Multicultural Orientation Training: An Innovative Method to Develop Cultural Humility Among Health Care Providers

Brittany Kemp

Project Chair: Debra Penney

Content Experts: Karen Tao and Susanna Cohen

University of Utah

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Abstract

The purpose of this pilot study was to trial Multicultural Orientation training among health care providers (HCPs) in a university academic health sciences setting. Multicultural orientation (MCO) is a method for training HCPs to navigate patient cultural values and incorporate these values into their care. The three components of MCO are (a) cultural humility, including self-reflection techniques; (b) identifying cultural opportunities with patients; and (c) increasing the cultural comfort of HCPs to use the identified opportunities to integrate a patient's culture into care. This training method has demonstrated improved patient outcomes in the field of psychology but has not yet been used with other HCPs.

The pilot study specifically aimed to 1) to explore the impact of MCO training on the confidence of HCPs in relation to cultural humility, identifying cultural opportunities and facilitating conversations using the identified cultural opportunities; 2) to measure HCP knowledge acquisition of these three training elements through a training session using MCO and 3) to explore the applicability, adaptability and feasibility of using MCO in training HCPs.

This quality improvement initiative included a pilot 2-hour MCO training workshop among 11 female HCPs employed by a large urban teaching hospital led by an educational psychologist and cofounder of MCO. Participant self-reported confidence and knowledge acquisition were measured comparing pre and post training scores. Applicability, adaptability and feasibility were assessed by participant feedback in a post-training focus group.

Pre and post training scores compared six matched questions demonstrated a 10.6% increase in overall knowledge acquisition and a 40% increase in correctly identifying the three main components of MCO. The Wilcoxon signed rank test was used to compare self-reported confidence levels for each participant using 10 matched items on the pre and posttests.

Participants reported a significant improvement in confidence in using and facilitating self-reflection techniques with themselves and peers after a challenging cultural interaction, facilitating conversations around identified cultural opportunities and ratings for cultural humility. Recorded and transcribed focus group data was inductively coded, categorized and revealed themes that indicated the training could be adapted to disciplines, or be interdisciplinary. Recommendations were made for more time within the workshop to engage in the concepts. Participants identified the challenge of time and scheduling for further training and getting buy-in for use of role-play.

From this pilot study, results indicate that MCO training can increase HCP confidence in self-reflection techniques and conversing with patients about identified cultural opportunities. Participants indicated that MCO training was innovative, feasible and applicable in a variety of clinical encounters and that it should be expanded to all HCPs. Further research should test the impact of MCO training on patient satisfaction and health outcomes.

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Health disparities are a growing concern in the United States due to the increasing number of vulnerable and disadvantaged populations (Adler & Rehkopf, 2008; LaVeist, Gaskin, & Richard, 2011; Proctor, Semega, & Kollar, 2016; Utah Department of Health [UDH], 2013). Health disparities are defined by the Centers for Disease Control and Prevention (CDC) as "preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations" (2015, para 1). Vulnerable and disadvantaged populations include, but are not limited to members of racial, ethnic, or sexual minority groups, persons living in poverty with and without access to Medicaid, refugee and immigrant status and person's whose first language is not English (CDC, 2017; City-data.com, 2017; Gates, 2017; Kem C. Gardner Policy Institute, 2016; Kripalani, Bussey-Jones, Katz, & Genao, 2006; Passel, Cohn, & Lopez, 2011; Proctor, Semega, & Kollar, 2016; UDH, 2013; UDH, 2017).

Every year in this country, health disparities account for the loss of thousands of lives and billions of health care dollars (LaVeist, Gaskin, & Richard, 2011). Vulnerable groups experiencing health disparities will continue to bear the burden of morbidity and mortality until health disparities are adequately addressed.

An important component of addressing disparities is a health care provider's ability to effectively communicate with the patient, navigate cultural barriers and ultimately address the health needs of vulnerable and disadvantaged patients. Multiple national governmental programs and professional organizations mandate that culturally appropriate care should be provided during every patient encounter (Office of Minority Health [OMH], 2001, reaffirmed 2011; U.S.

