Influence of Cultural Competency Program on Bias in a Community Volunteer Program

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Influence of Cultural Competency Program on Bias in a Community Volunteer Program

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This Manuscript Partially Fulfills the Requirements for the
Doctor of Nursing Practice Program and is Approved by:

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#### DNP Scholarly Project
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Influence of Cultural Competency Program on Bias in a Community Volunteer Program

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Abstract

**Practice Problem:** Individuals may express hesitancy in volunteering in community health programs that directly interface with persons experiencing poverty due to poverty biases. Failure to understand the issues and needs of those experiencing poverty may factor into disparities and inequities along the social determinants of health, leading to poorer population health, well-being, and quality of life.

**PICOT:** The PICOT question that guided this project was in volunteers (mentors) of community health programs (P) how does a cultural competency program (I) compare to the standardized training program (C) influence bias (O) over 8 weeks (T)?

**Evidence:** An evidence review indicated poverty simulation increases awareness of personal beliefs or attitudes of the impoverished. Additionally, it provided insight into psychosocial and physical challenges experienced by them. Evidence supported that mindfulness is effective in improving concentration, processing a situation in a non-judgmental way, while anticipating activities, and preparing for an actionable response that may positively influence engagement and empathy.

**Intervention:** A cultural competency program was developed. The program included a virtual online poverty simulation and mindfulness activities implemented over 8 weeks. Participants completed the System and Individual Responsibility for Poverty Scale tool pre- and post-intervention to measure perceptions of poverty and its causes.

**Outcome:** Persons interested in becoming volunteer mentors for a faith-based vocational readiness program were the participants of this program. The results were not statistically significant. Feedback from participants provided insight that can be utilized for future program planning. The feedback included having respect for persons experiencing poverty and attempts to overcome impacting factors (i.e., psychosocial, economic, and legal).
Conclusion: This cultural competency program highlighted how perceptions of poverty can be introduced into a volunteer or mentoring orientation program within organizations that focus on improving community health. Incorporating a peer discussion component into the implementation phase is an important consideration.
Influence of Cultural Competency Program on Bias in a Community Volunteer Program

While the U.S. population continues to widen in diversity, the diversity amongst healthcare professionals is not in alignment with the country’s demographics (Marcelin et al., 2019). This can have detrimental effects on patients particularly those from underrepresented groups. This misalignment may affect patients-clinicians and interprofessional communication practices. Healthcare professionals may display prejudices, microaggressions, and stereotyping when delivering patient care (Marcelin et al., 2019). Consequently, both implicit and explicit biases can directly affect the clinical decision-making of healthcare professionals. Gullo et al. (2019) reported that implicit bias occurs when these types of sentiments and behaviors occur, and people are unaware of their characterizations or unwilling to acknowledge these thought processes exists. An example of implicit bias is ageism. Explicit bias occurs when people are aware of their beliefs and attitudes toward other people, such as having prejudice (VanPuymbrouck et al., 2020). An example of explicit bias is when people state individuals are unemployed due to their unwillingness to seek a job.

Provider preference can contribute to cultural groups’ reluctance in seeking healthcare (Mbaku, 2019; Narayan, 2019). Acknowledging the presence of bias and its impact on healthcare disparities and inequities is a key step in delivering culturally competent care. Culturally competent healthcare is defined as the delivery of integral, effectual, and safeguarded culturally sensitive care (Foronda, 2008; Mbaku, 2019; Sharifi, et al, 2019). Culturally competent healthcare is a vital component in decreasing healthcare inequities while fostering patients’ trust and promoting cultural safety. Addressing bias in health care team members is crucial. Bias impacts delivery and perceptions of care to recipients. This scholarly project was an evidence-based practice (EBP) project focused on raising awareness of bias in community health workers via the implementation of a cultural competency program that includes simulation and mindfulness.
Significance of the Practice Problem

Poverty

In a U.S. Census report, Shrider et al. (2021) announced that 37.2 million people were living in poverty in 2020, approximately 11.4% of the population. This is an increase of 3.3 million people from the prior year and a 1% increase from 2019. Poverty rates increases were observed in the following groups: non-Hispanic whites (8% rate in 2020) Hispanics (17%), age groups below 18 years of age (16.1%), ages 18-64(10.4%), married-couple families (4.7%), and female householders (23.4%) (Shrider, et al., 2021). While there was no statistical change between the years 2019 and 2020, Blacks were the highest group (19.5%) (Shrider et al., 2021). The Bureau of Labor Statistics (2021) reported for the year 2020, the annual unemployment rate at the national level was 8.1%; in Virginia was 6.2%. The unemployment rate for Richmond, VA for the same year was 6.7% (Federal Reserve Bank of St. Louis, 2020).

The Office of Disease Prevention and Health Promotion (2021) reports poverty as a prime concern within the Social Determinants of Health and Economic stability domain. Poverty results when one or more of the following entities occur: lack of income or sustainable resources, malnourishment, limited accessibility to education, basic services, social discrimination, exclusion, inability to provide input in decision-making (United Nations, n.d.). Additional risk factors for poverty are marital status, social rank, and geographic regions (rural or urban). Regardless of defining characteristics for poverty qualification, it results in an unjust position for access to resources and possibilities.

Biases

The seminal work by Jost et al. (2009) reported that biases, conscious or unconscious, affect the delivery of care in areas of education, policing, judicial system, corporate hiring, and healthcare. Globally, biases exist along lines of gender roles, race, ethnicity, religion, and sexuality (FitzGerald...
& Hurst, 2017). Bias affects people’s judgment, particularly in situations when individuals use heuristic thinking. Heuristic thinking occurs when mental shortcuts are used to make quick decisions in situations in which in-depth solution probing is not optimal (Persky et al., 2019).

Healthcare providers' usage of representative heuristics (decision-making based on mental prototypes) may introduce cognitive bias into the decision-making process (Whelehan et al., 2020). Mental prototypes are formed by an individual’s personality and categorizations and classification of people from prior experiences (Guercini & Milanesi, 2020; Hussain & Oestreicher, 2018). Prior experiences may occur in the form of vignettes (Ishfaq et al., 2020). Notably, provider bias can result in cognitive errors, particularly in circumstances involving clinical diagnosis, treatments, or interventions (Hughes et al., 2020). FitzGerald and Hurst (2017) asserted that implicit bias alters clinician-patient relationships. The more adverse the exchanges, the greater likelihood of unfavorable outcomes.

**Bias Relationship with Poverty**

FitzGerald and Hurst (2017) investigated unconscious biases in patients and their effects on their perceptions. Before actual conversations, patients expressed negative feelings about communication interactions with providers. This was attributed to prior experiences. Consequently, these perceptions may influence trust and the ability to form and maintain therapeutic relationships.

Poverty may negatively impact mental well-being. Price et al. (2018) reported those living below poverty guidelines experience feelings of inferiority and disempowerment, particularly in psychosocial capacities and the ability to have political influence. These negative perceptions of self and others may impact individuals seeking healthcare which can lead to repeated cycles of poor health and multigenerational impoverishment.

Cheek and Shafir (2020) discovered that “thick bias” perceptions exist for persons living in poverty. Thick skin bias occurs when individuals view persons of lower socioeconomic status are
influences of cultural competency program

less harmed by negative life events (e.g., lack of money for housing or food). This has implications for healthcare. Providers may neglect the needs of persons experiencing poverty leading to treatment disparities (Cheek & Shafir, 2020). Public health workers are in a unique position to advocate for the poor, serve as a resource, implement health promotion, and conduct research that examines the effects of poverty (Price et al., 2018). This includes using interprofessional practice approach that addresses social determinants of health, such increasing economic prospects vocational training (Hult et al., 2020; Olshansky, 2017).

**PICOT Question**

The clinical question for this project was: In volunteers (mentors) of community health programs (P) how does a cultural competency program (I) compared to the standardized training program(C) influence bias (O) over 8 weeks (T)?

