disparities. The facility has a mission to make positive connections through a relationship-based framework that promotes an organizational culture in which there is never a missed opportunity to connect with empathy and kindness based on the simple notion that health care workers are human beings caring for human beings (*The Patient Experience*, 2019). Nurse residents reported that the power-point presentation on implicit bias was beneficial as evidenced by comments provided by participants.

Although the scores of the pre and post-test improved from 24.42 to 25.10 indicating some improvement after receiving the presentation It was not statistically significant. According to the scoring of the cultural awareness test the participants had low to average cultural awareness in both the pre and post-test. The mean awareness score in both tests scored under the average awareness range however there was a slight increase in scoring for the post-test, which could indicate heightened cultural awareness.

No participants in the study felt they had a high degree of cultural awareness however, there was a slight increase in the number of respondents reporting increased cultural awareness in the post-survey. The quantitative results from the convenience sampling were consistent with

the study by Shen, which evaluated several cultural competence assessment instruments in the form of Likert-type questionnaires, which explained limitations with quantitative instruments.

For one, there are not enough surveys that measure patient or recipient outcomes. Even tests with high validity and/or reliability must go through repetitive rigorous testing and retesting at appropriate intervals on a carefully selected, rather than convenience, sampling population (Shen, 2015). It was also noted that most instruments are not tested for psychometric evaluation (Shen, 2015). The survey data compiled during this educational intervention did not capture patient outcomes and the survey was given to a convenience sample of participants. The survey may have also provided further data if given in a longitudinal study at appropriate intervals.

Participants were also given comment cards to write any thoughts or insights about the presentation. Open ended responses were different than the survey results and were encouraging with participants expressing increased awareness towards their own biases, appreciation for hearing personal stories from the Black experience and perspective, an understanding of the importance of focusing on Black populations, and a desire for further educational sessions. The positive qualitative results were promising and relative to past and ongoing research.

One study emphasized the importance of informal, experiential elements of medical training in forming racial bias amongst future healthcare providers and expressed how positive contact experiences can have lasting, long term effects on intergroup attitudes which can reach beyond the current social context (Burke et al., 2017). This is consistent with the noted benefits of using CRT and KIND for decreasing bias through storytelling and intergroup activities. Participants also expressed that the use of the KIND communication model was beneficial in improving awareness towards personal biases and stereotypical assumptions that can impede care.

These findings align with the study by Debiasi et al., in which nurse practitioners were administered a cultural competence training model. It was noted that the post mean scores of the cultural assessments administered to the NPs were low, however there was a statistically significant improvement in awareness of generalizations giving them the momentum to decrease the frequency of making assumptions with patients. It was also suggested that although the training was valuable, live in-person presentations and training sessions would be more beneficial (Debiasi & Selleck, 2017).

Gatewood et al., conducted a study on 110 nursing students where the majority of nurses reported that preparatory learning materials such as videos aided in their recognition of implicit bias and found it helpful in managing their nursing care, which was equally expressed by the nurse residents that participated in this project's communication intervention.

Several studies emphasized the benefits that positive contact experiences have on increasing awareness towards implicit bias (Burke et al,.2017)(Debiasi & Selleck, 2017)(Burke et al., 2017) which aligns with the positive feedback and insights shared in the qualitative themes provided by the nurse residents. It is also noted that formal questionnaires do not contribute much towards the reduction of bias (Burke et al., 2017),which may explain the difficulty in capturing the benefits of cultural awareness trainings through quantitative assessments and the benefits of learning through participation and hearing others lived experiences.

Limitations

There were several limitations to the project. The first being the small sample size of only 32 initial respondents which then decreased to 24 for the post-test. Of those 24 respondents only 19 could be utilized due to attrition. Additionally, it could have been beneficial to carefully select

a diverse population, which include both new and experienced nurses and other healthcare providers.

Another limitation was the post-test questions failed to elicit true shared reflections and conceivably could have been more guided in nature with a deeper focus on implicit bias towards Black populations along with questions that can indicate with better clarity thoughts and behaviors that are associated with bias such as the belief that it exists, which may have impacted the results. Feedback cards could have been more specific and guided towards cultural awareness and implicit bias pre and post intervention and could have been shaped around the common themes noted by the participants. Based on the feedback given by the participants, a more structured post questionnaire with precise focus on bias towards Black populations may have yielded more variability.

