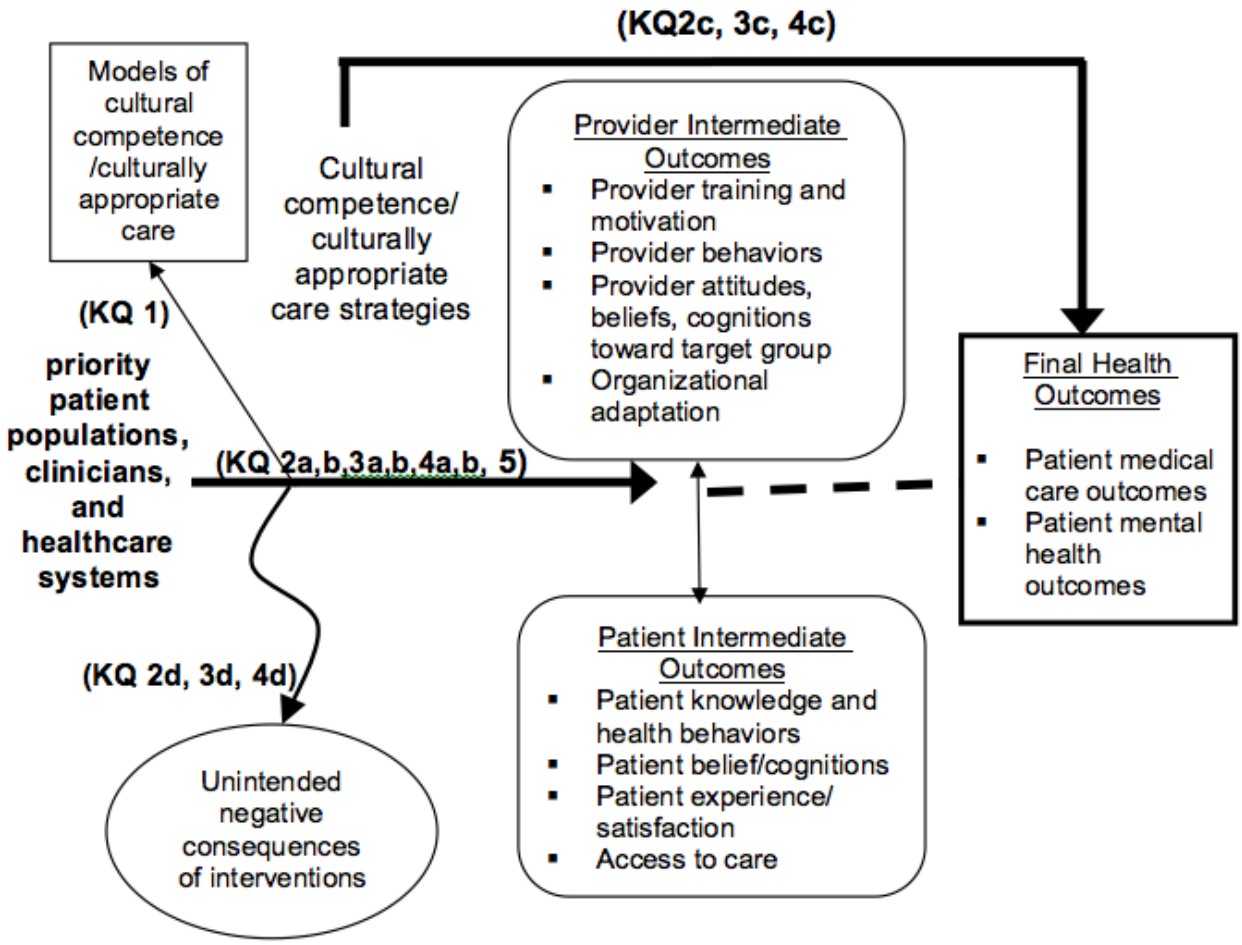
Appendix A. Analytic Framework

Analytic Framework for Improving Cultural Competence to Reduce Disparities in Priority Populations



Appendix B. Search Strings

Disability Search String

#	Searches
1	meta analysis as topic/
2	meta-analy$.tw.
3	metaanaly$.tw.
4	meta-analysis/
5	(systematic adj (review$1 or overview$1)).tw.
6	exp Review Literature as Topic/
7	or/1-6
8	cochrane.ab.
9	embase.ab.
10	(psychlit or psyclit).ab.
11	(psychinfo or psycinfo).ab.
12	or/8-11
13	reference list$.ab.
14	bibliograph$.ab.
15	hand search.ab.
16	relevant journals.ab.
17	manual search$.ab.
18	or/13-17
19	selection criteria.ab.
20	(data adj2 (extract* or abstract*)).ab.
21	19 or 20
22	review/
23	21 and 22
24	Comment/
25	Letter/
26	editorial/
27	animal/
28	human/
29	27 not (28 and 27)
30	or/24-26,29
31	7 or 12 or 18 or 23
32	31 not 30
33	randomized controlled trials as topic/
34	randomized controlled trial/
35	random allocation/
36	double blind method/
37	single blind method/
38	clinical trial/
39	clinical trial, phase i.pt.
40	clinical trial, phase ii.pt.
41	clinical trial, phase iii.pt.
42	clinical trial, phase iv.pt.
43	controlled clinical trial.pt.
44	randomized controlled trial.pt.
45	multicenter study.pt.
46	clinical trial.pt.
47	exp clinical trials as topic/
48	or/33-47
49	(clinical adj trial$).tw.
50	((singl$ or doubl$ or treb$ or tripl$) adj (blind$3 or mask$3)).tw.
51	placebos/
52	placebo$.tw.
53	randomly allocated.tw.
54	(allocated adj2 random$).tw.
55	or/49-54

56	48 or 55
57	case report.tw.
58	letter/
59	historical article/
60	or/57-59
61	56 not 60
62	exp cohort studies/ or comparative study/ or follow-up studies/ or prospective studies/ or cohort.mp. or compared.mp. or groups.mp. or multivariate.mp.
63	cohort$.tw.
64	controlled clinical trial.pt.
65	epidemiological methods/
66	limit 65 to yr=1971-1983
67	or/62-64,66
68	exp disabled person/ or (amputee$ or disabled person$ or disabled child$ or disab$ or disabled people or mentally disabled person$ or mentally disabled people or mentally ill person$ or mentally ill people or visually impaired person$ or visually impaired people or hearing impaired person$ or hearing impaired people).mp.
69	exp mental disorders diagnosed in childhood/ or (Asperger Syndrome or Aperger$ or Autism or Autistic or Autistic Disorde$ or learning disabil$ or learning disorder$ or developmental disability$ or Attention Deficit Disorder$ or Attention Deficit Disorder with Hyperactivity or behavior$ disorder$ or conduct disorder$ or dyslexia or affective Disorder$ or mood disorder$ or depress$ or depress$ disorder$ or personality disorder$).mp.
70	exp cognition disorders/ or (cognit$ disord$ or cognit$ disabil$ or Mild Cognitive Impairment$ or Huntington$ or cognitive$ impair$).mp.
71	exp intellectual disability/ or (intellectual disab$ or Down Syndrome or mental$ retard$ or Fragile X or Rett Syndrome or Prader-Willi Syndrome or Williams Syndrome).mp.
72	exp "Activities of Daily Living"/ or (activit$ of daily living or functional limitation$ or activity limitation$ or participation limitation$).mp.
73	Mobility limitation/ or (mobility limitation$ or mobility impairment$).mp.
74	Dependent ambulation/ or dependent ambulation.mp.
75	Paraplegia/ or paraplegia.mp.
76	Quadriplegia/ or quadriplegia.mp.
77	Hearing loss/ or (hearing loss or hearing impair$ or deaf$).mp.
78	Vision disorders/ or (blind$ or vis$ impair$).mp.
79	exp self-help devices/ or (assist$ techn$ or Commun$ Aid$ or commun$ device$ or Wheelchair$).mp.
80	Mental disorders/ or (mental disorder$ or psychiatric disabilit$ or mental health disabilit$ or mental health impairment$).mp.
81	or/68-80
82	minority groups/ or minority Health/
83	exp health personnel/ed
84	health services accessibility/ or healthcare disparities/
85	"Attitude of Health Personnel"/
86	Health Communication/
87	(divers* adj3 (competenc* or understanding or knowledg* or expertise or skill* or sensitiv* or aware* or appropriate* or acceptab* or safe* or humility or service* or communicat* or barrier* or divers* or comparison* or identity or specific or background* or value* or belief*)).tw.
88	stigma.tw.
89	Comprehensive Health Care/mt [Methods]
90	"Delivery of Health Care"/mt [Methods]
91	Health Promotion/mt [Methods]
92	or/82-91
93	61 and 81 and 92
94	limit 93 to yr="1990-Current"
95	32 and 81 and 92
96	95 not 94
97	limit 96 to yr="1990-Current"
98	67 and 81 and 92
99	intervention*.ti,ab.
100	program*.ti,ab.
101	99 or 100
102	98 and 101
103	102 not (94 or 97)
104	limit 103 to yr="1990-Current"