**Population**

The population for this project was community volunteers (church parishioners) in a faith-based vocational readiness program. The practice setting was a church in Richmond, Virginia. Historically, these volunteers have provided financial support to the program with limited engagement with its participants. The church’s outreach ministry and agency goals were to enhance the active engagement of its volunteers with program participants.

**Intervention**

Healthcare disparities, as defined by the Centers for Disease Control, are differences in areas of disease burden, injury, and violence by those who are socially disadvantaged (Center for Disease Control and Prevention, 2022). The agency reported poverty, individual and societal health behaviors, poor access to healthcare, and environmental challenges are causative factors to health disparities.
Jones-Burkes (2020) points out that healthcare providers and community health workers have an opportunity to improve health equity amongst the disadvantaged by providing holistic care while eliminating those barriers to care and biases. Biases, if not addressed, will impair healthcare professionals' ability to provide care that is compassionate, empathetic, and authentic. As a result, program recipients may feel detached, withdraw from the program, or fail to develop a therapeutic relationship with their healthcare team. Consequently, health disparities may continue.

The Institute for Healthcare Improvement (2017) reported that the implementation of an evidence-based bias program has been demonstrated to change organizational decision-making and healthcare practitioners' behaviors. These types of programs may help in alleviating any unfavorable effects of implicit bias. This is noticeable in staff hiring and promotions practices, correspondence, treatment conventions or suggested treatment alternatives, or choices for pain control.

The Institute for Healthcare Improvement (2017) presents six strategies healthcare organizations can incorporate into their culture. These techniques will assist healthcare professionals in reducing implicit bias: stereotype replacement, counter-stereotypic imaging, individuation, perspective taking, increasing intercultural contacts, and partnership building. Stereotype replacement occurs when individuals change responses after admitting initial thoughts are formed by stereotypes. Counter-stereotypic imaging involves using mindfulness to perceive people in an opposite manner of the stereotype. Individuation occurs when a person is viewed as a unique being. Perspective-taking entails being empathetic. Increasing intercultural contacts occur when a person expands one’s social circles or by participating in activities where persons of different racial and ethnic groups, gender identities, sexual orientation, and other groups are in attendance. Partnership building reconceptualizes the interaction with the patient as collaborative
instead of hierarchical. Each person is viewed as an equal during the conversation versus discussing a high-status person and a low-status person.

**Comparison**

The project compared the current processes and practices of this agency’s mentor training. Historically, mentors are provided with a 1-day training orientation that reviews program expectations and mentor roles and responsibilities. The orientation session reviews the program’s curriculum and students’ goals for the experience.

**Outcome**

The project measured differences in perception in certain socio-economical areas that are often associated with bias. A post program survey measuring differences in perceptions of identified socioeconomic areas was completed.

**Timeline**

The project’s timeframe was approximately 8 weeks. Baseline measurements were captured at the beginning of the implementation period using a pre-intervention survey. Participants were enrolled in a cultural competency program. A post-program survey was conducted to measure any differences in perceptions of identified socioeconomic areas.

**Evidence-Based Practice Framework and Change Theory**

Evidence-Based Practice (EBP) is a composite of exemplary nursing care based on interventions vetted via thorough evidence review (Li et al., 2019). The Johns Hopkins Evidence-Based Practice Model for Nurses and Healthcare Professionals [JHEBPM] is produced by the Johns Hopkins Nursing Center for Evidence-Based Practice, in collaboration with the Johns Hopkins Department of Nursing. The JHEBPM is a widely adopted EBP model that methodically integrates contemporary research findings quickly into clinical nursing practice using user-friendly tools (Brooks-Staub, 2005).
The JHEBPM comprises of a practical, three-phase process (Johns Hopkins Medicine, n.d.). The three-phase process entails identification of the practice question, compilation of the best supportive evidence to address the practice question, and translation of the evidence into clinical practice (PET) (Dang et al., 2022). The JHNEBPM has 20 steps within the PET Process. The process begins with the Practice Question phase. The Practice Question phase comprises seven steps: describing the EBP problem, developing the EBP question, substantiating the EBP project, recruiting an interprofessional team, establishing project leadership, identifying stakeholders, and scheduling team meetings. The second process area is the Evidence phase, which comprises five steps: acquiring evidence, appraising individual evidence for level and strength, condensing the evidence, synthesizing evidence, and making recommendations for a practice change. The third phase, Translation, entails eight steps. The steps include identifying an appropriate practice setting, establishing an action plan, ensuring support, implementing the action plan, analyzing results, reporting outcomes to stakeholders, formulating the next moves, and disseminating findings.

The student as project manager employed this EBP model in a faith-based community health ministry. The JHEBPM guided the development of bias awareness training for volunteers which promoted increased engagement as champions caring for the impoverished in finding meaningful work. The organization reports having meaningful work contributes to renewed self-identity which may improve the recipient’s emotional health (Evangelical Council for Financial Accountability, 2021; Jobs for Life, 2020). Agency leadership provided endorsement and resources to implement the project. University representatives provided guidance and administrative oversight. The project manager’s action plan included engaging key stakeholders. This promoted support, collaboration, and value which aids in early adoption and sustained change beyond the project (Ndonye et al., 2021).
Change Theory

Bridges Transition Model was the selected change theory for this project. This theory, developed by Dr. William Bridges, focuses on change via interpersonal and humanistic lenses (Campbell, 2020). It specifies that individuals experience a change in three stages: endings, neutral zone, and beginnings. People need time and support from leadership as they transition through each phase. This transition period allows for the integration of new ways so that changes are sustainable. The initial stage of change is called endings. The endings stage comprises bereavement and self-inventory. During this phase, individuals perform a self-reflection which consists of examining prior and current ways of being or doing. Individuals may express a sense of loss due to relocating and restructuring relationships and processes. The second stage, known as the neutral zone, occurs after loss is accepted and new processes are started. Individuals may have many concurrent feelings such as anxiety and disconcertment. The third stage, new beginnings, starts when individuals experience a new identity. During this stage, there is a renewed sense of purpose that includes new roles and responsibilities. Individuals may report vigor. During this period, the agency will incorporate bias reduction into its onboarding processes. By the project’s end, the program expected to experience an increase in the number of volunteers and participants, the number of volunteer hours, and an increase in participant attendance rate.

Evidence Search Strategy

An electronic literature search was conducted using University resources. The evidence search included key concepts and descriptors relating to the PICOT question. The search included a variety of search techniques using various databases. Salvador-Oliván et al. (2019) found using a variety of search strategies supports diminished error rates while optimizing the evidence quality. The following electronic databases were used in this process: American Psychological Association Psych Info, Cumulative Index to Nursing and Allied Health Literature (CINAHL) Complete,
EBSCOhost, Google Scholar, MEDLINE Complete, ProQuest, and PubMed Central. Keywords employed in initial searches were bias, cultural competency, recognition, management, strategies, and poverty attitudes measurement. Alternate terms "unconscious," "subconscious," and "transformative learning” were applied within different databases during advanced searches. The Boolean operator “AND” was paired with keywords or alternate terms. The operator “OR” was used with the following phrases “management,” OR “strategies.” This process assisted with refining results and affirming inclusion/exclusion criteria. The inclusion criteria were English studies, peer-reviewed articles, government entities’ publications, and published works from January 1, 2017, to the present period. Seminal works were also included. Exclusion criteria comprised of non-English-language and trade publications. A hand search of reference lists captured any relevant studies. Results included full texts and abstracts.

**Evidence Search Results**

An online search utilizing keywords and operators from the selected databases was conducted using the University of St. Augustine for Health Sciences Library and PubMed. Keyword searches were conducted using the Google Scholar website. The search produced 855 records. These results were prescreened for the presence of duplicates and pediatric articles. After the removal of duplicates and pediatric-focused articles, 699 articles were screened for inclusion qualifications. Abstracts and seminal works were included in the screening pool.