Participants also had little time to apply their new knowledge into their current practice as the post test was administered directly after the workshop. Re-testing participants at wider intervals such as one-month, three-month, and six-month periods in a longitudinal study may yield greater variability. Other potential barriers towards decreasing implicit bias could include rigid thinking amongst participants in the belief that implicit bias or bias toward Black populations does not exist or does not impede health care outcomes. There could also be a lack of buy-in as some participants may not believe that bias directly effects their practice or they may have low innate desire to change.

Overall, the feedback from the participants to the DNP students were positive with many participants commenting on the benefits of hearing the experiences of Black males in the presentation video, along with hearing stories from the DNP students own personal experiences which aided in their ability to reflect on their own biases. This could indicate benefits in utilizing

KIND and the CRT to explore decreasing racism and increasing understanding of one's own bias through storytelling and by hearing the lived experiences of others.

Conclusion

When there is poor cultural intelligence, individuals are at risk for continuing bias and creating a culture of distrust amongst coworkers and between health care providers and patients. Poor cultural intelligence can also increase misunderstandings resulting in confliction in communication. Culturally responsive training can help to reduce treatment disparities amongst racially and ethnically diverse groups.

Evidence supports there are a variety of tools and methods that are effective in increasing cultural awareness to enhance communication between providers and patients to improve patient outcomes. Critical race theory provides a frame for enhancing health equity research by developing nuanced understandings of multifaceted phenomena, which requires a shared language (Ford & Airhihenbuwa, 2018). This theory provides an antiracism concordance that can aid as the foundation for health equity discourse and can be used along with KIND to improve communication and decrease cultural and implicit biases. Although this quality improvement project did not yield significant quantitative survey results, the qualitative feedback from the participants indicate a continued need to provide opportunities to learn about racism and biases through the experiences of others.

It will be important to continue to explore how educating other from the Black perspective can offer valuable lessons to decrease racism and racial issues that may impede care. Further research will be required to evaluate the effects of cultural humility between coworkers and peers. To make this project sustainable it will be important to continue to administer KIND

Communication trainings and conduct more sensitive pre and post evaluations to demonstrate the effects of the educational intervention.

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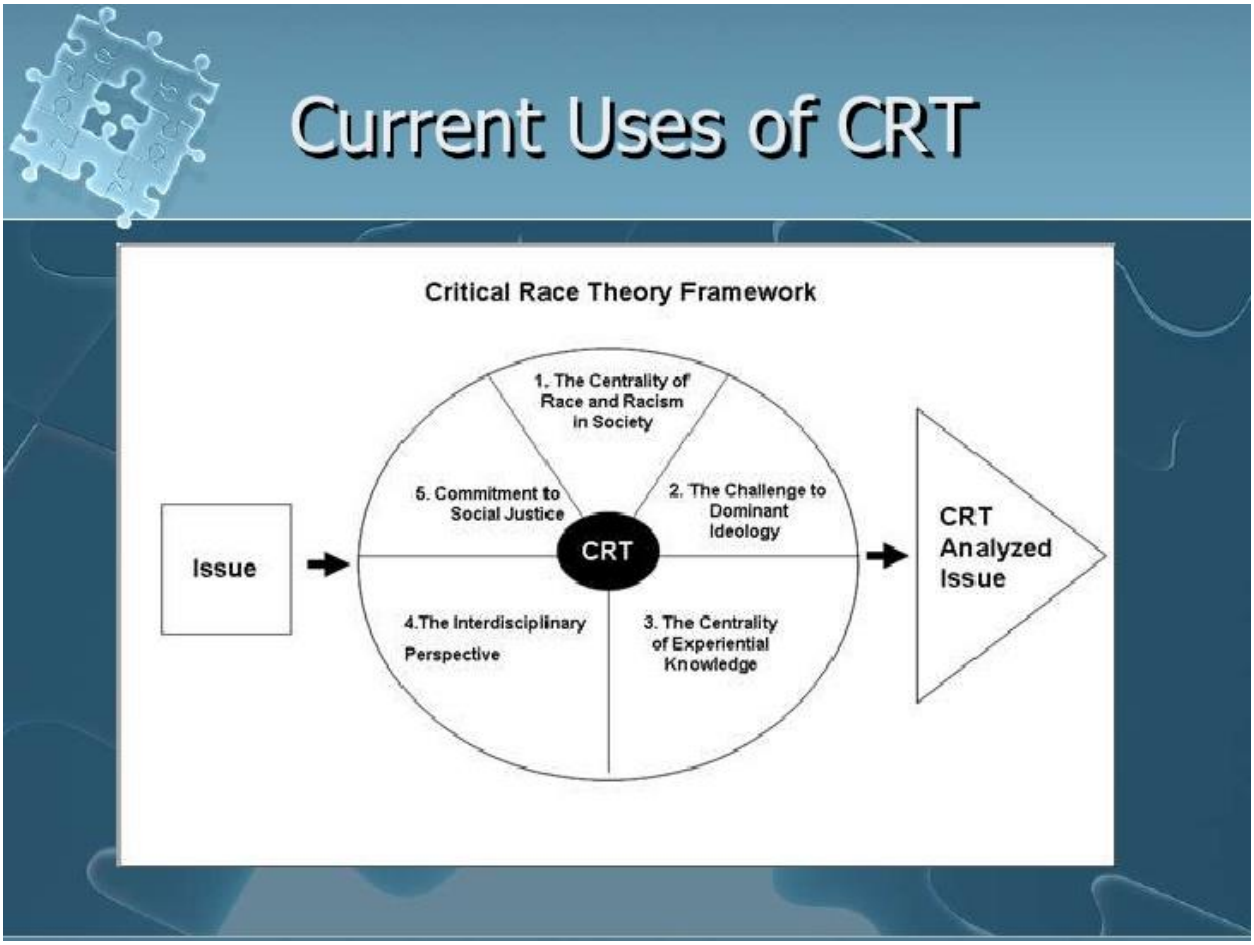
Appendix