Gender and Sexual Minority Search String

#	Searches
1	meta analysis as topic/
2	meta-analy$.tw.
3	metaanaly$.tw.
4	meta-analysis/
5	(systematic adj (review$1 or overview$1)).tw.
6	exp Review Literature as Topic/
7	or/1-6
8	cochrane.ab.
9	embase.ab.
10	(psychlit or psyclit).ab.
11	(psychinfo or psycinfo).ab.
12	or/8-11
13	reference list$.ab.
14	bibliograph$.ab.
15	hand search.ab.
16	relevant journals.ab.
17	manual search$.ab.
18	or/13-17
19	selection criteria.ab.
20	(data adj2 (extract* or abstract*)).ab.
21	19 or 20
22	review/
23	21 and 22
24	Comment/
25	Letter/
26	editorial/
27	animal/
28	human/
29	27 not (28 and 27)
30	or/24-26,29
31	7 or 12 or 18 or 23
32	31 not 30
33	randomized controlled trials as topic/
34	randomized controlled trial/
35	random allocation/
36	double blind method/
37	single blind method/
38	clinical trial/
39	clinical trial, phase i.pt.
40	clinical trial, phase ii.pt.
41	clinical trial, phase iii.pt.
42	clinical trial, phase iv.pt.
43	controlled clinical trial.pt.
44	randomized controlled trial.pt.
45	multicenter study.pt.
46	clinical trial.pt.
47	exp clinical trials as topic/
48	or/33-47
49	(clinical adj trial$).tw.
50	((singl$ or doubl$ or treb$ or tripl$) adj (blind$3 or mask$3)).tw.
51	placebos/
52	placebo$.tw.
53	randomly allocated.tw.
54	(allocated adj2 random$).tw.
55	or/49-54
56	48 or 55
57	case report.tw.
58	letter/

59	historical article/
60	or/57-59
61	56 not 60
62	exp cohort studies/ or comparative study/ or follow-up studies/ or prospective studies/ or cohort.mp. or compared.mp. or groups.mp. or multivariate.mp.
63	cohort$.tw.
64	controlled clinical trial.pt.
65	exp teaching/
66	exp health personnel/ed
67	exp teaching materials/
68	exp education/
69	((education* or teaching or learning or elearning or instruction* or training or skills or didactic or pedagogic* or online or online or web* or internet or cd-rom* or dvd or multimedia or multi-media or computer*) adj2 (intervention* or session* or course* or program* or activit* or presentation* or round* or material* or package* or module* or demonstration* or method* or process*)).tw.
70	(inservice or in service or workshop* or (discussion adj1 group*) or lectur* or seminar* or (short adj2 course*) or role play* or immersion or mentor* or lifelong learning or life long learning).tw.
71	((staff or professional or workforce or work force) adj (development or training)).tw.
72	((medical or continuing or residency or distance) adj2 education).tw.
73	((cultural* or transcultural* or multicultural* or intercultural* or bicultural*) adj2 (education or train* or teach* or learn* or instruct* or coach* or skills or content*)).tw.
74	(curriculum or curricul* intervent*).tw.
75	or/62-74
76	exp Bisexuality/ or bisexual*.mp.
77	exp Transsexualism/ or transsexual*.mp.
78	exp Homosexuality/ or homosexual*.mp.
79	exp Transgendered Persons/ or transgender*.mp.
80	(lgbt* or glbt*).mp.
81	(gay or lesbian).mp.
82	("men who have sex with men" or msm or "women who have sex with women" or wsw).mp.
83	(WSMW or WSWM or MSWM or MSMW).mp.
84	sexual minority.mp.
85	gender minority.mp.
86	gender expression.mp.
87	(gender identit* or sexual orientation or sexual identit*).mp.
88	or/76-87
89	32 and 88
90	61 and 88
91	75 and 88
92	limit 89 to yr="1990-Current"
93	limit 90 to yr="1990-Current"
94	limit 91 to yr="1990-Current"
95	intervention*.ti,ab.
96	program*.ti,ab.
97	curriculum.ti,ab.
98	or/95-97
99	94 and 98
100	93
101	92 not 93
102	99 not (93 or 92)

Racial/Ethnic Populations Search String

#	Searches
1	meta analysis as topic/
2	meta-analy$.tw.
3	metaanaly$.tw.
4	meta-analysis/
5	(systematic adj (review$1 or overview$1)).tw.
6	exp Review Literature as Topic/
7	or/1-6
8	cochrane.ab.
9	embase.ab.
10	(psychlit or psyclit).ab.
11	(psychinfo or psycinfo).ab.
12	or/8-11
13	reference list$.ab.
14	bibliograph$.ab.
15	hand search.ab.
16	relevant journals.ab.
17	manual search$.ab.
18	or/13-17
19	selection criteria.ab.
20	(data adj2 (extract* or abstract*)).ab.
21	19 or 20
22	review/
23	21 and 22
24	Comment/
25	Letter/
26	editorial/
27	animal/
28	human/
29	27 not (28 and 27)
30	or/24-26,29
31	7 or 12 or 18 or 23
32	31 not 30
33	randomized controlled trials as topic/
34	randomized controlled trial/
35	random allocation/
36	double blind method/
37	single blind method/
38	clinical trial/
39	clinical trial, phase i.pt.
40	clinical trial, phase ii.pt.
41	clinical trial, phase iii.pt.
42	clinical trial, phase iv.pt.
43	controlled clinical trial.pt.
44	randomized controlled trial.pt.
45	multicenter study.pt.
46	clinical trial.pt.
47	exp clinical trials as topic/
48	or/33-47
49	(clinical adj trial$).tw.
50	((singl$ or doubl$ or treb$ or tripl$) adj (blind$3 or mask$3)).tw.
51	placebos/
52	placebo$.tw.
53	randomly allocated.tw.
54	(allocated adj2 random$).tw.
55	or/49-54
56	48 or 55
57	case report.tw.
58	letter/

59	historical article/
60	or/57-59
61	56 not 60
62	exp cohort studies/ or comparative study/ or follow-up studies/ or prospective studies/ or cohort.mp. or compared.mp. or groups.mp. or multivariate.mp.
63	cohort$.tw.
64	controlled clinical trial.pt.
65	epidemiological methods/
66	limit 65 to yr=1971-1983
67	or/62-64,66
68	population groups/ or african continental ancestry group/ or african americans/ or indians, north american/ or inuits/ or asian americans/ or oceanic ancestry group/ or ethnic groups/ or arabs/ or hispanic americans/ or mexican americans/
69	"Emigration and Immigration"/ or "Emigrants and Immigrants"/ or "Transients and Migrants"/ or refugees/
70	race relations/ or racism/
71	(immigrant* or migrant* or refugee* or (displaced and (people or person*)) or ("foreign born" or "non us born" or "non-us born") or undocumented or second language* or ((language or english) and proficien*) or interpreter* or "minority group*" or "ethnic group*" or "urban health" or "urban population" or "inner city" or ethnic* or race or racial or minorit* or urban or inner-city or multiethnic).tw.
72	(non-english or hispanic* or latin* or ((african or black or asian or native or mexican) adj american*) or inuit* or islander*).tw.
73	or/68-72
74	culture/ or cross-cultural comparison/ or cultural characteristics/ or cultural competency/ or cultural diversity/
75	multilingualism/ or language/
76	((cultur* or linguistic* or language*) adj3 (competenc* or understanding or knowledg* or expertise or skill* or sensitiv* or aware* or appropriate* or acceptab* or safe* or humility or service* or communicat* or barrier* or divers* or comparison* or identity or specific or background* or value* or belief*)).tw.
77	(intercultural* or inter-cultural or transcultural* or trans-cultural or cross-cultural or crosscultural or multicultural* or multicultural* or bicultural or bi-cultural or multilingual* or multi-lingual* or bilingual or bi-lingual).tw.
78	transcultural nursing/
79	minority groups/ or minority Health/
80	((cultural* or transcultural* or multicultural* or intercultural* or bicultural*) adj2 (education or train* or teach* or learn* or instruct* or coach* or skills or content*)).tw.
81	Healthcare Disparities/
82	stigma.mp.
83	or/74-82
84	61 and 73 and 83
85	limit 84 to yr="1990-Current"
86	32 and 83
87	86 not 85
88	limit 87 to yr="1990-Current"
89	67 and 73 and 83
90	intervention*.ti,ab.
91	program*.ti,ab.
92	90 or 91
93	89 and 92
94	93 not (85 or 88)
95	limit 94 to yr="1990-Current"

