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# Infusion of Cultural Humility in Hospice Care: Effects of a Cultural Humility Training and Simulation Exercise on Hospice Employees

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# Infusion of Cultural Humility in Hospice Care: Effects of a Cultural Humility Training and Simulation Exercise on Hospice Employees

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This is to certify that I have examined this
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and have found that it is complete and satisfactory in all respects,
and that any and all revisions required by
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Health disparities are one of the most serious challenges facing the United States' (U.S.) healthcare system at the present time (Centers for Disease Control and Prevention [CDC], 2016). Health disparities are defined as differences in healthcare quality and outcome that are linked to racial or ethnic background, social and/or economic status, religious affiliation, geographic location, age, gender, sexual orientation (including lesbian, gay, bisexual, transgender, and queer [LGBTQ]), and disability. These differences in healthcare quality and outcomes also affect other marginalized groups that have historically experienced discrimination and oppression (Office of Disease Prevention and Health Promotion [ODPHP], n.d.).

End of life care is no exception to the ill-effects of health disparities (Haines et al., 2018; Karanth et al., 2018). While the population of U.S. continues to become increasingly diverse, its multiracial and cultural communities remain underrepresented in the hospice patient population (Du et al., 2015; Haines et al., 2018; Sammon et al., 2015; Schiovitz et al., 2015; Taylor et al., 2016). Providing quality end of life care to all individuals—no matter their race, ethnicity, religion, socioeconomic status, gender, or sexual orientation—is a matter of social justice (Reimer-Kirkham et al., 2016).

Delivery of high-quality end of life care is not feasible without the provision of culturally sensitive care (CDC, 2016). The concept of cultural humility has gained increased support in recent years as a means to improve cross-cultural care delivery within healthcare (Foronda, 2019; Foronda et al., 2016). While some authorities have called for the replacement of a more established concept of cultural competence with cultural humility, integration of cultural humility into cultural competence results in enhancement of both concepts (Campinha-Bacote, 2018).

This quality improvement (QI) project aims to improve cross-cultural care provided by hospice employees in a large urban healthcare system by encouraging adoption of cultural humility into practice. Training on cultural humility will be provided through a combination of lecture and simulation-based education, and the program outcomes will be evaluated using both qualitative and quantitative measures.

## Background

### Health Disparities

In the U.S., certain populations are disproportionately at increased risk for health conditions and have poorer health outcomes in comparison to others (CDC, 2016; Orgera & Artiga, 2020). For example, incidence, prevalence, morbidity, and mortality from conditions such as asthma, diabetes, hypertension, and heart disease are much higher in U. S. African Americans and Native Americans (Orgera & Artiga, 2020) as are maternal, neonatal, and infant mortality rates (Howell & Zeitlin, 2017; Loggins & Drumond Andrade, 2014). These differences in health outcomes characterize health disparities, which are the result of social, economic, and/or environmental disadvantages (CDC, 2016).

Racial and ethnic disparities are also prevalent in end of life care (Du et al., 2015; Haines et al., 2018; Karanth et al., 2018; Sammon et al., 2015; Schiovitz et al., 2015; Taylor et al., 2016). Researchers have demonstrated that racial and ethnic minorities in the U. S. access hospice care at lower rates in comparison to whites (Du et al., 2015; Schiovitz et al., 2015; Taylor et al., 2016). In addition, the growth in hospice use among the minorities has been slower compared to whites (Sammon et al., 2015). Disparities remain for minorities even after enrolling in hospice: racial and ethnic minorities are at increased risk of having emergency department

visits and hospitalizations; and are more likely to disenroll from hospice (Frahm et al., 2015; Karanth et al., 2018; Rizzuto & Aldridge, 2018).

**Cultural Competence vs. Cultural Humility**

For decades, the concept of cultural competence has been the cornerstone in addressing health disparities in the U.S. (Campinha-Bacote, 2018; Danso, 2018). However, a growing number of authors challenge the concept of cultural competence and its ability to solve cross-cultural challenges in the U.S. (Allwright et al., 2019; Fisher-Borne et al., 2015; Isaacson, 2014). The criticism of the cultural competence construct is based on challenging key premises that include: 1) portrayal of culture as a static monolith; 2) inconsistencies in its definitions and construct fragmentation; 3) lack of framework to address social justice issues; 4) emphasis on knowledge and skill acquisition; 5) potential for stereotyping; and 6) seeing competence as an endpoint (Campinha-Bacote, 2018; Danso, 2018; Fisher-Borne et al., 2015).

Cultural humility is often considered to be at conflict with cultural competence (Campinha-Bacote, 2018). Cultural humility places less emphasis on knowledge and skill attainment and, in its stead, focuses on lifelong learning and self-reflection (Campinha-Bacote, 2018; Foronda, 2019). Foronda and associates (2016) conducted a concept analysis of cultural humility and found openness, self-awareness, egolessness, supportive interactions, and self-reflection and critique as central attributes to cultural humility. These same authors propose mutual empowerment, partnership, trust, respect, and lifelong learning as consequences of cultural humility (Foronda et al., 2016). Cultural humility is also advanced over cultural competence by some authors because cultural humility attempts to addresses power dynamics and inequalities that lead to social injustice and inequities in healthcare (Allwright et al., 2019; Campinha-Bacote, 2018).

