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About Cultural Competency in Oregon

Author: Lauren Roberson, BA, MPT

Contact hours: 2

Cost: $24

The two-hour cultural competency training is required for healthcare providers in Oregon.

Course Objectives

Upon completion of this course, you will be able to:

1. Describe 5 ways in which culture influences healthcare providers.
2. Define power, privilege, and oppression.
3. List 5 social determinants of health.
4. Explain the 3 main components of patient rights and responsibilities for healthcare facilities.
5. Understand the ways in which cultural competence and good communication are linked.

1. Cultural Sensitivity in Healthcare

Cultural sensitivity is an ongoing process of self-assessment that helps all of us develop skills, attitudes, and behaviors to better understand people from diverse cultural backgrounds. It means you are "culturally humble"—understanding that you are not the expert in all cultural matters.

Cultural sensitivity helps us manage prejudices and stereotypes that can affect interactions with people from different cultures and backgrounds and helps us understand that a person's cultural and personal beliefs affect their perceptions of health, illness, and death, beliefs about causes of disease, and approaches to health promotion. Cultural sensitivity helps us understand that culture influences how illness and pain are experienced and expressed, where patients seek help, and the types of treatment patients prefer (Mayhew, 2018).

Source: NIH.

1.1 Self-Awareness and Self-Assessment

Self-awareness and self-assessment of cultural concepts are closely related to health equity, showing us that values often assumed to be universal can be relative in nature. These practices help us understand the influences of diverse but interrelated determinants of health and offers new models of care that account for more than just biology and medicine.

Test Your Knowledge

You may find it helpful to try these 10 "True or False" questions first before reading the course. The answers are at the end of the question list.

1. **Implicit bias** is a conscious process based on intentional mental associations.
2. **Health equity** means that everyone has a fair and just opportunity to be as healthy as possible.
3. **Structural racism** refers to ideologies, practices, processes, and institutions that produce and reproduce differential access to power and to life opportunities along racial and ethnic lines.
4. **Cultural sensitivity** is a respect for another person's strengths, culture, and knowledge.
5. A type of unconscious bias that occurs when our perception is skewed based on inaccurate and overly simplistic assumptions about a group or person is called **perception bias**.
6. Evidence shows that interventions focusing on social determinants of health rarely lead to better health outcomes.
7. **Perception bias** is a type of unconscious or implicit bias that occurs when our perception is skewed based on inaccurate and overly simplistic assumptions about a group a person "belongs" to.
8. Historically embedded structural racism is a fundamental cause of health inequities in the United States.
9. Measures of implicit bias rely on the assumption that automatic associations between two concepts will influence behavior in a measurable way.
10. Bias training has been shown to be more effective when the approach is multipronged, designed with context and professional identity in mind, and when people work and train together.

Answers: Questions 1 and 6 are False; all the others are True.
Source: NIH

1.2 Background

Cultural sensitivity in healthcare is not a new concept—it has been studied in the field of nursing at least since the 1970s. Early research included the analysis of different cultures, nursing care practices, values and beliefs, and concepts of health and disease (Gradellini et al., 2021).

In 2002, the National Academies published a comprehensive assessment of racial and ethnic disparities in healthcare. The report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* analyzed barriers to accessing care, historic and contemporary inequities, and pressures for cost-containment. They looked at the clinical encounter itself and found evidence that stereotyping, biases, and uncertainty on the part of healthcare providers can all contribute to unequal treatment (IOM, 2003).

Source: CDC.

The report found that people in racial and ethnic minority groups received lower-quality healthcare than whites received, even when they were insured to the same degree and when other healthcare access-related factors, such as the ability to pay for care, were the same. Clients in minority groups were also not getting their needs met in mental health treatment. The IOM report was a primary impetus for the cultural competence movement in healthcare (Stubbe, 2020).

Cultural sensitivity, cultural awareness, cultural safety, cultural humility, and cultural competence are closely related concepts. Awareness means you strive to improve your understanding of the norms and customs of multi-cultural groups. Safety means you work to protect the culture of vulnerable groups by identifying biases and power imbalances within organizational structures. Humility means you keep an open mind and a non-judgmental approach to patient care (Shepherd et al., 2019). Competence means you integrate knowledge into specific standards, policies, practices, and attitudes.

Healthcare providers who are unaware or insensitive to the process by which cultural identity develops can—regardless of their own race or ethnicity—often unwittingly minimize the importance of racial and ethnic experiences. This means they may fail to identify cultural needs or recommend appropriate treatments. They can operate from a superior perspective, take a patient's reactions or disagreements personally, and view a client through a veil of societal biases or stereotypes (SAMHSA, 2016).

1.3 How Culture Influences Healthcare Providers and Affects Patients

Whether you are aware of it or not, culture influences healthcare practices and can affect a provider's perceptions, practices, and decision-making. All forms of knowledge and practice are influenced by culture.

Culture can commonly be divided into two broad categories: **collectivistic** or **individualistic**. Most cultures include characteristics of both, although within any given culture, there are individual variations. Being familiar with characteristics of collectivistic and individualistic cultures helps practitioners personalize patient care and understand where patients and family members fall within their cultural continuum (Mayhew, 2018).

Characteristics of Collectivistic and Individualistic Cultures	
Collectivistic	**Individualistic**
Focus on “we”	Focus on “I”
Promote relatedness and interdependence	Value autonomy
Connection to the family	View ability to make personal individual choices as a right
Value respect and obedience	Emphasize individual initiative and achievement
Emphasize group goals, cooperation, and harmony	Lesser influence of group views and values, and in fewer aspects of life
Greater, broader influence of group views and values	

Source: Canadian Paediatric Society, Caring for Kids New to Canada; Centre for Innovation and Excellence in Child and Family Centred Care at SickKids Hospital, Toronto. How Culture Influences Health: Caring for Kids New to Canada—How Culture Influences Health. Used with permission.

1.4 Creating a Respectful Healthcare Environment

The foundation of good quality healthcare rests on respectful, non-judgmental decision making and good clinical reasoning. Respect means recognizing a patient’s value and honoring or acknowledging their dignity. Respect strengthens a clinician’s moral commitment to their patients and supports authentic interactions. Conveying respect has positive effects on health outcomes, patient satisfaction, and mutual trust (Bridges et al., 2021).