Cultural Competence Model Search String

#	Searches
1	Culture/
2	Cultural Competency/
3	Anthropology, Cultural/
4	Cultural Characteristics/
5	Cultural Diversity/
6	Cross-Cultural Comparison/
7	(cultur* adj3 competenc*).tw.
8	(cultur* adj3 understanding).tw.
9	(cultur* adj3 knowledg*).tw.
10	(cultur* adj3 skill*).tw.
11	(cultur* adj3 sensitiv*).tw.
12	(cultur* adj3 aware*).tw.
13	(cultur* adj3 appropriate*).tw.
14	(cultur* adj3 acceptab*).tw.
15	(cultur* adj3 safe*).tw.
16	(cultur* adj3 service*).tw.
17	(cultur* adj3 communicat*).tw.
18	(cultur* adj3 barrier*).tw.
19	(cultur* adj3 divers*).tw.
20	(cultur* adj3 comparison*).tw.
21	(cultur* adj3 identity*).tw.
22	(cultur* adj3 specific*).tw.
23	(cultur* adj3 background*).tw.
24	(cultur* adj3 value*).tw.
25	(cultur* adj3 belief*).tw.
26	Transcultural Nursing/
27	(intercultural* or inter-cultural or transcultural* or trans-cultural or cross-cultural or crosscultural or multicultural* or multi-cultural* or multiethnic or bicultural or bi-cultural or multilingual* or multi-lingual* or bilingual or bi-lingual).tw.
28	"Emigration and Immigration"/
29	"Emigrants and Immigrants"/
30	"Transients and Migrants"/
31	Refugees/
32	exp Population Groups/
33	Minority Groups/
34	Minority Health/
35	(immigrant* or migrant* or refugee* or ethnic* or racial or indigenous or aborigin*).tw.
36	(non-english or hispanic* or latino* or ((african or black or asian or native or mexican) adj american*) or inuit* or maori or islander*).tw.
37	exp Bisexuality/ or exp Transsexualism/ or exp Homosexuality/ or exp Homosexuality, Female/ or lgbt.mp. or exp Homosexuality, Male/ or exp Sexual Behavior/
38	exp child development disorders/
39	exp child development disorders, pervasive/
40	exp communication disorders/
41	exp developmental disabilities/
42	exp learning disorders/
43	exp intellectual disability/
44	exp psychomotor disorders/
45	exp Disabled Persons/
46	exp Disabled Children/
47	exp Models, Nursing/
48	exp Models, Theoretical/
49	model*.mp. or framework*.tw. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier]
50	exp Models, Organizational/
51	delivery of health care/

52	patient-centered care/
53	health knowledge attitudes practice/
54	exp Clinical Competence/ or exp Professional Competence/
55	or/1-27
56	or/28-46
57	or/47-50
58	or/51-54
59	55 and 56 and 57
60	55 and 56 and 57 and 58

This section briefly summarizes the methods used to search for the conceptual models. We searched Ovid MEDLINE® from 1990, when the concept of cultural competence gained traction, to February 2014. We used natural language key words and MeSH terms to capture the concepts of cultural competence, models, and the three included priority populations. The search algorithm is provided in Appendix B.

Two independent reviewers screened the references for articles that described the development of a cultural competence model, reviewed models of cultural competence, or appeared to have likely used a cultural competence model as the basis for research in order to identify likely models. Full texts of articles that might be a source for a model were then pulled and examined for likely descriptions of or references to cultural competence models. This process necessarily required backward citation searching to locate original source material for models. Identified models were included if they were intended for use by the formal healthcare system, were designed for or applicable to at least one of the three priority populations, and suggested possible point of interventions to improve cultural competence of providers or the healthcare system. Mid-level models that examined only one facet or factor of cultural competence, or only one type of patient behavior (such as help-seeking) were not included. Models were then collated and presented as unique models with one citation for the source from which it was eventually drawn. Each model was abstracted directly into an evidence table for whether the model focused primarily on the inner experience of the provider, externally on the person(s) the provider would be interacting with, or both; a brief description of the model; and the model characteristics. One investigator abstracted the model and a second investigator quality checked the abstraction.

Appendix C. Excluded Studies

Disability Populations

Not RCTs, reviews, protocols

1. Bonfioli E, Berti L, Goss C, et al. Health promotion lifestyle interventions for weight management in psychosis: a systematic review and meta-analysis of randomised controlled trials. BMC Psychiatry 2012; 12:78. PMID: 22789023.
2. Bridgemohan CF, Levy S, Veluz AK, et al. Teaching paediatric residents about learning disorders: use of standardised case discussion versus multimedia computer tutorial. Med Educ 2005; Aug;39(8):797-806. PMID: 16048622.
3. Commons Treloar AJ, Lewis AJ. Targeted clinical education for staff attitudes towards deliberate self-harm in borderline personality disorder: randomized controlled trial. Aust N Z J Psychiatry 2008; Nov;42(11):981-8. PMID: 18941964.
4. Dalky HF. Mental illness stigma reduction interventions: review of intervention trials. West J Nurs Res 2012; Jun;34(4):520-47. PMID: 21389251.
5. Gonzalez EE, Nathe CN, Logothetis DD, et al. Training caregivers: disabilities and dental hygiene. International Journal of Dental Hygiene 2013; Nov;11(4):293-7. PMID: 23437905.
6. Harper DC, Wadsworth JS. Improving health care communication for persons with mental retardation. Public Health Rep 1992; May-Jun;107(3):297-302. PMID: 1594740.
7. Jinks A, Cotton A, Rylance R. Obesity interventions for people with a learning disability: an integrative literature review. J Adv Nurs 2011; Mar;67(3):460-71. PMID: 21077935.
8. Lennox NG, Brolan CE, Dean J, et al. General practitioners' views on perceived and actual gains, benefits and barriers associated with the implementation of an Australian health assessment for people with intellectual disability. J Intellect Disabil Res 2013; Oct;57(10):913-22. PMID: 22774940.
9. McLaughlin C. The effect of classroom theory and contact with patients on the attitudes of student nurses towards mentally ill people. J Adv Nurs 1997; Dec;26(6):1221-8. PMID: 9429974.
10. Nguyen E, Chen TF, O'Reilly CL. Evaluating the impact of direct and indirect contact on the mental health stigma of pharmacy students. Soc Psychiatry Psychiatr Epidemiol 2012; Jul;47(7):1087-98. PMID: 21755345.
11. Parish SL, Swaine JG, Son E, et al. Receipt of mammography among women with intellectual disabilities: medical record data indicate substantial disparities for African American women. Disabil Health J 2013; Jan;6(1):36-42. PMID: 23260609.
12. Pittman JOE, Noh S, Coleman D. Evaluating the effectiveness of a consumer delivered anti-stigma program: replication with graduate-level helping professionals. Psychiatr Rehabil J 2010; 33(3):236-8. PMID: 20061261.
13. Prabhu NT, Nunn JH, Evans DJ, et al. Access to dental care-parents' and caregivers' views on dental treatment services for people with disabilities. Spec Care Dentist 2010; Mar-Apr;30(2):35-45. PMID: 20415799.
14. Scott JT, Entwistle VA, Sowden AJ, et al. Communicating with children and adolescents about their cancer. Cochrane Database Syst Rev 2001; (1):CD002969. PMID: 11279789.
15. Scott JT, Harmsen M, Prictor MJ, et al. Interventions for improving communication with children and adolescents about their cancer. Cochrane Database Syst Rev 2003; (3):CD002969. PMID: 12917938.
16. Sollom AC, Kneebone II. Treatment of depression in people who have multiple sclerosis. Mult Scler 2007; Jun;13(5):632-5. PMID: 17548443.
17. Spaite DW, Karriker KJ, Conroy C, et al. Emergency medical services assessment and treatment of children with special health care needs before and after specialized paramedic training. Prehospital Disaster Med 2001; Apr-Jun;16(2):96-101. PMID: 11513288.
18. Stenfert Kroese B, Jahoda A, Pert C, et al. Staff expectations and views of cognitive behaviour therapy (CBT) for adults with intellectual disabilities. J Appl Res Intellect Disabil 2014; Mar;27(2):145-53. PMID: 23682016.

19. Street KN, Eaton N, Clarke B, et al. Child disability case studies: an interprofessional learning opportunity for medical students and paediatric nursing students. Med Educ 2007; Aug;41(8):771-80. PMID: 17661885.

20. Swaine JG, Dababnah S, Parish SL, et al. Family caregivers' perspectives on barriers and facilitators of cervical and breast cancer screening for women with intellectual disability. Intellect Dev Disabil 2013; Feb;51(1):62-73. PMID: 23360409.

21. Tuffrey-Wijne I, Bernal J, Hubert J, et al. People with learning disabilities who have cancer: an ethnographic study. Br J Gen Pract 2009; Jul;59(564):503-9. PMID: 19566998.

22. Van Voorhees BW, Gollan J, Fogel J. Pilot study of Internet-based early intervention for combat-related mental distress. J Rehabil Res Dev 2012; 49(8):1175-90. PMID: 23341310.

23. Yuen HK. Effect of a home telecare program on oral health among adults with tetraplegia: a pilot study. Spinal Cord 2013; Jun;51(6):477-81. PMID: 23318557.

24. Baker A, Kay-Lambkin FJ, Richmond R, et al. Study protocol: a randomised controlled trial investigating the effect of a healthy lifestyle intervention for people with severe mental disorders. BMC Public Health 2011; 11(1):10. PMID: 21208433.

25. Jansen M, de Groot IJ, van Alfen N, et al. Physical training in boys with Duchenne Muscular Dystrophy: the protocol of the No Use is Disuse study. BMC Pediatr 2010; 10:55. PMID: 20691042.

26. Jones HF, Adams CE, Clifton A, et al. An oral health intervention for people with serious mental illness (Three Shires Early Intervention Dental Trial): study protocol for a randomised controlled trial. Trials 2013; 14:158. PMID: 23714397.

27. Lennox N, Ware R, Carrington S, et al. Ask: a health advocacy program for adolescents with an intellectual disability: a cluster randomised controlled trial. BMC Public Health 2012; 12:750. PMID: 22958354.

No formal system change/health promotion/primary and secondary prevention

1. Bombardier CH, Cunniffe M, Wadhwani R, et al. The efficacy of telephone counseling for health promotion in people with multiple sclerosis: a randomized controlled trial. Arch Phys Med Rehabil 2008; Oct;89(10):1849-56. PMID: 18929012.

2. Carraro A, Gobbi E. Effects of an exercise programme on anxiety in adults with intellectual disabilities. Res Dev Disabil 2012; Jul-Aug;33(4):1221-6. PMID: 22502848.