The exclusion criteria were expanded to omit articles that presented bias assessments and interventions in non-health settings, matters, or by non-health professionals, for example, school admission and grading policies and procedures, workplace recruitment and hiring practices, legal cases, beauty, or fashion competitions. This narrowed the search to ten articles applicable to the topic. A Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow diagram outlining the evidence selection process is presented in Figure 1.
The JHEBP model (Dang et al., 2022) was used for appraising the level of the evidence presented in the 10 articles selected. The three articles on strategies employed to raise awareness of bias received the following ratings Level V, Grade A, Level V, Grade B, and Level I Grade A. Three articles on activities that raised awareness of poverty received rating Level II Grade B, Level III Grade B, and Level III Grade A. One article on poverty simulation scored a Level III, Grade A Rating. The SIRP scale article (reviewing predictive validity) received a Level III, high-quality Grade A. Two systematic reviews scored Level II, high-quality grade A. The first article addressed virtual simulation (VS) and the second article examined effectiveness of various interventions aimed at decreasing implicit bias. Appendices A and B outline the evaluation and summary of the primary research and systematic review of evidence.

**Themes With Practice Recommendations**

An analysis of the literature illuminated several themes related to the PICOT question. The themes focused on increased awareness of bias, VS, and mindfulness. The VS assisted in increased awareness of perceptions of poverty and its impact on daily living in populations of lower income levels. Mindfulness was identified as a strategy that is used to change self-perception. Perceptions on poverty were measured using the SIRP instrument.

**Increased Awareness**

Interventions that contain activities having high involvement, and evaluative conditioning (e.g., games involving selected groups participating in identified good things or bad things) have shown to reduce implicit prejudice (Fitzgerald et. al, 2019; Lai et al. (2014) seminal works. Gonzalez (2021) indicates introducing activities that purposely induces discomfort in a safe learning environment have been utilized with positive effects in programs aimed to recognize and manage implicit bias. Safe learning environments are “brave” spaces in which sensitive conversations can occur. The author reports these spaces have privacy and confidentiality rules
established at the onset of the activity by a facilitator that normalizes bias and role models empathy and vulnerability. Normalizing bias fosters trust, encouragement, and engagement. This assists in reduction of self-blame, which in turn, offers self-compassion and self-forgiveness. Program activities should incorporate acquiring new skills and abilities that acknowledges bias presence yet will not allow the bias thinking to influence clinical practice behaviors. Additionally, the selected activities should encourage questioning of a person’s prior perspectives regarding a specific subject. These new viewpoints serve as catalyst for paradigm changes. Additionally, works by Gatewood et al (2019) have shown that program offering participants interactions coupled with preparatory learning activities show an increase implicit bias awareness and its adverse influence on health outcomes. Tools that evaluate implicit prejudices may be used and adapted to fit program needs in which there may be assessment of attributes, attitudes, or willingness to participate in events that may discuss or include topics related to implicit prejudices poverty in community programs (Cattaneo et al., 2019, 2021).

**Simulation**

VS is an example of a perspective building intervention that offers an opportunity to view the impact of a lived experience (Gonzalez, 2021). The author indicated perspective building activities are effective in demonstrating how standard practices and procedures interpretation may vary based on an individual’s sensitization to bias. Chae et al. (2021) reported that VS improved access to diverse cultures, specifically in scenarios involving marginalized populations. Additionally, VS provided learning opportunities for developing social and decision-making skills in areas of communication, team building, and exercising clinical judgment. The authors report that VS has enhanced cultural competence while giving positive satisfaction to users.

Engler et al. (2020) found poverty simulation increased awareness of the personal beliefs or attitudes of others. Poverty simulation raises awareness of negative feelings such as victim-blaming
(e.g., lack of morals) that occur when individualizing causes of poverty. Periodic poverty simulation may strengthen structural explanations of poverty over time. Loomis and De Natale (2017) indicated simulation provided insight into the psychosocial and physical challenges of those experiencing poverty. Consequently, poverty simulation enhances providers' practice by providing better poverty-informed care and advocacy acts (Engler et al. 2020; Loomis & De Natale 2017).

**Mindfulness**

Mindfulness is a purposeful awareness of the current state and experiencing the moment in a nonjudgmental way (National Center for Complementary and Integrative Health, 2022).

Practicing mindfulness provides an opportunity to analyze perception processes pre- and post-events. Mindfulness enhances the ability to concentrate, process current situations, anticipate activities, and prepare for an actionable response (Popescu, 2022). Mindfulness has been linked to positively influencing engagement and empathy (Lai et al, 2014; Perez-Fuentes et al. 2018).

**SIRP**

Shor et al. (2018) developed the SIRP in 2017. The SIRP tool is a validated tool that has been used in multicultural experiences designed to increase awareness of systematic causes of poverty while decreasing inferences of individual blame. Individual blame occurs when people attributed the causes of poverty to factors occurring within the individual, for example, laziness (Engler et al., 2020). The SIRP instrument measures perceptions of poverty as relates to poverty causation originating at individual and societal levels. It measures perceptions of ability to overcome poverty at the individual level.

**Practice Recommendations**

After a thorough review of literature, the recommendation was to implement a program aimed at increasing bias recognition using VS and mindfulness interventions. Participants complete a pre and post intervention survey using the validated SIRP tool. The evidence supports poverty
simulation and mindfulness are appropriate strategies for a bias training program. At minimum, they raise awareness to bias presence, in oneself and others (Gopal et al., 2021) They strengthen structural explanations for poverty, heightening awareness of structural challenges experienced by those in poverty, building empathy and trust, promoting shared decision making between patient and clinician, while reducing thick skin bias (Engler et al., 2020; Pérez-Stable & El-Toukhy 2018; Cheek & Shafir, 2020). Implications for practice are enhanced poverty-informed care, improved patient-clinician communication, and engaged advocacy endeavors, particularly in public service settings while reducing thick skin bias (Cheek & Shafir, 2020).

**Setting, Stakeholders, and Systems Change**

The project setting was a non-profit Christian vocation readiness organization in the metro region of Richmond, Virginia. The church supports various ministries that includes childcare, special needs, youth, and an internship program for young adults. Additional outreach opportunities for adults include monetary management, faith-building, church orientation, and engagement classes. The site offers various means by which members may serve within the church.

The organization’s mission aims to prepare Christian associations with skills and abilities that will assist the unemployed and underemployed to foster a path to purposeful sustainable employment via training and relationship building (Jobs RVA, n.d.). This is accomplished using a network partnership approach.

**Organizational Structure**

The company's network approach entails instructors, and mentors (champions) partnering with a community site to provide a job training program. Job readiness training program participants are underemployed or unemployed. The individuals have diverse backgrounds such as military service, incarceration, immigration, homelessness, substance, and physical abuse. Typical mentors are faith-based volunteers who are working or retired professionals in middle adulthood.
The job training readiness program consists of pairing a mentor with a participant during a 16-class series. The curriculum consists of creating a vocational plan, completing an employment assessment, preparing a resume, building interpersonal communication and interview skills, and conducting mock interviews with community business leaders. Mentors work to ensure the program requirements are met. Program participants meeting attendance and assignment criteria receive a certificate at a graduation ceremony. The community site provides a fellowship meal to participants and mentors at each lesson. The organization has 12 community sites around the Richmond, VA area.

**Stakeholders**

Concept mapping revealed the identification of the project’s stakeholders. The project’s stakeholders were the agency’s network director, board members, staff, site (church), pastors, elders, deacons, outreach minister, parish nurse, administration, staff, group leaders, and congregation. The project’s support was garnered via virtual meetings with the stakeholders reviewing the proposed practice change.

**Organizational Need and Support.**

Based on the needs of the organization, the agency’s network director recommended a cultural competence program. The organizational endorsement was obtained from the agency’s network director to implement a program that assesses bias using the SIRP Scale. The project manager developed a collaboration between the network director and the site’s outreach minister.

**Sustainability**

The plan for sustainability included continued site participation in addition to the inclusion of other community sites. Sustainability involved the agency network director infusing this program within the new mentors’ orientation training. This EBP project was a micro-level system change as it affected the mentors’ views on poverty when working with job training participants. The project
offered potential to have meso and macrosystem changes. Meso changes entailed its use within the job training agency’s mentor onboarding and retention process. The agency network director may incorporate this cultural competency program in the new mentor orientation in addition to periodic mentor training. Additionally, at the macro level, systems changes may occur if the cultural competence program implemented within other community health volunteer training programs working with the impoverished.