Healthcare organizations demonstrate respect by incorporating the perspectives of patients and community members into their policies and practices. Equitable access to care is a priority. Clinicians and organizations should be responsive to feedback from patients about how best to build a patient-centered culture of respect. Learning about a patient’s experiences of respect helps build clinical partnerships and promotes positive health outcomes (Bridges et al., 2021).

Historical factors have influenced healthcare practices and have contributed to a mistrust of the healthcare system. For example, patients from Indigenous and culturally and linguistically diverse backgrounds frequently report that healthcare staff is disrespectful, unwelcoming, and unfriendly. Healthcare personnel can provide a safe cultural environment by reflecting of their own cultural beliefs, understanding patient rights, and acknowledging patient-clinician power dynamics (Kayrouz et al., 2021).

1.5 Morality, Ethics, and Cultural Competence

Morality plays a fundamental role in the functioning of any human society by regulating social interactions and behaviors. Morality involves a set of values, implicit rules, and principles. This includes long-standing, shared cultural customs that guide social behavior (Bentahila, Fontaine, and Pennequin, 2021).

Ethics, morality, and culture are strongly related. In general, Western countries emphasize the ethical concepts of autonomy and the individual, while Eastern countries tend to emphasize autonomy and community. Some Eastern cultures, advocate the ethics of community and of divinity (Bentahila, Fontaine, and Pennequin, 2021).

Cultural differences depend upon the importance of certain ethical principles (Bentahila, Fontaine, and Pennequin, 2021):

- **Autonomy**—protects the individual, their liberty, and their rights, to help them satisfy their needs, and achieve their goals.
- **Community**—protects the integrity of the group, its structure, its organization, its reputation, as well as the roles and the status of its members.
- **Divinity**—insists upon protecting the soul and the spirit, as well as all the spiritual aspects of the individual and their natural environment.

Understanding and awareness of these differences involves basing decisions on a combination of medical knowledge and moral principles, including beneficence, non-maleficence, autonomy, justice, and respect for persons.

Beneficence is the act of being kind. Non-maleficence means do no harm. Autonomy is the respect for individual rights and freedoms. Justice is the degree to which healthcare services are distributed equitably throughout society as well as how healthcare is delivered at the individual level. Respect means recognizing a patient's value and honoring or acknowledging their dignity.

The principle of justice is perhaps the most relevant to cultural competence and diversity. It states that people have the right to be treated fairly and equitably. It means respecting the rights of individuals and treating all patients the same regardless of who they are (Olejarczyk and Young, 2022).

Ethical challenges, conflicts, or dilemmas can influence the care and treatment of patients. One such ethical threat is placing materialistic self-interest and profit over ethical care. Another is ethical questions related to scientific advances such as mapping of the human genome. Genetic advances have made possible some procedures that raise ethical issues. Should something like the cloning of animals—even humans—be allowed simply because the procedure is possible?

Healthcare quality measurements created by insurers, professional organizations, and government agencies can create ethical dilemmas because they often fail to incorporate the voices of diverse communities, leading to a lack of understanding of the needs of the entire population. Until these diverse voices are heard, communities experiencing social injustices caused by historical, racial, and systemic violence will continue to experience healthcare disparities (Culhane-Pera et al., 2021).

2. Power, Privilege, and Oppression

> Well, I found out that race runs deeply throughout all of medical practice. It shapes physicians' diagnoses, measurements, treatments, prescriptions, even the very definition of diseases. And the more I found out, the more disturbed I became.
>
> Dorothy Roberts
> University of Pennsylvania

Social injustices and structural inequities negatively impact the health of many low income and minority communities. This contributes to high disease burdens, difficulties accessing healthcare, and a lack of trust in the healthcare system. These complex and interconnected mechanisms can lead to physiological and psychological stress from repeated daily inequities, which can contribute to chronic diseases (Culhane-Pera et al., 2021).

Power, privilege, and oppression in healthcare are rooted in historic systemic and structural inequalities strongly related to race, gender, class, and economic status. People with more power and privilege have access to better healthcare, while those who are less privileged tend to have limited access to care. Power asymmetries are rooted in a long history of unequal and unfair relationships, including colonialism, imperialism, post-World War II governance structures, and patriarchal norms and practices (Global Health 50/50, 2020).

Power, Privilege, and Oppression

Power: the ability to influence and control material, human, intellectual, and financial resources to achieve a desired outcome. Power is dynamic, played out in social, economic, and political relations between individuals and groups (Global Health 50/50, 2020).

Privilege: a set of typically unearned, exclusive benefits given to people who belong to specific social groups (Global Health 50/50, 2020). Privilege is complex and relational. The social structures that create disadvantages are the same ones that create advantages and benefits (Abimbola et al., 2021).

Oppression: a form of discrimination, leading to disparities. People of color, those with disabilities, and individuals from lower socioeconomic backgrounds are more likely to encounter discrimination when seeking healthcare services. This can range from being denied care or receiving lower quality care due to race, gender, or economic status.

Implicit racism is a form of power and oppression that continues to have a profound impact on how patients experience healthcare. Research has shown that Black and Indigenous peoples and other minority groups are more likely to experience poorer health outcomes, be given less-effective treatments, and have a lower quality of care than White Americans.

There is a growing desire to acknowledge and abolish racism and disparities in healthcare institutions. Healthcare advocates have sought to rid clinical care of the pervasive legacy of the biologic determinism of race and have encouraged care providers to understand that race is a sociopolitical construct (Essien and Ufomata, 2021).

Strategies that can reduce racism and improve cultural competency in healthcare include (Essien and Ufomata, 2021):

1. Committing to desegregation of the healthcare system.
2. Divesting from racist practice and policy.
3. Diversifying the healthcare workforce.
4. Ensuring antiracist public health training for health professionals.
5. Deepening our investments in the community.

Dismantling oppressive systems requires more than one group of people demanding change. Undoing marginalization requires more than the marginalized speaking up. Many groups—such as Black, Indigenous, and people of color, sex workers, migrants and refugees, women and girls, ethnic minorities, people with disabilities, and lesbian, gay, bisexual, transgender, intersex, and questioning people—are systematically denied platforms for political, social, and cultural reasons (Abimbola et al., 2021).