3. Faulks D, Hennequin M. Evaluation of a long-term oral health program by carers of children and adults with intellectual disabilities. Spec Care Dentist 2000; Sep-Oct;20(5):199-208. PMID: 11203899.

4. Finkelstein J, Lapshin O, Wasserman E. Comparison of long-term results of computer-assisted anti-stigma education and reading anti-stigma educational materials. AMIA Annu Symp Proc 2007; Annual Symposium Proceedings/ AMIA Symposium.:245-8. PMID: 18693835.

5. Flatt-Fultz E, Phillips LA. Empowerment training and direct support professionals' attitudes about individuals with intellectual disabilities. J Intellect Disabil 2012; Jun;16(2):119-25. PMID: 22491507.

6. Gephart EF, Loman DG. Use of prevention and prevention plus weight management guidelines for youth with developmental disabilities living in group homes. J Pediatr Health Care 2013; Mar-Apr;27(2):98-108. PMID: 23414975.

7. Horner-Johnson W, Drum CE, Abdullah N. A randomized trial of a health promotion intervention for adults with disabilities. Disabil Health J 2011; Oct;4(4):254-61. PMID: 22014673.

8. Perez-Cruzado D, Cuesta-Vargas AI. Improving Adherence Physical Activity with a Smartphone Application Based on Adults with Intellectual Disabilities (APPCOID). BMC Public Health 2013; 13:1173. PMID: 24330604.

9. Robinson-Whelen S, Hughes RB, Powers LE, et al. Efficacy of a computerized abuse and safety assessment intervention for women with disabilities: a randomized controlled trial. Rehabil Psychol 2010; May;55(2):97-107. PMID: 20496965.

10. Robinson-Whelen S, Hughes RB, Taylor HB, et al. Improving the health and health behaviors of women aging with physical disabilities: A peer-led health promotion program. Womens Health Issues 2006; Nov-Dec;16(6):334-45. PMID: 17188216.

11. Stuifbergen AK, Becker H, Blozis S, et al. A randomized clinical trial of a wellness intervention for women with multiple sclerosis. Arch Phys Med Rehabil 2003; Apr;84(4):467-76. PMID: 12690582

12. Verschuren O, Ketelaar M, Gorter JW, et al. Exercise training program in children and adolescents with cerebral palsy: a randomized controlled trial. Arch Pediatr Adolesc Med 2007; Nov;161(11):1075-81. PMID: 17984410.

13. Wu C-L, Lin J-D, Hu J, et al. The effectiveness of healthy physical fitness programs on people with intellectual disabilities living in a disability institution: six-month short-term effect. Res Dev Disabil 2010; May-Jun;31(3):713-7. PMID: 20172687.

Care coordination or patient-centered / individualized care

1. Antonelli RC, Stille CJ, Antonelli DM. Care coordination for children and youth with special health care needs: a descriptive, multisite study of activities, personnel costs, and outcomes. Pediatrics 2008; Jul;122(1):e209-16. PMID: 18595966.

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4. Mier N, Ory MG, Medina AA. Anatomy of culturally sensitive interventions promoting nutrition and exercise in hispanics: a critical examination of existing literature. Health Promot Pract 2010 Jul;11(4):541-54. PMID: 19193933.

Appendix D. Description and Characteristics of Included Studies

Appendix Table D1. Description and characteristics of included studies—disability populations

Reference	Target of Intervention	Disability Population	Article Framing	Study Design and Aim	Intervention Duration and Intensity	Population	Setting	Primary Outcomes
Clement, 2012{Clement, 2012 #2314}	Nursing Students	People with Mental Illness	"Social contact interventions in which individuals affected by mental illness share their personal stories…are common components of mental health anti-stigma programmes, and are increasingly being used in the training of health professionals as their attitudes and behaviour may also be stigmatising."	RCT To test the following hypotheses that: (a) there would be no difference in stigma between the filmed (indirect social contact) and live (direct social contact) interventions; and (b) the conditions with social contact, either direct or indirect (live or filmed) would be more effective in reducing stigma than a control condition with no social contact (lecture).	Participants were randomized to DVD intervention, live intervention, or lecture control arms. The DVD and live intervention arms both had similar content: personal narratives from mental health consumers and a researcher facilitated discussion. The lecture was given by a nurse and contained no indirect or direct contact with consumers.	360 student general nurses in their university foundation year following diploma, degree or accelerated diploma courses were randomized, 216 participated.	University, UK *Note: some association between researchers and DVD*	The following were measured immediately following intervention and 4 months later: stigmatizing attitudes, intended social proximity, knowledge, prosocial emotional reactions to people with mental illness, cost effectiveness, participant satisfaction and emotional response
Domenech, 2011{Domenech, 2011 #385}.	PT Students		"Health care providers' conceptualisations of LBP and disability may also influence the recommendations they provide to their patients."	RCT The objectives of this study were to determine the effectiveness of 2 brief educational modules with different orientations (i.e., biomedical or biopsychosocial) on changing the	Students were cluster randomized into 2 groups: The experimental group received a specific education module based on the bio-psychosocial model of back-pain management, and the control	A total of 170 second-year physical therapy students participated in the study. Before inclusion in the study, all participants received theoretical and practical lessons on managing LBP,	University, Spain	To evaluate any changes in attitudes, 7 dependent variables were considered: FABQ–Work scores, FABQ–Physical Activity scores, HC-PAIRS scores, the perceived severity of symptoms and

Reference	Target of Intervention	Disability Population	Article Framing	Study Design and Aim	Intervention Duration and Intensity	Population	Setting	Primary Outcomes
				beliefs and attitudes of students, and to verify whether there were also changes in the recommendations given to their patients.	group received lectures on the biomechanics of the spine. The intervention in the experimental group consisted of 2 sessions of 3 hours each, 1 week apart. The educational sessions in the control group also consisted of 2 sessions 3 hours each, 1 week apart.	following the recommendations of the CPG, as part of their regular curriculum. The students had observed patients with back pain in clinical settings but had not directly managed or treated patients without supervision.		pathology, and recommendations for work and activity levels.
Friedrich, 2013{Friedrich, 2013 #2718}	Medical Students		"People with mental illness die prematurely. One reason is that their physical healthcare is on average worse than that provided to people without mental health problems. A potential mechanism underlying these disparities is discrimination against people with mental illness by health professionals who share the general public's stigmatising views towards such people."	RCT The aim of this study was to ascertain the effects of the training on medical students both immediately and after 6 months with respect to mental health-related knowledge, attitudes, intended behaviour and empathy.	The intervention consisted of a short lecture with key facts and figures about stigma and discrimination; testimonies about the experiences of mental health problems and stigma from people with direct experience of mental health problems, either personally or as carers; and role-plays in small groups, using professional role-players to act the parts of service users and carers. It is not clear what	1,452 third-year medical students randomized at baseline, 625 immediately after intervention, 137 at 6 month followup.	Four participating medical schools, UK	Mental health related knowledge, mental health related attitudes, reported and intended behavior scale, physician empathy

Reference	Target of Intervention	Disability Population	Article Framing	Study Design and Aim	Intervention Duration and Intensity	Population	Setting	Primary Outcomes
					happened with the controls.			
Goddard, 1998{Goddard, 1998 #2794}	Nursing Students		The attitudes of nurses and other health care professionals are believed to influence their interactions with people who have disabilities	RCT To determine whether or not there are significant differences between the Sensitivity Lab and control groups on the Attitudes Toward Disabled Persons scale immediately, 6 weeks and 6 months after lab.	The experimental group participated in the Sensitivity Lab and the control group did not. Sensitivity lab was an 8-hour clinical activity with three major parts: 1) a simulation activity in which students assumed various disabilities while carrying out normal activities in the community, 2) panel presentations by persons with a variety of disabilities and their caregivers, and 3) debriefing in small clinical groups	67 nursing students enrolled in a chronic disease course received the intervention, 54 students enrolled in the same course served as the control	University, Texas	Attitudes toward persons with disabilities scale
Kassam, 2011{Kassam, 2011 #3225}	Medical Students		"Like the general public, medical students often hold the stereotypical views that people with mental illness are unlikely to recover and people with severe mental illness are dangerous and violent"	RCT To compare the effects of 3 different interventions, and directly assessed students' mental illness related knowledge, attitudes and behaviour towards people with mental	The study was a nonrandomised controlled trial with three conditions: A. Control Condition (CC): none of the intervention elements below. B. Experimental Condition 1 (EC1): A presentation on	Of the 188 students who completed baseline instruments 110 (59%) had both pre- and post intervention instruments (Knowledge Quiz and MICA scale) completed and were used for subsequent	University, UK	Knowledge quiz, clinician attitudes scale, role play score

Reference	Target of Intervention	Disability Population	Article Framing	Study Design and Aim	Intervention Duration and Intensity	Population	Setting	Primary Outcomes
				illness.	mental illness related stigma that included the social and personal impacts of stigma against people with mental illness together with personal testimonies from a mental health service user and a caregiver of a person with mental illness. C. Experimental Condition 2 (EC2): As B above plus a role-play training session in a classroom setting with mental health service user and caregiver feedback.	analyses. Of the 204 allocated to EC1, 154 attended the lecture and completed satisfaction questionnaires. Of the 65 of the 204 allocated to EC2, 33 attended the role-play training and completed satisfaction questionnaires.		
Kirby, 2011{Kirby, 2011 #3292}	Undergraduate Medical Students		"Physicians too should be comfortable and knowledgeable about wheelchair use when caring for patients who use wheelchairs, to meet the patients' functional needs and to work effectively with other members of the healthcare team. However, many family physicians have	RCT The primary objective of this study was to test the hypothesis that a workshop tailored for undergraduate medical students would be effective in improving wheelchair-related knowledge, skills, and attitudes.	The intervention group received the 4-hour educational experience 6-9 days later. All participants from both groups attended an evaluation session 6 days after the workshop. The 6-mo questionnaire was Emailed to the participants in the intervention group, with follow-	A total of 196 first- and second-year medical students were invited to participate, 26 participants were randomly allocated into two equal-sized groups (intervention and control)	University, Canada	The main outcome measures were a written knowledge test, a practical examination, the Scale of Attitudes Toward Disabled Persons, and students' perceptions.

