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### Reducing Implicit Bias: Evaluating Cultural Humility and Mindfulness Practices in the Perinatal Microsystem

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# EVALUATING CULTURAL HUMILITY AND MINDFULNESS

Reducing Implicit Bias:

Evaluating Cultural Humility and Mindfulness Practices in the Perinatal Microsystem

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School of Nursing and Health Professions

Nurse 670: Internship

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## Section I: Abstract

**Problem:** In one perinatal microsystem, an assessment revealed 49 reported events that alleged perceived bias occurred over a one-year period. This project aims to address implicit bias and educational solutions to improve communication and create a culture of humility and equity.

**Context:** The setting was an urban hospital within a large non-profit healthcare organization. The improvement team included registered nurse champions, obstetrical technicians, midwives, physicians, managers, and an educator.

**Intervention:** A virtual interactive education session for a multidisciplinary volunteer group (n=18) was introduced followed by five weekly follow-up discussions. The education focused on translating the cultural humility theory (Foronda, 2020) into clinical practice. Two tools were integrated into the education sessions: 1. the 5 R's (reflection, respect, regard, relevance, and resiliency) and 2. the Quick Coherence technique (Buchanan & Reilly, 2019).

**Measures:** One primary outcome measure was defined as the percentage of participants (n=18) who completed both the pre and post cultural humility scale. The target was defined as 80% completion. The second outcome measure calculated the number of healthcare team members (n=18) who increased their ability to perform the Quick Coherence technique. The target was defined as 80% and measured via self-reports. Three process measures included 1. Percentage of learning needs assessments completed (n=18; target=80%); 2. Percentage of volunteers (n=18; target=80%) who completed initial education session; 3. Percentage of volunteers (n=18; target=65%) who completed all 6 education sessions. Two balancing measures were included and monitored: 1. the number of escalation events (target=<2 over 6 weeks); 2. Percentage rate of weekly participant dropouts.

**Results:** The primary outcome resulted in 100% completion of both the pre and post cultural

humility scale (n=18). The scores on the Cultural Humility Scale (Foronda et al., 2021) for three factors were relevant in the post education survey. Factor 1 (difference in perspective) indicated an increase in awareness of the different factors that may impact a shift in perspective. Compared to the pre-survey, Factor 2 (self-attributes) showed a decrease in three of four items reflecting the degree of flexibility, openness, and awareness related to cultural humility. Factor 3 (knowledge of cultural humility) scores increased in all 7 items concerning knowledge of cultural humility and beneficial teaching efforts. The second outcome measure resulted in 72% of team members who performed the Quick Coherence technique during the 6-week project. Results of process measures indicated 80% completion of learning needs assessment and 65% participant completion of 6 education sessions. Balancing measures indicated 2 escalation events over the 6-week project and a 50% dropout rate.

**Conclusion:** A structured evidence-based tool such as the Foronda Cultural Humility scale is strongly recommended for integration into interdisciplinary team development and education initiatives across systems. This Cultural Humility and Mindfulness practice quality improvement project demonstrated promising results despite the competing priorities related to a global pandemic. Nurse leaders need to provide caregivers with tools to evaluate their own biases and to communicate more effectively to improve patient interactions and outcomes.

**Keywords:** Cultural humility, bias, mindfulness, education, quality improvement, communication

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## Section II: Introduction

Childbirth should be one of the most exciting times in a woman's life, yet many women experience anxiety, fear, and frustration (Taylor et al., 2019). In a recent qualitative study of disparities in women's health, Wang and colleagues (2021) identified multiple missed opportunities among healthcare team members who lacked self-awareness and the ability to effectively communicate with diverse populations. These missed opportunities led some women to feel unheard or misinformed throughout the birth process, which could result in lasting negative emotional outcomes (Wang et al., 2021). For example, Black and Latina women emphasized communication gaps and they perceived that providers were not attentive to their emotional and physical needs.

Racial and ethnic disparities do exist in perinatal care, and they impact both neonatal and maternal outcomes (Howell et al., 2018). The question becomes, if implicit bias and racism were addressed, is it possible it could narrow the gap of racial disparities? The Centers for Disease Control and Prevention (CDC, 2020) found that birth-related mortality rates are not equal among races and ethnicities. In fact, infants have a 75% chance of being born premature if they are born to a non-Hispanic Black woman compared to other races, which accounts for 54% of the disparity in infant mortality (Kalata et al., 2020). The CDC (2020) reported that Black women are three to four times more likely to die from a preventable problem during pregnancy. Between 2011 to 2013, research showed that Latina, Asian, Pacific Islander and American Indian mothers had a 20% increase of severe maternal morbidity and were twice as likely to die from a pregnancy condition compared to White women (CDC, 2020; Wang et al., 2021).

Healthcare systems need to provide safe and equitable care to all childbearing women regardless of age, race, or cultural background. Often, women of color receive suboptimal care

because of implicit biases and lose their sense of autonomy in the health-care decision making process (Kalata et al., 2020). Implicit biases are unconsciously formed connections that lead to an unfavorable assessment of a person based on irrelevant factors such as race or gender (FitzGerald & Hurst, 2017). Long-lasting biases and stereotypes could be dismantled so prenatal and postpartum women may receive equitable care regardless of race or cultural differences by introducing mindfulness practices into nursing care. Further, the integration of cultural humility using the 5Rs of reflection, respect, regard, relevance, and resiliency in the workplace was proven to help care providers break down biases, improve mutual understanding, and heighten cultural sensitivity when caring for diverse patients (Masters et al., 2019; Yeager & Bauer-Wu, 2013). A quality improvement project was planned by a unit CNL to address both the problem of implicit bias and present educational solutions to improve communication and create a culture of humility, learning, equity, and mutual respect.

### **Problem Description**

#### **Current Knowledge**

At the facility where this CNL conducted the quality improvement project, the perinatal staff, providers, and leadership team were not using a framework or tools to help recognize perceived bias among staff and patients. Within the perinatal unit at an urban hospital in Northern California, nurses and other providers sometimes disregarded the practice of cultural humility and allowed implicit biases to influence practice and behaviors. Since October 2020, there were 49 perceived bias incidents reported by staff or patients to the leadership team (see appendix A). This was an average of four perceived bias events a month. The problem included a lack of awareness regarding cultural humility and lack of adequate models to educate staff about how to use this concept in practice.

## Sample Scenario

A Black couple entered the community hospital in Northern California to welcome a new addition to the family. Upon admission to the unit, the expecting mother was screened for marijuana per hospital policy and tested positive. The hospital policy stated that when mothers test positive for marijuana, infants must also be tested, and a social worker consult must be initiated before discharge. The couple stayed for two days in postpartum until it was time for discharge. The couple had their discharge teaching by the nurse completed, and they were excited to take their baby home. The father went outside to get the car seat and upon return was told they could not be discharged until the social worker arrived.

The family refused to see social worker and began to walk out of the hospital, which triggered a Code Pink. When a Code Pink is activated, this triggers an emergency alert throughout the hospital that there is a potential infant abduction. Within moments, the father, carrying his infant in the car seat, was surrounded by six security guards. The situation escalated to nurses, leaders, a social worker, and security confronting and surrounding the father. The father became distraught, used profanity, yelled at the manager, and urged everyone to let them leave. The situation continued to escalate, and the police were summoned to the scene.

After several minutes, police were able to empathize and deescalate the situation. On the mother's follow-up appointment, the family shared with the physician how traumatic and disappointing their experience was. She told the physician that her beautiful birth turned into a nightmare, and they feared for their lives. A letter was written by the parents addressed to the senior leadership, which conveyed dissatisfaction and humiliation during and after this unfortunate occurrence. In the letter, the parents wrote to the perinatal leadership team that there were three areas they wanted to see improved within the perinatal department. They asked that

training on de-escalation, racism, and communication be implemented in the department. After the letter was received from the parents, a multidisciplinary structural debrief was performed. The results of the debrief showed lack of communication across the care continuum, policy misinterpretation by staff, and lack of empathy and situational awareness.

During such vulnerable moments, establishing trust between the patient and their significant other is essential for the healthcare team (Foronda, 2019). Masters et al. (2019) used a valid coaching tool in a study that addressed biases. The cultural humility clinician coaching tool used the 5Rs of cultural humility, and the results showed the tool could help mitigate implicit bias and promote empathy in healthcare (Masters et al., 2019). Cases like the one presented above could be avoided if the healthcare team uses the 5Rs of cultural humility and mindfulness practices. Using the 5Rs would help the healthcare team to be more aware of their own implicit biases and help with building authentic connections between patients and clinicians (Masters et al., 2019).

### **Communication: Opportunity for Improvement**

According to a Kaiser Family Foundation survey performed in the fall of 2020, considerably fewer Black adults trust doctors and hospitals to do the right thing most of the time than White adults (Butler & Sheriff, 2020). A systematic review found that compared to White patients, Black patients had consistently inferior communication, information, patient participation, and participatory decision-making in their healthcare experiences (Shen et al., 2018). The medical system has lost the trust of people of color (Butler & Sheriff, 2020). Healthcare organizations must bridge the gap of mistrust and begin to move toward providing effective, equitable, and respectful quality care that is responsive to different cultural health beliefs and practices (Backsdale et al., 2017).

Communication among care providers, patients, and families are central to building trust, respect and mutual understanding of health needs and values (Butler & Sheriff, 2021). When the patient voice is included in decision-making, active participation and engagement result, and the patient care experience is enhanced (Spooner et al., 2015). Ineffective communication in the healthcare setting is one of the leading causes of medical errors and patient harm (The Joint Commission, 2018). The Joint Commission (2018) also defined communication as a major contributor to medical errors and correlated increased communication to better patient outcomes.

Furthermore, patient populations are increasingly diverse, resulting in health behaviors that are influenced by cultural backgrounds as well as other social determinants (Prasad et al., 2016; CDC, 2020). Healthy People 2030 set national goals to achieve health equity and eliminate health disparities (Pronk et al., 2021). The Agency for Healthcare Research and Quality (AHRQ, 2019) uses tools to measure healthcare quality, including the National Healthcare Quality and Disparities Reports, which reports the vision on care coordination and how it was created to ensure the care providers and patients are all working in unison to ensure that the patient gets the care and support needed and wanted. According to the AHRQ the aim for provider communication and care coordination is to include six important elements: open discussions, gathering information, the patients' perspective, sharing information, reaching agreement on problems and plans, and providing closure. The National CLAS Standards were implemented to help advance equity, improve patient quality, and to decrease health care disparities (United States Department of Health and Human Services, 2015). The CLAS standards are a blueprint for healthcare teams to follow and consist of 15 action steps to help implement appropriate cultural and linguistical services.

## **Microsystem Assessment**

### **Setting**

This quality improvement project was conducted in a perinatal department within a 224-bed urban hospital located in Northern California. This tertiary care facility was part of the nation's largest not-for-profit health plan. The hospital was located in a culturally diverse community with a large percentage of patients who had limited prenatal care (Kaiser Permanente, 2019). The perinatal unit consisted of 13-bed labor and delivery rooms, two triage rooms, four overflow rooms, and an eight-bed level II nursery. Postpartum was a separate 25-bed unit. On average, the monthly delivery rate was 300, and there were over 600 patients assessed to determine urgency and decision for treatment or admission.

### **Metrics that Matter**

Despite the double pandemic and the lingering public health crisis with COVID-19, perinatal services continued to improve and sustain quality metrics. For example, the Hospital Consumer Assessment of Healthcare Providers (HCAHPS) scores, which includes nurse communication, discharge information, medication side effects, and staff responsiveness, improved throughout 2020. The surgical site infection (SSI) goal for 2020 was 0.8, which the facility met at 0.5. The breastfeeding goal was 80%, and it was at 77%. Although there had been substantial progress in terms of care experience and quality metrics, there was still an opportunity to improve these metrics and decrease incidents of reporting biased behaviors to less than two events monthly. Upon completion of the microsystem assessment (see Appendix B) it was determined that there was a gap with perceived bias incidents that escalated among Black patients more frequently than among other races who were cared for in the facility.

To improve this metric and decrease incidences of perceived bias from an average of four events a month to less than two events a month, training sessions were piloted with a volunteer perinatal group. The training sessions focused on cultural humility and mindfulness practices. The goal was twofold: (1) to increase staff's confidence to engage in multicultural crucial conversations with patients and families and (2) to decrease perceived bias in patient encounters that cause escalation and dissatisfaction for the patients and families.

### **Available Knowledge**

#### **PICOT Question**

A PICOT formatted question can be described as the following: P-population/problem, I-Intervention, C-comparison/control, O-outcome, and T-time (Eldawlatly et al., 2018). This is an evidence-based tool to evaluate data and guide a literature search for change in a process (Eldawlatly et al., 2018). The formulated PICOT question was: Among the volunteer group in perinatal (P), how does cultural humility and mindfulness training (I), compared to no cultural humility and mindfulness training (C), increase staff confidence to have multicultural crucial conversations with patients and families (O), during a six-week period (T)?