2.1 Colonization and Colonial Medicine

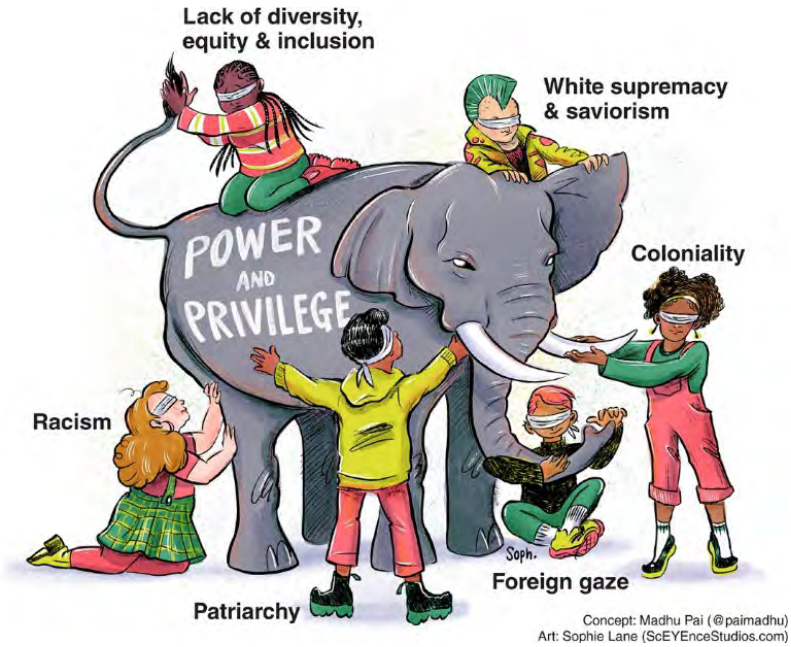
> Colonization is the process of assuming control of someone else's territory and applying one's own systems of law, government, and religion.
>
> Stolen Lives: The Indigenous Peoples of Canada and the Indian Residential Schools / Historical Background

Over the past 500 years, colonization has had a deadly impact on many cultures throughout the world. It has weakened or destroyed cultural practices that helped maintain community health such as traditional food systems, access to clean water, Indigenous languages, and access to land. It replaced long held cultural practices with unsupported and underfunded systems, leading to systemic health disparities, high rates of diabetes, suicide, and cardiovascular diseases (Jensen and Lopez-Carmen, 2022).

While colonial physicians and scientists made substantial contributions to medicine, they worked almost entirely on health issues that were unique to the colonies. The primary focus was controlling and managing the spread of infectious diseases. This was achieved through vaccination campaigns, quarantine measures, and the construction of hospitals and clinics. In doing so, they established a focus on infectious diseases exclusive to the colonies—an interest that has been inherited by global health today (Global Health 50/50, 2020).

Lack of diversity, equity, and inclusion, White supremacy and saviorism, colonialism, racism, patriarchy, and the "foreign gaze"* have impacted healthcare in the U.S. and throughout the world. Because healthcare education was developed in the shadow of colonialism, it continues to impact diversity and equity.

*__Foreign gaze__: more than looking at a person—there is an implied imbalance of power or unequal power dynamic; the gazer is superior to and objectifying the object of the gaze. Also: male gaze, imperial gaze, medical gaze.



Global health has many asymmetries in power and privilege. Image source: Madhukar Pai, with artwork by Sophie Lane. Reprinted under the terms of the Creative Commons Attribution License.

2.2 The Impact of Slavery on Black and Indigenous Peoples

> Early travelers to the American West encountered unfree people nearly everywhere they went—on ranches and farmsteads, in mines and private homes, and even on the open market, bartered like any other tradeable good. Unlike on southern plantations, these men, women, and children weren't primarily African American; most were Native American. Tens of thousands of Indigenous people labored in bondage across the western United States in the mid-19th century.
>
> Kevin Waite
> The Atlantic, November 25, 2021

Slavery has cast a long shadow over healthcare for Black and Indigenous Americans. Enslaved people were often denied any form of medical care, while also being subjected to medical experimentation without their consent. Both of these practices have had long-lasting effects, resulting in ongoing disparities in access to healthcare, and perpetuating the systemic racism that has plagued the healthcare system for centuries.

The American medical establishment has a long history of unethical treatment of Black research subjects. Medical ethicist Harriet A. Washington details some of the most egregious examples in her book "Medical Apartheid." There's the now notorious Tuskegee syphilis experiment, in which the government misled Black male patients to believe they were receiving treatment for syphilis when, in fact, they were not. That study went on for a total of 40 years, continuing even after a cure for syphilis was developed in the 1940s (Jones, 2021).

Group of men who were test subjects in the Tuskegee Syphilis Experiments. Wikimedia. Public domain.

Perhaps less widely known are the unethical and unjustified experiments J. Marion Sims performed on enslaved women in the U.S. in the 1800s that helped earn him the nickname the “father of modern gynecology.” Sims performed experimental vesicovaginal fistula surgery on enslaved women without anesthesia or even the basic standard of care typical for the time (Jones, 2021).

J. Marion Sims experimented on Anarcha, a 17-year-old slave, over 30 times. His decision not to give anesthesia was based on the racist assumption that Black people experience less pain than their white peers—a belief that persists among some medical professionals today (Jones, 2021).

Cases of medical malfeasance and malevolence have persisted, even after the establishment of the Nuremburg code, a set of medical ethical principles developed after World War II and subsequent trials for crimes against humanity (Jones, 2021).

For Indigenous peoples, colonization resulted in the destruction of their existing health practices and the introduction of unfamiliar and inadequate systems, while also resulting in the displacement, exploitation, loss of homelands, and widespread murder of Indigenous peoples. Colonization led to loss of cultural practices, language, traditional medicines, and ways of knowing and being.

When European explorers arrived in the Americas in the late 1400s, they introduced diseases for which the Indigenous peoples had little or no immunity. The impact was rapid and deadly for people living along the coast of New England and in the Great Lakes regions. In the early 1600s, smallpox alone (sometimes intentionally introduced) killed as many as 75% the Huron and Iroquois people.

The exploitation and loss of tribal lands reflects the lasting impact of historical racist policies. Indigenous peoples have been exposed to racist reproductive policies, limited access to reproductive health services, and environmental contamination (Yellow Horse et al., 2020).

Forced onto reservations, Indigenous peoples have been exposed to pollution, pesticides, and lack of clean water. As a group, they are less wealthy, are more often homeless, and experience food insecurity on levels greater than their White counterparts. For example, the Pine Ridge Sioux reservation, home of the Oglala Lakota Nation, has the lowest life expectancy in the U.S, and the second lowest in the entire western hemisphere (Jensen and Lopez-Carmen, 2022).