Reference	Target of Intervention	Disability Population	Article Framing	Study Design and Aim	Intervention Duration and Intensity	Population	Setting	Primary Outcomes
			reported discomfort when dealing with people who have physical disabilities"		up reminders as necessary.			
Melville, 2006{Melville, 2006 #3695}	Practice Nurses		"Practice Nurses have been identified as a group of professionals who make an important contribution to primary health care teams. However, they have significant unmet training needs relevant to their work with people with IDs."	RCT		Of the 201 Practice Nurses who completed the first questionnaire (69% response rate), 79 volunteered to participate in the training intervention. Practice Nurses who volunteered were sent the training pack and instructions, and invited to attend a training event on one of two arranged dates. Sixty-three Practice Nurses participated in the intervention and completed the research outcome measures. Of the participants, 42 (67%) Practice Nurses received the training pack and attended the training event (Group 1), and 21 (33%) Practice Nurses received the training pack only (Group 2). Sixty of the		

Reference	Target of Intervention	Disability Population	Article Framing	Study Design and Aim	Intervention Duration and Intensity	Population	Setting	Primary Outcomes
						Practice Nurses who had not participated in any aspect of the training initiative (Group 3) completed the questionnaire at Time 2.		
Meurs, 2010{Meurs, 2010 #3715}	Dentists		"People who are intellectually disabled have poorer oral hygiene and a higher prevalence of oral health problems compared to the general population…it seems that the dentist's attitude and experience with regard to patients who are intellectually disabled play a significant role, as dental treatment of this particular patient group demands extra time, and specific knowledge and skills."	RCT The purpose of the current study, therefore, was to investigate whether background information of a patient who is intellectually disabled would positively contribute to the level of cooperation during dental care.	In case of an unsealed envelope, the practicing dentist would read the completed questionnaire before starting the intake. In the case of a sealed envelope, the dentist was not allowed to see the questionnaire and received only limited information about the subject	58 persons with ID were randomly allocated to treatment or control conditions	The study was conducted from September 2007 to June 2008 at two centers of special dental care (CBT Fatima and CBT Nijmegen) in the Netherlands.	Cooperation scores
Munro, 2007{Munro, 2007 #1083}	Mental Health Nurses		"Substance misuse can trigger or be causally associated with mental health problems. Therapeutic	The aim of the study was to assess the impact of a tailored training programme on the therapeutic	Those who were allocated to the experimental group received 4 days of training. A range of teaching methods were	49 mental health nurses employed in adult generic mental health and addiction services were recruited to the study: 24 were	The study was conducted in an NHS mental health service in the West of	Therapeutic attitude was measured using the comorbidity problems perceptions questionnaire

Reference	Target of Intervention	Disability Population	Article Framing	Study Design and Aim	Intervention Duration and Intensity	Population	Setting	Primary Outcomes
			attitude is important in predicting effective engagement with people with alcohol and drug problems but health professionals' attitudes towards this client group are often negative."	attitudes and knowledge of mental health nursing staff with regard to working with people who have co-existing substance misuse and mental health problems.	employed, including small interactive group-work and lectures that were delivered over 4 full days, from 9.30 am–4.30 pm. The control group received no intervention.	randomly allocated to the experimental group (who received training) and 25 were allocated to the control group (who received no training). Random number generation from within the statistical package for the social sciences was used to allocate random samples from each strata into each group. Due to the nature of the intervention, no blinding of the participants was possible. Registered nurses who were employed in adult generic mental health and addiction services.	Scotland. A venue was purpose- built for staff training	(CMPPQ). The knowledge questionnaire was designed specifically for the study to reflect the course content
O'Reilly, 2011{O'Reilly, 2011 #3944}	Pharmacy students		"Mental illness is the leading cause of nonfatal disease burden in Australia…stigma remains the major barrier to receiving effective mental health care. Mental health stigma is not restricted to members of the public and can	RCT The aim of this study was to assess the impact of delivering Mental Health First Aid (MHFA) training for pharmacy students on their mental health literacy and stigma	Two MHFA courses (standard adult MHFA training program, first edition), of 12 h duration were conducted in September 2009. MHFA teaches participants skills to recognize the early warning signs of mental	All pharmacy students in their third year of a four-year Bachelor of Pharmacy degree were invited to participate, 174 applied to attend the training, 60 students were randomly selected to attend the training. 212	University of Sydney, Australia	Social distance scale, correct identification of mental disorder in vignette, beliefs about treatments for schizophrenia and depression, confidence with medication counseling and dealing with drug related problems

Reference	Target of Intervention	Disability Population	Article Framing	Study Design and Aim	Intervention Duration and Intensity	Population	Setting	Primary Outcomes
			extend to health care professionals, including pharmacists."	towards mental illness.	illness and how to provide initial help to someone in a mental health crisis.	students were in the control group.		
Papish, 2013{Papish, 2013 #3975}	Medical Students		"The stigma of mental illness among medical students is a prevalent concern that has far reaching negative consequences."	cluster-randomized trial design This study examined the impact of a one-time contact-based educational intervention on the stigma of mental illness among medical students and compared this with a multimodal undergraduate psychiatry course that integrates contact-based educational strategies.	A randomized control trial was designed to assess the impact of two different educational interventions on medical student attitudes towards mental illness: a one-time contact based educational intervention and a 4 week mandatory psychiatry course at the University of Calgary, in Calgary (U of C), Canada. The Psychiatry and Family Violence Course is part of the U of C Medical School's three-year, year-round program where clinical presentations are the foundation of the curriculum [44] and the majority of students have an undergraduate or graduate university degree prior to entering medical school.	Of the 179 students eligible to participate in the study, 111 completed a baseline survey (62.0% response rate). Of these, 81.0% (n=90) completed the second survey, 86.5% (n=96) completed the third survey and 52.1% (n=50) completed the 3 month followup survey. Although 96.1% (n=172) of the class responded to the third survey, only data from students who completed the baseline survey was used to assess the impact of the contact-based interventions.	University of Calgary, Canada	OMS-HC scores, Attitudes towards mental illness vs. type 2 diabetes Mellitus

Reference	Target of Intervention	Disability Population	Article Framing	Study Design and Aim	Intervention Duration and Intensity	Population	Setting	Primary Outcomes
					Students completed the course in their second year immediately prior to starting the clerkship component of their education.			
Symons, 2014{Symons, 2014 #4634}	Medical Students		'People with disabilities have reported physician attitudes as a barrier to receiving health care services.10,11 There is evidence that when health care providers are placed in a situation where they need to care for people with disabilities they may develop negative attitudes about working with this population because they lack training.	The study design is a controlled no-randomized before and after trial They developed and implemented a longitudinal curriculum to improve medical students' knowledge, attitudes, and skills pertaining to patient-centered care of persons with disabilities. This paper examines the effect of this curriculum on medical students' self-reported attitudes and comfort level in caring for people with disabilities.	The curriculum is described in detail in a previous publication. In brief, the curriculum is integrated into existing course curricula in all 4 years of medical student education.	Participants in the intervention group consisted of medical students enrolled in a public medical school (the State University of New York at Buffalo, NY). They were specifically the first cohort of students to participate in the entire core curriculum. The entire class participated in all elements of the curriculum. Participants in the control group consisted of medical students at a comparable public medical school in the same region (the State University of New York at Syracuse, NY).	Medical students in two public medical schools in NY	Medical students' self-reported attitudes and comfort level toward people with disabilities

Appendix Table D2. Risk-of-bias for cultural competence interventions targeting persons with disabilities