Praise and acceptance are not the only response to cultural humility. Danso (2018) offers a critique on cultural humility by calling attention to its limitations. Identified limitations include: 1) lack of unified definition and conceptual clarity; 2) tendency to focus on individual level practice over issues at structural level; and 3) an overlying assumption that being culturally humble automatically equates with respect for diversity. Danso (2018) defends cultural competence and its potential by stating that cultural competence is in reality a dynamic concept capable of growth and adaptation and warns that cultural humility has no actual advantage over cultural competence.

While there exists an ongoing debate about whether or not cultural humility should replace cultural competence, the most prudent choice may be to incorporate cultural humility into cultural competence. Campinha-Bacote (2018) suggests cultural humility and cultural competence enter into a synergistic relationship—a state termed "cultural competemility"—where the resulting effect is greater than the sum effects of each component. Fahlberg and associates (2016) advocate for the incorporation of cultural humility to improve conversations at the end of life as well as to guide clinicians in assisting patients and their families to make difficult decisions in a culturally sensitive manner. Finally, a theory of cultural humility has recently been developed and published by Foronda (2019) based on a synthesis of previous literature. Fronda (2019) provides a much-needed definition and clarification to the concept of cultural humility and introduces the rainbow model of cultural humility to guide in understanding of the concept.

**Use of Simulation in Cultural Competence Education**

Simulation is a well-validated method of teaching that enhances learning by application of new skills and concepts in a safe and risk-free environment (Long, 2012; Drevdahl, 2018).

The International Nursing Association for Clinical Simulation and Learning (INACSL) (2016) offers a standardized simulation design and best-practice guideline for implementing simulation-based education. Careful development of a simulation program based on the 11 INACSL-defined criteria ensures successful implementation and accomplishment of outcomes that are consistent with the program objectives (INACSL Standards Committee, 2016).

Although simulation was initially developed to assist students with mastering technical skills, current findings support the use of simulation to foster cross-cultural communication, empathy, and cultural competence (Ozkara San, 2019; Ward et al., 2018). However, it is important to consider that there are potential unintended and negative consequences related to the use of simulation-based education to teach cultural competence (Drevdahl, 2018). Great care must be provided to avoid stereotyping and "othering" of cultures when developing cultural competence education using simulation (Drevdahl, 2018). Incorporating cultural humility into the simulation helps to minimize these risks (Drevdahl, 2018). Foronda and associates (2018) assert that current simulation-based education lacks cultural humility. In addition to providing simulation scenarios reflecting diversity, these authors urge that all facilitators and students receive training on cultural humility (Foronda et al., 2018).

Debriefing is an essential and possibly the most important component of a simulation-based education (Dufrene & Young, 2014). Learning, critical reflection, and translation of theory into practice take place during debriefing (Edgecombe et al., 2013). Hall and Tori (2017) provide the best practice recommendations related to successful debriefing which include creating a confidential and safe environment; structuring debriefing based on the learning objectives; and debriefing immediately following the simulation (Hall & Tori, 2017).

## Problem Statement

Dying with comfort and dignity are basic human needs regardless of race, ethnicity, gender, sexual orientation, religious affiliation, national origin, disability, age, or socioeconomic status (Morrissey et al., 2015; Reimer-Kirkham et al., 2016). Health disparities in hospice care exist just as inequities occur and persist in the larger healthcare sphere (Du et al., 2015; Elk et al., 2018; Haines et al., 2018; Karanth et al., 2018; Sammon et al., 2015; Schiovitz et al., 2015; Taylor et al., 2016). Inability to provide culturally sensitive care contributes to health disparities and poor patient outcomes (Foronda, 2019). If the problem of health disparities remains unaddressed, then more individuals from culturally diverse backgrounds will unnecessarily and disproportionately suffer throughout the lifespan including the end of life.

## Needs Assessment

This quality improvement (QI) project focuses on cultural humility training for new hospice employees in a large non-profit healthcare organization located in the Midwest. This organization is comprised of several hospitals, nearly a hundred clinics, pharmacies, home care, and hospice services. The population demographics served by this organization, especially in the urban areas, represent diverse groups of communities including, but not limited to, immigrants and American-born individuals of East African, South East Asian, and South American descent. In this geographical area, during the last decade, the highest increase in population has originated from the traditionally-termed minority groups and this trend is expected to continue. These evolving sociocultural factors represent the urgent need for the healthcare organization to better prepare to provide care for increasingly diverse populations.

The need to improve diversity and inclusion within the organization had previously been identified by the leadership groups within the organization. In the last year, the organization has hired a Director of Diversity, and established a multidisciplinary committee. The goal in

effecting these changes is to identify the needs of the organization and to create an action plan related to diversity and inclusion.

There has been an effort to improve workforce representation of diversity and inclusion, as well as provision of implicit bias training among small groups of health care providers. This inclusionary work is ongoing and still early in development. However, this change in focus represents the organization's awareness and desire to improve care for the underrepresented and underserved communities.

As a part of the needs assessment for this QI project, data relevant to the representation of ethnic and cultural minorities within the healthcare organization and its hospice service is examined. This assessment reveals that patients of color are underrepresented in hospice care. Among hospice patients, only 2.28% are African American, 1.42% are Asian, and 1.25% are Hispanic/Latino, in comparison to the patients served by the organization as a whole who are 6.34% African American, 3.22% Hispanic/Latino, and 2.45% Asian. The existing data does not distinguish African immigrants and their descendants from African Americans, nor white immigrants from native-born whites. These are important distinctions in terms of cultural and ethnic heritage. However, the current system of racial categorization does not acknowledge these differences.