**SWOT Analysis**

An organizational needs assessment was conducted using interviews, observation, and completion of a Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis. SWOT analysis aids in identifying internal and external factors that may impact the ability to make program (micro to mesosystem) changes in addition to sustainability (Benzaghta et al., 2021). Appendix C outlines the SWOT analysis.

**Implementation Plan with Timeline and Budget**

**Project Objectives**

The project's purpose was to decrease bias among volunteers within a faith-based vocational readiness organization. This was in alignment with the agency's mission to equip Christian associations with skills and abilities to assist the underemployed and unemployed in mapping a pathway to sustainable employment. To meet the project’s goal of creating an evidence-based cultural competency program, the following objectives were established:

- After the project, participants completed a cultural competency program that consists of a baseline survey, intervention, and evaluation of impact.

- Within 2 weeks post EBPC approval, recruitment occurred amongst volunteers to participate in the program.
• After the project, an analysis of data occurred and a plan for the dissemination of results was shared with stakeholders.

• After the project, a sustainable plan was initiated within the sponsoring agency.

A schedule of the project’s activities was used to determine if the proposal’s objectives were met. The project’s timelines listed in Appendix D reflect the development of the cultural competency program, including initiation, and evaluation means. The activity schedule outlined the timeframe for approval by the university’s EBPC council, communication with pertinent project members, dissemination of findings, in addition to a collaboration plan with the agency for sustainability.

**EBP and Change Model**

The JHEBP evidenced-based practice model and Bridges Transition change theory guided this recommended practice change. The JHEBP model three-phase process identified bias relevance in community health workers, diagrammed systematic literature review and evidence appraisal means, in addition to outlining the practice change.

The Bridges Transition Model interpersonal and humanistic perspective provided the foundation for introducing awareness of bias presence and its impact, in addition to the poverty simulation and mindfulness interventions. To ensure effective and sustainable practice change, the project manager collaborated with agency and church leadership during each stage of change. The initiation meeting with the volunteers and champions hallmarked the ending stage. The project manager used encouragement, motivation, and positive feedback for short-term gains to move participants through the neutral zone, which consists of people feeling anxious and having skepticism. The interventions were initiated in the neutral zone stage. As participants completed the interventions, program, their renewed energy, and commitment was rewarded by the project manager via a thank-you measure. This marked transitioned into the new beginnings stage. The
project manager assessed the site’s preference for recognition. During this stage, the site integrated the cultural competency program into its volunteer orientation schedule.

Interventions consisted of utilizing a toolkit that contained a protocol on how to complete the program’s interventions (VS and mindfulness activities), a data collection tool, evaluation tools (SIRP), poverty simulation instructions, mindfulness experience instructions, welcome letter, and a reminder call template. Figures 2, 3, 4, 5, and 6 contains images of the toolkit, protocol, instructions for poverty simulation and mindfulness, welcome letter, and a reminder call template.

The welcome letter identified the job readiness organization, instructions for completion of the survey pre and post activities. The letter provided an overview of activity portion of the program consisted of completion of the virtual poverty simulation and a mindfulness meditation activity. The VS, “Making Tough Choices” was adapted from the United Way’s Asset Limited, Income Constrained, Employed (ALICE) research initiative that explores the financial difficulties of low-wage individuals and families (United Way, n.d). Additionally, participants participated in a mindful meditation activity.

Utilizing a timeline and budget was key to ensuring the project met its scope. The budget consisted of office supplies for recruitment, and reporting of surveys, food, and condiments for initiation and celebration, in addition to a statistician. The budget is presented in Table 1.

**Evaluation**

The project manager collaborated with the agency’s network director and the church’s outreach minister in developing an implementation strategy. The program implementation included a recruitment plan that consisted of periodic church announcements by the pastoral staff during services and postings in the church’s newsletter. Additionally, the project manager overviewed the project and addressed questions and concerns at the site’s initiation meeting.
Project recruitment began after obtaining approval from the university's EBPC committee and agency approval. The agency's network director served as a champion for the project. This was a key component of the successful implementation of the program. The project manager provided periodic updates to the agency’s network director who shared findings with the pastoral staff. This process ensured timely communication with pertinent organizational stakeholders. Data collection and analysis were conducted by the project manager. Data security risks were mitigated by assigning each participant a random unique number. The survey results were secured in a locked cabinet by the project manager. This process minimized HIPAA concerns.

Program participants consisted of those aged 18 interested in volunteering. Program participants' demographics were collected at the program’s onset. The demographic information collected included gender, ethnicity, highest educational level, and annual household income. A copy of the demographic information collected is presented in Appendix G. Intellectus Statistics software was used to perform a descriptive statistical analysis. Participants' demographic data were analyzed using frequencies and percentages. Frequencies and percentages are presented in Table 2. The most frequently observed Gender category was Female \((n = 13, 44.83\%)\). The most frequently observed Ethnicity category was White \((n = 13, 44.83\%)\). The most frequently observed category of the Highest Education Level category was Bachelor's Degree \((n = 14, 48.28\%)\). The most frequently Annual Household Income category was $50,001 to $75,000 \((n = 8, 27.59\%)\).

The SIRP Scale was utilized to measure the project’s outcome. The SIRP is a validated tool developed in conjunction with researchers at George Mason University. Research studies report that SIRP is an accurate tool for measuring a person’s attitudes regarding the causes and sustainment of poverty (Shor et al., 2018). The (SIRP) Scale is a 17-item self-reported questionnaire using two scales: Individual Blame and Systems Blame. The Individual Blame Scale component consists of two subscales: Individual Blame-Being in Poverty Subscale (4 items) and Individual Blame-Not
Getting Out of Poverty Subscale (4 items). This area measures causal attitudes towards persons in poverty, as relates to individual behaviors that may contribute to being impoverished. The Individual Blame–Not Getting Out of Poverty Subscale measures perceptions in terms of a person’s ability or willingness to come out of poverty. The Systems Blame Scale component has 9-items. The questionnaires measure causal poverty attributes in areas of socioeconomic factors.

The SIRP Scale uses a 5 Likert Scale 5-item Likert scale (from 1 = "strongly disagree" to 5 = "strongly agree"). Participants completed the SIRP pre- and post-intervention. Participants were requested to respond to each question. The total score for each participant was obtained by summing each response provided using the numerical values assigned via the Likert scale. The project manager obtained permission to use SIRP. Appendix E contains permission information. A copy of SIRP is found in Appendix F.

Individual scores were calculated by summing the responses from the Subscales. Scores were analyzed by comparing each participant total score pre and post intervention. Individual responses that did not include pre-and post-intervention survey completion were extracted and not included in the data analysis. A two-tailed paired samples t-test was conducted to examine the mean differences of the pre and post SIRP scores. Results were not statistically significant (p = .264); however, clinical significance was demonstrated in understanding the value of the participants perceptions of poverty. Findings are presented in Table 3.

Impact

Implementation of this cultural competency program raised awareness that individuals have varying perceptions of persons experiencing poverty. Although there was no statistical significance between pre and post interventions scores amongst the various demographic groups, the program supports there is value in ascertaining perceptions of poverty for those interested in volunteering for the program. Program participants provided anecdotal feedback on their views of the causes and
humanness of poverty in addition to approaches to alleviating it. Specifically, participants indicated they have gained respect for those experiencing poverty and trying to overcome social inequities, economics, and laws that contribute to its prevalence. There was feedback that revealed a myriad of thoughts on how poverty can be alleviated. Participants expressed that having a ministry would be helpful, yet participants indicated educational programs may be more beneficial. There was no mention of a specific education program or method. Two of the program participants reported the program inspired them to serve in the program or ministry afterward. The participants discussed the program material. People reported that the videos were helpful and recommended others view them. One participant reported that poverty simulation was not tailored to the state of Virginia and that was not helpful as they were unable to relate to the issues experienced. Another program participant relayed the case scenarios in the poverty simulation issues were nonsensical and unrealistic. An individual commented that the person in the poverty simulation might have been able to experience all those issues simultaneously.