2.3 Intersectionality

> Intersectionality promotes an understanding of human beings as shaped by the interaction of different social locations. These interactions occur within a context of connected systems and structures of power.
>
> Olga Hankivsky
> Intersectionality 101

Intersectionality is a social theory that explains how different forms of oppression, such as racism, sexism, and classism, intersect and compound to create marginalization and privilege. It highlights the interconnected nature of social identities and the ways in which systems of power interact and overlap to shape individual experiences.

An individual's cultural background is not merely a matter of race or language, but is at the intersection of heritage, language, beliefs, knowledge, behavior, common experience, and self-identity. A culturally sensitive assessment must consider all the aspects that make up cultural diversity, as well as their complex interactions (Mortaz Hejri, Ivan, and Jama, 2022).

By its very nature, health equity is intersectional. This means that individuals belong to more than one group and, therefore have overlapping health and social inequities, as well as overlapping strengths and assets. Understanding how social identities overlap can help a provider better understand, interpret, and communicate health outcomes (CDC, 2022, August 2).

2.4 Gender and Culture

Gender refers to the roles, behaviors, activities, and attributes that a given society at a given time considers appropriate for men and women and people with nonbinary gender identities. These attributes, opportunities and relationships are socially constructed and are learned through socialization. They are context and time-specific and changeable (Global Health 50/50, 2020).

Gender determines what is expected, allowed, and valued in a woman or a man. In most societies there are differences and inequalities between women and men in responsibilities, activities, access to—and control over—power and resources, as well as decision-making opportunities. Gender is part of the broader context of sociocultural power dynamics, as are class, disability status, race, poverty level, ethnic group, sexual orientation, and age (Global Health 50/50, 2020).

Gender equality means having the same opportunities, rights, and potential to be healthy and benefit from the results. Inclusion means actively building a culture of belonging, inviting the contribution and participation of all people, and creating balance in the face of power differences (Global Health 50/50, 2020).

2.4.1 Health Inequities in Perinatal Care

Recognizing the need to humanize birth, the World Health Organization and leading scholars have incorporated “respectful maternity care” as a central tenet of high-quality care. Person-centered maternity care is “care that is respectful of and responsive to women’s preferences, needs, and values and is a core component of quality maternity care” (Ibrahim et al., 2022).

Inequities in the quality of preconception, prenatal, intrapartum, and postpartum care contribute to racial disparities in maternal health outcomes. Notably, when mode of delivery is disaggregated by race, Black women in the U.S. have the highest rates of cesarean birth, despite similar predisposing factors (Ibrahim et al., 2022).

Black and Indigenous women in the U.S. are significantly more likely to die within a year of giving birth than White women. They also experience disproportionately higher rates of severe maternal morbidity. Nearly half of these maternal events are preventable (Ibrahim et al., 2022).

Improving maternal health and health equity is a key priority. Racism and racial discrimination are linked to poor health, and specifically, negative birth outcomes for women of color and their infants. Mistreatment during pregnancy and childbirth has been associated with both short- and long-term adverse mental health outcomes that include pain and suffering, postpartum depression and post-traumatic stress disorder, fear of birth, negative body image, and feelings of dehumanization (Ibrahim et al., 2022).

2.4.2 Reproductive Justice

At United Nations conferences in 1994 (Cairo) and in 1995 (Beijing), participants considered the status of women, population, and development. They adopted the principles of *reproductive justice*, i.e., that it is a fundamental right to be able to control the number and timing of childbearing. This requires access to family planning information, contraceptive services, and abortion (Speidel and Sullivan, 2023).

Reproductive justice calls for the right to have children or not have children, to choose their number and timing, and the right to live in supportive environments that provide reproductive rights, equal opportunities for women, education, fair wages, housing, and healthcare (Speidel and Sullivan, 2023).

The concept of reproductive justice represents a significant shift from traditional notions of reproductive rights. As described by Ross and colleagues, “The ability of any woman to determine her own reproductive destiny is directly linked to the conditions in her community and these conditions are not just a matter of individual choice and access. For example, a woman cannot make an individual decision about her body if she is part of a community whose human rights as a group are violated, such as through environmental dangers or insufficient quality healthcare” (Fleming et al, 2019).

The recent Supreme Court ruling overturning Roe v. Wade has already affected pregnancy-related healthcare for many women. It has also impacted OB/GYN training in the states that have restricted abortion services. This means some hospitals will no longer offer vital training used to manage miscarriages and other pregnancy-related complications.

3. Culturally Competent Practice / Acquisition of Knowledge

To provide culturally responsive healthcare services, clinical staff, and organizations need to become aware of their own attitudes, beliefs, biases, and assumptions about others. Providers must learn about the cultural backgrounds of the populations they serve and obtain specific cultural knowledge as it relates to help-seeking, treatment, and recovery (SAMHSA, 2016).

Cultural competence training can improve patient satisfaction. In some circumstances, patients whose providers completed training report better opinions of their clinicians or participate longer in mental health counseling than patients whose providers did not (UW, 2020).

3.1 Cultural Competence

> It is (an individual's) health views, needs, and experiences that matter when making an informed decision, not a patient's ethnicity, race, or social status.
>
> Togioka et al, 2022
> Diversity and Discrimination in Healthcare

Cultural competence is a lifelong process that encourages healthcare providers to integrate knowledge into standards, policies, practices, and attitudes. The goal is to improve the quality of services—thereby producing better outcomes. Cultural competency evolves over time, allowing providers to work effectively in cross-cultural situations (NPIN, 2021).

Providing culturally appropriate care creates a healthcare system and workforce that can deliver accessible and effective healthcare regardless of a person's background. It recognizes that health is inseparable from cultural perceptions of wellbeing (Liu, Miles, and Li, 2022).

Source: NIH, public domain

3.2 Diversity

Broadly defined, diversity is the inclusion of varied attributes or characteristics. Diversity education encourages providers to understand their position of power and privilege in society, develop a critical consciousness*, and recognize their own implicit biases and those of the institutions and systems in which they work (Togioka et al., 2022).

***Critical consciousness**: a reflective awareness of the self, others, and the world and a commitment to addressing issues of societal relevance in healthcare.