Study Country Funding	Type of Study	Overall Risk of Bias Assessment	Rationale
Interventions Aimed at Changing Health Professionals' Attitudes			
Clement, 2012[13] United Kingdom Government Primary researchers have investment in DVD tested by this trial	Randomized Trial	High	Blinding likely not possible, self-reported outcomes, differential duration of intervention arms, more a test of intervention modality than cultural components of intervention
Domenech, 2011[22] Spain Funding not reported	Cluster-randomized trial	Moderate	Blinding likely not possible, self-reported outcomes. Caveat – the biopsychosocial model may not be considered by all people to be a reasonable proxy for cultural competence, but we chose to include it because it was tailored to low back pain disability groups and was framed as addressing a disparity.
Friedrich, 2013[14] United Kingdom Government	Randomized Trial or Cluster-randomized trial	High	Unclear randomization and allocation concealment blinding likely not possible, self-reported outcomes, no attention control, controls not available for all participating colleges
Goddard, 1998[19] United States Funding not reported	Pre-Post, historical control	High	No randomization, blinding likely not possible, self-reported outcomes
Kassam, 2011[15] United Kingdom Industry, Government	Clustered trial	High	Not true randomization, allocated concealment adequately described, blinding likely not possible, self-reported outcomes, lack of attention control
Kirby, 2011[20] Canada No External Funding	Randomized Trial	High	Allocation concealment not adequately described, blinding likely not possible, self-reported outcomes, no attention control, small Ns (12 per arm)
Melville, 2006[12] Scotland Government	Controlled Trial	High	No randomization, blinding likely not possible, self-reported outcomes
Munro, 2007[18] Scotland Government	Randomized Trial	High	Allocation concealment and blinding not possible, 37% attrition, no attention control, self-reported outcomes
O'Reilly, 2011[17] Australia University funded	Randomized Trial	High	Process for randomization and allocation concealment not adequately described, blinding likely not possible, no attention control, some self-reported outcomes
Papish, 2013[16] Canada Government	Cluster-Randomized trial	High	Potential for contamination as those who received intervention early interacted with controls post-intervention (in the same course), significant differences in control and intervention clusters at baseline, only 52% of participants completed 3 month follow-up assessments
Symons, 2014[21] United States Government	Controlled Trial	High	No randomization, unclear if controls similar enough at baseline, no blinding, self-reported outcomes

Study Country Funding	Type of Study	Overall Risk of Bias Assessment	Rationale
Interventions Prompting Interaction Between Patients and Physicians			
Lennox, 2007[23] Australia Government	Clustered-randomized trial at the general practitioner level	Moderate	Unblinded, no attention control
Meurs, 2010[25] Netherlands Funding not reported	Randomized trial	Moderate	Inadequate sample size (<30 per arm)
Turk, 2010[24] United Kingdom Government	Cluster-randomized trial at practice level	High	Blinding not possible, only 54% of adults with learning disabilities completed the research interview at baseline and 32% of adults with learning disabilities dropped out before follow-up
Wolraich, 2005[26] United States Funding not reported	Longitudinal	High	No randomization, low treatment uptake (only 34% of students randomized to the intervention arm had a parent receive the intervention, and only 19% had a PCP receive the intervention)
Interventions Improving Access to Care			
Finlayson, 2011[28] United States Government	Randomized Trial	High	No attention control
Knaevelsrud, 2007[34] Germany NGO	Randomized Trial	High	Randomization, allocation concealment and blinding not adequately described, self-reported outcomes, describe having a wait list control group but data not analyzed against control
Shigaki, 2013[29] United States Government	Randomized Trial	High	Unclear randomization and allocation concealment, no blinding, 22% attrition in intervention arm, no attention control, self-reported outcomes

Appendix D3. Description and characteristics of included studies—LGBT

	Bowen et al., 2006{Bowen, 2006 #288}	**Blas et al., 2010{Blas, 2010 #287}**	**Peck et al., 2005{Peck, 2005 #289} Shoptaw et al., 2005{Shoptaw, 2005 #367}**	**McKirnan et al., 2010{McKirnan, 2010 #285}**	**Marrazzo et al., 2011{Marrazzo, 2011 #284}**
Sequence generation	The sequence generation process was not described.	Per study protocol, a computer randomly assigns the participant to one of the two arms of the intervention. The randomization will be automatically done by an algorithm that evaluates each case and uses a random number generator to make an independent assignment.	An urn randomization procedure was used that provided multivariate balance across conditions based on level of drug use (heavy versus light) and ethnicity (Caucasian, Hispanic, African American, other).	The sequence generation process was not described.	"…randomization included a simple randomization scheme generated by a statistician." (p.400)
Allocation concealment	Allocation concealment was not described.	Web-based allocation allowed for concealment.	Allocation concealment was not described.	The research assistant called a central research office to receive randomly assigned participant number. The assigned identification number coded the participant as intervention or comparison.	"After enrolment, the study coordinator obtained the randomization assignment from a sealed envelope that was generated in a sequence reflecting this scheme." (p.400)
Blinding of participants, personnel and outcome assessors	No evidence of blinding	Investigators were blinded to condition assignments.	No evidence of blinding	No evidence of blinding	No evidence of blinding
Incomplete outcome data	It is not clear whether or not intent to treat (ITT) analysis was conducted.	The authors describe using an ITT analysis.	The authors describe using an ITT analysis.	The authors described first using an ITT analysis (80% completion) followed by multiple imputation. It appears the analysis was conducted on only those who completed followup (Figure 1).	The authors describe using an ITT analysis.
Selective outcome reporting	I don't think there was selective outcome reporting. More transparent to present all outcomes in Table 3.	No evidence of selective outcome reporting	Missing values on outcome variables were not imputed for univariate or multivariate analyses. Missing data were handled using casewise deletion.	No evidence of selective outcome reporting	No evidence of selective outcome reporting

	Bowen et al., 2006{Bowen, 2006 #288}	**Blas et al., 2010{Blas, 2010 #287}**	**Peck et al., 2005{Peck, 2005 #289}** **Shoptaw et al., 2005{Shoptaw, 2005 #367}**	**McKirnan et al., 2010{McKirnan, 2010 #285}**	**Marrazzo et al., 2011{Marrazzo, 2011 #284}**
			No evidence of selective outcome reporting.		

Appendix Table D4. Risk-of-bias for cultural competence interventions targeting gender and sexual minorities

Study Country Funding	Type of Study	Overall Risk of Bias Assessment	Rationale
Interventions Aimed at Prompting GSM Patients to Interact With the Formal Healthcare System for Screening or Testing			
Blas, 2010[110] Peru Government/NGO	Randomized trial	High	Lack of equivalent control
Bowen, 2006[114] United States Government	Randomized trial	High	Unclear randomization process and allocation concealment, unblinded, no attention control
Clinic-based Mental Health and Substance Use Interventions Tailored to a GSM Population			
Peck, 2005[111] United States Government Shoptaw, 2004[112] United States Government	Randomized trial	High	Unclear blinding of participants or assessors. Unclear attrition reporting and missing data analysis for sexual risk behavior outcomes. ,
Interventions Aimed at Behavioral Risk Reduction That Involve Formal Healthcare Providers			
Bachmann, 2013[108] United States Government	Longitudinal	High	Nonrandomized longitudinal design, possible bias due to attrition
Patel, 2012[109] United States Government	Prospective cohort, pre-post	High	Nonrandomized pre-post design
McKirnan, 2010[103] United States Government	Randomized trial	High	Unclear randomization process and allocation concealment, unblinded, no attention control
Marrazzo, 2011[115] United States Government	Randomized trial	High	Unclear blinding of participants or assessors, lack of clarity in describing intervention components
Interventions Testing Medical Training Curricula			
Kelly, 2008[117] United States Government	Pre-post	High	Nonrandomized pre-post survey design
McGarry, 2002[95] United States Funding not reported	Pre-post	High	Nonrandomized pre-post survey design
Beagan, 2003[116] Canada	Prospective cohort, historical control	High	Nonrandomized pre-post survey design

Study Country Funding	Type of Study	Overall Risk of Bias Assessment	Rationale
Government			
Psychosocial Interventions			
Fobair, 2002[113] Unites States Government	Pre-post	High	Nonrandomized pre-post design, insufficient sample size

Appendix Table D5. Risk-of-bias for cultural competence interventions targeting racial/ethnic minorities

Study Funding	Type of Study	Overall Risk of Bias Assessment	Rationale
Interventions to improve provider/patient interactions			
Alegria, 2014[171] Government	Randomized trial	High	Unblinded, no attention control
Cooper, 2013[170] Government, Foundation	Cluster randomized trial with patient-level ITT analyses	High	Unblinded, possible confounding (cultural competence one component of multicomponent intervention)
Penner, 2013[169] Government	Randomized trial (at physician level)	High	Unclear randomization process and allocation concealment, unblinded, inadequate sample size (n=14 physicians)
Aragones, 2010[168] Government	Randomized trial (at physician level)	High	Unblinded, no attention control
Michalopoulou, 2010[173] Government	Controlled trial	High	Nonrandomized design, noattention control, possible reporting bias
Alegria, 2008[172] Government	Controlled trial	High	Nonrandomized design, no attention control
Culturally tailored interventions			
Breitkopf, 2014[174] Government	Randomized trial	Moderate	Possible bias due to attrition
Kim, 2014[178] Government	Randomized trial	High	Unblinded, lack of time equivalent control, possible bias due to attrition
Calsyn, 2013[183] Government	Randomized trial	High	Nonrandomized design, possible bias due to attrition, possible reporting bias
Lee, 2013[180] Government	Randomized trial	High	Unclear randomization process and allocation concealment, unblinded
Burrow-Sanchez, 2012[175] Government	Randomized trial	High	Unclear randomization process and allocation concealment, unblinded, inadequate sample size
Ell, 2011[184] Government	Randomized trial	High	Unblinded, no attention control, possible bias due to attrition
Pan, 2011[182] Government	Randomized trial	High	Unclear randomization process and allocation concealment, unblinded, inadequate sample size, possible reporting bias
D'Eramo Melkus, 2010[177] Government	Randomized trial	High	Unclear randomization process, allocation concealment, unclear blinding, possible bias due to attrition, possible confounding (cultural competence one component of multicomponent intervention)
Marsiglia, 2010[181] Government	Randomized trial	High	Unblinded, no attention control
Kohn, 2002[179] Funding not reported	Cohort study	High	Nonrandomized design, inadequate sample size