**Limitations**

Program participants were self-selected. The reasons for declining to participate were not collected. There was a time constraint. There were limited abilities to be onsite at the church due to the COVID-19 pandemic, resulting in many aspects of the program being conducted virtually. These factors, in addition to the asynchronous structure, limited the ability to have multiple group activities. There were no honorarium, lunch, or appreciation gifts offered to program participants. These activities, or lack thereof, affected the communication and engagement of participants. Before this program, the agency offered an interest meeting for those wanting to volunteer and periodic meetings with partner organizations. There was no prior data available from those interest meetings for comparison.
Considerations for the sustainability of the program included addressing the limitations. A protocol option to incorporate the SIRP Scale, a poverty simulation exercise, and mindfulness videos during future interest meeting was proposed. The program may offer a longer implementation period, participants' enrollment in phases, and virtual group discussion sessions after a brief period post-completion of the SIRP Scale Survey and interventions. The agency discussed incorporating the program into its new champion volunteer orientation to raise awareness that poverty bias exists. The team discussed how raising awareness may impact volunteers’ readiness, availability and communication style when working with job readiness students. The agency considered adding a face-to-face group discussion component to this cultural competence program. The program may add more spiritual-based ministry videos which focus on volunteering tailored toward perceptions views on poverty and volunteering. Community-based partnerships that utilize these types of EBP programs to address various sectors (i.e. Bias) influencing health are in alignment with the proposed Healthy People 2030 (United States Department of Health and Human Services (2021, October 27) initiative. Healthy People 2030 encourage use of simulations and game to measure population level interest in addressing Leading Health Indicators (e.g. Social Determinants of Health). The agency may consider applying for any eligible available public or private funding to support this program.

**Dissemination Plan**

The project’s results were shared with key stakeholders within the agency, church leadership, ministry leaders, and the professional community. At the facility level, a meeting was held with the preceptor and network director to review the project’s findings. Due to the COVID-19 pandemic, onsite meetings with church board members, pastors, and outreach ministers did not occur. The network director updated the project’s findings to the sponsoring agency and church leadership team. A summary of the project was shared with the Bon Secours St. Mary’s Faith
Community Nursing Coordinator which provides parish nurses with continuing education and network opportunities in the greater Richmond, VA area. A manuscript was prepared for submission to The International Journal of Faith Community Nursing. An abstract was prepared for submission for the annual Virginia Nurses’ Association conference.

The manuscript was submitted to the university’s course faculty and the library services for publication to SOAR@USA, the repository for students’ scholarly projects.

A virtual poster presentation occurred at the Alpha Alpha Alpha Chapter Sigma at USAHS DNP Scholarly Project Symposium in August 2022.

**Conclusion**

Bias testing, poverty simulation, and mindfulness have been demonstrated to have a positive impact on persons’ perceptions when providing healthcare to those who are impoverished and to those who are of diverse cultural groups (Cattaneo, et al., 2019; Engler, et al., 2020; Perez- Fuentes, et al. 2020). The EBP project aimed to develop a cultural competency program that encompassed assessing bias pre- and post-interventions. The interventions consisted of assimilating real-world choices of persons having limited incomes, in addition to performing a mindfulness activity that enhances participants' self-awareness of perceptions as relates to caring for those who may be experiencing poverty. Results of the data analysis conducted were integrated into a new orientation protocol that will be used by the agency when onboarding new volunteers serving as champions within the job-readiness program.
References


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Loomis, J., & De Natale, M. L. (2017). Teaching compassion for impoverished patients through simulation. *Nursing, 47*(8), 20–23. https://doi.org/10.1097/01.NURSE.0000521039.35454.09


Table 1

**Budget**

<table>
<thead>
<tr>
<th>EXPENSES</th>
<th>REVENUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct</td>
<td></td>
</tr>
<tr>
<td>Food and Condiments</td>
<td>125   Grants</td>
</tr>
<tr>
<td>Supplies &amp; Printing</td>
<td>100   Institutional budget support</td>
</tr>
<tr>
<td>Services</td>
<td>Statistician</td>
</tr>
<tr>
<td>Indirect</td>
<td></td>
</tr>
<tr>
<td>Overhead</td>
<td></td>
</tr>
<tr>
<td>Total Expenses</td>
<td>375   Total Revenue</td>
</tr>
<tr>
<td>Net Balance</td>
<td></td>
</tr>
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</table>
### Frequency Table for Demographic Variables

<table>
<thead>
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<th>Variable</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-29</td>
<td>2</td>
<td>6.90</td>
</tr>
<tr>
<td>30-39</td>
<td>4</td>
<td>13.79</td>
</tr>
<tr>
<td>40-49</td>
<td>5</td>
<td>17.24</td>
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<tr>
<td>50-59</td>
<td>9</td>
<td>31.03</td>
</tr>
<tr>
<td>60-69</td>
<td>5</td>
<td>17.24</td>
</tr>
<tr>
<td>70-79</td>
<td>2</td>
<td>6.90</td>
</tr>
<tr>
<td>Missing</td>
<td>2</td>
<td>6.90</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
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<td></td>
</tr>
<tr>
<td>Male</td>
<td>12</td>
<td>41.38</td>
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<tr>
<td>Female</td>
<td>13</td>
<td>44.83</td>
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<tr>
<td>Non-binary/third gender</td>
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<td>0</td>
</tr>
<tr>
<td>Prefer not to answer</td>
<td>3</td>
<td>10.34</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>3.45</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
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<tr>
<td>Asian Descent</td>
<td>1</td>
<td>3.45</td>
</tr>
<tr>
<td>Black or African American</td>
<td>9</td>
<td>31.03</td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Native American</td>
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<td>0</td>
</tr>
<tr>
<td>White</td>
<td>13</td>
<td>44.83</td>
</tr>
<tr>
<td>Prefer not to answer</td>
<td>5</td>
<td>17.24</td>
</tr>
<tr>
<td><strong>Highest Education Level</strong></td>
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</tr>
<tr>
<td>High School Graduate or GED</td>
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<td>3.45</td>
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<tr>
<td>Some College</td>
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<td>20.69</td>
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<tr>
<td>Associate Degree</td>
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<td>3.45</td>
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<tr>
<td>Bachelor’s Degree</td>
<td>14</td>
<td>48.28</td>
</tr>
<tr>
<td>Graduate Degree (Master’s or Doctorate)</td>
<td>6</td>
<td>20.69</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>3.45</td>
</tr>
</tbody>
</table>

*Note. Due to rounding errors, percentages may not equal 100%.*
### Table 3

Two-Tailed Paired Samples *t*-Test for the Difference Between SIRP Scores Pre-Intervention and Post-Intervention

<table>
<thead>
<tr>
<th>SIRP Score Pre-Intervention</th>
<th>SIRP Score Post-Intervention</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$M$</td>
<td>$SD$</td>
<td>$M$</td>
<td>$SD$</td>
<td>$t$</td>
</tr>
<tr>
<td>3.19</td>
<td>0.37</td>
<td>3.28</td>
<td>0.43</td>
<td>-1.15</td>
</tr>
</tbody>
</table>

*Note.* $N = 24$. Degrees of Freedom for the $t$-statistic = 23. $d$ represents Cohen's $d$. 
Figure 1

PRISMA Figure

**PRISMA**

Identification

- Records identified from*: Databases (n =855), Registers (n = 0)

Screening

- Records screened (n =699)
- Reports sought for retrieval (n =52)
- Reports assessed for eligibility (n = 49)

Included

- Studies included in review (n = 1)
- Reports of included studies (n =5)

Records removed before screening:
- Duplicate records removed (n =76)
- Records removed for other reasons (n =110)

Records excluded** (n =647)