Department of Health and Human Services [DHHS], 2011; American College of Obstetrics and Gynecology [ACOG], 2011; American Nurses Association [ANA], 2015).

Literature Review

Culturally competent care is defined as "having the capacity to function effectively within the realm of cultural beliefs, behaviors, and needs presented by consumers and their communities" (OMH, 2001, p. vi). Health care providers find it difficult to provide nationally-mandated, culturally competent care, as they do not possess a clear practical definition of cultural competency and commonly believe that diversity consists predominantly of race and ethnicity (Engebretson et al., 2008). Conceptual issues are compounded by the disagreement that surrounds how cultural competency is best taught, by whom it is taught and when it is taught in the educational/professional timeline (Engebretson et al., 2008). As of 2016, only 32 states reported formal programs of teaching cultural competency to health care providers (OMH, 2016). In Utah, the Department of Health is the only documented health entity that has undergone cultural competency training and has met the National Standards for Culturally and Linguistically Appropriate Services (CLAS) standards review and intervention with the approved national *ToolKit* (OMH, 2016). Currently, there is limited cultural competency training for health care providers at the University of Utah. The only online learning module for any University of Utah staff is not compulsory and focuses exclusively on Spanish speaking patients (University of Utah, 2016).

Research has shown that training health care providers to be culturally competent is difficult to measure and has currently produced limited positive results for mitigating long term health disparities (Drevdahl, Canales, & Dorcy, 2008; Like, 2011). However, provider training that incorporates the concept of cultural humility has shown to increase provider awareness of

disparities, improve their attitudes and ability to communicate with patients and increase patient satisfaction (Like, 2011, Prasad et al., 2016; Ruberton et al., 2016). Tervalon and Murray-García (1998) described 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" (p. 117). These authors further explain that this approach to cultural competency seeks to promote provider adaption and growth within a dynamic health care system and to address patients as individuals during every provider-patient encounter. A meta-analysis conducted by Gallagher and Polanin (2015) and additional studies have called for further research in best practices on how to train health care providers to increase cultural humility to improve patient outcomes (Roberts, Warda, Garbutt, & Curry, 2014; Isaacson, 2014).

Rationale

This project seeks to influence and mitigate the causes of health care disparities arising from the provider-patient interaction by increasing provider awareness, improve their capacity and intention to operate with cultural humility. The Theory of Planned Behavior created by Icek Ajzen (Ajzen & Fishbein, 1980) informs the process of adopting the practice of cultural humility and is explained in this case, by altering the provider's attitude, perceived behavioral control and the subjective norms of the clinical environment so that the intention to perform the desired behavior will lead to the execution of cultural humility.

Specific Aims

The aims of this project are to explore the impact of multicultural orientation training on the confidence level of health care providers (HCPs) to utilize the concepts of MCO, to assess HCPs knowledge acquired during MCO training, and to explore the applicability and feasibility

of training HCPs in MCO.

Methods

Context

This quality improvement initiative was implemented with 11 health care providers that are employed in direct patient care at a large urban university hospital that is connected to 12 community health centers. The university system provides care to members of underserved communities in the most diverse county in Utah and uses integrated interdisciplinary teams of medical doctors (MD), physician assistants (PA), registered nurses (RN), and advance practice nurses (APRN). Currently, active health care providers receive limited cultural diversity training via an online learning module system (University of Utah Health Portal, 2016). The institution's geographic position, its values on client services, and its emphasis on teamwork make this an ideal institution to address cultural humility.

Intervention

Eleven healthcare providers at the university voluntarily attended a one-day pilot workshop titled "Facilitating Relationships in a Global World." Content for the workshop was partially informed by an online survey of providers' perceived interest and needs. The objectives of this workshop were to broaden providers' concept of cultural humility and to practice skills for improving effective communication with patients, students and communities in a global setting. The objectives of this workshop were (a) to increase health care providers' knowledge and awareness of cultural humility, and its positive impact on patient satisfaction and its role in providing culturally competent care; (b) to increase health care providers' self-reported confidence in using intra and interpersonal reflection and critique techniques central to cultural

humility; and (c) to increase health care providers' self-efficacy and intention to use a more culturally humble approach with clients.