Diversity training encourages providers consider the unique, individual context of each patient and to remember that a situation may be experienced differently by different patients. It helps providers employ an attitude of curiosity about how each patient's experiences and culture shape their views and behaviors (Togioka et al., 2022).

There are five key principles associated with diversity training (Ogrin et al., 2020):

1. **Awareness**: understanding unconscious bias and prejudice, self-identifying biases.
2. **Promotion**: focusing on similarities between people rather than differences.
3. **Embedding:** ensuring access and equity in policy and practice.
4. **Identifying:** uncovering individual characteristics that promote participation, sharing decision-making, trust-building, and rapport.
5. **Understanding:** acknowledging the intersectionality of people's various characteristics.

Efforts to diversify the healthcare workforce have largely centered on individuals designated underrepresented in medicine relative to their numbers in the general population. Several studies examining race/ethnicity at the undergraduate, graduate, and faculty level have reported modest improvements in the proportions of underrepresented racial/ethnic and sex groups within medicine over time. These studies have shown that the medical workforce has indeed become more diverse but have not accounted for the shifting demographics of the U.S. population (Lett et al., 2019).

Most states do not train providers who are demographically representative of the surrounding population. There is mounting evidence that diversifying the workforce to reflect the population served is key to providing high-quality, high-value, culturally effective care (Lett et al., 2019).

Gender diversity is a key part of improving cultural competence. In nursing, the male advantage has been described as a "glass escalator," in which men are put on a fast track and pushed to achieve positions that include greater responsibility, higher salary, and more organizational benefits. While diversity is necessary and important, equity is also needed to decrease disparities and mitigate the impact of discrimination (Togioka et al., 2022).

The lack of gender diversity is also evident in management positions. For example, more than half the pediatricians and gynecologists in the U.S. are now female, yet department leaders remain predominantly male. Men are more likely to be selected for editorial board membership and achieve status as an associate or full professor, department chair, or medical school dean. Men also earn more at each academic rank (Togioka et al., 2022).

3.3 Social Determinants of Health

Healthy People 2030 defines social determinants of health (SDOH) as "the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks." SDOH form the dynamic context for what we experience in our everyday lives. They are not abstract concepts—they are our life circumstances (Reed, 2022).

Social determinants of health are often grouped into 5 domains (Healthy People 2030, 2022):

1. Healthcare access and quality
2. Neighborhood and the built environment
3. Social and community context
4. Economic stability
5. Education access and quality

Resources that enhance quality of life, such as safe and affordable housing, access to education, public safety, availability of healthy foods, local health services, and environments free of life-threatening toxins can have a significant influence on population health outcomes.

Social determinants of health. Source: ODPHP, public domain

Oppressive systems dictate which people have access to key resources that determine health. Racism and classism create conditions where people of color, those living in poverty, and other marginalized groups have limited access to resources that impact health (Julian, Hardeman, and Huerto, 2020). Income, education, employment, and housing contribute to 50% of the variability in the length and quality of life and are largely responsible for many observed disparities in health (Towe et al., 2021).

The data are hard to ignore (Towe et al., 2021):

- Black Americans are 5.1 times more likely than White Americans to be incarcerated.
- Black Americans earned 61 cents for every dollar White Americans earned (Hispanic Americans earn 74 cents), disparities which have remained largely unchanged over the last several decades.
- Lower income people are more likely than higher income people to lack access to care and have poorer self-reported general health.

Most Americans are unaware of these health gaps, do not understand what causes them, and do not necessarily find them to be unfair. A survey conducted in 2008–2009 based on a national sample showed that most respondents (73%) were aware of health differences between the poor and middle-class people, but less than half (46%) reported awareness of health differences between White and Black Americans. Additionally, many Americans placed the responsibility for these outcomes on individual behaviors such as smoking, diet, and exercise, as well as access to clinical care as the primary drivers, and less so social determinants of health (Towe et al., 2021).

4. Regulatory Issues / Oregon Resources

4.1 Legal, Regulatory, and Accreditation Issues

The Oregon Health Authority (OHA) has established regulations against discrimination in any of its programs in relation to protected classes as defined by State of Oregon law and Federal law. Protected classes include but are not limited to:

- Age (18 or older)
- National origin
- Color
- Pregnancy
- Disability
- Race
- Gender identity
- Religion
- Limited English proficiency
- Sex
- Marital status
- Sexual orientation (OHA, Nd)

Non-discrimination policies and procedures are posted within the *Oregon Administrative Rules*, which outlines, along with other policies, that the Oregon Health Authority shall not, either directly or through another entity, discriminate against any individual, or harass, exclude from participation, or deny the benefit of programs, services or activities because the individual belongs to a protected class (Oregon Secretary of State, 2022).

The full text of Oregon's non-discrimination policy is available here.

4.1.1 Patient Rights and Responsibilities

Commonly established patient rights derive from the field of ethics. Modern bills of patient rights establish that people can expect certain treatment regardless of their socioeconomic status, religious affiliation, gender, or ethnicity (Olejarczyk and Young, 2022).

Oregon Administrative Rules (OAR 333-700-0115) establish patient rights and responsibilities for healthcare facilities. These rules require that healthcare facilities establish and maintain policies and procedures related to patient care. Among other rules, patients must be informed of their rights and responsibilities, be allowed to participate in the planning of their medical care, be treated with consideration and respect, and be informed of the facility's grievance process (Oregon Laws, 2021).

The full list of patient rights and responsibilities for Oregon healthcare facilities can be accessed here.

4.1.2 Civil Rights Laws and Regulations

Healthcare organizations and their employees are required by state and Federal law to implement nondiscrimination policies including Title VI of the Civil Rights Act of 1964, the Americans with Disabilities Act of 1990, Section 504 of the Rehabilitation Act of 1973, Oregon Revised Statute Chapter 659A, and Section 1557 of the Affordable Care Act.

Civil Rights Act of 1964

More than 50 years ago, one of the most important civil rights laws in our nation's history was signed into law by President Lyndon Johnson. Title VI of the landmark *Civil Rights Act of 1964*, stated:

> "No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."

Title VI of the act prevents discrimination by programs and activities that receive federal funds, including hospitals and other healthcare facilities.