Reports not retrieved (n = 3)

Reports excluded:
- Non-health setting (n =23)
- Non-Health professional (n =20)
Figure 2

Toolkit
Figure 3

*Protocol*

<table>
<thead>
<tr>
<th>Purpose:</th>
<th>The protocol serves as a guideline for implementation of a cultural competency program by the Jobs RVA team. The cultural competency program can be conducted at a community site interested in recruiting volunteers to serve as mentors for students enrolled in the job readiness program.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Background:</td>
<td>Students enrolled in the Jobs RVA vocational readiness program are often from low income communities. Individuals interested in serving as volunteers are offered participation in a cultural competency program focusing on poverty in effort to increase self-awareness of feeling towards poverty &amp; control judgmental thinking for those experience economic hardships.</td>
</tr>
</tbody>
</table>
| Pathway | 1. Interested persons are enrolled into the cultural competence program.  
2. Limited demographic information is collected (sex, race, income level, education level)  
3. Individuals complete the Systems and Individual Responsibility for Poverty (SIRP) Scale.  
4. Upon completion of the SIRP Scale, individuals are provided instructions on how to complete the Virtual Poverty Simulation Activity. Individuals are asked to complete the simulation within 1 week period from time of receiving instructions.  
5. Individuals participate in a Mindfulness Experience Activity after completing the poverty simulation. The Mindfulness Experience consists of  
   - viewing an introductory video on mindfulness.  
   - participating in guided awareness meditation session on awareness  
The mindfulness experience concludes with a guided mindfulness session on how individuals can focus attention in stay in the present and how to forgo automatic judgements of self or others. Individual are asked to complete the mindfulness experience within 2 weeks.  
6. Persons are asked to complete the SIRP Scale within 48 hours after participating in the mindfulness experience.  
7. Staff members may compare pre and post SIRP scores of individuals. |
| Support List | Jobs RVA team members is available to answer any questions or concerns.  
Primary Point of Contact  
Aja Blue-Saunders Agency Network Director  
jobsrvainfo@gmail.com or 804.387.4949 |
**Figure 4**

*Poverty Simulation Instructions*

Instructions on Completing the Virtual Poverty Simulation

1. Go to United Way Making Choices Website. Click the link below.
2. After reading the instructions and overview, click Take the Challenge.
3. Review the scenario: Click Start.
4. Enter the challenge: Click Start Over.
5. Review the instructions: Click Take the Challenge.
6. Select a different job offer to proceed with the Challenge.
7. Review the scenario: Click Start.
8. Select the job offer you want to proceed with the Challenge.
9. Review the scenario: Click Start.
10. Select the job offer you want to proceed with the Challenge.
11. Review the scenario: Click Start.
12. Continue until you reach the end of the simulation.

You have one week to complete the activity. Send an email to [name] once you complete the activity.
INFLUENCE OF CULTURAL COMPETENCY PROGRAM

Step 1: Select the remaining job offer that takes precedence. Complete the challenge.

Step 2: Select the next highest priority job offer, if any, to continue the challenge.

Step 3: Review the job offer page.
Figure 5

*Mindfulness Experience Instructions*

Instructions on Completing the Mindfulness Experience

Below are the steps to complete the Virtual Mindfulness Experience

Step 1 – View the "What is Mindfulness?" Video on Youtube website.

Step 2 – Review the "How to Embrace Your Own Awareness || Jon Kabat-Zinn Meditation" Video on Youtube Website.


You have two weeks to complete this experience. Send an email to A. Blue Sanders upon completion.

Non-Judging is a very important element of mindfulness practice.
Figure 6

Welcome Letter

Cultural Competency Program

Welcome Letter Template

The Jobs RVA Team invite you to participate in a program that examines individuals' views on poverty.

You will complete a form which asks for your views on the causes of poverty.

Afterwards you will complete an interactive virtual simulation activity which presents experiences that a family having limited financial means have to face over the course of a month.

You will be asked to participate in an online mindfulness activity. The online mindfulness activity involves an increasing self-awareness of virtues that impact our ability to understand our feelings and beliefs and how it impacts our ability relate to others.

At the end of the program, you will complete the form on the causes of poverty in addition to completing a feedback questionnaire.

If you have any questions or want further information please contact the Agency Network Director, Ms. Ajai Blue-Saunders. She can be reached via email (jobsrvainfo@gmail.com) or telephone at 804.387.4949.
Figure 7

Reminder Call Template

Cultural Competency Program

Reminder Call Template

Hello (name of person),

I am checking into see if you have any questions regarding the Jobs RVA Project. Additionally, I wanted to provide a friendly reminder to complete your SIRP forms, online simulation activity. This is followed by the virtual mindfulness experience.

Please feel free to reach out to Ms. Ajai Blue-Saunders, Netword Director at 804.387.4949 or email jobsrvainfo@gmail.com.

Thank you for all that you are doing in ministry to the church.
## Appendix A

### Summary of Primary Research Evidence

<table>
<thead>
<tr>
<th>Citation</th>
<th>Design Level</th>
<th>Sample Size</th>
<th>Intervention Comparison</th>
<th>Theoretical Foundation</th>
<th>Outcome Definition</th>
<th>Usefulness Results Key Finding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engler et al., 2020</td>
<td>Level III</td>
<td>N=224 (126 in Study 1, 98 Study 2)</td>
<td>Comparison of 2 groups (students) and social workers, student population shift of internal to structural /external attributions Social work groups are more internally focused, with fewer degrees of internalization after poverty simulation</td>
<td>None</td>
<td>Some varying education levels amongst, simulation helpful in providing care to persons living in poverty</td>
<td>Regular poverty simulation may shift providers perspectives to structural attributions of poverty, which can assist in advocating for patients</td>
</tr>
<tr>
<td>Gatewood et al. 2019</td>
<td>Level V</td>
<td>n=110 Nursing students from four institutions</td>
<td>Institutional Review Board/Office of Protection of Research Subjects approved quality improvement initiative/exempt educational activity. A three-step implicit bias assignment was incorporated into a required course within the nursing program of study.</td>
<td>None</td>
<td>Evaluation Questionnaire consisted of student experiences of learning activity using the five-step Likert Scale and narrative feedback. Participants were given a choice of questionnaire completion online or in person</td>
<td>Limitations – no pre assessment of students’ knowledge on implicit bias and its impact on healthcare; no collection of faculty feedback: key faculty involved in implementation was not part of the design process.</td>
</tr>
<tr>
<td>Citation</td>
<td>Design Level Quality Grade</td>
<td>Sample Size</td>
<td>Intervention Comparison</td>
<td>Theoretical Foundation</td>
<td>Outcome Definition</td>
<td>Usefulness Results Key Finding</td>
</tr>
<tr>
<td>----------</td>
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<td>--------------------------</td>
<td>------------------------</td>
<td>--------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>The 3-step process included:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- step 1. Initiatory actions (reading/viewing literature on implicit bias identification, assessment tool, and impact on healthcare)</td>
<td></td>
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<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>- step 2. Assessment (completion of 5 concepts within the Project Implicit, Implicit Association Tests (IATs).)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- step 3. Online or In-person participation in discussion activity using guided questions by qualified faculty</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gonzalez, et al., 2021</td>
<td>Level V</td>
<td>Grade A</td>
<td>N/A</td>
<td>Subject matter experts affiliated with four academic institutions provided 12 strategies for incorporating implicit bias into a medical education program. 12 strategies were presented as tips.</td>
<td>The 12 strategies were based on an empirical foundation.</td>
<td>Suggestions of how formative and summative feedback should be assessed. Presentation of different modalities such as active discussion, video presentations, creating a conducive learning environment, defining facilitator's roles and expectations</td>
</tr>
<tr>
<td>Shor et al., 2018</td>
<td>Level III Grade A</td>
<td>N=260 undergraduate students</td>
<td>The test developed in 2 phases. Phase 1 had 8 items (4 items measuring individual attribution; 4-items measuring systematic causes). Phase I results reviewed more items (20) added for clarity. The final measure has 17 items under 2 subscales (Individual Blame &amp; Systems Blame Scale)</td>
<td>None</td>
<td>SIRP was found to have good reliability and validity. SIRP can be used to measure attitudes regarding individual blame and system blame on causes of poverty individual</td>
<td>Practical applications may consist of score results that may assist in evaluating the level of engagement an individual may have in addressing alleviation of poverty or working with an impoverished person. May applied to projects that address increasing awareness of poverty</td>
</tr>
</tbody>
</table>
Shor et al., 2019