Overall, 94.53% of hospice patients are white, compared to 86.5% of the patients served by the organization. This data reveals the gap that exist in hospice care, and work that needs to be done in a variety of areas in and out of the healthcare organization in order to provide equitable care to all subpopulations represented in the larger community. Provision of cultural humility training is one way to address the readiness of hospice workers to provide culturally sensitive care to patients of all backgrounds at the end of life. Currently there is no education

regarding cultural humility within the organization, and therefore there is a need to implement cultural humility training for hospice employees.

## Purpose Statement

### PICO Question

Population: New hospice employees

Intervention: Training program on cultural humility and transcultural awareness simulation exercise

Comparison: In contrast to having cultural awareness education by itself

Outcome: Participants' understanding of cultural humility concept, and participants' openness to adopting cultural humility into hospice practice

PICO question: What is the effect of cultural humility training program and transcultural simulation exercise on hospice employees' understanding of cultural humility and their willingness to adopt cultural humility into practice?

### Project Scope, Goals, and Objectives

The scope and boundaries of this project involve a hospice agency within a large and urban Midwestern healthcare system. Target audience of this project include hospice employees of this organization and encompass hospice registered nurses (RNs), licensed practical nurses (LPNs), home health aides (HHAs), medical social workers (MSW), chaplains, massage therapists, music therapists, and volunteer coordinators.

Project goals include: 1) increase awareness of the problem of health disparities in hospice care at the end of life within the organization and in the U.S., 2) facilitate understanding of the cultural humility concept and promote its adoption among the hospice staff, and 3)

empower each new hospice employee to be a change agent in confronting social injustice within each hospice patient and family encounter.

Project objectives include: 1) education program on health disparities that exist in end of life care, 2) training on cultural humility and how cultural humility enhances cultural competence, and 3) assessment of understanding and application of cultural humility using the Cultural Competence Assessment (CCA) instrument, transcultural simulation and debriefing session, and a cultural humility survey.

## Theoretical Framework

This QI project is supported by a theory of cultural humility developed by Foronda (2019), which provides clarity to the concept and guides healthcare professionals to apply cultural humility in practice. According to Foronda, cultural humility enables healthcare professionals to anticipate the development of cultural conflicts and embrace those conflicts as opportunities.

To apply cultural humility in practice, one must first understand that cultural humility is not an end point but a process that involves self-reflection and lifelong learning (Foronda, 2019). A flexible mindset and a focus on others, as opposed to an exclusive self-focus, are needed in this construct. The five key assumptions corresponding with the cultural humility theory include: 1) all humans are diverse from each other in some way, yet part of a global community; 2) humans are inherently altruistic; 3) all humans have equal value; 4) cultural conflict is a normal and expected part of life; and 5) all humans are lifelong learners (Foronda, 2019). Additionally, Foronda describes cultural ambivalence and cultural destruction as based exclusively on the needs and desires of one’s self, resulting in unfavorable outcomes.

Foronda developed a visual model of their theory of cultural humility named the rainbow model of cultural humility. The rays of a rainbow represent the worldview of diversity and the context within which individuals and groups live. These contexts include historical precedent, political climate, personal beliefs, physical environment, and the immediate situation at hand. These defined contexts intermingle and influence the views and beliefs of individuals and groups, thereby creating discordant perspectives and power imbalances that can result in a cultural conflict.

According to Foronda (2019), when a cultural conflict emerges there also arises an opportunity to make decisions and take actions. Foronda defines three possible decisions and actions when encountering a cultural conflict: cultural humility, cultural ambivalence, and cultural destruction. The decisions and actions based on cultural humility result in lifelong learning and positive interactions, while the decisions and actions steeped in cultural ambivalence and cultural destruction result in negative outcomes (Foronda, 2019).

Foronda's theory of cultural humility provides the foundational framework upon which this QI project on cultural humility training is built. This theory on cultural humility offers a more holistic way to approach diversity (Foronda, 2019). Cultural conflicts are viewed as important opportunities for individuals and organizations to establish common goals, empower each other, and to address power imbalances (Foronda, 2019). Application of cultural humility allows healthcare professionals to be flexible, open, and self-aware so that mutual understanding and improved human interactions can take place (Foronda, 2019). Positive outcomes, such as improved communication, patient satisfaction, empowerment, partnership, respect, and health and wellness are expected as a result of applying cultural humility in practice (Foronda, 2019).

## Review of Literature

## Search Process

CINAHL and PubMed databases were used to conduct the literature search. Boolean Operation with key terms, Medical Subject Heading (MeSH), and subject heading terms were used to find pertinent sources. Articles older than 10 years were excluded from the search results, and articles within the last five years were preferred. Twelve additional sources were found from the references listed in related articles. Overall, a total of 33 relevant scholarly articles were identified and reviewed.

### *Health Disparities at the End of Life*

A literature search for background information on health disparities at the end of life was conducted using the following subject headings and key terms: *healthcare disparities, health disparities, disparities, minorities, race hospice, end of life, hospice patients, hospice and palliative nursing*, *hospice care,* and *palliative care*. This search resulted in 139 articles, and among these 25 articles were selected as applicable to the clinical question. Ten additional sources were found from the references listed in significant articles. In total, 35 pertinent articles related to health disparities in end of life were identified and 12 were included in this review.