The Americans with Disabilities Act of 1990

This Act provides equal opportunities for people with disabilities as well as a comprehensive national mandate for the elimination of discrimination against individuals with disabilities. It provides clear, strong, consistent, enforceable standards addressing discrimination against individuals with disabilities and ensures that the Federal government plays a central role in enforcing the standards established on behalf of individuals with disabilities. The Act invokes the sweep of congressional authority, including the power to enforce the 14th amendment and to regulate commerce, in order to address the major areas of discrimination faced day-to-day by people with disabilities (ADA.gov, 2023).

Rehabilitation Act of 1973

Section 504 of the Rehabilitation Act of 1973 states: "no otherwise qualified individual with a disability in the United States, as defined in section 705 (20) of this title, shall, solely by reason of his or her disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance or under any program or activity conducted by any Executive agency or by the United States Postal Service (USDOL, Nd).

Oregon Revised Statute Chapter 659A

This statute covers unlawful discrimination in labor and employment. It prohibits discrimination based on:

- Race, color, religion
- Sex, sexual orientation
- National origin
- Marital status
- Age

The full statute is available here.

Section 1557 of the Affordable Care Act (ACA)

This act prohibits discrimination based on race, color, national origin, sex, age, or disability in certain health programs and activities. The ACA states that an individual shall not, on the grounds prohibited under *Title VI of the Civil Rights Act of 1964*, *Title IX of the Education Amendments of 1972*, the *Age Discrimination Act of 1975*, or *Section 504 of the Rehabilitation Act of 1973*, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, or under any program or activity that is administered by an Executive Agency or any entity established under Title I of the Act or its amendments. Enforcement mechanisms available under Title VI, Title IX, Section 504, or the Age Act shall apply for purposes of addressing violations (HHS, 2016).

The entire section 1557 of the ACA is available here.

OR Senate Bill 567

In 2021, Oregon passed Senate Bill 567, establishing the right to be free from unlawful discrimination and bias in the healthcare system. SB 567 clarifies that it is unlawful for an individual licensed or certified by a health professional regulatory board, hospital, a long-term care facility, an ambulatory surgical center, a freestanding birthing center, an outpatient renal dialysis facility, or an extended stay center to discriminate on the basis of a protected class by:

- denying medical treatment to the patient that is likely to benefit the person based on an individualized assessment of the patient using objective medical evidence; or
- limiting or restricting in any manner the allocation of medical resources to the patient (DRO, 2023).

4.1.3 Joint Commission Standards

Effective January 1, 2023, new and revised requirements to reduce healthcare disparities apply to organizations in the Joint Commission's ambulatory healthcare, behavioral healthcare and human services, critical access hospital, and hospital accreditation programs (JC, 2022).

Based on the idea that healthcare disparities are "quality of care" issues, the Joint Commission requires healthcare organization to examine and understand the root causes of health disparities and address them with targeted interventions. The Joint Commission has established regulations to improve patient-provider communications as well.

4.1.4 Higher Education

In the U.S., the inclusion of diversity in policies and plans in higher education dates to the Civil Rights Movement of the 1960s. During that era, important regulations—including the *Civil Rights Act* in 1964 and executive orders about affirmative action introduced diversity policies into government regulations. Previous regulations also had some impact, including the 14th* and 15th** amendments to the Constitution in 1868 and 1870, and the *2nd Morril Act* that promoted the creation of the Historically Black Colleges and Universities (HBCUs in 1890 (Buenestado-Fernández et al., 2019).

***14th amendment**: passed after the U.S. Civil War, stated that all persons born or naturalized in the U.S. are U.S. citizens, no state can deprive any person of life, liberty, or property without due process or law, nor deny any person of equal protection of the laws.
****15th amendment**: The right of citizens of the United States to vote shall not be denied or abridged by the United States or by any State on account of race, color, or previous condition of servitude.

Schools that educate healthcare providers employ a variety of teaching methods that allow students to explore their attitudes, increase their knowledge, and develop relevant cultural competency skills. Most encourage active student participation through case studies and group-based discussions. However, there are considerable variations in teaching methods across schools and across teaching areas (Liu, Miles, and Li, 2022).

Cultural competence training has mostly focused on developing knowledge, attitudes, awareness, and sensitivity for those working in healthcare. However, the literature reiterates the need to reach further and focus on teaching the skills needed to translate knowledge and awareness into tangible practitioner behaviors which can be consistently applied and assessed in healthcare encounters and settings (Jongen et al., 2018).

4.1.5 Accreditation Standards

Agencies that provide accreditation to educational institutions have, until recently, had few standards related to diversity, equity, and inclusion. This is beginning to change as the impact of the COVID-19 pandemic uncovered horrific disparities in the availability of health services, especially in under-resourced and minority communities.

In the field of nursing, as in other professions, accreditation is a non-governmental, voluntary, self-regulatory, peer-review process that recognizes programs that meet or exceed standards that ensure educational quality. Nursing programs in the U.S. may choose to seek accreditation from 1 of 3 nursing accreditation bodies. Of these three, only the *National League for Nursing Commission for Nursing Education Accreditation* (CNEA) has criteria that relates to ethnic minority diversity and inclusion with respect to both students and faculty (Iheduru-Anderson and Wahi, 2021).

In an effort to diversify the healthcare workforce, the *Liaison Committee on Medical Education* adopted formal accreditation guidelines in 2009 that require medical schools to develop programs or partnerships designed to "make admission to medical education more accessible to potential applicants of diverse backgrounds" (Lett et al., 2019).

In 2021, the *Council for Higher Education Accreditation* added requirements to its accreditation standards saying, "every recognized accrediting organization must demonstrate that it manifests a commitment to diversity, equity, and inclusion."

Although the COVID-19 pandemic and the *Black Lives Matter* movement have exposed long-standing inequalities in society and healthcare, cultural competence training remains inconsistent across medical schools, and little is known about how students develop their cultural competence through campus-based classroom teaching (Liu, Miles, and Li, 2022).

4.1.6 Professional Standards and Cultural Competence

Human resource departments are often tasked with overseeing cultural competence education and training within health organizations. Healthcare systems usually employ one, or a combination, of several popular cross-cultural training models. This can include training in cultural awareness, cultural safety, cultural humility, cultural intelligence, and cultural competence. Other off shoots include anti-racism and diversity training (Shepherd et al., 2019).