#### **Literature Search**

A comprehensive literature review was conducted to synthesize evidence that addressed the question: Does mindfulness practices and cultural humility training using the 5Rs increase staff confidence and self-awareness to have multi-cultural crucial conversations with patients and families? A search of the CINAHL, PubMed, Fusion, and Ovid databases was conducted using the following terms: "mindfulness," "nurse education," "cultural humility," "cultural competence," "Heartmath© and resilience," "diversity," "childbirth and negative interactions and perinatal," and "cultural humility theory." Research limitations were set to include only

peer-reviewed articles published after 2015. Twelve studies resulted from the search and were evaluated using the Johns Hopkins Nursing Evidence Based Practice Research Evidence Appraisal Tool (see Appendix C).

### **Literature Synthesis**

In multiple studies, implicit bias, or attitudes and stereotypes among different races and cultures were a contributing factor to racial health disparities (Foronda, 2020; Saluja & Bryant, 2021). According to a 2015 literature review on implicit racial bias among healthcare professionals, many experienced healthcare practitioners of various specializations and degrees of training exhibited implicit bias against Black, Hispanic/Latino/Latina, and dark-skinned patients (Hall et al., 2015). Howell (2019) stated that Black women die from preventable pregnancy-related complications three to four times more than non-Hispanic White women. Disparities in maternal child health are derived from racism (Howell, 2019). According to Perea-Diltz and Greenidge (2018), mindfulness techniques assist professional counselors (PCs) to move beyond superficial application to a more culturally sensitive approach in counseling. Mindfulness practices are used to develop cultural knowledge and awareness into classroom activities that may foster continual personal reflection, which could lead to culturally appropriate client services (Perea-Diltz & Greenidge, 2018). The multicultural counseling competence model and cultural humility model provide structure for incorporating education and training to increase cultural sensitivity (Perea-Diltz & Greenidge, 2018).

Foronda (2020) developed a cultural humility theory guided by Walker's and Avant's strategy. The cultural humility theory serves as a guide for nurses and other health-care professionals to better understand the many factors that go into being culturally humble. The cultural humility hypothesis proposes a novel strategy to address diversity and interpersonal



conflict. According to Foronda (2020), applying the theory of cultural humility could help caregivers see conflict through a different lens, which may flatten hierarchies, lead to better valuing of humankind, and help providers emanate grace to resolve conflict positively.

Masters et al. (2018) revealed that the practice of cultural humility helps to mitigate implicit bias, promote empathy, and aid clinicians in acknowledging and respecting patients' uniqueness. The 5 R's of cultural humility are a coaching tool that give physicians a clear framework for addressing hidden biases and adopting a more thoughtful and compassionate approach (Masters et al., 2018). According to Masters and colleagues, the 5 R's promote perspective-taking, emotional regulation, and partnership-building.

Key constructs from previous research were used to develop an instrument to measure the effectiveness of cultural humility training (Foronda, 2021). Six expert faculty validated the instrument. Two hundred twenty-four students in baccalaureate-level nursing and health science programs participated. The measurement instrument was shown to have high face and content validity, indicating that it had the potential to be useful and relevant in nurse education (Foronda, 2021). This instrument was introduced in the perinatal unit in this quality improvement project.

Halm (2017) described mindfulness as empowering nurses to respond rather than react to stressful situations. Mindfulness, according to Savello and Munro (2017), is paying attention on purpose in the present moment without judgement to the unfolding of an experience. Most of the evidence supporting mindfulness-based stress reduction (MBSR) as a self-care modality for nurses revealed that a mindful practice is related with comprehensive mind/body/spirit benefits for nurses, which can begin after only a short period of usage.

## **Rationale**

According to the Institute for Healthcare Improvement (IHI, 2021) care must be safe, effective, patient-centered, timely, efficient, and equitable and quality improvements must focus on equity. The sixth aim for improvement infers equal benefits should be available to everyone, regardless of their age, background, color, gender, or socioeconomic status (AHRQ, 2019). Since the perinatal unit had recently experienced several incidents of perceived bias, the fallout left staff, patients, and families traumatized. This quality improvement project aimed to increase cultural humility and self-awareness through educational sessions that introduced cultural humility and mindfulness practices to health care workers. Organizations have recognized that to improve outcomes and bridge the gap in health care disparities, both cultural competence and cultural humility must be a part of every patient interaction (Foronda, 2019). Thus, professional nursing practice necessitates using a theoretical foundation on which nurses can continue to cultivate culturally sensitive practice on a day-to-day basis (Watson, 1985).

### **Cultural Humility Theory**

The cultural humility theory (CHT) provided a framework for the improvement project, which worked towards a new approach to embrace diversity and resolve conflict at the project site (Foronda, 2019). When conflicts arose and there was a difference in perspectives or a misunderstanding, it was the author's objective that this theory would guide the healthcare team in mutual understanding and improve human interactions during difficult conversations. CHT encourages the provider to appreciate diversity and recognize that humans are inherently altruistic, have equal value, are lifelong learners, expect conflict, and are unique but part of a global community (Foronda, 2020). The cultural humility rainbow model (see Appendix D) serves as a framework for nurses to better understand the various aspects considered in decision-

making (Foronda, 2019). In a world where inequities exist, cultural humility invites openness, self-awareness, selflessness, and a willingness to self-reflect after adverse interactions (Foronda, 2019). Practicing cultural humility results in mutual empowerment, respect, collaboration, partnership, exceptional care, and lifelong learning (Foronda et al., 2016).

Under difficult conditions, health care providers must think clearly and make vital decisions. Providing appropriate stress management and mindfulness skills in the moment helps to reduce the emotional and psychological effects of caring for others while also promoting resiliency (Buchanan & Reily, 2019). Building and maintaining the resiliency of health care professionals is critical to reducing the negative consequences of caregiving, promoting emotional well-being, and establishing a work life balance (Buchanan & Reily, 2019). According to Perera-Diltz and Greenidge (2018), incorporating mindfulness practices enhances cultural knowledge and awareness, which can lead to continual personal reflection and in turn, culturally appropriate client services. This project aimed to increase knowledge of cultural humility and mindfulness practices to improve patient outcomes. As a result, both short- and long-term patient and organizational metrics were expected to improve in both quantitative and qualitative measures, such as HCAHPS scores, unit-based employee engagement, and regular staff development opportunities.

## **Basic Definitions**

### **The Cultural Competence Model**

The cultural competence model was created in 1989 to ensure health professionals were trained to care for the increasingly diverse populations; however, over time, lack of improvement in provider-patient relationships revealed that poor outcomes remained (Velott & Forte, 2019). Cultural competence is the ability to gain and master knowledge about diverse groups through

training in a short time (Foronda, 2019). While cultural competence is important for improving communication and understanding in an increasingly diverse world, it is not enough to eliminate health inequities (Velott & Forte, 2019). Communication goes beyond language and knowledge; as such, cultural humility needs to be an additional approach used to improve interactions between patients and providers (Foronda, 2020).

### **Cultural Humility**

Cultural humility is a process of reflection and inquiry that involves self-awareness of personal biases and pushes individuals to challenge their assumptions and judgements. It helps people to be humble and respectful towards individuals of other cultures (Yeager & Bauer-Wu, 2013). Tervalon and Murray-Garcia (1998) specified that “cultural humility incorporates a lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances in the patient-physician dynamic, and to developing mutually beneficial and non-paternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations” (p. 117).

### **Conflict**

Conflict arises when a difference in perspectives is misunderstood or not sufficiently considered, interfering with the achievement of goals and relationships (Foronda, 2020). When cultural conflict arises, it results in blending contexts and differing viewpoints, presenting opportunities for many options and actions (see Appendix E). These options and actions may lead to both negative and positive outcomes (Foronda, 2020).

Frequently, patients of color and other minorities are spoken “to” rather than “with,” causing ineffective interactions and a lack of empathy and acknowledgment of concerns, which leads to poor outcomes (Shen et al., 2018). The Healthy People 2030 initiative reaffirmed the

need to expand access to high-quality care, and part of that care includes tackling the cultural obstacles, such as unconscious bias, that negatively impact health outcomes (Rebar, 2021). The ongoing reports of failing to meet standards of care for culturally diverse patients emphasize the crucial need for care providers and educators to thoroughly assess ways of incorporating cultural competence and cultural humility into training curriculum for conflict resolution (Markey, 2019).

### **Mindfulness**

Mindfulness is an intervention that fosters a greater attention to the present moment by using breath awareness and focusing on the heart (Halm, 2017). The concept of mindfulness can be used to help alleviate stress among care providers and increase resiliency (Halm, 2017). Evidence showed mindfulness practices can be a very effective intervention to use by health care teams to increase the awareness of the present moment and block past and future thoughts (Halm, 2017; Koren, 2017; Mealer et al., 2014). One type of mindfulness is known as HeartMath, which is a technique that focuses on people's awareness of a stressful situation and the emotions that come with it (Buchanan & Reilly, 2019). Once a HeartMath practitioner recognizes an incident or scenario, he or she can use one of many learned techniques to assist with staying in the moment. Two of the principles utilized to create coherence are heart-focused breathing and positive emotions (Buchanan & Reilly, 2019). According to Buchanan and Reilly (2019), coherent caregivers are better able to hear, recognize, and serve the needs of patients they care for as well as create more meaningful interactions with patients and coworkers.

## **Project Aims**

### **Global Aim Statement**

The global aim was to decrease the number of annual incidents characterized by perceived bias in a perinatal microsystem from four to two a month by December 2022. This

metric will be monitored through analysis of adverse incident reports in the perinatal microsystem.

### **Specific Aim Statement**

The specific aim of this project was to conduct an evaluation of cultural humility knowledge of the volunteer group in the perinatal department before and after the implementation of a six-week interactive education series (see Appendix F). The goal of this educational series was to integrate cultural humility and mindfulness practices for 80% of the volunteer group attendees in the perinatal microsystem by October 2021. The training aimed to increase cultural humility by increasing the use of mindfulness practices (Quick Coherence) and the 5 R's cultural humility framework. Through the educational trainings and using the evidence-based tools, the CNL anticipated the healthcare team would gain more confidence to conduct conversations with diverse populations as well as increased practice of cultural humility. These interventions were expected to decrease the number of incidents of perceived bias within the perinatal microsystem in both the short-term (October 2021) and long-term (December 2022).

### **Improvement Model for Change Management**

The IHI described the model for improvement (MFI) as a framework for change including three questions: (1) what are we trying to accomplish?, (2) how will we know a change is an improvement?, and (3) what change can we make that will result in an improvement? In question 3, small tests of change are implemented through a rapid cycle testing process recognized as plan-do-study-act (PDSA) cycles in the microsystem (Langley et al., 2009). The PDSA tool can also be used for project planning. For example, in this improvement project, the PDSA framework was used in addition to the new framework for cultural humility to achieve and monitor progress.

The PDSA cycle is a four-step iterative process improvement model (Chistoff, 2018). The first stage is to create a strategy that includes explicit forecasts of outcomes as well as work assignments. The who, what, when, and where of the plan are all decided during this phase. The plan is put into action in the "do" phase. In the "study" phase, the collected data and outcomes are examined. Finally, in the "act" phase, the plan is either adopted, altered, or abandoned. The lessons learned in one cycle should be applied in subsequent cycles (Chistoff, 2018). The following is the description of each step of the PDSA cycle used in this quality improvement project.

### *Plan*

- Obtain baseline data of perceived bias and escalated events in the perinatal department to acknowledge gaps.
- Decide what group within the perinatal unit would be part of the training sessions on cultural humility and mindfulness practices to be able to reach a variety of disciplines within the perinatal areas (labor and delivery, special care nursery, and mother baby).
- Create objectives, predictions, and who and what data would be collected.

### *Do*

- Begin to implement the plans.
- Start with a pre-survey to assess the knowledge level of the volunteer group about their understanding of cultural humility.
- Document observations and record the data.
- Identify a quality liaison to assist in determining type of data display.

### *Study*

- CNL held educational trainings.

- The first training was a three-hour session that went over cultural humility versus cultural competence and providing mindfulness training using Quick Coherence.
- There were five subsequent follow-up sessions.

### *Act*

- Implement trainings into everyday practice between patients and the healthcare team.
- Incorporate role play and scenarios into sessions.
- Once the volunteer group was comfortable using the 5 R's of cultural humility and mindfulness techniques, the project was expanded to the other team members.

The evidence-based MFI and PDSA structure developed for this project is outlined in Appendix G, which reflects the thought process of stakeholders that led to implementation as well as recommendations for next steps and subsequent phases of replication of this project.

## **Section III: Methods**

### **Context**

#### **Microsystem Assessment**

One of the initial steps was conducting a microsystem assessment (see Appendix B) of the perinatal unit in an urban hospital in Northern California. The microsystem assessment analyzed the 5Ps: purpose, patients, professionals, processes, and patterns of data (Dartmoth, 2005). This type of microsystem assessment is a powerful tool for leadership, collaboration, and continuous development of clinical teams. It is a great way to assess, diagnose, and treat broken processes that develop in the microsystem (Batalden et al., 2007). This assessment tool invites the team to view the bigger picture to see beyond one patient. The 5P assessment was used to explore the patients served, the professionals who worked within the microsystem, the processes used to deliver care, and the metrics that mattered to improve patient outcomes.



## **SWOT Analysis**

To further support implementation, a Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis was developed. Benzaghata et al. (2012) noted SWOT analyses is a popular technique for strategic planning in organizations. It enables teams to build on strengths, identify weaknesses, reduce risks, and maximize chances of success (Benzaghata et al., 2021). The SWOT analysis outlined in Appendix H provides a better look at the strengths for this project, which aimed to build the trust of the patients of color in the staff of the perinatal unit.