### *Cultural Humility and Cultural Competence*

Searching CINAHL using the key term *cultural humility* produced 172 results, and eight were selected as suitable to the clinical question. Using the Boolean Operation *cultural humility* and *hospice patient, hospice and palliative nursing, hospice care,* or *palliative care* resulted in three articles and one of which was determined to be relevant to the clinical question. Finally, searching with the Boolean Operation *cultural humility* and *healthcare disparities* resulted in 12 articles, and two articles were identified as applicable to the clinical question. Searching PubMed

database with the key term *cultural humility* resulted in one additional pertinent article. In total, eight articles related to cultural humility were identified to be reviewed.

### *Simulation*

Scholarly articles related to the use of simulation and cultural humility were identified using the subject terms *simulations* and *cultural humility*. This search resulted in six articles, and among these two articles were identified as applicable to the clinical question. Searching the database with subject terms *simulations* and *healthcare disparities* resulted in 12 articles, of which two were identified as pertinent to the clinical question. Finally, using the subject terms *simulations* and *cultural competence* resulted in 45 articles and four were selected as relevant to the project. In total, eight articles related to simulation were selected to be reviewed.

### *Debriefing*

Literature search regarding best practices related to debriefing was conducted using the subject terms *debriefing* and *simulations*. Search results were further narrowed down to those pertaining to evidence-based practice. This search produced 27 results and three articles relevant to the project to be reviewed.

### *Outcome Assessment Tools*

Searching CINAHL using *cultural competence assessment* and *cultural humility assessment* resulted in 89 articles. Two articles were found to be relevant to the project and were reviewed.

## Synthesis

Thirty-three scholarly articles related to the project purpose and question were systematically reviewed and analyzed.

### *Health Disparities at the End of Life*

Several barriers to utilizing hospice are present for racial and ethnic minorities. The results of a study conducted by Carrion et al. (2014) concluded that Hispanic/Latino Americans are less likely to have ever heard about hospice and are more likely to have inaccurate information about hospice than white participants. Dillon and Basu (2016) conducted a qualitative study in which the authors interviewed African American hospice patients and their caregivers to better understand barriers and opportunities for improvement related to underutilization of hospice. Several barriers to hospice enrollment specific to African Americans were identified: 1) inconsistent health care access; 2) experiences of discrimination; 3) hospice reimbursement policies which require the patient to forego life prolonging treatments; 4) misinformation and stigma about hospice; and 5) poor communication by health care providers (Basu & Dillon, 2016).

Patients from racially and ethnically diverse backgrounds are known to have increased risk of unnecessary and aggressive care at the end of life (Check et al. 2016, Karanth et al., 2018;). In a study conducted by Karanth et al. (2018), racial and ethnic minority patients experienced increased medical encounters in the last month of their lives that were potentially preventable compared to white patients. Check et al. (2016) noted that African American women with cancer were more likely to have intensive care unit (ICU) stays, emergency department (ED) visits or hospitalizations in the last one month of their lives, and to die in the hospital compared to white women with similar conditions.

Having an advanced care directive form on file is helpful in honoring each patient's wish related to end of life care and to avoid unnecessary, costly, and often undesirable hospitalizations (Frahm et al., 2015). In studies by Frahm et al. (2015) and Taylor et al. (2016), the authors concluded that racial and ethnic minorities are less likely to complete advanced care directives

compared to whites, and therefore are at higher risk of receiving unnecessary and aggressive care at the end of life.

The authors of many studies conclude that there are significant disparities in hospice utilization among racial and ethnic minorities in the U. S. Studies conducted by Check et al. (2016), Du et al. (2015), Guadagnolo et al. (2014), Sammon et al. (2015), Schiovitz et al. (2015), and Taylor et al. (2016) compared the rate of hospice utilization among cancer patients at the end of life and found that racial and ethnic minorities utilized hospice at lower rate than whites. Similarly, Haines et al. (2018) examined the racial/ethnic and socioeconomic disparities in hospice use among trauma patients and found that racial and ethnic minority patients received less hospice care compared to white patients. In addition to the lower use of hospice care, it was also noted that the rate of increase in hospice care use has been slower among racial and ethnic minorities compared to whites (Guadagnolo et al., 2014; Sammon et al., 2015).

For racial and ethnic minorities, health disparities continue to exist after enrolling in hospice. African American patients on hospice care have significantly higher rates of ED visits, hospitalizations, and disenrollment from hospice compared to white patients (Rizzuto & Aldridge, 2018). Frahm et al. (2015) reported that African American, Hispanic/Latino, and Asian residents in long-term care facilities are significantly more likely to be hospitalized while enrolled in hospice than white residents.

### *Cultural Humility and Cultural Competence*

It is important to clearly understand and define a concept before attempting to utilize or teach it. A concept analysis of cultural humility was performed by Foronda et al. (2016) while also providing a clear definition of cultural humility. The result of the analysis of 62 articles revealed the following attributes to cultural humility: openness, self-awareness, egolessness,

supportive interactions, and self-reflection/critique. Cultural humility is represented as a way of being that strives towards transformation rooted in lifelong learning. The authors urge individuals not to be preoccupied with cultural knowledge and skill attainment, but instead to focus on embracing cultural humility so that inequities and power imbalances that exist in healthcare can be mitigated (Foronda et al., 2016).

The first and only theory on cultural humility by Foronda (2019) was developed by synthesizing the knowledge base gained from previous studies and definitions related to cultural humility. The rainbow model of cultural humility is presented as a visual representation and guide to understand the theory of cultural humility (Foronda, 2019).