The MCO training intervention was coordinated and sponsored in conjunction with the "Bridging Gaps in Global Learning and Leadership" team, which is comprised of four College of Nursing faculty and was supported by the University's Office for Global Engagement. A collaborative group of experts in educational psychology, simulation training and nursing constructed the cultural humility curriculum and modified the pre- and posttests. Pre- and posttests were constructed using content defined by Tervalon & Murray-García (1998), Carrillo (1999) and Owen et al., (2016).

Study of the Intervention

The impact and effectiveness of the facilitator workshop was measured by the collective percent change in comparing the pre- and posttests. The concepts measured in the pre and posttests included knowledge acquisition and comprehension of key cultural humility beliefs (self-reflection, self-critique and mitigation of power imbalances surrounding patient interactions) as well as the provider's self-efficacy and intent to use the practical communication skills taught within the workshop. Multicultural orientation fuses aspects of cultural humility with the innovative concepts of cultural opportunity and cultural comfort of HCPs to use the identified opportunities to integrate a patient's culture into care. The workshop defined these concepts, then guided participants through exercises to explore implicit biases and used participant experiences of uncomfortable interpersonal reactions with patients. The workshop presenter facilitated role-playing of these experiences with opportunities to practice alternative communication techniques and debriefing for participants.

Measures

The measures chosen to assess the effectiveness of the facilitator workshop were based upon the principles of cultural humility as defined by the sentinel article *Cultural Humility Versus Cultural Competence: A Critical Distinction in Defining Physician Training Outcomes in Multicultural Education (*Tervalon & Murray-García, 1998). These authors defined cultural humility as life-long commitment to a continual process of self-reflection and self-critique that uses patient-focused interviewing and a mutually respectful partnership with the patient and their community. Dr. Icek Ajzen's (2006) directive writings on how to construct a survey using his Theory of Planned Behavior was used to construct participant surveys. This data-gathering survey informed the pre and posttests that were reviewed by the "Bridging Gaps in Global Learning and Leadership" team to achieve consensus validity of the instrument.

Analysis

Knowledge on key MCO concepts was measured by a percent change in pre and post test scores on six questions. Self-reported confidence was measured on 10 pre and posttest questions using the Wilcoxon signed rank test on ordinal data points. The post-test also included written comments on the training session which were combined with the qualitative data that participants provided at the end of the training through a focus group. Semi-structured questions were used in the focus group and responses were recorded and transcribed verbatim. A qualitative researcher analyzed the data through inductive coding and categorization of frequent ideas and development of themes.

Ethics

The University of Utah Institutional Review Board approved this study. All participation in this study was voluntary. The author has no conflict of interest affecting this study.

Results

Participants included 11 female health care providers. Eight participants were from the College of Nursing, one from the Huntsman Cancer Institute, one from the Medical Laboratory Science/Pathology, and one from the Physical Therapy department. All participants completed the pretest and posttests and participated in a semi-structured interview at the conclusion of the workshop.

Survey

Comparison of six matched pre and posttest knowledge questions revealed a collective increase in participant scores by 10.6%, with a 40% increase in correctly being able to identify the three main components of MCO. The Wilcoxon signed rank test was used to compare self-reported confidence levels for each participant using 10 matched items on the pre and posttests. Using a two-tailed test ($\alpha = 0.25$), participants reported a significant improvement in confidence in four areas (1) using and facilitating self-reflection techniques with themselves (2) utilixing self-reflection techniques with peers after a challenging cultural interaction, (3) facilitating conversations around identified cultural opportunities and (4) asking patients to rate the provider using a cultural humility scale. The changes in provider confidence for the additional six statements were not significant and are outlined in Table 1.