Appendix Table D6. Map of studies included in Truong 2014 review of systematic reviews, with focus on provider training—racial/ethnic populations

Study	Aims	Provider Training in Scope	Number of Included Studies	Map to Our Review: Inside or Outside Our Scope; Inclusion of Provider Training	Results for Provider Training
Anderson, 2003{Anderson, 2003 #608}	To review interventions to improve cultural competence in healthcare systems (provider training, translation, tailored media, recruitment of diverse staff, and culturally specific settings)	Yes and broader	6	Outside: translation, health education material Training – 1 study	1 RCT (Wade, 1991)in Horvat
Beach, 2005{Beach, 2005 #609}	To synthesize the findings of studies evaluating educational interventions to improve the cultural competence of health professionals	Yes	34	Training: 34 studies	There is good evidence that cultural competence training improves staff knowledge, attitudes, and skill, and that the provision of training to staff improves patient satisfaction. Evidence to show improvements in patient adherence was poor and no studies reported patient health outcomes.
Bhui, 2007{Bhui, 2007 #610}	A systematic review that included evaluated models of cultural competence training or service delivery	Yes and broader	9	Training: 3 with quantitative outcomes, 1/3 reporting prevalence of services Inside: service delivery – 1 study, case series only	2 pre-post studies with positive results for provider behavior and satisfaction, no patient outcomes
Chipps, 2008{Chipps, 2008 #611}	To review studies evaluated cultural competence training in community-based rehabilitation settings	Yes	5	Training: 5 studies	3/5 studies overlap with Horvat (Wade, Thom, Majumdar) 2/5 studies overlap with Beach (Wade, Smith)
Downing, 2011{Downing, 2011 #612}	To review approaches to indigenous cultural training for health workers in Australia	Yes, but outside our scope	9	Outside: training within Australia	N/A
Fisher, 2007{Fisher, 2007 #613}	To review interventions (that modified patient behavior, access, or the health care system) using cultural leverage to narrow racial disparities in health care	Yes and broader	38 (35 unique studies)	34/35 lacked comparison to test CC Training: 1 study	1 study (Briscoe, 1999), pre-post: 10-30% of participants implemented cultural strategies at 6 month followup
Forsetlund, 2010{Forsetlund, 2010 #614}	To review interventions to improve health care services for ethnic minorities	Yes and broader	19 RCTs	Training: 8 studies, 5/8 not on CC Outside: translation, matching, or not CC (reminders, care organization)	3 CC training studies, all in Horvat (Wade, Thom, Harmsen)
Harun, 2013{Harun, 2013 #615}	To review interventions to improve 3 aspects of participation in cancer care among CALD groups: involvement in decisionmaking, communication with health providers and treatment	No	7	In scope/no comparison: patient navigation (3 studies) Outside: culturally tailored video, individualized decision support software	N/A

Study	Aims	Provider Training in Scope	Number of Included Studies	Map to Our Review: Inside or Outside Our Scope; Inclusion of Provider Training	Results for Provider Training
	adherence				
Attridge, 2014{Attridge, 2014 #673} (updated – Truong included earlier version)	To assess the effectiveness of culturally appropriate health education for people in ethnic minority groups with type 2 diabetes mellitus	No	33	In scope 32/33 lacked comparison to test CC 1/33 included: D'Eramo Melkus	N/A
Henderson, 2011{Henderson, 2011 #617}	To review of the literature on the effectiveness of culturally appropriate interventions to manage or prevent chronic disease in CALD communities	Yes and broader	24	Training:4 studies, 1/4 outside scope (translation) Outside: translation, culturally tailored media, establishment of point-of-care testing In scope: culturally tailored interventions (CHW, 16 studies) 16/16 no comparison	1/4 studies in Horvat (Majumdar), 1 pre/post study (Chevannes et al. 2002) and 1 longitudinal study (Schim et al. 2006) reported improved provider knowledge/attitudes
Kehoe, 2003{Kehoe, 2003 #618} good early discussion of intensity/duration	To review culturally relevant healthcare interventions, and their effect on health outcomes	No	14	In scope/ no comparison: culturally tailored interventions (12 studies) Outside: media only	N/A
Kokko, 2011{Kokko, 2011 #619}	To describe the learning experiences of nursing students studying abroad	Yes, but outside our scope	7	Training	N/A
Lie, 2011{Lie, 2011 #620}	To review the effects of cultural competency training on patient-centered outcomes	Yes	7	Training: 7 studies	4/7 overlap with Horvat (Wade, Majumdar, Thom, Sequist) 2 pre/post studies reported improved evaluations of care (patient family satisfaction, perceived environmental changes favoring their interests and 'ethnic affinity' toward staff), 1 pre/post study reported improvement in provider perception of communication
Lu, 2012{Lu, 2012 #621}	To synthesize knowledge about the effectiveness of cancer screening interventions targeting Asian women	Yes, but outside our scope	37	Cancer screening interventions, sometimes culturally tailored, lack of design to test CC	N/A
McQuilkin, 2012{McQuilkin, 2012 #622}	To evaluate the effectiveness of educational strategies for cultural competence of undergraduate baccalaureate nursing students	Yes, but outside our scope	37 (16 interventions)	Training	N/A

Study	Aims	Provider Training in Scope	Number of Included Studies	Map to Our Review: Inside or Outside Our Scope; Inclusion of Provider Training	Results for Provider Training
Pearson, 2007{Pearson, 2007 #623}	To evaluate evidence on the structures and processes that support development of effective culturally competent practices and a healthy work environment	Yes	19	Training: 2 quantitative studies (outside scope, matching), 4 qualitative, 13 textual	N/A
Smith, 2006{Smith, 2006 #624}	To examine the effectiveness of multicultural education in mental health care professions	Yes	37 on interventions	Training: 37 studies, lack of detail on individual studies and outcomes	N/A
Sumlin, 2012{Sumlin, 2012 #625}	To synthesize research that tested culturally competent food-related interventions designed for African American women with type 2 diabetes	No	15	In scope/ no comparison (15 studies) Culturally tailored interventions or targeted not tailored	N/A
Whittemore, 2007{Whittemore, 2007 #539}	To synthesize the research on culturally competent interventions for Hispanic adults with type 2 diabetes	No	11	In scope, culturally tailored interventions10/11 no comparison,1/11 not on CC	N/A

Abbreviations:CALD = culturally and linguistically diverse; CC=culturally competence; N/A=not applicable

Appendix Table D7. Quality of previous systematic reviews—racial/ethnic populations

Study	A priori Study Design	Dual Study Selection and Data Abstraction	Comprehensive literature search	Publication Status	Lists of Included and Excluded Studies Provided?	Scientific Quality of Included Studies Assessed and Documented?	Scientific Quality of Included Studies Used Appropriately in Formulating Conclusions?	Methods of Combining Studies Appropriate?	Likelihood of Publication Bias Assessed?	Conflict of Interest Stated?	Overall Quality
Horvat, 2014{Horvat, 2014 #162}	yes	yes	yes	yes	yes	yes	yes	yes	unclear	yes	good
Truong, 2014{Truong, 2014 #571}	yes	yes	yes	yes	yes	yes	unclear	unclear	unclear	yes	fair

Appendix Table D8. Outcomes reported by studies of cultural competence interventions for racial/ethnic minority populations

Study	Clinical Outcomes	Patient Perceptions	Patient Satisfaction	Utilization/ Adherence	Provider Attitudes or Perceptions	Adverse Events
Patient/provider interaction						
Alegria, 2014{Alegria, 2014 #551}	NR	Yes, patient assessment of patient activation and self-management	NR	Yes, engagement, retention	NR	NR
Cooper, 2013{Cooper, 2013 #559}	Yes, depression symptom reduction	Yes, rating of clinicians' participatory decisionmaking	Yes, rating care manager as helpful in identifying concerns, identifying barriers, providing support, and improving treatment adherence	Yes, treatment rates	NR	NR
Penner, 2013{Penner, 2013 #570}	NR	Yes, sense of being on the same team, perception of patient-centeredness, trust of physician and trust of physicians in general.	NR	Yes, adherence to physicians' recommendations	Yes, sense of being on the same team	NR
Aragones, 2010{Aragones, 2010 #553}	NR	NR	NR	Yes, completed CRC screening, physician recommendation for CRC screening, and patient adherence to physician recommended CRC screening	NR	NR
Michalopoulou, 201{Michalopoulou, 2010 #568}	NR	Yes, perceived Cultural Competency Measure, fair procedures, participation	Yes	NR	NR	NR
Alegria, 2008{Alegria, 2008 #552}	NR	Yes, self-reported patient activation and empowerment	NR	Yes	NR	NR
Culturally tailored interventions						
Breitkopf, 2014{Breitkopf, 2014 #554}	NR	NR	NR	Yes, adherence, delay in care, completeness of care	NR	NR
Kim, 2014{Kim, 2014 #564}	Yes	NR	NR	Yes, number of sessions completed	NR	NR
Calsyn, 2013{Calsyn, 2013 #556}	Yes	NR	NR	Yes	NR	NR
Lee, 2013{Lee, 2013 #566}	Yes	NR	NR	NR	NR	NR