Foronda (2019) assumes that cultural conflict is a normal part of human life and is to be expected. Further, applying cultural humility in cultural conflicts lead to positive outcomes such as partnership, optimal care, mutual empowerment, and mutual respect. Conversely, cultural ambivalence or cultural destruction result in negative outcomes such as inequity, oppression, marginalization, discrimination, prejudice, stereotyping, and exclusion. Foronda (2019) developed this cultural humility theory and model to be applied not only in personal levels but to be applied across groups and communities to flourish in a diverse world.

An explanation of the concept of humility is offered by Cueller (2018) who suggests that humility is on a continuum. According to Cueller (2018), on one end of the continuum is the state of having too much pride, which is characterized by narcissistic, judgmental, and oppressive behaviors. The excessively proud individual is closed off from differing perspectives and has little ability to understand or listen. At the other end of the continuum according to Cueller (2018) lies the state of humiliation, which is characterized by feelings of worthlessness;

individuals in a state of humiliation voice feeling unimportant and as if there is nothing they can offer to the world.

Finally, in the middle of the continuum is the state of humility, where there is neither too much nor too little pride (Cueller, 2018). Humble individuals have the capacity to accept their own limitations and learn from them, and these individuals engage in lifelong learning. Humble individuals also have confidence in having something to contribute to the society, while protecting space for others to contribute as well (Cueller, 2018). This state of humility concept is highly useful in understanding and applying the concept of cultural humility.

Many authors highlight the differences between cultural competence and cultural humility, and often note-the superiority of cultural humility over cultural competence. Allwright et al. (2019) and Fisher-Borne et al. (2015) offer criticism on cultural competence and advocate for replacement of cultural competence with cultural humility. Limitations of cultural competence highlighted by Allwright et al. (2019) and Fisher-Borne et al. (2015) include the assumption of culture and cultural groups as uniform and unchanging, and the disregard to the notion of intersectionality—which asserts that individuals have overlapping identities and cultural backgrounds—that predispose individuals to experience discrimination in multiple levels. Allwright et al. (2019) assert that heavy emphasis on achieving mastery in other cultures discourages healthcare providers from engaging in continual learning. When healthcare providers rely solely on cultural knowledge and skills and ignore the patients' unique individual needs, incorrect assumptions and reinforcement of stereotypes are more likely to occur (Allwright et al., 2019). Lastly, Fisher-Borne et al. (2015) note that cultural competence fails to address social justice issues.

Several authors advocated for the replacement of cultural competence with cultural humility, while others promote the incorporation of cultural humility into cultural competence. Allwright et al. (2019), Fisher-Borne et al. (2015) and Fahlberg et al. (2016) conclude that cultural competence should be replaced with cultural humility. Allwright (2019) cites the potential to perpetuate marginalization of sexually and/or gender diverse patients in healthcare as a reason to replace education on cultural competence with cultural humility education. Adoption of cultural humility is suggested as a prerequisite to connecting with and guiding patients and their families in crisis situations such as end of life (Fahlberg et al., 2016).

Not all scholars agree that cultural humility should replace cultural competence as a superior concept. In their critical reflection, Danso (2018) provides a "critique on the critiques" of cultural competence and notes that many cultural competence critiques lack analytical rigor. In defending cultural competence and its potential, Danso (2018) points out that cultural competence is a dynamic concept capable of growth and adapting to an ever-evolving society. Alluding to one of the central challenges in cultural competence, Danso (2018) suggests that the main problem with cultural competence is not the concept itself but the numerous ways in which various scholars, at times and in error, conceptualize and present the concept of cultural competence.

Danso (2018) also calls attention to the limitations of cultural humility which include: 1) lack of unified definition and conceptual clarity; 2) tendency to focus on individual level practice over issues at structural level; and 3) an overlying assumption that being culturally humble automatically equates to having respect for diversity. The author states that cultural humility has no theoretical or practical advantage over cultural competence and warns that focusing too much

on semantics only serves to distract healthcare providers from the real issues at hand (Danso, 2018).

One of the most outspoken proponents for the incorporation of cultural humility into cultural competence is Campinha-Bacote (2018), who introduced the new concept of cultural competemility. Campinha-Bacote (2018) describes cultural competemility as a synergistic process in which all five components of cultural competence—cultural knowledge, cultural skill, cultural encounters, and cultural desire—are infused with cultural humility. According to Campinha-Bacote (2018) the potential negative effects of cultural competence can be minimized when cultural humility is incorporated into cultural competence. It is also noted that a commitment to social justice becomes evident when cultural humility is fully embraced (Campinha-Bacote, 2018).

***Simulation***

Several authors indicate that simulation-based education is a favorable method to improve transcultural health care. Long (2012) reviewed current teaching strategies used for cultural competence education in nursing and noted simulation as a potentially impactful mode of teaching. In the intervening years, many authors have developed their own cultural competence education simulation models to assess the impact of simulation-based education. These studies examine perceptions of transcultural self-efficacy and empathy; changes in attitudes; and increase in knowledge, skills, comfort, and confidence in providing culturally sensitive care among nursing students (Díaz et al., 2017; Fioravanti et al., 2018; Ozraka San, 2019; Ozkara San et al., 2019; Ward et al., 2018). The authors arrive at a similar conclusion: a carefully constructed simulation-based education is an effective teaching method in nursing and

is beneficial in improving transcultural health care (Ozraka San, 2019; Ozkara San et al., 2019; Fioravanti et al., 2018; Ward et al., 2018).

Adoption of cultural humility in simulation-based education is supported by Drevdahl (2018) and Foronda et al. (2018). Recently, Foronda et al. (2018) reviewed and appraised 16 studies to evaluate the presence of cultural humility in simulation-based education and found that cultural humility was not mentioned in any of the reported simulation-based education research. As a result, Foronda et al. (2018) urges incorporation of cultural humility into simulation.