## **Proposed Budget**

Kothari and Patterson (2021) analyzed 43 maternal mortality litigation cases between June 2011 to August 2020 involving medical negligence or obstetric violence. Medical malpractice and negligence lawsuits are routinely filed to seek compensation for improper medical care during childbirth (Kothari & Patterson, 2021). It is important to note that in the United States, Black women are three times more likely to die from pregnancy-related causes than White women, and it is estimated that two out of those three deaths are preventable (CDC, 2021). The CNL discovered millions of dollars per family awarded in many cases. The average cost for health care workers to attend the interactive education session and bi-monthly follow-up discussions at a rate of \$91.44 is \$12,802 per 20 employees (Appendix I). The proposed budget for the entire perinatal unit would be \$140,821. Cost would vary depending on the skill mix of the attendees. However, compared to the lawsuit settlements paid to families that experience medical negligence or maternal morbidity, this is a very low cost.

## **Additional Tools Used to Structure and Implement the Change Project**

### ***TeamSTEPPS***

There will be times when all best efforts fail and there is a conflict between the patient and family, so to prepare conflicts using the Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS) is a great option. According to Agency for Healthcare Research and Quality (AHRQ) TeamSTEPPS offers several evidence-based tools for effective communication. The mutual support tool DESC—describe, express, specify, consequences script provides an assertive approach to make difficult conversations more effective. When (AHRQ, 2016) the stakes and emotions are high and conflict is present, defensiveness often sabotages the best intentions.

### ***Tools to Support***

Badge buddies were made to provide the volunteer group with a quick reminder of cultural humility when working on the frontline. One side of the card had the 5 R's of cultural humility and the reverse side had the Quick Coherence Technique (see Appendix P). Flyers were created to advertise and socialize the kick-off of the pilot (see Appendix Q).

## **Interventions**

### **Educational Session**

Educational sessions included an introduction of Foronda's cultural humility framework and two key tools: the 5 R's and Quick Coherence technique. The teaching of the culture of humility framework and mindfulness practices involved an initial, three-hour interactive session and then weekly one-hour sessions for the next five weeks. A pre- and post-survey was performed before and after the training sessions to assess participants' knowledge and skills of cultural humility. The intervention for this quality improvement project was a six-week

interactive educational series using scenarios, roleplaying, and interactive conversations. The hope was that these interventions and trainings would raise awareness of unconscious biases and give a platform for addressing these prejudices using cultural humility, mindfulness, and compassion as seen in other evidence-based projects (Masters et al., 2019).

### **Cultural Humility Theory**

Leaders have begun to realize the importance of recognizing diversity and applying cultural humility leads to successful outcomes. When a difference in perspective is misunderstood or not considered, the resulting conflict interferes with the accomplishment of goals and relationships. The Theory of Cultural Humility can act as a guide for nurses and healthcare team professionals on how to appreciate diversity and to foster a better understanding of the multiple considerations involved in being culturally humble. This theory helps to provide clarity of the related concepts, influence, and outcomes. Appendix D displays the cultural humility rainbow model, which was used to help learners to recognize the multiple factors that lead to discordant perspectives to foster positive outcomes (Foronda, 2020).

### **5 R's**

The 5Rs clinician coaching tool addressed reflection, respect, regard, relevance, and resiliency (see Appendix J). The tool can be used to improve health care by reducing inequities, increasing the patient-clinician connection, showcasing common humanity, and strengthening provider resilience (Masters et al., 2019). Each R invites the clinician to become more conscious of his or her decisions and interactions with others. Each R has a distinct aim of decreasing biases and gives the practitioner coaching through a self-reflection inquiry (see Appendix J). The Cultural Humility coaching tool gave participants a quick way to start addressing unconscious bias and choose a more mindful and compassionate response.

## **Quick Coherence Technique**

According to Buchanan and Reilly (2019), when a caregiver notices an undesirable incident or condition, the quick coherence approach can be used to prevent the energy loss associated with depleting emotions. Positive emotions and heart-focused breathing are two of the principles utilized to develop coherence and build resilience. Coherent people benefit themselves and everyone around them. Additionally, the Quick Coherence technique was used to provide the health care team with mindfulness breathing techniques to build resilience during difficult interactions (Buchanan & Reilly, 2019).

There are many ways to practice mindfulness, but for this project improvement project, breath awareness, focusing on the area of the heart, and paying attention to the present were taught during the training sessions (Bajaj & Pande, 2015; Goh et al., 2015). Practicing mindfulness techniques where one focuses on breathing and maintains awareness of the moment for five minutes a day can help with stress reduction, enhance thoughts, emotions, and increase positive behaviors overall (Sarwari & Wahab, 2018; Savel & Munro, 2017).

## **Studying the Intervention**

The pilot group, which consisted of 18 volunteer multidisciplinary staff members in the perinatal department, were introduced to the cultural humility theory, 5 R's clinical coaching, and the Quick Coherence technique. Scenarios, role play, case studies, and reflection were used during the learning sessions. An opportunity was provided to each member of the pilot group to engage in open discussion regarding the use of cultural humility in the scenarios of the realistic case studies and life experiences. Foronda's Cultural Humility Scale questions were administered (see Appendix K). The first survey was provided to all the volunteer group before the training sessions, and then the second survey was provided at the end of the intervention to determine if

there was increase confidence level of the participants in the group per the total number in Foronda's Cultural Humility Scale Interpretation Guide (see Appendix L). Also, after each weekly session was conducted a short, four-question anonymous survey was provided to see if the tool was being used and the barriers to implementation. The data from these surveys will be displayed on the unit after the intervention period is complete. The timeline of the project is shown in Appendix M.

## **Measures**

### **Family of Measures**

Measures are reflected in the process and outcomes of this quality improvement project. specific, measurable achievable, realistic, timely (SMART) goals were used to help assess the intervention's effectiveness and to increase awareness of cultural humility and the ability of providers to adapt mindfulness practices. Measuring the effectiveness of the interactive educational intervention designed to enhance cultural humility was of the utmost importance to better prepare health care providers to interact and care for diverse populations.

The Foronda's Cultural Humility Scale instrument was first primary outcome measure. The instrument uses a Likert-type scale with five options: never/rarely, once-in-a-while, sometimes, usually, and all the time. The instrument contains 19 items congruent with the construct of cultural humility statements (see Appendix K). Foronda's Cultural Humility Scale provided a starting point to measure if the interactive education session resulted in improved cultural humility. This scale assessed the efficacy of the training program aimed at improving cultural humility in health care workers (Foronda, 2020). One hundred percent of participants (n=18) completed pre- and post-surveys. The percentage of volunteer group increasing the ability to practice Quick Coherence was 72% of the 80% goal.

The two process measures were the percentage learning needs assessment and the attendance for the first educational session. The first process measure goal was to achieve 80% of the volunteer group to perform a learning needs assessment survey; 72% of the team completed assessment. The second process measure's goal was 80% of the volunteer group to participate the initial educational session; 100% of the volunteers attended the interactive educational session. The third process measure was 65% of the volunteer group participating in the weekly follow up sessions over the six weeks; 50% of the participant attended the sessions at different times.

The balancing measure used was the percentage of participant dropouts bi-weekly and unintended consequences of escalated events. There were greater than two volunteer dropouts for weekly follow-up sessions related to the increased unit census and a Covid-19 surge. There were two escalated events that occurred related to the Covid-19 visitation guideline restrictions, which were mandated by a state order.

### **Ethical Considerations**

This project met the University of San Francisco's course guidelines for evidence-based implementation of a CNL change project (see Appendix O). This project was undertaken as an evidence-based change of practice project at the urban community hospital. The Cultural Humility and Mindfulness statement of Non-Research Determination (see Appendix R) was reviewed by the research determination committee and it was determined that the project did not meet the regulatory definition of research involving human subjects per 45 CFR 46.102(d) (see Appendix R).

Ethical principles of nursing that were foundational to this change project included the principle of autonomy. Autonomy is a moral principle that highlights a person's right to be

treated with dignity and respect. Regardless of socioeconomic status, education, race, gender, ability, each person should be regarded and treated the same (Grace, 2018). When implementing the cultural humility and mindfulness project, staff privacy and confidentiality had to be considered. Since each volunteer would be receiving the same pre- and post-survey, they were encouraged to create a unique identifier four-digit number. The identifier helped the participant assess personal results after the training.

In addition, the first provision in the American Nurses Association (ANA, 2015) Code of Ethics for Nurses encourages respect for every person. It seemed appropriate to re-engage healthcare professionals with a fresh strategy to address health-care inequities and to consider cultural humility in every patient interaction (Rebar, 2021). The University of San Francisco values encapsulate care of the whole person and the commitment to diversity. Ethical concerns were reduced as much as possible, and human subjects were protected by collecting no identifying patient information and keeping all members of the volunteer group anonymous. Nursing must move from the language of having a contract with society to a calling, which indicates a strong ethic to do no harm to those served.

## **Section IV: Results**

### **Implementation**

Before the implementation of the educational training to the perinatal volunteer group, there was a monthly average of four perceived bias events which sometimes increased to as many as eight events a month. The project aimed to provide training on cultural humility for a period of six-weeks and determine if the trainings helped decrease the number of perceived bias events and escalations. The hope was that between the initial pre- and post-surveys, the outcome of the training would indicate that the intervention had a positive impact on the volunteer group

as seen through increases in their understanding of cultural humility and resilience. Globally, there would be a significant decline in perceived bias and escalated events. During this six-week period there were many discoveries and much learning occurred.

To initiate the project, the multidisciplinary volunteer group were sent a learning needs assessment to determine the delivery method for the new cultural humility content. Due to Covid-19 restrictions in-person meeting spaces were prohibited; although, the CNL would have preferred this method. There were three delivery method options in the survey: online self-paced modules, online team sessions, or an instructional PowerPoint presentation. The volunteer group selected live team discussion as their preferred choice of content delivery. When the project rolled out there was the initial introduction to the cultural humility and mindfulness interactive educational session followed by five weekly discussions held on Microsoft teams.

### **Outcomes**

The volunteer group was comprised a multidisciplinary team of providers (See Appendix S1). Each participant was given Foronda's Cultural Humility Scale anonymously prior to the live teams interactive education session. Most of the participants who chose to participate in the educational training sessions were registered nurses. The 18 participants were asked to rate themselves on a scale of 1= rarely culturally humble to 5 = habitually culturally humble. The instrument consisted of 19 items: diversity, environment, historical precedent, political climate, power imbalances situational context, openness, self-reflection, flexibility, awareness, ego, respect, optimal care, the other person, empower mutual benefit, partnership, supportive interactive, and lifelong learner. Appendix S2 shows the changes in scores for all 19 items pre- and post-education. There were improvements in eleven of the items, seven items scored lower post intervention, and one item remained unchanged.



Foronda's Cultural Humility Scale categorizes the 19 items into three factors: context for difference in perspective, self-attributes, and outcomes of cultural humility. The post-education scores for Factor 1 displayed an increase in awareness of the different factors that may impact a shift in perspective. Appendix S3 displays five out of seven items increased post education session. One item stayed the same and one decreased. Factor 2 displayed a decrease in regard to personally doing things to become more culturally humble. Three out of the four items decreased (see Appendix S4). Dr. Foronda shared during the informational interview that for this factor that the ceiling effect takes place because people tend to rate themselves higher in the pre-survey, which makes it difficult to detect a change or an improvement. For Factor 3, outcomes of cultural humility, there was a demonstrated increase in every item for knowledge of cultural humility and the benefit of guiding teaching efforts. (see Appendix S5). The Foronda Cultural Humility Scale demonstrated promising results of the impact the interactive educational training and weekly session had on participants.

Interactions are critically important for meeting the goal of fewer escalated events Appendix S7 displays a remarkable improvement in the volunteer group's responses to having supportive interactions after the pilot. Supportive interaction includes several different kinds of interactions and behaviors that occur when cultural humility is embraced (Foronda et al., 2016). Item 18 asks, "Do you strive for a supportive interaction?" In a short period of six weeks, which included high census and a fourth Covid 19 surge, the instrument item supportive interaction increased by 40%. Improved supportive interactions by providers potentially decreases conflicts and escalated interactions.

## Section V: Discussion

### Summary

The purpose of this improvement project was to introduce the theory of cultural humility, 5 R's clinical coaching tool, and the practice of quick coherence to a volunteer multidisciplinary group at a community hospital in California. The aim was to empower the volunteer group to develop and incorporate the practice of cultural humility and quick coherence into their daily practice especially during adverse interactions.

The intervention was designed to be implemented as an initial three-hour interactive educational sessions followed by five follow-up weekly discussions. The first interactive educational session was delayed a week because of the Covid-19 pandemic, high census, and limited resources on the perinatal unit. The first interactive educational session covered the cultural humility theory, 5 R's cultural humility coaching tool, and the mindfulness practice of Quick Coherence. One hundred percent of the multidisciplinary volunteers were present and engaged in the content. Several of the participants shared stories of perceived bias in which they were the recipient or the instigator of bias. The weekly one-hour follow-up sessions were held to promote discussions of scenarios, cases, and adverse interactions during the week. In addition to the discussions, a short review of the 5 Rs of cultural humility and Quick Coherence was reviewed. The weekly sessions stimulated rich dialogue between the team and personal stories of bias and barriers were openly discussed. During two of the weekly sessions during high census, a 15-minute video review of cultural humility, quick coherence practice, and expanded discussion on the 5 Rs were created and emailed by the CNL to participants to enhance learning.