Table 1. HCP Change in Self-reported Confidence Using MCO Training

Confidence Statements	*Sample Size (N)*	*W-value*	*Mean Difference*	*Z-value*	*Critical Value of W at $p \leq 0.05$ value*
Identifying your personal culture, biases and beliefs	5	*6*	*0.6*	-0.4045 (*nb. N* too small)	*Sample size too small to determine a critical value*
***Using self-reflection techniques after a challenging cultural interaction with a patient	7	*0*	*-2.29*	-2.3664 (*nb. N* too small)	*2*
***Facilitating self-reflection techniques with peers, team members and coworkers after a challenging cultural interaction has been identified.	6	*0*	*-5*	-2.2014 (*nb. N* too small)	*0*
Identifying cultural opportunities to discuss and incorporate a patient's cultural beliefs	9	*7*	*-3.22*	-1.8363 (*nb. N* too small)	*5*
***Facilitating conversation with patients using the identified cultural opportunity	6	*0*	*-3*	-2.2014 (*nb. N* too small)	*0*
Identifying and acknowledging the power differences between yourself and the patient with whom you are working.	5	*5*	*-1.8*	-0.6742 (*nb. N* too small)	*Sample size too small to determine a critical value*
Acknowledging and reducing these power differences on the individual level	8	*3.5*	*-2*	-2.0304 (*nb. N* too small)	*3*
Identifying power imbalances at the institutional level	8	*14.5*	*-2.88*	-0.4901 (*nb. N* too small)	*3*
Acknowledging and reducing these power imbalances on the institutional level	8	*6*	*-3*	-1.6803 (*nb. N* too small)	*3*
***Asking a patient to rate you using the Cultural Humility Scale	9	*0*	*-1.56*	-2.6656 (*nb. N* too small)	*5*
***Statistically Significant					

Focus Group

Qualitative data included a focus group and written phrases about the workshop. Focus group data consisted of one focus group with 11 participants. The themes that emerged included MCO training: value, application, adaptability, possible teaching formats, time required, method of teaching, content and challenges. These were then categorized and then developed into four themes which described the participant's evaluation of the training. Themes included (a) value of training, (2) adaptability of information, (3) means of teaching, and (4) the benefits of the workshop.

Training value. This theme, described how participants found the information in the session to be applicable, valued and replicated. They spoke of bringing the information to their

departments to be shared with a wider audience. One participant expresses this idea by stating, “I would love to see this, a version of this as either departmental or interdisciplinary.” Another participant expressed value of the content by stating, “One …I didn’t expect that this would be new information to me. I expected something completely different and I thought this was unbelievably valuable.” The idea of expanding and sharing the information was mirrored in the free text questions on the evaluation form where 9 participants made statements that they desired further application of the workshop contents along with more opportunities to for training. Most participants also thought that the content was valuable and communicated well by the presenters.

Adaptability of information. This theme explained participants’ ideas of how the workshop contents could be taught in an interdisciplinary setting or be adapted to a specific discipline and could be a good basis for an interprofessional education class. A sense of the adaptability of the workshop in an interdisciplinary setting came across clearly as one participant expressed, “I think there are some things that you could get into some discipline specific scenarios, but we’re all in this together and I think eventually there needs some interdivision or interdepartmental communication.”

Method of teaching. This theme included possible formats and methods for teaching the workshop content. Formats for teaching had many expressions and included ideas of “a full-day workshop,” an “hour or two workshops over 3 weeks,” and something that is offered “every 2 years.” In addition, a proposal was made for on-line content that could be applied later in a workshop that used scenarios. Ideas were given on a format that would give incentive with continuing education credits to faculty. Participants also presented ideas about how the teaching could be improved and this included, giving more time to concepts and practice as one participant expressed, “I could just think about the one thing and then I could learn it better.”

Other ideas included teaching faculty first, so that they could be prepared to teach students, including an assessment of faculty needs, making scenarios applicable to specific disciplines, and methods that could be used in the classroom to bring the content to students effectively.

Benefits. This theme included participants' ideas of the potential impact of the workshop contents. Participants related the timeliness of the workshop content to what is needed for students today. One participant expressed,

> "I think that doing workshops like this with faculty … can facilitate for students before they even enter into any content. About respect, relationships, listening, giving feedback. If you don't have that, it's going to be a battle the entire time".