Appendix A



Appendix B

Table 1 Cultural Assessment Screening Tool

Statement	Always	Sometimes	Never
I feel comfortable when discussing alternative lifestyles with clients.	3	2	1
I support the use of traditional cultural healing practices for hospitalized clients.	3	2	1
I know the limits of my communications skills with clients from different cultures.	3	2	1
Outside the work setting, I make an effort to be involved with people from different cultures.	3	2	1
When assessing clients, I recognize the biologic variations of different ethnic groups.	3	2	1
I accept that there is a strong relationship between culture and health.	3	2	1
I consider the race, sex, and age of my clients when administering medications.	3	2	1
When caring for clients from different cultures, I consider the specific diseases common among their group.	3	2	1
I openly acknowledge my own prejudices and biases when working with clients from different cultures.	3	2	1
I seek out and attend in-service classes that deal with cultural and ethnic diversity.	3	2	1
I remain calm when my healthcare values or beliefs clash with those of a client.	3	2	1
I practice culturally competent nursing when dealing with all clients, not only those from different ethnic groups.	3	2	1
When assessing clients initially, I consider their geographic origins, religious affiliation, and occupation as important elements of the care plan.	3	2	1
I have a high level of knowledge about the beliefs and customs of at least two different cultures.	3	2	1
I use a standardized cultural assessment tool when performing admission assessments on clients from different cultures.	3	2	1
I take into consideration the policies of my institution that serve as barriers for the effective provision of culturally competent care.	3	2	1
I recognize the cultural differences between the members of the same culture.	3	2	1
Cultural Awareness Scale			
40 to 51 points = High degree of cultural awareness			
30 to 39 points = Average degree of cultural awareness			
17 to 29 points = Low degree of cultural awareness			

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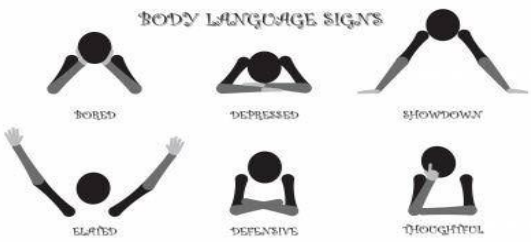
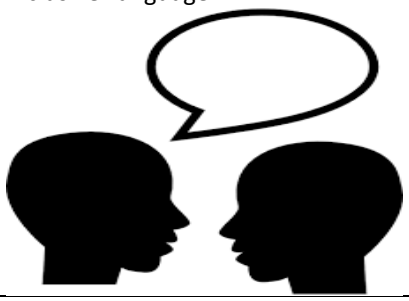
Appendix C

K	Knowledgeable Kinesics 	Are you knowledgeable about your kinesics (communicating through body language including facial expressions, gestures, personal space, and postures)? ✓ Cool, Calm, and Collected
I	Inclusive Language 	Words in Ways that Work ✓ Gender neutral (Fireman vs Firefighter) ✓ Plural Pronouns (Their, They, Them) ✓ Avoid idioms, jargons, and acronyms ✓ Ask about preferences and acknowledge limited awareness
N	Non-biased 	Individuation vs stereotypes and generalizations, and categorization ✓ One box does not fit all
D	Deliverable 	Was communication effective? ✓ Did you make a compassionate connection? ✓ Was the patient satisfied with their care