## **Key Findings**

The initial findings indicate that the interactive cultural humility and mindfulness training sessions will likely have a positive impact on providers' self-awareness, supportive interactions, cultural humility, and resiliency. The pre- and post-training surveys that were administered as well as the in-person feedback offered during the sessions suggest that care providers who attended the training increased their perception of how often they were culturally humble. There was a 10% increase in participants being "usually culturally humble," a 2% increase in "habitually culturally humble," and a 12% increase in participants being "sometimes culturally humble."

Although there was an improvement in context for difference in perspective and outcome of cultural humility, there was a decline in participants self-attribute ratings. The author of the cultural humility scale explained the ceiling effect (REF or personal communication?). The ceiling effect is where participants score themselves high on the pre-survey, making it hard to detect change. After the actual education and discussions, many participants recognized that they were not as culturally humble as they thought they were before the training. Another potential explanation is that one educational session with optional weekly check-ins need to be expanded out for a longer period. The surveys, as well as the verbal feedback offered during the scheduled training discussions, suggest that the volunteer group found the first session of the introduction to cultural humility tool and Quick Coherence be relevant and helpful (see Appendix S8).

The weekly follow-up discussions were optional and attended by available staff. The sessions ranged from five to ten participants per week. Fifty percent of the participants used the 5 R's cultural humility tool, 80% used the Quick Coherence breathing technique, and 60% of participants encountered situations that called for the interventions.

## Lessons Learned

During the fourth Covid-19 surge for this urban hospital as well as the increased acuity and patient census, organizing and implementing an educational session with follow-up weekly session had its share of challenges. Although the volunteers were excited to be a part of the pilot group, they attended in the midst of working 12 to 16 hour shifts and consecutive days in a row. It was difficult to remember the 5 R's clinical coaching tool, so participants needed a reminder. Badge buddy cards were designed and ordered to enhance learning. The majority of the participants started off practicing the Quick Coherence technique, but really had to remember to pause and breathe because of how busy they had been. There was an awakening and awareness that came to light in the weekly discussions that clinical staff must be careful with their words because a word in one culture can be a trigger for another. When inquiries were made about the barriers that made it difficult for them to use the interventions, 20% of participants said they had no barriers, 30% could not remember to use the interventions at times, 20% needed more practice, and 20% needed to slow down to be able to use it.

A post-education survey was conducted one month after the pilot (see Appendix S8). Most of the participants felt that the content was relevant and other peers in the microsystem would benefit from the education session. 100% of the participants felt the educational session increased awareness of personal bias and that the training prepared participants to handle difficult interactions. Additionally, a free text question was asked on the post-survey about what could enhance this educational training. The responses from the participants included adding more role play sessions to practice these difficult interactions and conversations, helping others realize it is not always what is wrong with you, rather, what happened to you to develop personal bias, and having more diversity among the participants in the sessions.

## **Sustainability**

Because the role of the nurse requires connection with people from other cultures and lifestyles, cultural humility is a desirable quality. Nurses should be prepared with an appreciation for diversity, the capacity to grasp the numerous reasons for opposing viewpoints, and the necessity for flexibility. Racial and ethnic disparities exist in perinatal care, and they impact both neonatal and maternal outcomes (Howell et al., 2018). In order to sustain the cultural humility and mindfulness interactive training, cultural humility champions from the volunteer group will be co-facilitating the training and leading weekly discussions. The goal is to roll this quality improvement project out to the entire perinatal microsystem. Incorporation of the 5R's of cultural humility into debriefs, case studies, and quality reviews to enhance awareness is another way to integrate these tools on the frontline. Cultural humility can be practiced at every touch point, so it is planned to expand the training beyond the perinatal microsystem to other mesosystems.

## **Conclusion**

It has been noted that a “maternal death is more than just a number or part of a count. It is a tragedy that leaves a hole in a family” (Roeder, 2019). Healthcare workers have a responsibility to do no harm. The American Nurses Association (2015) Code of Ethics for nurses addresses respect for every person. Despite the emphasis on addressing healthcare inequities throughout the years, inequities persist in Black and Brown women in the United States (Shen et al., 2019). This paper is an appeal for a fresh commitment and strategy to eliminate cultural obstacles and personal bias in every microsystem. A structured evidence-based tool such as the Foronda Cultural Humility scale is strongly recommended for integration into interdisciplinary team development and education initiatives across systems. This Cultural Humility and Mindfulness practice quality improvement project demonstrated promising results despite the

competing priorities related to a global pandemic. Nurse leaders need to provide caregivers with tools to evaluate their own biases and to communicate more effectively to improve patient interactions and outcomes. According to the U.S. Department of Health and Human Services, the Culturally and Linguistically Appropriate Service standards (CLAS) are in place so that all clinicians strive to provide every patient with effective, equitable, understandable, and respectful quality care and services that is responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs—a goal worth fighting for.

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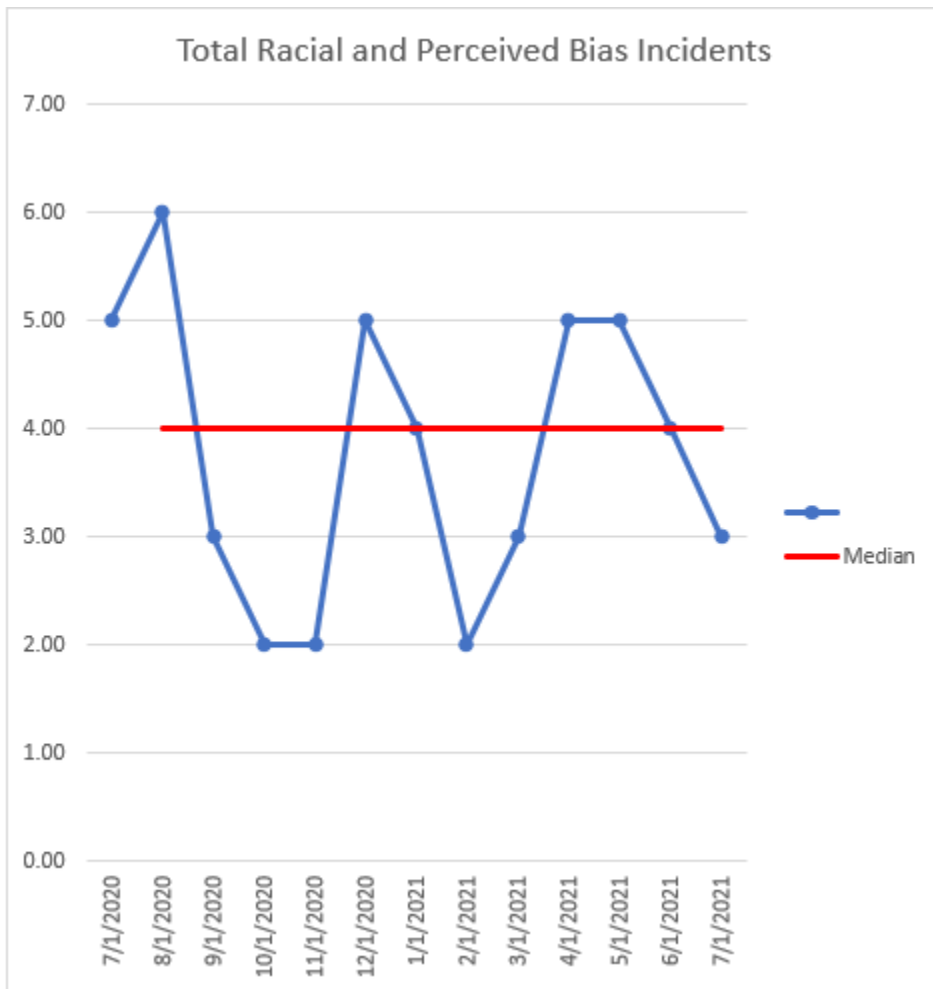
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### Section VII: Appendices

#### Appendix A

#### Racial and Perceived Bias incidents





## Appendix B

### Microsystem Assessment of Community hospital

Inpatient Unit Profile							
<b>A. Purpose:</b> Why does your unit exist? South Sacramento's Perinatal Departments vision is that every family that chooses Us to bring their child into the world will tell their friends that our entire staff did everything possible to make their birth experience wonderful; that they were always nurtured and safe and that we deserve the trust they place in us.							
Administrative Director: Rachel Wyatt		Site Contact: Charlene Johnson			Date: 3-16-2021		
		Nurse Director: Stacy Alves			Medical Director: Dr Rachel Dong		
<b>B. Know Your Patients:</b> Take a close look into your unit, create a "high-level" picture of the PATIENT POPULATION that you serve. Who are they? What resources do they use? How do the patients view the care they receive?							
<b>Est. Age Distribution of Pts:</b>		<b>List Your Top 10 Diagnoses/Conditions</b>			<b>Patient Satisfaction Scores</b>		<b>% Always</b>
19-40 years	90	1. Normal Delivery	6. Group B Strep Carrier		Nurses	4	
12-18 years	10	2. C-Sections	7. Premature rupture of membranes		Doctors	4	
		3. Gestational Diabetes	8. Obesity in Pregnancy		Environment	2	
		4. Pre-eclampsia	9.		Pain	4	
		5. HELLP Syndrome	10.		Discharge	% Yes	5
% Females					Overall	% Excellent	3
					Reported perceived bias escalated events: <small>2-5 reported/month</small>		
<b>Living Situation</b>	<b>%</b>	<b>Point of Entry</b>				<b>Ethnicity/Race for 2020: (total census 3218)</b>	<b>%</b>
Married	45	Admissions	65		Asian (950) 29		
Domestic Partner	20	Clinic	15		White (830) 25		
Live Alone	10	ED	20		Hispanic (759) 23		
Live with Others	15	Transfer	5		Black/AA (466) 14		
Homeless	10	<b>Discharge Disposition</b>	<b>%</b>		Native/Hawaiian/Other Pacific Islander (50) .02		
		Home	93		American Indian/Alaska Native (24) .007		
Homeless	10	Other Hospital / Transfer ICU	7		Other (129) 4		
					Decline (10)		
<b>Patient Type</b>	<b>LOS avg.</b>	<b>Rang e</b>			<b>*Complete "Through the Eyes of Your Patient", pg 8</b>		
Medical			2				
Surgical							
Mortality Rate			5				
<b>C. Know Your Professionals:</b> Use the following template to create a comprehensive picture of your unit. Who does what and when? Is the right person doing the right activity? Are roles being optimized? Are all roles who contribute to the patient experience listed?							
<b>Current Staff</b>	<b>Day FTEs</b>	<b>Evening FTEs</b>	<b>Night FTEs</b>	<b>Weekend FTEs</b>	<b>Over-Time by Role</b>	<b>Ethnicity/ Race (225 total)</b>	<b>%</b>
MD Total	11		11			White	60
Hospitalists Total	5		5			Asian	15
Unit Leader Total	4		4			Indian	4
CNSs Total	None					Black	20
RNs Total	100		85			Male	1
LPNs Total	None					Other	
LNAs Total	None					<b>Supporting Diagnostic Departments</b> • Respiratory • Lab • Radiology)	
Residents Total	seasonal						
Technicians Total	13		13				
Secretaries Total	9		9				
Clinical Resource Coord. Perinatal Educator	1						
Social Worker	3		1				
Health Service Assts.							
Ancillary Staff	2						
Do you use Per Diems?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> NO	<b>Staff Satisfaction Scores</b>				<b>%</b>	
Do you use Travelers?	Seasonal <input type="checkbox"/> Yes <input type="checkbox"/> NO	How stressful is the unit?				% Not Satisfied	80
Do you use On-Call Staff?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> NO	Would you recommend it as a good place to work?				% Strongly Agree	85
Do you use a Float Pool?	Yes <input checked="" type="checkbox"/> <input type="checkbox"/> NO						
<b>*Each staff member should complete the Personal Skills Assessment and "The Activity Survey", pgs 10 - 12</b>							
<b>D. Know Your Processes:</b> How do things get done in the microsystem? Who does what? What are the step-by-step processes? How long does the care process take? Where are the delays? What are the "between" microsystems hand-offs?							
<b>1. Create flow charts of routine processes.</b> a) Overall admission and treatment process b) Admit to Inpatient Unit		<b>Do you use/initiate any of the following?</b> Check all that apply <input checked="" type="checkbox"/> Standing Orders/Critical Pathways			<b>Capacity</b>	<b># Rooms</b> 17	<b># Beds</b> 19
					<b># Turnovers/Bed/Year</b>		

d) Change of shift process	<input type="checkbox"/> Bed Management Rounds	<b>Linking Microsystems</b> ED to OB transfers Perinatal to ICU
e) Discharge process	<input type="checkbox"/> Multidisciplinary/with Family Rounds	
f) Transfer to another facility process	<input type="checkbox"/> Midnight Rounds	
g) Medication Administration	<input type="checkbox"/> Preceptor/Charge Role	
h) Adverse event	<input type="checkbox"/> Discharge Goals	
<b>2. Complete the Core and Supporting Process Assessment Tool, pg 14</b>		
<b>E. Know Your Patterns:</b> What patterns are present but not acknowledged in your microsystem? What is the leadership and social pattern? How often does the microsystem meet to discuss patient care? Are patients and families involved? What are your results and outcomes?		
<ul style="list-style-type: none"> <li>Does every member of the unit meet regularly as a team? Yes</li> </ul>	<ul style="list-style-type: none"> <li>Do the members of the unit regularly review and discuss safety and reliability issues? Daily</li> </ul>	<ul style="list-style-type: none"> <li>What have you successfully changed? Quality metrics</li> </ul>
<ul style="list-style-type: none"> <li>How frequently? 3 Times a year</li> </ul>		<ul style="list-style-type: none"> <li>What are you most proud of? Breastfeeding work. Care Experience work,</li> </ul>
<ul style="list-style-type: none"> <li>What is the most significant pattern of variation?</li> </ul>		<ul style="list-style-type: none"> <li>What is your financial picture?</li> </ul>

© 2001, Trustees of Dartmouth College, Godfrey, Nelson, Batalden, Institute for Healthcare Improvement  
Adapted from the original version, [Dartmouth-Hitchcock, Version 2](#), February 2005

## Appendix C

### Evaluation Tables

#### PICOT Question

Among the volunteer group in perinatal(P), how does cultural humility and mindfulness training (I), compared to no cultural humility and mindfulness training (C), increase staff confidence to have multicultural crucial conversations with patients and families (O), during a 6-week period (T)?