Drevdahl asserts that infusion of cultural humility is needed to overcome potential problems with simulation-based education that include stereotyping, perpetuation of biases and stigma, and "othering" of diverse groups. While the use of simulation in transcultural healthcare education has its benefits, educators must be intentional in presenting complex stories of culture and avoid presenting culture as a rigid concept only applying to certain groups. Drevdahl (2018) concludes that infusion of cultural humility in simulation-based education is beneficial because the exercise focuses on self-reflection (i.e., realization of own culture and biases) and changes in attitudes instead of knowledge and skill attainment (Drevdahl, 2018).

### *Debriefing*

Debriefing is an effective method of learning which enhances simulation by way of reflection. Systematic reviews of literature by Dufrene and Young (2014) and Edgecombe et al. (2013) both conclude that debriefing is an integral part of simulation. Other benefits of debriefing include solidification of clinical knowledge and skills; improved performance of skills; and increased self-perception of competence (Edgecombe et al. (2013).

The best-practice recommendations for a successful debrief is outlined by Hall and Tori (2017) through their integrative review of literature. A systematic review of randomized control

studies presented by Joanna Briggs Institute (2012) is included in the review. Best-practice recommendations for debriefing emerge as the following: debrief immediately following the simulation; provide a confidential and safe environment for successful debriefing; provide the debrief facilitator with appropriate training, feedback, and ongoing practice in debriefing; make sure the debrief is facilitated by the observer of the simulation; and structure debrief based on learning outcomes (Hall & Tori, 2017).

### *Outcome Assessment Tools*

Schim et al. (2003) developed the Cultural Competence Assessment (CCA) instrument. The CCA is a 25 item self-report questionnaire based on the earlier Schim and Miller's (1999) Cultural Competence Model. The scoring of CCA is based on 5-point Likert scale responses (5=always, 4=often, 3=not sure, 2= at time, and 1=never) with final scores ranging from 25 to 125, with higher score associated with higher cultural competence (Schim et al., 2003).

The CCA instrument's content and face validity were established through expert panel, subject feedback, and field testing with an interdisciplinary group of hospice employees. Construct validity of the CCA instrument was also demonstrated by establishing correlation to a widely utilized and validated instrument, *Inventory for Assessing the Process of Cultural Competence among Health care Professionals* (IAPCC) developed by Campinha-Bacote (1999) (Schim et al., 2003). The CCA is identified as one of the tools appropriate for assessment of cultural awareness and cultural sensitivity, and as having favorable test-retest reliability by Lin et al. (2017).

## Project Implementation

## Methods

### *Design*

This quality improvement project consists of three intervention components: 1) a brief informational presentation on health disparities at the end of life; 2) a training session to clarify the concept of cultural humility, and to inform the audience on how adoption of cultural humility can enhance cultural competence in the healthcare setting; and 3) a transcultural simulation exercise to implement cultural humility in clinical practice followed by a debriefing session to reflect on understanding and attitudes related to adoption of cultural humility.

There is a lack of a validated self-assessment instrument to measure cultural humility in the professional literature (Allwright et al., 2019; Foronda et al., 2018; Paparella-Pitzel et al., 2016). Therefore, this project's outcome will be evaluated using an existing instrument measuring cultural competence with components most congruent with cultural humility. The Cultural Competence Assessment (CCA) instrument was chosen based on its focus on cultural awareness and sensitivity in addition to culturally competent behaviors (Schim et al., 2003).

While the components of cultural awareness and sensitivity are not synonymous with cultural humility, the CCA questionnaire items demonstrate concepts integral to cultural humility such as openness, respect, self-reflection, and growth. Another benefit of the CCA instrument is that it is intended to be used by interdisciplinary members of healthcare systems rather than by one specific discipline and was tested on hospice workers (Schim et al., 2003). Construct validity of the CCA was demonstrated by established correlation to a widely utilized instrument developed by Campinha-Bacote (1998), the *Inventory for Assessing the Process of Cultural Competence among Health care Professionals* (IAPCC) (Schim et al., 2003). Lin et al. (2017) support the use of the CCA instrument for assessment of cultural awareness and sensitivity by demonstrating the internal consistency, retest reliability, and content validity of the CCA instrument.

A pre-and post-assessment using the CCA instrument was administered to assess potential changes, if any, in the participants' cultural awareness, sensitivity, and culturally competent behaviors. The CCA instrument was administered one week prior to the cultural humility training as a pre-implementation assessment, and administered immediately after the simulation debrief as a post-implementation assessment. A post-survey developed by this author evaluating the participants' familiarity with cultural humility, willingness to adopt cultural humility, and confidence in applying cultural humility in clinical practice was also administered at the end of the simulation.

### *Participants*

Participants included one registered nurse (RN), one home health aide (HHA), and one medical social worker (MSW) for the total of three new hospice employees.

### *Intervention*

**Cultural Humility Training.** An instructor-led, approximately 15-minute presentation consisting of three components: 1) an explanation and clarification of the cultural humility concept; 2) differentiation of cultural humility from cultural competence; and 3) how cultural humility enhances cultural competence in healthcare settings was provided at the beginning of the program.