**Level II**

- **Grade B**
- n=280 university undergraduate students
- Examination of explicit and implicit measures in areas of attitudes about poverty, social desirability, social class, and behaviors aimed at assisting persons in poverty
- None

Cattaneo et al., 2021

**Level III**

- **Grade B**
- N=113 senior junior college students, psychology majors took Community Engagement for Social Change course; 230 participants Time 2 Point; 177 participants at Time 3
- 3-year study. Students completed the CESC curriculum which presented topics relating to social justice issues covering discrimination, poverty, and racism. Completed Civics Attitudes and Skills Questionnaire (CASQ), Class Privilege Awareness. Systems and Individual Responsibility for Poverty (SIRP) Scale and Implicit Association Test-Classism (IAT-C) all measure attitudes toward poverty and social justice.
- None

**Explicit bias differed amongst social classes, with no difference in implicit bias amongst social class groups.**

**Articles support educational training to include activities that address explicit bias recognition and management.**

**Service-learning and longitudinal work has longstanding effects on civic action engagement; enhance activism; students experiencing similar issues presented in the course change attributions view from individual (blaming) to system attribution.**

**These tools were effective in capturing changes in areas relating to explicit attitudes relating to poverty and social justice. Service learning is a viable option in shifting poverty attributes thinking from individual to structural.**
<p>| Lai et al., 2014. | Level II Grade A | n=6000 non-Black U.S. citizens/residents, participants of Project Implicit Research Site | Comparison of effective intervention tasks on implicit and explicit preferences | None | Activities that contain a high degree of self-involvement or link the outgroup with positivity were the most effective interventions. | Implications for practice may be more effective in some outgroups versus others. |</p>
<table>
<thead>
<tr>
<th>Citation</th>
<th>Design Level</th>
<th>Quality Grade</th>
<th>Sample Size</th>
<th>Intervention Comparison</th>
<th>Theoretical Foundation</th>
<th>Outcome Definition</th>
<th>Usefulness Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loomis et al., 2017</td>
<td>Level III</td>
<td>Grade A</td>
<td>n=110</td>
<td>3-hour simulation</td>
<td>None</td>
<td>Debriefing using guided questions focused on empathy, understanding barriers</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>participants included BSN, NP, DNP, MPH Students, behavioral health and educational students, recent graduates, faculty, staff, community partners (schools, social services, healthcare, banking, food, and goods vendors served as mock business</td>
<td>Participants assigned to 1 of 26 families or various community resource centers</td>
<td></td>
<td>Common themes acknowledging time &amp; resource limitations prevalent Situations were stressful to meet basic needs</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Activity is divided into 4 weeks (15 min times each) and weekends (5-minute lengths) of sessions consisting of living in poverty. Participants select options and consequences for paying for basic expenses-food, water, rent, car, childcare, etc.</td>
<td></td>
<td>Opportunities to obtain insight into decision-making experiences of persons experiencing poverty; interaction with community partners insightful learning needs of persons experiencing poverty foster awareness, promote advocacy for needs of impoverished</td>
<td></td>
</tr>
<tr>
<td>Citation</td>
<td>Quality Grade</td>
<td>Question</td>
<td>Search Strategy</td>
<td>Inclusion/Exclusion Criteria</td>
<td>Data Extraction and Analysis</td>
<td>Key Findings</td>
<td>Usefulness/Recommendation/Implication</td>
</tr>
<tr>
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<td>--------------</td>
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<td>----------------</td>
<td>-------------------------------</td>
<td>------------------------------</td>
<td>--------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>Chae et al., 2021</td>
<td>Level II Grade A</td>
<td>Identify and appraise virtual simulation (VS) evidence as used to improve cultural competence when used by pre-licensure and licensed health professionals</td>
<td>Databases Searches: PubMed, CIHNAL, EMBASE, Ovid MEDLINE, and Korean Databases (KISS, RISS, DBpia) Search terms: population, nurse, nursing student, medical professional, health professional, health worker, intervention, simulation, virtual, reliability outcomes cultural competence, cultural attribute, cultural efficacy, cultural capacity</td>
<td>Inclusion: licensed health professionals (nurses, physicians, other health professionals) or students, VS for increasing cultural competence, control groups with no VS or VS on other topics, cultural competence (overall or subdomain) focused, treatment-controlled designs, full-text publication in peer-reviewed English or Korean journal Exclusion: Non-experimental studies, manikin simulators, standardized patients, clinical practicum, no peer-reviewed</td>
<td>N=887 articles initial retrieval, 277 duplicates removed, 610 screened; 23 articles selected based on title and abstract, and manual search of the reference list, 14 excluded as did not meet criteria</td>
<td>Studies demonstrated VS effective for non-technical skills learning, VS served as a new learning platform, continued study needed to identify reliable &amp; valid measurement tools</td>
<td>Effective in a pandemic, able to be used by multiple users, variety of design</td>
</tr>
<tr>
<td>Citation</td>
<td>Quality Grade</td>
<td>Question</td>
<td>Search Strategy</td>
<td>Inclusion/Exclusion Criteria</td>
<td>Data Extraction and Analysis</td>
<td>Key Findings</td>
<td>Usefulness/Recommendation/Implication</td>
</tr>
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<tr>
<td>FitzGerald et al., 2017</td>
<td>Level II Grade A</td>
<td>Identify interventions that are effective in decreasing implicit bias in the adult population.</td>
<td>Keyword searches were performed in ERIC, PUBMED, and PSYCHINFO databases for peer-reviewed literature between May 2005 and April 2015 period. The study's three reviewers reviewed the search results which consisted of 1931 titles. Independent screening of each title was performed by at least two of three reviewers to extract the categories.</td>
<td>Inclusion criteria: English-written peer-reviewed literature examining human adult (age 18 and over) populations. Studies identifying specific targets. Research that employed frequently used implicit bias tool measures: SC-IAT (Single Category Implicit Association Test), GNAT (Go/No-go Association Task), and BIAT (Brief Implicit Assortment Test).</td>
<td>Interventions were put in one of eight classes dependent on mental components. The categories were extracted from the competition article of 17 interventions. Categories included: types of engagement with the outgroup, openness to counter stereotypical models, views of equalitarian principles, recognizing self with the outgroup, evaluative molding, initiating feeling deliberate approaches to conquer prejudices, utilization of drugs. Effective strategies in reducing individuals' bias were those that participants conducted deliberate strategies to counter biases were the most effective. These include instruction to avoid stereotyping, and purposeful intentions. Aligning themselves with people in the simulated example, presenting the outgroup in positive views means, exposure to.</td>
<td>Small sample size Some interventions work in some situations, however, there is no clear direction in which interventions can be applied consistently to obtain a favorable response. Implementing interventions that consist of presenting the outgroup with a more favorable viewpoint, engaging in groups with the outgroup, and directing activities that will promote identification with the outgroup may be used in certain circumstances and may promote decreasing implicit bias.</td>
<td></td>
</tr>
<tr>
<td>Citation</td>
<td>Quality Grade</td>
<td>Question</td>
<td>Search Strategy</td>
<td>Inclusion/Exclusion Criteria</td>
<td>Data Extraction and Analysis</td>
<td>Key Findings</td>
<td>Usefulness/Recommendation/Implication</td>
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<td>Association Test) Interventions involved real-world contextual constructs. Exclusion criteria: Animal, inanimate object-focused research Studies requiring extensive participant time commitments Interventions entail activities encroaching on the participant’s personal life. Works intended to multiply certain biases or generalizations.</td>
<td>included pre-/post-test design, those which included a control group, The majority of studies were in the United States (35 interventions) and examined Black/White Race (34 interventions). Interventions were also tested in the United Kingdom, Australia, Spain, Netherlands, Belgium, Taiwan, Hungary, Italy, Pakistan, and New Zealand. Bias in areas of Latino/white, Arab-Muslim/Black, Asian/Anglo, weight, sexuality, religion, age, and gender were assessed. A preponderance of studies reviewed implicit prejudice, some (5) works reviewed implicit</td>
<td>counter stereotypical persons, social connecting with members of outgroup, focus on common characteristics between ingroup and outgroup were also effective in overcoming biases,</td>
<td>Changes (decreases in bias) may be short-term unless interventions are frequently repeated or provide opportunities for ingroup to enmesh themselves with changes in habits. This is important considering participants are members of cultures and are influencers and influenced by norms.</td>
</tr>
</tbody>
</table>
involved in a competition. Three projects exclusively examined implicit stereotypes. Undergraduate psychology students were the participants in many studies.
## Appendix C