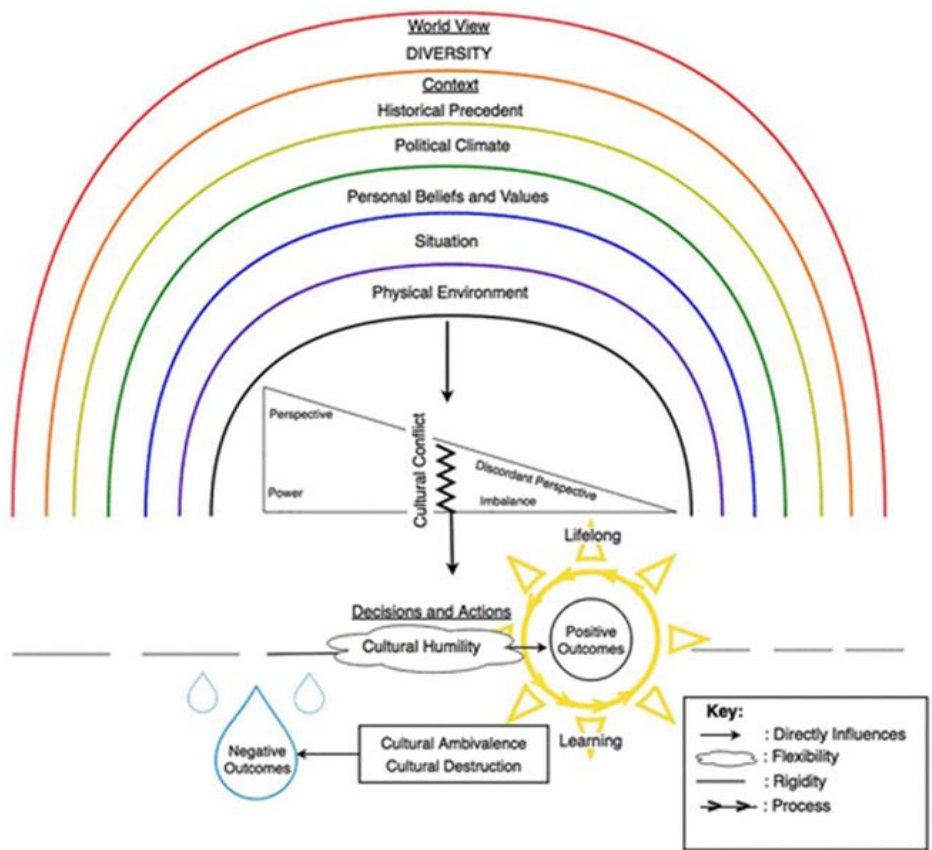
Study	Design	Sample	Outcome/Feasibility	Evidence rating
Foronda, C. (2020). A theory of cultural humility. <i>Journal of Transcultural Nursing</i> , 31 (1), 7–12	Concept analysis, statement analysis, theory synthesis, and theory analysis.	NA	The article develops a theory to guide nursing practice in Cultural humility. There are multiple factors to consider when making decisions when it comes to diverse populations.	LVA
Foronda, C., Porter, A., & Phitwong, A. (2021). Psychometric testing of an instrument to measure cultural humility.  Foronda et al (2021). <i>Journal of Transcultural Nursing</i> , 32 (4), 399–404	Key constructs from previous research to develop the instrument	N=322	The instrument was shown to have strong face and content validity. The instrument has the potential to be useful in showing the effectiveness of education of health care professionals	L I B
<b>Cultural competence development: The importance of incorporating culturally responsive simulation in nurse education (2021)</b>  Markey, K., Doody, O., Kingston, L., Moloney, M., & Murphy, L. <i>Nurse Education in Practice</i>	Consensus paper	none	discusses the importance of threading culturally responsive simulation across nursing curricula.  Providing culturally responsive simulation can support cultural	L IV B

			competence by providing opportunities to practice and rehearse ways of responding sensitively during cross cultural encounters in a risk-free setting	
Communication training course with simulation (2017)  Gabrielsen, A. K., Wallander Karlsen, M.-M., Falch, A. L., & Stubberud, D.-G.. <i>Norwegian Journal of Clinical Nursing</i>	Simulation based communication survey	N=49	There was greater understanding of how to use the communication during role modeling simulation.	L V A
Masters, C., Robinson, D., Faulkner, S., Patterson, E., McIlraith, T., & Ansari, A. (2019). Addressing biases in patient care with the 5Rs of cultural humility: A coaching clinician coaching. <i>Journal of Gen Internal Med, 34</i> (4), 627-630.	Concept analysis	N/A	The framework of the 5Rs presents an approach for clinicians to explore more mindful interactions and enriching patient-provider interactions	L IV B
Storytelling: A Strategy for Providing Context for Learning  Billings DM. Storytelling: <i>Journal of Continuing Education in Nursing.</i>	NA	NA	Storytelling is a learning use to facilitate active and engaged learning.	L IV B
The effect of using standardized patients or peer role play on ratings of undergraduate communication training: A randomized controlled trial. (2012)  Bosse HM, Schultz JH, Nickel M, Lutz T, Möltner A, Jünger J,	randomized controlled study	N=103	Participant's ability to do peer role play had a significant effect on self-efficacy ratings as well as their performance measures.	L II B

Huwendiek S, & Nikendei C. <i>Patient Education &amp; Counseling</i>				
Black Women’s Perspectives on Structural Racism across the Reproductive Lifespan: A Conceptual Framework for Measurement Development. (2021)  Chambers, B. D., Arega, H. A., Arabia, S. E., Taylor, B., Barron, R. G., Gates, B., Scruggs-Leach, L., Scott, K. A., & McLemore, M. R.	Focus group	n-35	Bias, structural racism and social determinants of health negatively impacts black mothers in obstetrics.	L I B
Halm, M. (2017). The role of mindfulness in enhancing self-care for nurses. <i>American Journal of Critical Care</i> , 26 (4), 344-348.	Systematic review (5 were randomized controlled trials, 1 was a nonrandomized trial, and 5 were observational studies)		There was improvement in physiological and psychological well-being was evident	L I B
Buchanan, T. M. & Reilly, P.M. (2019). The impact of HeartMath resiliency training on health care providers. <i>Dimensions of critical care nursing</i> , 38 (6), 328-336 doi: 10.1097/DCC.0000000000000384.	pretest/posttest model	N= 15 to 44 for 8 hours	Significant improvements were found in 3 of 4 primary scales (organizational stress, emotional stress, and physical stress)	L IV B

## Appendix D

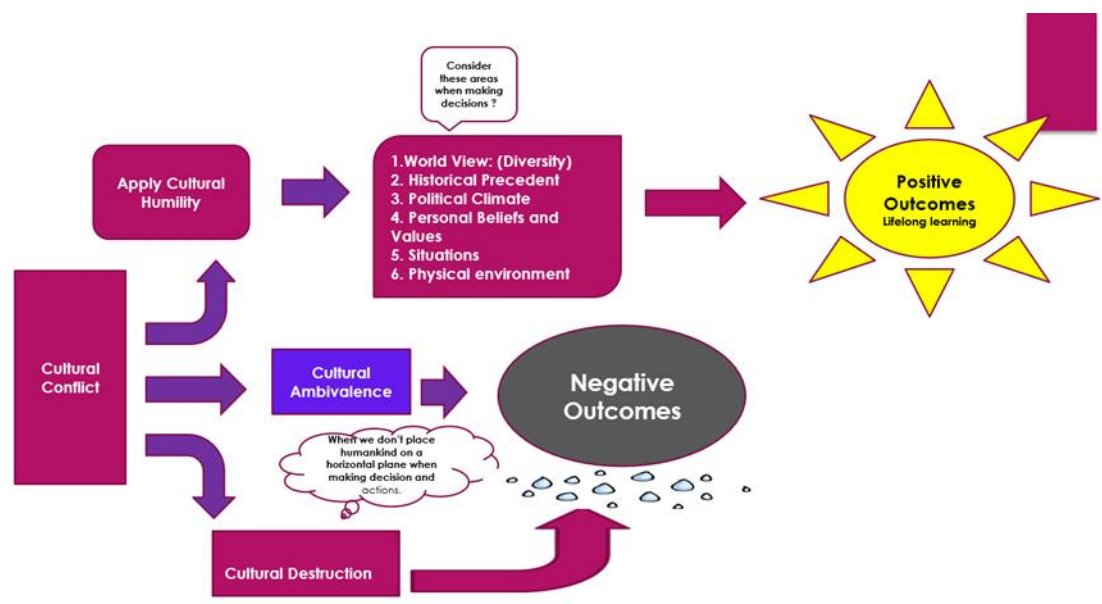
### Theory of Cultural Humility



Foronda (2020)

### Appendix E

### Flowchart for Cultural Humility Theory



Flow diagram when making conflict arises

## Appendix F

### **Reducing Implicit Bias: Evaluating Cultural Humility and Mindfulness Practices in the Perinatal Microsystem**

**Project Charter:** Introduction and implementation of a Cultural Humility framework using the 5Rs (reflection, respect, regard, relevance, resiliency) and mindfulness practices in a perinatal unit will increase a work environment characterized by cultural humility. This project is anticipated to result in increased confidence in communication related to implicit bias among the healthcare team. This new framework will foster empower of the healthcare team to conduct more culturally responsive and patient centered conversations with diverse populations to reduce perceptions of implicit bias and increase confidence related to de-escalation of potential adverse interpersonal interactions.

**Global Aim:** To decrease the number of annual incidents characterized by perceived bias in perinatal services from four to less than 2 by December 2022.

**Specific Aim:** To implement an interactive education series by November 2021 that integrates cultural humility and mindfulness practices for 80% of the volunteer group in the perinatal department. The voluntary group is a multidisciplinary team off nurses, doctors, midwives, surgical scrub techs, and leadership in the perinatal department.

#### **Background:**

Childbirth should be one of the most exciting times in a new mother's life. However, because of a lack of self-awareness, cultural humility, and the inability of providers, leaders, and nurses to communicate meaningfully with diverse patient populations, there are many missed opportunities that potentially impact the childbirth experience for underserved patient populations (Kalata et al., 2020; Wang et al., 2021) This leaves women of color and/or women who hold certain cultural beliefs that may be different from the healthcare provider team at risk for miscommunication and misinformation related to their maternal childcare (Wang et al., 2021). The Centers for Disease Control and Prevention (CDC) found that mortality rates are not equal among different races (CDC, 2020). Furthermore, leaders in maternal – fetal medicine report that African American women are three to four times more likely to die from a preventable pregnancy related complication compared to white women (Kalata et al., 2020).

Healthcare organizations need to provide safe, equitable care to all childbearing women and their partners regardless of race or cultural background. This may be challenging; however, evidence demonstrates there is success when cultural humility and mindfulness practices are taught to healthcare teams (Foronda, 2020). The goal to use the cultural of humility and mindfulness practices is for the healthcare team to become more self-aware, which can reduce implicit biases and long imbedded stereotypes (Foronda, 2020; Masters et al., 2019). Inadequate training about cultural humility and mindfulness among the health care team can result in poor



patient outcomes (Masters, 2019). Healthy People 2030 describes national goals to achieve health equity and eliminate health disparities (Pronk et al., 2021).

### Sponsors

Chief Nurse Officer	R. W.
Chief of Obstetrics	R.D.
Perinatal Director	S.A.

### Goals

As a Clinical Nurse Leader (CNL) the goal is to provide standardized education tools including interactive case studies to promote cultural humility and mindfulness practices to a voluntary multidisciplinary team of nurses, doctors, midwives, and leadership team to bridge the communication gaps related to cultural diversity and perceived biases in the work environment.