**Transcultural Simulation and Debriefing.** Simulation-based education and debriefing are used to enhance student learning and translation of theory into practice (Foronda et al., 2018; Hall & Tori, 2017; Ozkara San, 2019). To solidify the understanding of cultural humility and explore ways in which cultural humility can be applied in practice, a transcultural simulation and debriefing took place as the third intervention component of this project. Simulation scenario and scripts were developed in collaboration with two other colleagues who bring a variety of cultural

perspectives and expertise in simulation development. Care was provided to represent culture with its complex and dynamic nature and to avoid telling a "single story" that perpetuates stereotypes. A standardized guideline for simulation design published by the INACSL Standard Committee (2016) was followed in developing this simulation. Finally, a structured debriefing session was conducted based on Hall and Tori's (2017) best-practice recommendations to facilitate self-reflection and learning from the simulation experience.

During the implementation, the bulk of the time, a total of approximately 20 minutes, was spent focusing on a transcultural simulation exercise and debriefing. An expectation that what takes place during the simulation and debrief sessions will remain strictly confidential was established at the onset. The simulation exercise involved a mock hospice patient from a background underrepresented in the current hospice patient population. Immediately following the simulation, a structured debriefing session based on the program objectives was facilitated by an instructor observer. All participants and audience participated in the debriefing session to reflect and learn from the experience.

**Data Collection and Analysis.** Quantitative data were collected using the Staff Perceptions of Cultural Humility Survey and the CCA instrument as pre-and post-program assessment. Qualitative data consisting of program reflection and comments were collected at the end of the program. The CCA and the Staff Perceptions of Cultural Humility Survey were all administered in pen-and-paper format. No individual identifiable information was collected to maintain anonymity of the results. After the conclusion of the program, all of the collected data were transferred to a digital and password protected cloud drive by hand by this author.

**Data Analysis.** Data analysis for this Quality Improvement (QI) project was limited in scope due to a small sample size of three. Resulting data was presented using descriptive statistics.

### Ethical Considerations

IRB approval from the healthcare organization where this project takes place and the educational institution associated with this author were obtained. As this is a QI project involving employees of a hospice agency, the risk of harm to individuals participating in the project were considered to be minimal. Any risk to the participants, if any, were deemed to be outweighed by the potential benefit of the project.

The American Nurses Association (ANA) provides the Code of Ethics to guide nurses in providing care that are consistent with the ethical standard of the profession (ANA, 2015). The ANA has a strong stance against discrimination and addresses the issue of health disparities as ethical and moral obligation for all nurses to confront (ANA, 2018). Additionally, the ANA upholds the position that fundamental principle of nursing lies in its commitment to protection and promotion of human rights and respect for the inherent dignity and worth of all individuals (ANA, 2016b). Finally, the ANA asseverates that nurses have the obligation to provide compassionate end of life care for all patients and their families (ANA, 2016a).

The problem of health disparities in the U.S. is rooted in ethical, moral, and social justice issues. Dying while respecting individual dignity, autonomy, and comfort are additional important ethical considerations that inform this project's goals and objectives. By attempting to improve cross-cultural care at the end of life through a training on cultural humility, this project attempts to mitigate the effects of health disparities at a hospice agency level.

## Evaluation

## Analysis Methods

Outcome variables consisted of pre- and post- assessment scores from the CCA instrument and numerical scores from the Staff Perceptions of Cultural Humility survey. The possible score range for the CCA instrument was 25 to 125, with higher score associated with higher cultural competence (Schim et al., 2003). The Staff Perceptions of Cultural Humility survey had the possible score range of 5 to 25. Main outcome of interest was the changes in the CCA instrument score from pre- and post- assessment. Question items 18 through 25 were of particular interest because these items focused on components most consistent with cultural humility. Using descriptive statistics, measures of independent variable distribution and central tendency were analyzed. Qualitative data was analyzed to identify themes.

Two independent samples t-test was not an appropriate method to use in this QI project due to a small sample size of three and the lack of a normally distributed variable outcomes. With larger sample size the use of two independent sample t-test would be useful in comparing the means of two independent outcomes.

## Results

### *Quantitative Results*

**Distribution.** Total of three participants, all female, participated in this QI project (Table 1). Age range was from 26 to 40, with one participant in 26-30 range, one in 31-35 range, and another in 36-40 range (Table 2). Total CCA scores ranged from 97 to 105 for pre-intervention and 112 to 118 for post-intervention (Table 3). For the CCA items 18 through 25 only, pre-intervention scores ranged from 28 to 40 while post-intervention scores ranged from 36 to 40 (Table 4). Finally, the scores for the Staff Perceptions of Cultural Humility survey ranged from 22 to 25 (Table 5).

| Sex | Number |
|---|---|
| Female | 3 |
| Male | 0 |

Table 1

| Age | Number |
|---|---|
| 26-30 | 1 |
| 31-35 | 1 |
| 36-40 | 1 |

Table 2

| Total scores for all CCA items | Pre-intervention | Post-intervention |
|---|---|---|
| 96-100 | 1 | 0 |
| 101-105 | 2 | 0 |
| 106-110 | 0 | 0 |
| 111-115 | 0 | 1 |
| 116-120 | 0 | 2 |

Table 3

| Total sores for CCA items 18-25 | Pre-intervention | Post-intervention |
|---|---|---|
| 26-30 | 1 | 0 |
| 31-35 | 1 | 2 |
| 36-40 | 1 | 1 |

Table 4

| Staff Perceptions of Cultural Humility Survey Score | Number |
|---|---|
| 22 | 1 |
| 23 | 0 |
| 24 | 1 |
| 25 | 1 |

Table 5

**Central Tendency.** Mean overall CCA score for pre-intervention was 101.33 points and post-intervention was 116. Median overall CCA score for pre-intervention was 102 points and post-intervention was 118 points. For CCA items 18 through 25, mean score was 33.67 points for pre-intervention and 38.33 points for post-intervention, and median scores were 33 points for pre-intervention and 39 points for post-intervention.