### SWOT ANALYSIS

<table>
<thead>
<tr>
<th><strong>Strengths</strong></th>
<th><strong>Weaknesses</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Early endorsement agency leadership</td>
<td>Time constraints, volunteers, may have limited time</td>
</tr>
<tr>
<td>Motivated Outreach Minister, promoting Community engagement</td>
<td>Competing Site Community Projects may affect availability of mentors</td>
</tr>
<tr>
<td>Currently parishioners provide financial support to agency along with meal support to other community sites</td>
<td>Bias Testing and Simulation Online Tools, need Internet connection</td>
</tr>
<tr>
<td>Parishioners are adept in using technology</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Opportunities</strong></th>
<th><strong>Threats</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Enhance awareness of bias, permission to acknowledge bias presence and impact in volunteerism</td>
<td>COVID 19 Pandemic</td>
</tr>
<tr>
<td>Initiate evidence-based approach in identifying and addressing bias</td>
<td>Individuals may be reticent in participating in bias assessment</td>
</tr>
<tr>
<td></td>
<td>Intervention requires the use of a computer, mobile tablet, or a smartphone device</td>
</tr>
</tbody>
</table>
Appendix D

Project Schedule

<table>
<thead>
<tr>
<th>Activity</th>
<th>NUR7801</th>
<th>NUR7802</th>
<th>NUR7803</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meet with Faculty</td>
<td>x</td>
<td>x</td>
<td>X</td>
</tr>
<tr>
<td>Meet with preceptor</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Prepare project proposal</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Conduct Literature Review</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Conduct Organizational Assessment</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Meet with Key Stakeholders</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Submit the proposal to USA EBP Project Review Council (EPRC)</td>
<td>x</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Receive EPRC Approval</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conduct champion training</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commence Recruitment</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initiate Bias Testing</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Initiate Poverty Simulation and Mindfulness Intervention</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Administer Post Intervention Bias</td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Activity</td>
<td>NUR7801</td>
<td>NUR7802</td>
<td>NUR7803</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>---------</td>
<td>---------</td>
<td>---------</td>
</tr>
<tr>
<td>Testing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conduct Data Analysis</td>
<td></td>
<td></td>
<td>x x</td>
</tr>
<tr>
<td>Disseminate Results</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Prepare Organization to Initiate Sustainability Plan</td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Celebrate Project’s Completion</td>
<td></td>
<td></td>
<td>x</td>
</tr>
</tbody>
</table>
Appendix E

Permissions to use SIRP

Permission was obtained to use SIRP Scale via video teleconference (R. Shor, personal communication, December 2, 2021).

From: Shor, Rachel <Rachel.Shor@va.gov>
Sent: Tuesday, November 30, 2021, 10:31 AM
To: Anderson, Melodie L. RICVAMC <Melodie.Anderson@va.gov>
Cc: Samuel, Naveen H RICVAMC <Naveen.Samuel@va.gov>
Subject: RE: Gratitude & Reach out for Poverty Related Tools

Melodie,

Good morning! I’d love to hear more about your project and am happy to schedule another time to talk more through some available measurement tools.

Below are some times that I am available this week. If none of these times work, I can provide some availability for next week:
Thursday 12/2 from 9am -12:30pm
Friday 12/3 from 1pm – 4pm

I’m also attaching some resources you may find helpful, and a list of additional measurement tools that could be of interest.
Attached are the following:
- 2017 article which provides how we conceptualized the transformative process of service learning in challenging negative attitudes about people living in poverty
- 2017 article describing the development of the Systems and Individual Responsibility for Poverty (SIRP) Scale – this is a self-report measure that we developed to assess explicit attitudes about why people live in poverty and reasons why some people may have a harder time getting out of poverty
- A copy of the SIRP

Feel free to let me know if you have any additional questions before we touch base. Even if I’m not able to respond beforehand, I can try to prepare answers/materials for when we meet.

Best,
Rachel Shor, Ph.D.
Women’s Health Sciences Division
National Center for PTSD
VA Boston Healthcare System
Phone: 617-435-8742
Appendix F

SIRP Scale

The Systems and Individual Responsibility for Poverty (SIRP) Scale


**Instructions:**
Think for a moment about people who are affected by poverty and the society in which we live. While we know that there are many reasons why people end up in poverty, what is your understanding regarding most people living in poverty?

Examine the following list of statements and indicate the extent to which you agree or disagree with each statement.

**Response options:**

|---|----------------------|------------|-------------------------------|---------|-------------------|

**Items:**

**Individual Blame Scale**

**Individual Blame - Being in Poverty Subscale**
- If you are experiencing poverty in the United States, it is the result of your own choices.
- If you are experiencing poverty in the United States, it is the result of your own attitudes.
- If you are experiencing poverty in the United States, it is the result of your own skills and abilities.
- If you are experiencing poverty in the United States, it is the result of your priorities.

**Individual Blame - Not Getting out of Poverty Subscale**
- If you work hard enough, you can get out of poverty.
- If you are motivated enough, you can get out of poverty.
- If you are willing to accept support from friends and family, you can get out of poverty.
- If you are willing to accept support from social services, you can get out of poverty.

**Systems Blame Scale**

- If you are experiencing poverty in the United States, it is the result of problems in our system of education.
- If you are experiencing poverty in the United States, it is the result of problems in our system of government.
- If you are experiencing poverty in the United States, it is the result of problems in our economic system.
- If you are experiencing poverty in the United States, it is the result of the behavior of everyone in society.
- Wealthy people are responsible for the amount of poverty in the United States.
- Government policies are responsible for the amount of poverty in the United States.
- Discrimination causes poverty in the United States.
- Policies related to the workplace (e.g., minimum wage, child care, health care) cause poverty in the United States.
### Appendix G

#### Demographic Information

<table>
<thead>
<tr>
<th>Participant ID</th>
<th>Age</th>
<th>Gender</th>
<th>Ethnicity</th>
<th>Highest Education Level</th>
<th>Income Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-29</td>
<td>30-39</td>
<td>Male</td>
<td>Asian Descent</td>
<td>High School or GED</td>
<td>&lt;$25,000</td>
</tr>
<tr>
<td>30-39</td>
<td></td>
<td>Female</td>
<td>Black or African American</td>
<td>Some College</td>
<td>$25,001 to $50,000</td>
</tr>
<tr>
<td>40-49</td>
<td></td>
<td>Non-binary/third gender</td>
<td>Hispanic or Latino</td>
<td>Associate Degree</td>
<td>$50,001 to $75,000</td>
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<tr>
<td>50-59</td>
<td>60-69</td>
<td>Male</td>
<td>White</td>
<td>Bachelor’s Degree</td>
<td>$75,001 to $100,000</td>
</tr>
<tr>
<td></td>
<td>70-79</td>
<td>Non-binary/third gender</td>
<td>Prefer Not to Answer</td>
<td>Graduate or Doctoral Degree</td>
<td>$100,000&gt;</td>
</tr>
</tbody>
</table>