### Education session preliminary development plan:

Bridging the Gaps: Introducing Cultural humility and mindfulness education practices for perinatal staff.

1. Develop three patient care scenarios and case studies demonstrating perceived bias in perinatal services.
2. Provide an initial 3-hour education session to the Unit Practice Council, leadership team, and providers in the perinatal unit to introduce the 5Rs of Cultural Humility framework and mindfulness practices using the Quick Coherence technique over a six-week period. This will consist of the initial educational training following weekly trainings, for a total of five sessions.
3. Conduct weekly 1-hour sessions with the volunteer participant group to review case studies and practice using the 5Rs of Culture Humility tool and Quick Coherence techniques to model recommended communication for scenarios demonstrated within the case studies.
4. Create a unit-based plan and budget for replication within perinatal department over 2 years to promote sustainability.
5. Develop a metric related to cultural humility.
6. Develop a mechanism to integrate to more visibly integrate the voice of the patient into perinatal care services.

## Measures

Measure	Data Source	Target
<b>Outcome</b>		
1. % of participants who completed pre and post Foronda's cultural humility scale	Pre- and post-surveys	80%
2. % healthcare members (providers, nurse leaders, & Unit Practice Councils) increase their ability to perform Quick Coherence	Self-report during weekly Zooms	80%
<b>Process</b>		
1. % learning needs assessments completed for the pilot group of up to volunteer perinatal team members	Survey	80%
2. % healthcare team who participate in the initial educational session	Surveys (survey will be provided after each session to assess attendance and level of satisfaction of the training sessions)	80%
3. % healthcare team who participated in all the weekly educational sessions over 6-weeks	Surveys (survey will be provided after each session to assess attendance and satisfaction of the training sessions)	65%
<b>Balancing</b>		
1. Unintended consequences – data you will monitor throughout project	Number of Escalation Events	< 2 during the project improvement period over an a 6- week period

2. % of participant dropouts bi-weekly	Attendance Report	< 2 staff from the pilot group weekly

### Team

CNL MSN graduate/Manager	C.J.
Manager/Preceptor- Co-Lead	T.F.
ANM Nurse Leader Co-lead	A.H.
Diversity Pilot Group	Unit Practice Council
CNS/Educator	M.L.
MD champions	R.D.
Nurse midwives' champions	A.R.

### References

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Wang, E., Glazer, K., Sofaer, S., Balbierz, A., & Howell, E. (2021). Racial and ethical disparities in severe maternal morbidity: A qualitative study of women's experiences of peripartum care. *Women's Health Issues*. 31(5), 75-81.

### **Measurement Strategy**

**Background (Global Aim)** To decrease the number of annual incidents characterized by perceived bias in Perinatal Unit? Services from five to < 2 by December 2022 utilizing the Cultural Humility framework with the 5Rs of (reflection, respect, regard, relevance, & resiliency), and Mindfulness Practices in 80% of the multidisciplinary team of nurses, doctors, midwives, and leadership in the Perinatal department.

**Population Criteria:** Diverse population:29% Asian, 5% White, 23% Hispanic, 14% Black, .02% Native/Hawaiian/ Pacific Islander, .007% American Indian/Alaska Native, and 4% other.

**Data Collection Method:** Data will be obtained from pre and post surveys of the volunteer pilot group in perinatal. The CNL will also keep a log of observations and lessons learned throughout the project.

### **Data Definitions**

Data Element	Definition
Cultural Humility	the recognition of diversity and power imbalances among individuals, groups, or communities, with the actions of being open, self-aware, egoless, flexible, exuding respect and supportive interactions, focusing on both self and other to formulate a tailored response. Cultural humility is a process of critical self-reflection and lifelong learning, resulting in mutually positive outcomes.
Implicit Bias	without our awareness, racial stereotypes and assumptions creep into our minds and affect our actions
Cultural Competence	gaining knowledge of different cultural practices and world views. Developing positive attitudes towards cultural differences
Mindfulness	meditative practice that develops the capacity to adopt an observing self,
5R's	reflection, respect, regard, relevance, resiliency.

**Measure Description need more**

Measure	Measure Definition	Data Collection source	Goal
Outcome 1 measure	Healthcare members begin to use mindfulness practices using the quick coherence technique and the use of the 5 R'S of Cultural Humility	Pre and Post Surveys	80%
Process measure	Learning Needs Assessment with pilot volunteer group	Survey	80%
Process measure	Attendance for 1 <sup>st</sup> educational session	Surveys (survey will be provided after each session for the satisfaction of the training sessions)	80%
Balancing measure	% of participant dropouts bi-weekly	Attendance Report	< 2 bi-weekly

## Appendix G

### PDSA

#### PDSA Cycle Diagram



## Appendix H

### SWOT Analysis

#### SWOT ANALYSIS



## Appendix I

## Projected Budget for Cultural Humility and Mindfulness Project

<b>Cultural humility and Mindfulness Training</b>			
SSC - KP			
Year 2021			
<b>Projection</b>	<b>2021 Annual</b>	<b>Monthly</b>	
Staff	220	20	<i>People</i>
Rate	\$ 91.44	\$ 91.44	<i>Dollars</i>
Training Hours per month	7	7	<i>Hour</i>
<b>Total Cost</b>	<b>\$ 140,821</b>	<b>\$ 12,802</b>	
<b>Hourly Rate based on 40Hrs/week</b>			
<b>Skills Mix</b>	<b>2021 Annual</b>	<b>Monthly</b>	<b>ek</b>
Pediatrician Salary	\$ 300,000.00	\$25,000.00	\$ 144.23
RNs	\$ 200,000.00	\$16,666.67	\$ 96.15
Manager	\$ 200,000.00	\$16,666.67	\$ 96.15
Assistant Manager	\$ 175,000.00	\$14,583.33	\$ 84.13
OB Tech	\$ 76,000.00	\$ 6,333.33	\$ 36.54
<b>Average Rate- Skills mix</b>			<b>\$ 91.44</b>



## Appendix J

### Framework: The 5 R's of Cultural Humility

CLINICAL COACHING TOOL	AIM	REFLECTION QUESTION
Reflect	Clinicians will approach every encounter with humility and understanding that there is always something to learn from everyone	What did I learn from each person in that encounter?
Respect	Clinicians will always treat every person with the utmost respect and strive to preserve dignity.	Did I treat everyone involved in that encounter respectfully?
Regard	Clinicians will hold every person in their highest regard, be aware of, and not allow unconscious biases to interfere in any interactions	Did unconscious biases drive this interaction?
Relevance	Clinicians will expect cultural humility to be relevant and apply this practice to every encounter.	How was cultural humility relevant in this encounter?
Resiliency	Clinicians will embody the practice of cultural humility to enhance personal resiliency and global compassion.	How was my personal resiliency affected by this interaction?

Masters et al., (2019)

## Appendix K

### Foronda's Cultural Humility Scale

#### Content Validity Ratings

Item	Factor	I-CVI
	Factor 1: Context for difference in perspective	
1	Do you consider diversity as a factor for difference in perspective?	0.83
2	Do you consider the physical environment as a factor for difference in perspective?	1.0
3	Do you consider the historical precedent as a factor for difference in perspective?	1.0
4	Do you consider the political climate as a factor for difference in perspective?	1.0
5	Do you consider the power imbalances as factors for difference in perspective?	1.0
6	Do you consider situational context as a factor for the difference in perspective?	1.0
7	Do you attempt to be open to considering the differing perspective?	0.83
	Factor 2: Self-attributes	
8	Do you self-reflect and critique yourself afterward?	1.0
9	Do you attempt to be flexible?	1.0
10	Are you aware of your own biases?	1.0
11	Do you attempt to shed your ego?	0.83
	Factor 3: Outcomes of cultural humility	
12	Do you seek to establish respect?	1.0
13	Do you seek to provide optimal care?	1.0
14	Do you focus on the other person in addition to yourself?	1.0
15	Do you seek to empower others?	1.0
16	Do you work toward a mutual benefit?	1.0
17	Do you seek to develop a partnership?	0.83
18	Do you strive for a supportive interaction?	1.0
19	Do you see yourself as a lifelong learner?	0.83
Scale content validity index		0.96

Note. I-CVI = item content validity index.

(Foronda, 2021)

**Appendix L****Foronda's Cultural Humility Scale (19-item)– Interpretation Guide**

Scores 19-38	Rarely Culturally Humble
Scores 39-75	Sometimes Culturally Humble
Scores 76-85	Usually Culturally Humble
Score of 86-95	Habitually Culturally Humble

(Foronda, 2021)



## Appendix N

### Evidence-based Change of practice project checklist



This project involves research with human subjects and must be submitted for IRB approval before project activity can commence

#### EVIDENCE-BASED CHANGE OF PRACTICE PROJECT CHECKLIST \*

Instructions: Answer YES or NO to each of the following statements:

Project Title: Reducing Implicit Bias: Evaluating Cultural Humility and Mindfulness Practices in the Perinatal Microsystem	YES	NO
The aim of the project is to improve the process or delivery of care with established/ accepted standards, or to implement evidence-based change. There is no intention of using the data for research purposes.	x	
The specific aim is to improve performance on a specific service or program and is a part of usual care. ALL participants will receive standard of care.	x	
The project is NOT designed to follow a research design, e.g., hypothesis testing or group comparison, randomization, control groups, prospective comparison groups, cross-sectional, case control). The project does NOT follow a protocol that overrides clinical decision-making.	x	
The project involves implementation of established and tested quality standards and/or systematic monitoring, assessment or evaluation of the organization to ensure that existing quality standards are being met. The project does NOT develop paradigms or untested methods or new untested standards.	x	
The project involves implementation of care practices and interventions that are consensus-based or evidence-based. The project does NOT seek to test an intervention that is beyond current science and experience.	x	
The project is conducted by staff where the project will take place and involves staff who are working at an agency that has an agreement with USF SONHP.	x	
The project has NO funding from federal agencies or research-focused organizations and is not receiving funding for implementation research.	x	
The agency or clinical practice unit agrees that this is a project that will be implemented to improve the process or delivery of care, i.e., not a personal research project that is dependent upon the voluntary participation of colleagues, students and/ or patients.	x	
If there is an intent to, or possibility of publishing your work, you and supervising faculty and the agency oversight committee are comfortable with the following statement in your methods section: <i>"This project was undertaken as an Evidence-based change of practice project at Kaiser South Sacramento Medical Center and has received approval from the Research Determination Committee for the Kaiser Permanente Northern California region which has reviewed the documents submitted for this project. The project does not meet the regulatory definition of research involving human subjects (see attached letter dated 7/21/21).</i>	x	

ANSWER KEY: If the answer to ALL of these items is yes, the project can be considered an Evidence-based activity that does NOT meet the definition of research. IRB review is not required. Keep a copy of this checklist in your files. If the answer to ANY of these questions is NO, you must submit for IRB approval.

\*Adapted with permission of Elizabeth L. Hohmann, MD, Director and Chair, Partners Human Research Committee, Partners Health System, Boston, MA.



**STUDENT NAME (Please print): Charlene Johnson**

Signature of Student: *Charlene Johnson* DATE 7/24/21

**SUPERVISING FACULTY MEMBER NAME (Please print):**

CATHERINE COLEMAN  
Signature of Supervising Faculty Member *Catherine M. Coleman DNP* DATE <sup>26</sup>7/27/21

## Appendix O

### IRB Non-Research Determination

#### CNL Project: Statement of Non-Research Determination Form

**Student Name:** Charlene Johnson

**Title of Project:** Reducing Implicit Bias: The Impact of Cultural Humility and Mindfulness Practices in the Perinatal Unit to Bridge the Gaps of Cultural Diversity and Disparities.

**Brief Description of Project:**

- A) **Aim Statement:** To implement an interactive education series by November 2021 that integrates cultural humility and mindfulness practices for 80% of the volunteer group in the perinatal department. The voluntary group is a multidisciplinary team of nurses, doctors, midwives, surgical scrub techs, and leadership in the perinatal department.
- B) **Description of Intervention:** The CNL who will be conducting this project improvement, will collect data from a valid evidence based pre- and post-survey taken by the volunteer group in the perinatal department. These surveys will be anonymous, and they will measure the baseline of cultural humility before the educational sessions begin. The target population will be a volunteer group consisting of nurses, doctors, midwives, surgical scrub techs, and leadership in the perinatal department. They will receive the intervention of an initial 3-hour education session to introduce the 5Rs of Cultural Humility framework and mindfulness practices using the Quick Coherence technique training. Following the initial training, bi-weekly trainings will be held to practice mindfulness techniques and review textbook diversity scenarios using the Cultural of Humility theory. There will be a total of five sessions including the initial training.
- C) **How will this intervention change practice?** The health care team will be more confident having conversations with culturally diverse populations, have an increase in cultural humility, and self-awareness, and this should show a decrease in the number of incidents of perceived bias within the perinatal department.
- D) **Outcome measurements:** After the educational sessions the comparison of the baseline data and post-education data will be analyzed to see if the health care team are more confident having conversations in culturally diverse populations, have an increase in cultural humility, and self-awareness, which should show a decrease in the number of incidents of perceived bias within the perinatal department.

To qualify as an Evidence-based Change in Practice Project, rather than a Research Project, the criteria outlined in federal guidelines will be used: (<http://answers.hhs.gov/ohrp/categories/1569>)

This project meets the guidelines for an Evidence-based Change in Practice Project as outlined in the Project Checklist (attached). Student may proceed with implementation.