From pre- to post intervention, the overall CCA score average increased by 14.67 points and median increased by 16 points. For CCA items 18 through 25, from pre- to post-intervention the average score increased by 4.66 points and the median score increased by six (6) points.

### *Qualitative Results*

The most consistent response to the cultural humility training and simulation session was that participants noted the information on health disparities and historical examples of racism to have been the most surprising component of the program.

## Interpretation

This quality improvement (QI) project was limited by its sample size. The small sample size was due, in part, to slow hiring within the organization, leading to a smaller number of new hospice workers entering orientation. A second cause for the small sample size was due to the outbreak of SARS-CoV-2 which led to halting of all in-person orientation activities. Given the inherent limitations of a sample size of three, it is not possible to perform substantial analysis nor to arrive at a meaningful conclusion regarding the outcome of this QI project. Although there appears to be a trend towards overall improvement in the post-implementation CCA score, the result cannot be sufficiently analyzed nor generalized.

Without the ability to analyze or generalize, it is still possible to consider this project as a pilot and use the information thus far attained to improve the process of cultural humility training

in the immediate future. The number of participants in the cultural humility training will increase overtime as new employee orientations occur monthly and typically have four to eight participants during each orientation session.

It is also feasible to increase the number of participants in this QI project by implementing the cultural humility training and simulation for all currently existing hospice employees. Including all the current employees and not just the ones going through the orientation process would increase the overall impact of this QI project and ensure that all hospice employees were given the opportunity to go through cultural humility training and simulation.

The process of planning and implementing this QI project provided multiple insights about the challenges and opportunities facing the work on expanding diversity and cultural humility in clinical healthcare. It is clear that awareness about health disparities, both in general and in end-of-life care, is still lacking among healthcare workers. This gap points to the need for education of healthcare professionals and the general public regarding the existence of health disparities and their historical context.

There is also a noted lack of representation of workers from diverse ethnic, racial, social and cultural backgrounds in healthcare. In hospice work, it is important to include workers from the various cultural, racial/ethnic, socioeconomic, and religious backgrounds represented in the larger community. This representation would alleviate the burden felt by patients and their families who have historically had poor experiences and mistrust in health care by having their cultures and values represented in their care providers.

One positive aspect of having a small number of participants was that having a small group ensured that each participant has the opportunity to engage during the cultural humility

training and simulation. It was also encouraging to find strong support from the leadership of the health care organization for this QI project. As a result of this support, the cultural humility training and simulation will continue to be provided on an ongoing basis for hospice workers, including the existing staff, and possibly be extended to other healthcare professionals in the organization.

### Limitations

As noted under the interpretation section, having a small sample of three greatly limited this quality improvement (QI) project results and its analysis. This limitation is critical because it reduces the project outcome generalizability.

Another limitation facing this QI project was the lack of validated tool to measure cultural humility. Without a validated tool it is difficult to ascertain the impact the training and simulation had on the participant's understanding and adoption of cultural humility.

## Discussion

### Recommendations and Future Implications

Continued education of healthcare professionals regarding the pervasive and harmful effects of health disparities in the U.S. is essential. Hospice workers need increased awareness of the presence of health disparities in end-of-life care and how these disparities affect their patients. Although the objective results of this quality improvement project were insufficient to support the positive impact of the cultural humility training and simulation, it was clear that the training and simulation were well received and appreciated by the participants.

If health care professionals are to provide quality care to all patients and their families, then cultural humility is not only a desired characteristic but an essential aspect of the care.

Therefore, integration of cultural humility concepts into education and training of all health care providers is recommended.

Additional evidence on the outcome of cultural humility training and simulation would be helpful in supporting this QI project and its means to provide education on cultural humility. A larger number of participants and quantitative results would be helpful in revealing the impact of the cultural humility training and simulation on the hospice workers.

Cultural humility is described as a "way of being" and a process of lifelong learning that encompasses openness, ego-lessness, listening, self-awareness, and reflection. In regards to the lack of validated tools to measure cultural humility, it may be argued that there is no way to objectively measure such an intangible quality as cultural humility. One may also make the argument that cultural humility is a quality perceived by the person who is on the other side of the interaction. Therefore, it may be possible to measure or detect cultural humility only qualitatively: by asking the receiving end (i.e. the patient) their perception of cultural humility in the health care providers.

Hook et al. (2013) developed and used a tool which assessed the "client-rated" measure of a therapist's cultural humility. Future projects and research aimed at cultivating cultural humility in health care professionals may choose to use such an instrument which may more accurately measure the development of cultural humility.

## Conclusion

Health disparities continue to threaten health and wellness of the U.S. population and disproportionately affects groups who have historically experienced discrimination and oppression. High-quality, whole-person centered end-of-life care cannot be adequately provided to meet the needs of those served without incorporation of cultural humility.

As a QI project, this work strived to improve cross-cultural care for hospice patients by providing cultural humility training to new hospice employees. While the result of the project was inconclusive due to a small sample size, much was learned about the process of providing training on cultural humility and conducting simulation to enhance learning. This DNP-student led QI project will be considered a pilot, and the experience gained from implementing the cultural humility training and simulation will be used for the ongoing provision and improvement of the cultural humility education for hospice workers and beyond.

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