This same participant also pointed out that if the content is ignored, faculty will not have longevity at their post. Another participant noted that feedback is very important and can benefit the teacher-student relationship if done well and faculty is not currently trained to use these techniques. In relation to the extent of benefits impacting communication, one participant stated, " I think language is huge (yeah), I mean it affects everything from how we feel about going to work, how active we are at work and how we communicate with (patients)."

Discussion

Participants overwhelming reported that training health care providers using a Multicultural Orientation (MCO) Framework was desired, applicable and feasible. Participants felt the principles of MCO were innovative, applicable in a variety of clinical encounters and could be adapted to use with interdisciplinary groups or specific health science disciplines. Additionally, health care providers (HCPs) exhibited improved self-reported confidence in self-reflection techniques and facilitating conversations with clients to incorporate the client's culture into their care. The Theory of Planned Behavior states that by altering the provider's attitude and

perceived behavioral control it is more likely that HCPs will perform the intended behavior (Ajzen, 2006). Therefore, an increase in HCP confidence and verbalized intention to use MCO training techniques with clients will translate into the actual use of these techniques.

The quality of the workshop facilitators was a recognized asset of this study reported by 7of 11 participants. Multicultural orientation (MCO) was developed at the University of Utah Educational Psychology department and a member of the designing team conducted the workshop. Participants also identified the reported relevance and importance of the components of MCO training as a strength. The trainers were not present during the evaluative focus group in order to decrease bias.

The results indicate a statistically significant increase in provider confidence that can be attributed to the MCO workshop. An increase in provider knowledge was also achieved and may contribute to the increase in participant confidence. The qualitative data reveals that providers enjoyed the topic, felt that it was important and applicable to their profession and 6 of 11 participants stated that they desired more time to practice concepts. Five of 11 participants indicated that they would like to have future workshops on MCO.

There are several recommendations for this training as a result of this pilot project. Discipline specific simulation was recommended by the focus group and further research could inform the function of inter verses intra-disciplinary workshops. Currently, there is limited research on training health care providers in MCO. In the field of psychology, MCO has equated to increased patient satisfaction, attendance to patient appointments and improved patient outcomes (Owen et al., 2016).

The possible impact of training healthcare providers using MCO could potentially improve patient compliance, patient outcomes and patient satisfaction in any field of health care.

Multicultural orientation should be considered as standard training for all HCPs and incorporated into healthcare curriculum, although, further research needs to be completed to trail the impact of MCO training on patient satisfaction and health outcomes.

The anticipated outcomes of the pilot MCO training were slightly different from the expected outcomes. The participant group was unexpectedly knowledgeable. It was not expected for (3 of 11) participants to have scored 100% on the knowledge portion of the pretest. The participants were also mostly registered nurses and advance practice nurses that attended the workshop on a voluntary basis.

The primary cost of conducting MCO training is the fees of hiring an MCO expert to conduct the training and the hours that the health care providers were required to attend the training instead of providing patient care. Participants identified HCP schedules as a challenge to completing MCO training.

Limitations

Limitations of the project included a small number of volunteer participants with homogeneity of disciplines with most participants working in the field of nursing. The participants were also all female. The convenience sampling method will lead to participants attending that already have a predisposition for possible acceptance of the information and willingness to incorporate culturally humility skills that might differ from the generalized population. Strong representation from one discipline and one gender may also distort results about MCO training's applicability and acceptability to additional disciplines and across gender lines. Another limitation of this study was the allowance of twenty minutes to conduct the focus group held at the end of the workshop. The limited amount of time could have decreased the depth and breadth of responses from participants. The focus group comments were mingled with

other content from the entire workshop, which may have confounded findings in regards to MCO training.

Conclusion

This pilot workshop demonstrated that training HCPs in this setting about MCO is desired, applicable and feasible. Multicultural orientation should be considered as a method of training that can be incorporated into health care provider continuing education as well as future health care provider curriculum. Further study is warranted and an appropriate next step in bringing MCO training to health care providers across all disciplines.

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