This project involves research with human subjects and must be submitted for IRB approval before project activity can commence

### EVIDENCE-BASED CHANGE OF PRACTICE PROJECT CHECKLIST \*

**Instructions: Answer YES or NO to each of the following statements:**

<b>Project Title:</b>	<b>YES</b>	<b>NO</b>
The aim of the project is to improve the process or delivery of care with established/ accepted standards, or to implement evidence-based change. There is no intention of using the data for research purposes.	<b>x</b>	
The specific aim is to improve performance on a specific service or program and is <b>a part of usual care</b> . ALL participants will receive standard of care.	<b>x</b>	
The project is <b>NOT</b> designed to follow a research design, e.g., hypothesis testing or group comparison, randomization, control groups, prospective comparison groups, cross-sectional, case control). The project does <b>NOT</b> follow a protocol that overrides clinical decision-making.	<b>x</b>	
The project involves implementation of established and tested quality standards and/or systematic monitoring, assessment or evaluation of the organization to ensure that existing quality standards are being met. The project does <b>NOT</b> develop paradigms or untested methods or new untested standards.	<b>x</b>	
The project involves implementation of care practices and interventions that are consensus-based or evidence-based. The project does <b>NOT</b> seek to test an intervention that is beyond current science and experience.	<b>x</b>	
The project is conducted by staff where the project will take place and involves staff who are working at an agency that has an agreement with USF SONHP.	<b>x</b>	
The project has <b>NO</b> funding from federal agencies or research-focused organizations and is not receiving funding for implementation research.	<b>x</b>	
The agency or clinical practice unit agrees that this is a project that will be implemented to improve the process or delivery of care, i.e., <b>not</b> a personal research project that is dependent upon the voluntary participation of colleagues, students and/ or patients.	<b>x</b>	
If there is an intent to, or possibility of publishing your work, you and supervising faculty and the agency oversight committee are comfortable with the following statement in your methods section: <i>“This project was undertaken as an Evidence-based change of practice project at X hospital or agency and as such was not formally supervised by the Institutional Review Board.”</i>	<b>x</b>	

**ANSWER KEY:** If the answer to **ALL** of these items is yes, the project can be considered an Evidence-based activity that does NOT meet the definition of research. **IRB review is not required. Keep a copy of this checklist in your files.** If the answer to ANY of these questions is **NO**, you must submit for IRB approval.



\*Adapted with permission of Elizabeth L. Hohmann, MD, Director and Chair, Partners Human Research Committee, Partners Health System, Boston, MA.

**STUDENT NAME (Please print): Charlene Johnson**

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**Signature of Student:**

**DATE** 7/9/21

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**SUPERVISING FACULTY MEMBER NAME (Please print):**

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**Signature of Supervising Faculty Member**

**DATE** \_\_\_\_\_

## Appendix P

### Badge Cards

#### The 5 R's of CULTURAL HUMILITY - Clinical Coaching Tool

1. Reflection: AIM: I approach encounters with humility and understanding that there is always something to learn from everyone. Question: What did I learn from each person in that encounter?
2. Respect: AIM: I treat every person with the utmost respect and strive to preserve dignity. Question: Did I treat everyone involved in that encounter respectfully?
3. Regard: AIM: I hold every person in their highest regard, be aware of, and not allow unconscious biases to interfere in any interactions. Question: Did unconscious biases drive this interaction?
4. Relevance: AIM: Cultural humility is relevant and I apply this practice to every encounter. Question: How was cultural humility relevant in this encounter?
5. Resiliency: AIM: I embody the practice of cultural humility to enhance personal resiliency and global compassion. Question: How was my personal resiliency affected by this interaction?

Masters et al, 2019)

#### MINDFULNESS PRACTICE: QUICK COHERENCE TECHNIQUE

Step 1: Focus your attention in the area of the heart. Imagine your breath is flowing in and out of your heart or chest area, breathing a little slower and deeper than usual.

*(Suggestion: Inhale 5 Seconds, exhale 5 seconds (or whatever rhythm is comfortable)*

Step 2: Make a sincere attempt to experience a regenerative feeling such as appreciation or care for someone or something in your life.

*(Try to re-experience the feeling you have for someone you love, a pet, a special place, an accomplishment, etc., focus on a feeling of calm or ease.)*



## Appendix Q

## Cultural Humility &amp; Mindfulness Flyer for Kick off

*Kick off August 30th @ 4:30pm*



**BRIDGING THE GAP PERINATAL  
EDUCATIONAL EXPERIENCE**

*If you are interested in being a part of the change please email  
for a teams link*

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**BRIDGING THE GAP EDUCATIONAL EXPERIENCE**  
Email [charlene.x.johnson@kp.org](mailto:charlene.x.johnson@kp.org) for teams invite

**6-week PILOT**

August 23 @ 4:30pm to 7:00pm-3 hour Interactive Education experience  
with 5 practice & 45 minute follow up sessions

**9-06-21**  
**9-13-21**  
**9-20-21**  
**9-27-21**  
**10-4-21 (Pilot ends)**

*Cultural Humility and Mindfulness  
PILOT*

## Appendix R

### IRB Approval



**Date:** July 21, 2021  
**Subject:** RDO 21 - 099  
**Title:** Reducing Implicit Bias: The Impact of Cultural Humility and Mindfulness Practices in the Perinatal Unit

Dear Ms. Friedli:

The Research Determination Committee for the Kaiser Permanente Northern California region has reviewed the documents submitted for the above referenced project. The project does not meet the regulatory definition of research involving human subjects as noted here:

#### **Not Research**

The activity does not meet the regulatory definition of research per 45 CFR 46.102(d): Research means a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge.

This determination is based on the information provided. If the scope or nature of the project changes in a manner that could impact this review, please resubmit for a new determination. The word "research" should not appear in any posters or publications resulting from this project. Further, if publications, presentations or posters are generated from this project the following wording must be used to reference to the project research determination outcome:

*"The Research Determination Committee for the Kaiser Permanente Northern California region has determined the project does not meet the regulatory definition of research involving human subjects per 45 CFR 46.102(d)"*

You are expected, however, to implement your study or project in a manner congruent with accepted professional standards and ethical guidelines as described in the Belmont Report (<http://www.hhs.gov/ohrp/humansubjects/guidance/belmont.html>).

Additionally, you are responsible for keeping a copy of this determination letter in your project files as it may be necessary to demonstrate that your project was properly reviewed.

Provide this approval letter to the Physician in Charge (PIC), your Area Manager, and Chief of Service, to determine whether additional approvals are needed.

Sincerely,

The Research Determination Committee  
 KPNC-RDO@kp.org

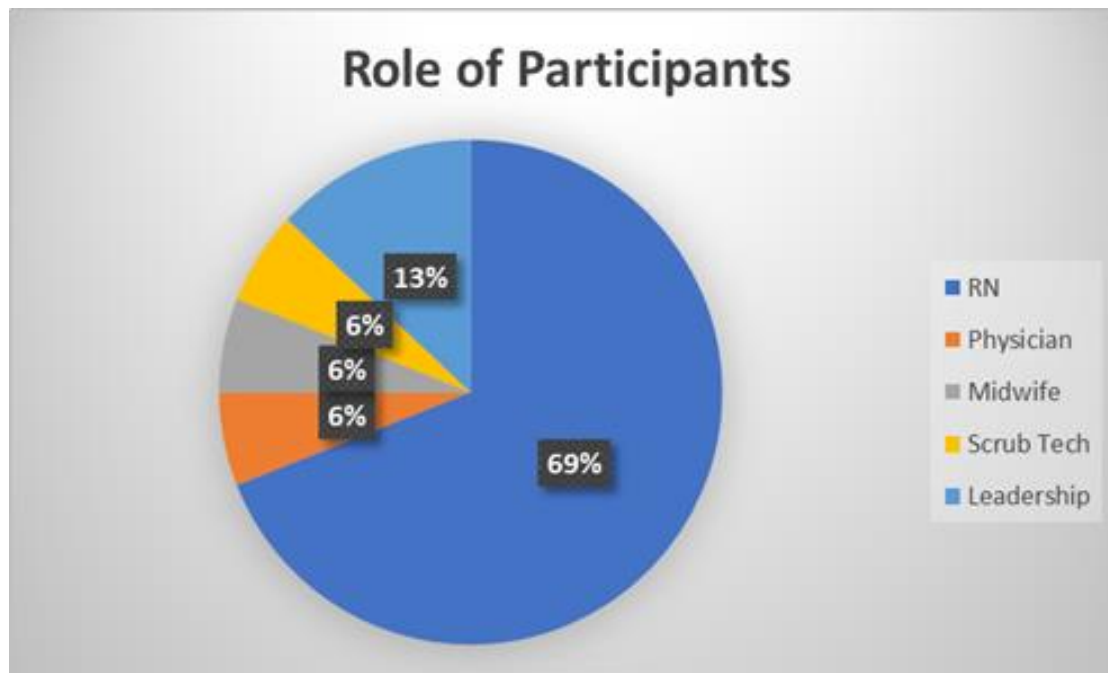
Research Determination Office  
 KPNC-RDO@kp.org