The general focus of cultural competence workforce training has been on educating and training the healthcare workforce with the knowledge, attitudes, and skills needed to effectively respond to sociocultural issues arising in clinical encounters. Cultural competence training usually includes:

- understanding the central role of culture in all lives and how it shapes behavior.
- learning to respect and accept cultural differences.
- learning to utilize culturally adapted and culturally specific practices.
- developing awareness of personal cultural influences and prejudices or biases (Jongen et al., 2018)

4.2 Oregon Resources

4.1.1 OR Equity Advancement Plan

The Oregon Health Authority (OHA) is a state government agency with an overarching strategic goal: eliminate health inequities in Oregon by 2030. The equity advancement plan primarily focuses on communities experiencing health inequities and the healthcare system that has failed to serve them. Guided by its *Affirmative Action Plan*, the OHA uses a variety of proactive efforts to advance workforce equity and inclusion (OHA, 2023).

The OHA has established the *Office of Equity, Health Disparities, and Cultural Competence* to addresses the needs of diverse populations. This office is responsible for developing, implementing, and evaluating health equity initiatives that reduce health disparities among vulnerable populations.

4.1.2 Developing Equity Leadership through Training & Action

Developing Equity Leadership through Training & Action (DELTA) is a leadership program in Oregon that includes training, capacity building, and networking for health, community, and policy leaders. The purpose of this program is to promote equity and diversity within Oregon's public health and health systems (OEI, 2022).

DELTA includes 40 hours of classroom training, hours of individualized technical/coaching assistance, and facilitates opportunities for cross-sector partnership. Each participant submits a project proposal that drives and institutionalizes best practices in their organizations that promote health equity and inclusion (OEI, 2022).

4.1.3 Oregon Health Care Interpreter Program (HCI)

Health Care Interpreters (HCIs) are bilingual individuals who help people in their communities by providing high quality health care interpretation at in person medical appointments or over the phone. The purpose of the Health Care Interpreter (HCI) programs is to help HCIs in Oregon become trained and qualified or certified to meet current requirements, diversify the healthcare workforce in Oregon, provide high-quality healthcare interpretation to Oregon's growing diverse populations, and promote health equity (OHA, 2022).

4.1.4 Additional Oregon Programs

Additional initiatives and programs aimed at improving cultural competence in Oregon's healthcare systems include:

- **Oregon Equity and Inclusion Division**—carries out more than 16 distinct functions for the state, providing expertise and technical assistance on equity, inclusion, anti-racism, anti-oppression, universal accessibility, and social justice topics.
- **Oregon Health Equity Alliance**—a statewide coalition of organizations, agencies, and individuals working to advance health equity and reduce health disparities.
- **Health Equity Network**—a coalition of community health clinics—provides technical assistance to the OHA and other stakeholders on health equity issues.

5. Acquisition and Integration of Skills

Acquiring and integrating knowledge, attitudes, and skills is a key component of cultural competence. Acquiring skills allows a provider to communicate across cultures, address cultural differences in communication, and understand the needs, values, and preferences of their patients. Cultural differences in communication, such as preferences regarding how and when interactions take place, tone, eye contact, and other factors must be considered, even when using interpreters (HHS, 2022).

5.1 Cultural Competence Training

There is strong evidence that cultural competence training for healthcare professionals improves providers' knowledge, understanding, and skills for treating patients from culturally, linguistically, and socio-economically diverse backgrounds (UW, 2020).

Cultural competence training focuses on developing skills and knowledge that value diversity, cultural differences, and raise awareness of providers' and care organizations' cultural norms. Trainings can provide facts about patient cultures or include more complex interventions such as intercultural communication skills training, exploration of potential barriers to care, and institution of policies that are sensitive to the needs of patients from culturally and linguistically diverse backgrounds (UW, 2020).

In recent years, improvements have been seen in cultural competence training, although problems remain:

- Lack of consensus on what should be taught
- Timing of training
- Lack of standard references

Limited and inconsistent formal evaluation of interventions (Gradellini et al., 2021).

5.1.1 Notes on Educational Approaches

> For many white people, a single required multicultural education course taken in college, or required "cultural competency training" in their workplace, is the only time they may encounter a direct and sustained challenge to their racial understandings.
>
> Robin DiAngelo
> White Fragility

Cultural competence occurs when knowledge, attitudes, and skills are integrated into a person's daily actions. It requires a self-examination of one's own cultural and professional background and helps healthcare providers manage prejudices and stereotypes that may affect their behavior when interacting with someone from a different culture (Gradellini et al., 2021).

Training is effective when it is multipronged, when people work and train together, and when it is designed with context and professional identity in mind. Training in teams helps individuals feel comfortable sharing their biases and accepting their vulnerabilities. Training in this way enhances collaboration and openness and reinforces behavioral change (Sukhera, 2020).

In one study, students who practiced responding in non-stereotypical ways to members of other groups were better able to avoid activating negative stereotypes. Other studies have found that contact between members of different groups reduces prejudices and hostilities. Equality of status, social and institutional support, pleasant contact, and intergroup cooperation produce positive results (Brusa et al., 2021).

A short video modified the racial attitudes of White college students towards peers of color. In this study, students were assigned to two experimental groups: one group viewed a short documentary depicting the life of a Caucasian and a Black subject, followed by hidden cameras over the course of a day, the other group did not view the video. Researchers found that the experimental group showed reduced prejudicial attitudes and reduced fear of minorities compared to the control group as assessed by the *Color-Blind Racial Attitudes Scale*, the *Psychosocial Costs of Racism to Whites* scale, and the *Quick Discrimination Index* (Brusa et al., 2021).

A widely used tool for understanding and improving cultural sensitivity is Bennett's Developmental Model of Intercultural Sensitivity. Milton Bennett, a professor at Portland State University in Oregon, developed the tool as a framework to explain how people experience and engage cultural difference. It provides a roadmap of how we move from an ethnocentric to an ethnorelative perspective and highlights stages of development with the goal of intercultural acceptance, adaptability, and integration. It nicely sums up the principles discussed in this course.

Learn more about this tool here.

5.1.2 Using Case Review as a Teaching Tool

In the example that follows, the failure of an organization to provide language assistance services (or the doctor's failure to use available services) led to a frustrating experience for the doctor, the hospital, and the patient.

Example Case: Mr. Louis and His Granddaughter

Mr. Louis just celebrated his 70th birthday with his family and neighbors with lots of good food, music, and dancing. Mr. Louis kept everyone up late, telling stories about his childhood in Haiti. Mr. Louis was grateful to have so many loved ones close by, but he still misses Haiti after moving so many years ago.