Appendix D

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Appendix E

<table>
<tr><th>Critical Race Theory (CRT)</th><th colspan="2">KIND Communication</th></tr>
<tr><td>Developed in the 1970s to study and improve the relationship between race, racism, and power
by exploring unconscious feelings to improve outcomes for different racial groups</td><td colspan="2">Learning Goals:
After completion of this workshop, new nurse residents will gain an understanding of Capstone project as well as implicit bias, and its impact on healthcare.
Nurses will gain an understanding of KIND (Knowledgeable Kinesics, Inclusive Language, Non-Biased, and Deliverable) communication to improve healthcare outcomes and increase awareness of personal biases.
Teaching Methods:
The workshop will include personal experiences of presenters as well as audience participation, videos as well as a power point presentation</td></tr>
<tr><th>CRT Theoretical Constructs</th><th>CRT and KIND</th><th>Objectives will be met by:</th></tr>
<tr><td>Ordinariness: Racism has become normal and thus hard to address</td><td>Knowledgeable Kinesics: looks to remove ordinariness and normality by cuing providers on body language and subconscious feelings</td><td>1. Complete cultural assessment tool
2. Open discussion re: implicit biases
3. Video presentation
4. Offer opportunity for feedback on implicit/unconscious biases</td></tr>
</table>

Differential Rationalization: The unscientific process done by dominant groups by categorizing and discussing personality, intelligence, and moral behavior based on specific physical traits	**Inclusive Language:** Utilized to challenge innate beliefs and thoughts that automatically assign traits to dominant groups	1. Activity done by second DNP student on Inclusive Language 2. Offer opportunity for feedback on inclusive language
Legal storytelling and narrative analysis: Gathering experiential knowledge through family histories, biographies, scenarios, and narratives to move away from categorization and move towards individuation	**Non-biased Communication:** Seeks to increase individuation during encounters to avoid stereotypes, generalizations and categorization	1. Video on micro-aggressions and microtrauma 2. Activity by second DNP student 3. Offer opportunity for feedback on non-biased communication
Commitment to social justice: CRT brings light to racial phenomena by challenging racial hierarchies that implicitly affect patient care	**Deliverable Communication** Ensuring that race is consciously bought to the forefront of care to enhance patient outcomes by effectively decreasing stereotypes	1. Video on inclusive care 2. Activity by second DNP student on effective use of KIND 3. Offer opportunity for feedback

Appendix F

Component	Definition
Cultural awareness	Self-examination and in-depth exploration of one's own cultural and professional background; identification of biases and possible prejudices when working with specific groups of clients
Cultural knowledge	The process of seeking and obtaining an information base on different cultural and ethnic groups, as well as understanding the groups' world views, which will explain how members of a group interpret their illness and how being a member guides their thinking, doing, and being
Cultural skill	Ability to collect relevant cultural data about patients' immediate problem and accurately perform culturally specific assessments; involves how to perform cultural assessments and culturally based physical assessments
Cultural encounter	The process that encourages nurses to engage directly in cross-cultural interactions with patients from culturally diverse backgrounds; directly interacting with such patients will refine or modify existing beliefs about a cultural group and prevent possible stereotyping that may have occurred
Cultural desire	Motivation to want to engage in the process of becoming culturally aware, knowledgeable, and skillful and to seek cultural encounters, as opposed to being required to seek such encounters; includes a genuine passion to be open to others, accept and respect differences, and be willing to learn from others as cultural informants

Appendix G

	Description		Cost
Salaries	**DNP Student**	**Voluntary**	**$0.00**
Supplies	**Screening tools**		**Cost**
	Copies of assessment tools	**100 screens copied at Staples**	**100 = $50.00**
	Big Y refreshments	**Juice, water, fruit and cheese plate for 4 groups x 3 meetings**	**$75 x 3= $225.00**
			Total Cost **$275.00**
Time	**Visits to Community Clinic, phone meetings, and coordination of project**	**4-5 Days/week** **3 Hours/ Day** **(Based on availability of meeting times with participants)**	**15 Hours/ Week x 4 weeks=60**
	Development of KIND, Compilation of Data, and Statistical Analysis	**16 Hours** **(limited time because of FT practice-so break down into periods of time)**	**16 Hours/ Week x 4 Weeks = 62 Hours**
			Total Time **112 Hours**

Appendix H

Timeline

Table 2

Simplified Project

TASK	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH	APRIL
RECRUITMENT	X	X				
PRE-SURVEY				X		
INTERVENTION/EDUCATION				X		
POST SURVEY					X	
ANALYSIS				X	X	
RESULTS						X