## Appendix S

### Pilot Results and Outcomes Data

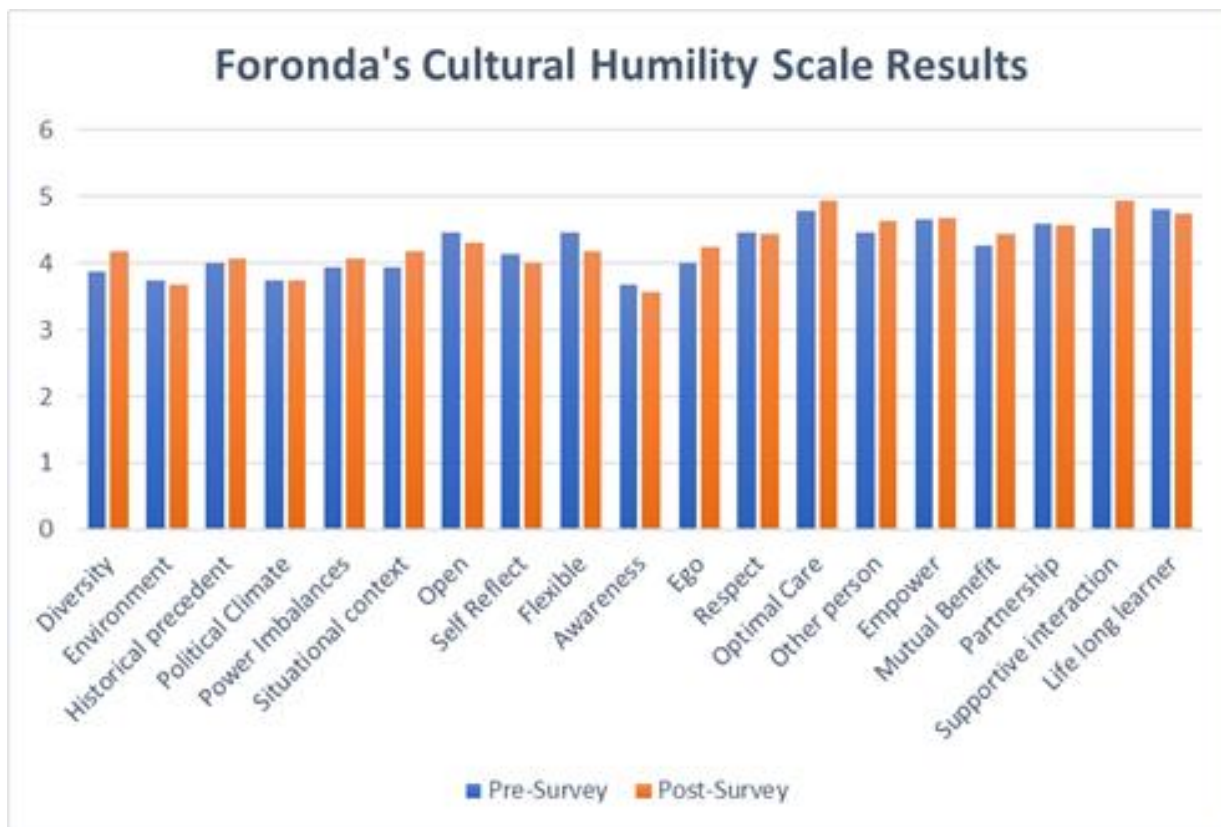
**Figure 1**

*Clinical Role of Participants*



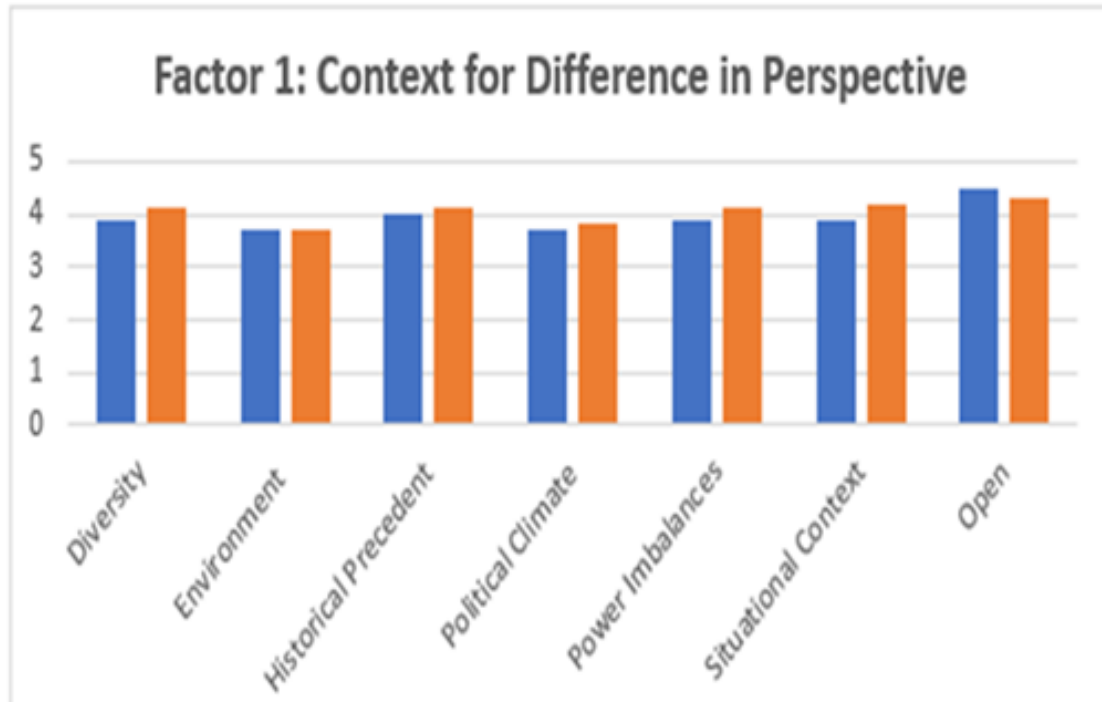
**Figure 2**

*Pre and Post Foronda's Cultural Humility Scale Comparison*



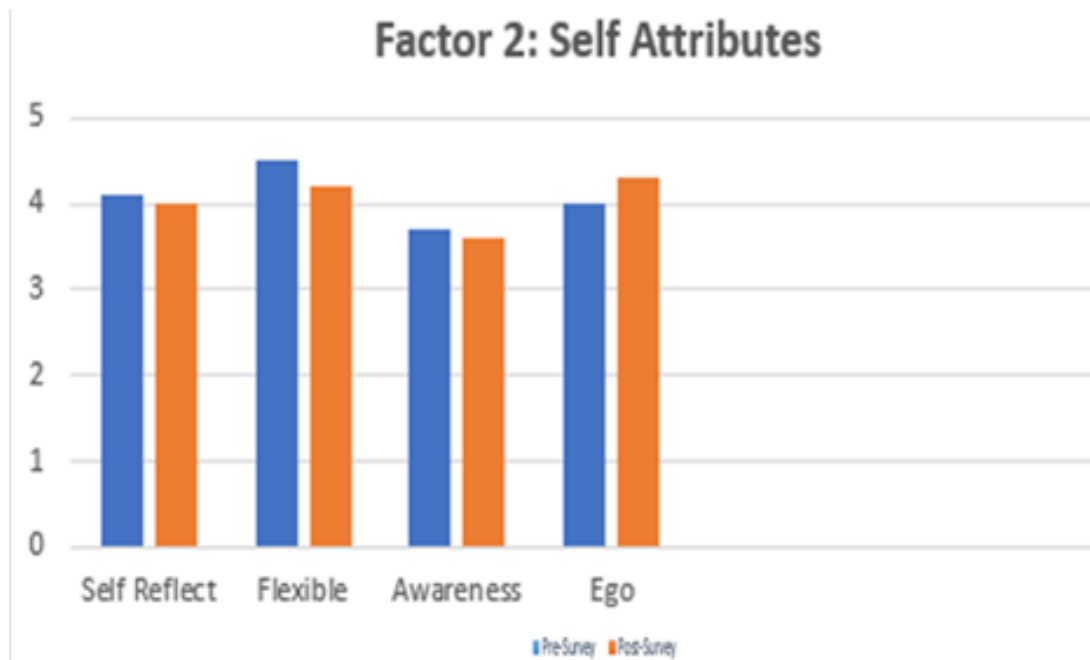
**Figure 3**

*Foronda Cultural Humility Scale—Context for Difference in Perspective*



**Figure 4**

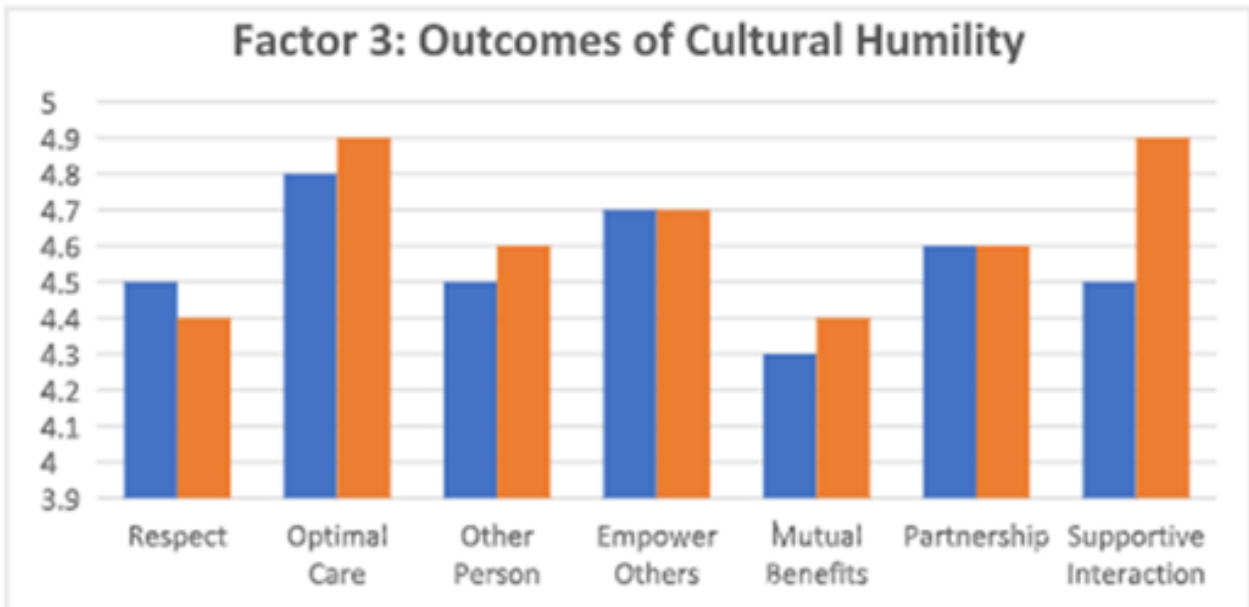
*Foronda Cultural Humility Scale--Self Attributes*





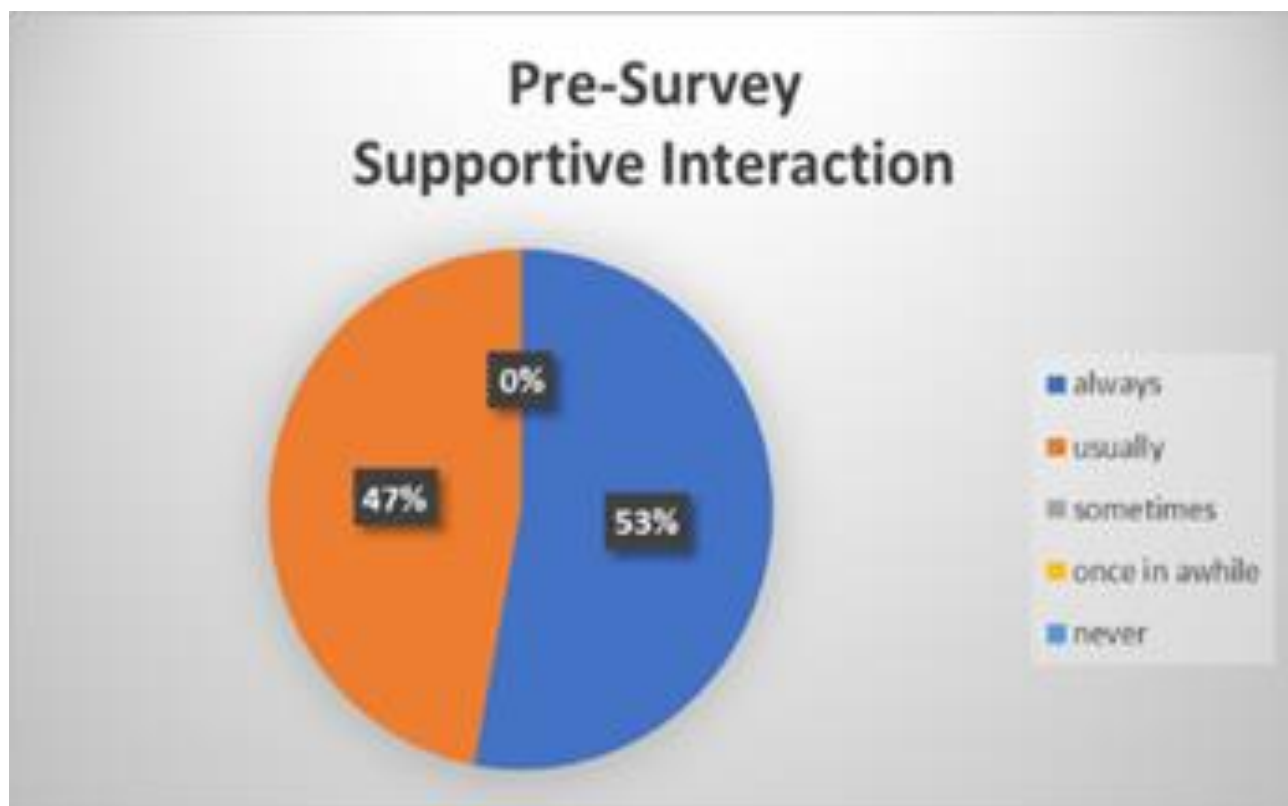
**Figure 5**

*Foronda Cultural Humility Scale--Outcomes of Cultural Humility*



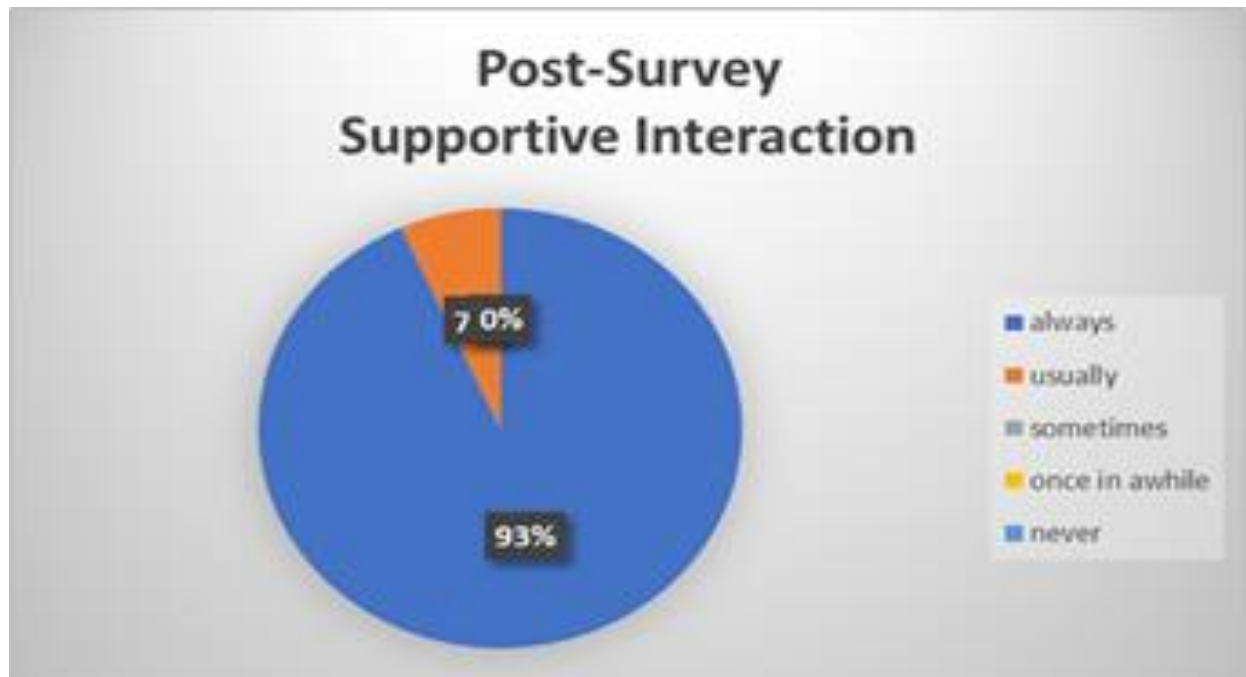
**Figure 6**

*Foronda Cultural Humility Scale for Supportive Interaction Pre-Survey*



**Figure 7**

*Foronda Cultural Humility Scale for Supportive Interaction Post-Survey*



**Figure 8***Follow-Up Survey One-Month Post Pilot*