Study	Clinical Outcomes	Patient Perceptions	Patient Satisfaction	Utilization/ Adherence	Provider Attitudes or Perceptions	Adverse Events
Burrow-Sanchez, 2012{Burrow-Sanchez, 2012 #555}	Yes	NR	Yes	Yes	NR	NR
Ell, 2011{Ell, 2011 #562}	Yes	NR	NR	Yes	NR	NR
Pan, 2011{Pan, 2011 #569}	Yes	Yes, participant – therapeutic working alliance	NR	NR	Yes, therapist – therapeutic working alliance	NR
D'Eramo Melkus, 2010{D'Eramo Melkus, 2010 #560}	Yes	Yes, perceived provider support for diet and exercise	NR	NR	NR	NR
Marsiglia, 2010{Marsiglia, 2010 #567}	NR	NR	NR	Yes	NR	NR
Kohn, 2002{Kohn, 2002 #565}	Yes	NR	NR	NR	NR	NR

Appendix E. LGBT – Summary of Published Recommendations

	General Recommendations	Specific Recommendations
Hanssmann, 2008	• General need for more training • Organizational or agency-wide change and support • integrate patient satisfaction measures into practice	
Heck, 2006	• More information in residency programs and CME for PCPs • Encourage government and industry to offer health coverage for individuals involved in domestic partnerships	
Tillery, 2010	• Health professional students and health professionals to need training about sexual orientation, gender identity and expression and HIV status • Require all health care facilities and education programs that receive government funding to develop and implement goals, policies and plans to ensure that LGBT people and people living with HIV are treated fairly and provide ongoing cultural competency training • Prohibit discriminatory practices by insurance providers that deny or limit coverage for needed care by LGBT people	• Develop and implement goals and plans to ensure that LGBT people and people living with HIV are treated fairly • Establish nondiscrimination, fair visitation and other policies that prohibit bias and discrimination based on sexual orientation, gender identity and expression and HIV status • Report discriminatory practices, sharing stories and contacting Lambda Legal and other advocacy organizations and/or attorneys
Reed 2010	Clinicians knowledgeable and skilled in the follow-up of abnormal anal cytology results, including high resolution anoscopy and biopsy	More than 25% of our respondents indicated that they had not disclosed that they have sex with men to their health care providers. This finding indicates a greater need for health care providers to create environments that facilitate disclosure of their sexual behaviors to allow providers to identify men most likely to benefit from anal cancer prevention services
Mimiaga et al., 2007	• training around the special needs and vulnerabilities of MSM • clinical presentation of STDs among MSM, and to project a nonjudjemental manner when performing STD screening, providers also need to be trained to understand that STD and HIV risk-taking behavior among MSM is often occurring in the context of intertwined syndemics •	• clinicians must demonstrate their comfort in addressing health issues tied to sexuality to draw people into testing and treatment • Medical histories and examinations can be conducted in ways that do not presume heterosexuality but are inclusive of various sexual identities, family/relationship arrangements, and sexual behaviors • Be especially attuned to patients who may be reticent to fully disclose issues around sexuality, health risks, and exposures
Grant et al., 2010	• Medical establishment must fully integrate transgender-sensitive care into its professional standards, and this must be part of a broader commitment to cultural competency around race, class and age • Anti-transgender bias in the medical profession and U.S. health care system has catastrophic consequences for	Doctors and other health care providers who harass, assault, or discriminate against transgender and gender non-conforming patients should be disciplined and held accountable according to the standards of their professions

	General Recommendations	Specific Recommendations
	transgender and gender non-conforming people • Public and private insurance systems must cover transgender-related care; it is urgently needed and is essential to basic health care for transgender people	
Gay & Lesbian Medical Association, 2006	Training for all staff is critical to creating and maintaining practice environments deemed safe for LGBT patients. Training should be periodic to address staff changes and keep all staff up-to-date	• Filling out the intake form gives patients one of their first and most important impressions of your office. The experience sets the tone for how comfortable a patient feels being open about their sexual orientation or gender identity/expression • Lesbian, gay, bisexual, and transgender (LGBT) patients often 'scan' an office for clue to help them determine what information they feel comfortable sharing with their health care provider • When talking with transgender people, ask questions necessary to assess the issue, but avoid unrelated probing. Explaining why you need information can help avoid the perception of intrusion • Discuss safer sex techniques and be prepared to answer questions about STDs and HIV transmission risk for various sexualities relevant to LGBT people • When talking about sexual or relationship partners, use gender-neutral language such as 'partner(s)' or 'significant other(s).' Ask open-ended questions, and avoid making assumptions about the gender of a patient's partner(s) or about sexual behavior(s) • Listen to your patients and how they describe their own sexual orientation, partner(s) and relationship(s), and reflect their choice of language • Universal gender-inclusive 'Restroom
Dodge et al., 2012	• Maintain privacy normalize bisexuality on a structural level, so that other individuals' potentially negative feelings about bisexual men do not interfere with decisions about health services • improved education and access for bisexual men are a critical for increasing knowledge and improving uptake of services for rectal STI	• The fear of inadvertent disclosure appeared throughout the narratives and across participants. Our data establish that the influence of others' perceptions of their sexuality have an impact on their likelihood of engaging in health services • Use broad terms like men's health, or list all three sexual orientation categories (bisexual, heterosexual, and homosexual) on health service materials, since this diminish concerns related to other's perceptions of their sexuality • Providing information that is pertinent to men of all behavioral repertoires would allow men the option to read about issues facing men of all sexual orientations without fear of inadvertent disclosure • Set up systems that facilitate an individual being seen by the same provider over time, versus one of many providers at a clinic
Kaestle,et al., 2011	• Sexual minorities may have particular difficulty communicating with their physicians, and physicians may be uncomfortable interacting with sexual minority patients • To facilitate a more accurate perception of risk among sexual minorities, health practitioners can work to	• Health care providers should not make assumptions about sexual risk behaviors on the basis of a patient's self-reported sexual identity; rather, they should take a careful sexual history of sexual minority patients and provide safer-sex information to all patients

	General Recommendations	Specific Recommendations
	promote the development and implementation of more effective curricula and to break down some of the stigma and barriers in communication about sensitive sexual behaviors in public health services and physician offices	
Politi et al., 2009		• Women who partner with women reported a strong preference for female providers because of perceived difficulties communicating about sexuality with male physicians. Male providers should be aware of both patients' and their own potential discomfort and should remain sensitive to discussions about sexual health • [Prior] to obtaining a sexual history, primary care providers should explain the reason for asking questions about sexual health • If written information is deemed necessary prior to a verbal history, questions should be phrased in ways that allow inclusion of all women regardless of partner gender or partner status
Bradford et al., 2012		• Providers may not be comfortable asking these questions, or lack knowledge on how to elicit information…. this should not prevent providers from asking such questions and trying to gather such data • Providers should ask permission to include information about a patient's sexual orientation and gender identity in the medical record, remind the patient of its importance to quality health care, and assure him or her that the information will be kept confidential • When seeing a patient for the first time, providers should also ask questions about sexual orientation, behavior, and gender identity during the patient's visit • Questions both on registration forms and during patient exams will alert providers to screen patients for conditions disproportionately affecting LGBT people, and to provide preventative health education appropriate to LGBT people • Respondents are 1.5 to 1.6 times more likely to report same-sex behavior and attraction on an audio computer assisted self-interviewing survey than in response to questions asked by an interviewer
Reisner et al., 2010		• Safer sex education materials are needed that are tailored to meet the needs of TMSM, including differentiating by partner genders (i.e., male, female, transmen, transwomen), type (i.e., casual, anonymous, monogamous, etc.), and sexual behaviors (i.e., frontal/vaginal or anal sex; oral sex; body contact with the exchange of body fluids; sex toys, etc.). Also needed is information about sexual health more broadly, including information about pregnancy and how to navigate pregnancy-related health care services as a transman • Integrating sexual health information 'by and for' Transmen into other healthcare services, involving peer support, addressing mood triggers such as depression and anxiety, Internet-delivered information and

	General Recommendations	Specific Recommendations
		services for Transmen and their sexual partners, making safer sex materials 'hot' (i.e., erotic) and pleasure-focused
Polek, et al., 2010		Healthcare providers can help reduce barriers that women may encounter by assessing their offices for approachability, attitudes, accountability, and awareness
Heck, et al., 2006		outreach programs aimed toward the lesbian community to improve this population's regular use of health services
National LGBT Health Education Center, 2013		• Health care organizations should have a system that allows patients to input their preferred name, gender, and pronouns into registration forms and other relevant documents • Avoid asking unnecessary questions: People are naturally curious about transgender people, which sometimes leads them to want to ask questions. However, like everyone else, transgender people want to keep their medical and personal lives private • Have procedures in place that hold staff accountable for making negative or discriminatory comments or actions against transgender people • Have single-occupancy bathrooms that are not designated as male or female • Avoid gender terms
Martinez et al., 2005		• Extend the health guidance (or anticipatory guidance) time that clinicians spend with young women engaging in sexual activity • Have providers who can develop trusting relationships with them to have them openly disclose their sexual activities
Marrazzo et al., 2005		• Because participants generally believed the risk of STD transmission between women to be low, interventions need to include an educational component explaining the evidence that exists to support such a possibility. If this is not adequately conveyed, women may have little motivation to practice protective behaviors.... interventions need to target a range of common sexual practices, including digital-vaginal penetration and use of vaginally insertive sex toys • Emphasize cleanliness, particularly as part of 'natural health,' and if they frame the preventative practice in terms of sexual enjoyment and healthy sexuality, rather than in terms of disease and emphasize respect for one's body and one's sexual choices