Soon after his birthday, Mr. Louis visited his physician for a checkup. His physician sent him for additional testing, which showed the presence of prostate cancer. Let's see what happens during Mr. Louis' appointment with the oncologist, Dr. Emily Parker.

The Initial Appointment

Mr. Louis brought his granddaughter, Esther, to his oncology appointment at the hospital to help him speak with the oncologist. He knows some English, but he was worried that he would not understand everything that the doctor might say. Plus, Mr. Louis was nervous, he wanted his granddaughter there for support.

Once the appointment began, Dr. Parker and Esther did all the talking. Mr. Louis did not get a chance to speak, and he did not understand most of what Dr. Parker and Esther were saying. After a few minutes, Esther seemed to be arguing with Dr. Parker. This embarrassed Mr. Louis, and he stayed quiet.

After the First Appointment

After the appointment, Esther explained to her grandfather in French that, to treat his cancer, he would undergo a procedure the next week that would implant radioactive seeds. Esther told Mr. Louis that the procedure was simple, painless, and without side effects. She did not mention what else the doctor said or what she seemed they seemed to be arguing about during the visit.

Back at home, Mr. Louis began to worry about the procedure. He researched the procedure online and talked with his friends. He learned that the procedure did have side effects, including the possibility of incontinence. Remembering how Esther had argued with the doctor, Mr. Louis wondered if she had told him the truth about her conversation with Dr. Parker.

The Surgical Appointment

The next week, Mr. Louis and Esther arrived at the admissions office at the hospital. "No surgery," said Mr. Louis firmly. The admissions clerk looked up in surprise, and Esther quickly started talking to her in English. She explained that Mr. Louis did not really understand the issue and that he really did want the surgery.

Esther asked to sign the papers for her grandfather, but the admissions clerk explained that without legal standing, Esther was not eligible to do so. Mr. Louis continued to quietly say, "No surgery." The admissions clerk had no idea what to do. The surgical staff called to say that they were waiting for Mr. Louis. Esther glared at her grandfather.

The clerk spent almost half an hour trying to find a hospital staff member who spoke French, but no one was available. The surgery staff called again, saying that if Mr. Louis did not arrive shortly, they would have to reschedule his procedure.
Exasperated, Esther insisted that Mr. Louis undergo the procedure. She said, "The hospital has people ready to do this. All those people's time will just be wasted. Come on, just sign the paper and we can get you upstairs." Mr. Louis said again, "No surgery." Esther had no choice but to take him home.

Mr. Louis's Response

"I depended on my granddaughter to help me with my oncology appointment. But she did not tell me the truth about the surgery and my options to treat my illness. I am really angry that I came very close to having a surgery I did not want! It was so frustrating to not be able to communicate directly with my doctor. All I wanted was someone who could listen to me and explain my options."

Mr. Louis's Doctor Responds

"These days, I see a lot of patients who don't speak English very well or at all. I'm used to communicating with a family member or friend instead of the patient. In fact, I ask patients to bring someone who can interpret for them. It's so much easier that way!

"But when I heard about Mr. Louis' situation from our admissions clerk, I was shocked! I did not recommend the procedure that Esther scheduled for her grandfather. I actually suggested "watchful waiting" as Mr. Louis' treatment option. But, during the consultation, his granddaughter insisted that Mr. Louis undergo the procedure. "Now that I think about it, I didn't speak much with Mr. Louis since Esther seemed to be in charge. I thought I was doing the right thing by speaking with the family member that Mr. Louis brought with him. Now, knowing that Mr. Louis did not want surgery scares me. I wish I had been able to speak directly with Mr. Louis without his granddaughter interfering."

Conclusion

Offering language assistance services, including a competent medical interpreter, helps patients with limited English proficiency understand and make informed decisions about their medical care. Unfortunately, Mr. Louis almost had a surgery that he did not want, and the surgery could have caused side effects about which he had not been informed. Operating on a patient who did not want surgery or who was not aware of potential adverse effects could have serious liability implications for the doctor and the hospital.

Furthermore, the hospital had a surgery team and room sitting idle because a patient was scheduled for a procedure that he did not want. In this case, the cost of providing a trained interpreter would have been significantly less than the costs that the hospital incurred from this.

Think About It

- How would you feel if this happened to you or a family member?
- Could this happen at your organization?
- Does your workplace offer communication assistance?

Source: HHS, 2022

5.2 Promoting Collaboration on Healthcare Decisions

Healthcare providers recognize they have a special relationship with their patients that is based on trust, which is one of the pillars of the professionalism on which the healthcare relationship rests. When patients have an injury or disability, their increased vulnerability creates special challenges within the general population and within the healthcare system. Engaging patients in their care is a key component of good practice.

The World Health Organization describes *collaborative practice* as occurring when healthcare workers from diverse professional backgrounds work with patients and their families to deliver high quality care. The involvement of patients as central to healthcare is recognized as essential and differs fundamentally to traditional clinician-centered healthcare (Davidson et al., 2022).

Collaborative decision-making occurs when patients work together with their healthcare providers to make decisions about screening, treatments, and managing chronic conditions. Shared decision-making upholds person-centered care and allows people to take an active role in their healthcare decisions. With shared decision-making, the person's individual preferences, beliefs, and values are considered when making health decisions (Jull et al., 2021).

Importantly, shared decision-making helps people understand the risks and benefits of different options through discussion and information sharing. In fact, shared decision-making has been called "the pinnacle" of person-centered care. A key feature of shared decision-making is the exploration of patient values and priorities, which can be facilitated by using evidence-based decision support tools and approaches (Jull et al., 2021).

“Decision-coaching” and decision aids encourage patients to take an active role in their healthcare decisions. Decision aids include booklets, videos, and online tools that help people clarify what matters to them. These tools help people feel more knowledgeable, better informed, and encourage them to take an active role in decision-making (Jull et al., 2021).

5.3 Developing Good Communication Tools

Data from the U.S. Census reveal a high degree of linguistic diversity, with more than 59 million residents speaking a language other than English at home. More than 25 million people live in linguistic isolation, a termed coined by the U.S. Census Bureau in which no one in a household over 14 years of age speaks English at least very well (NCCC, Nd).

In Oregon, 15% of residents speak a language other than English. The largest non-English language spoken in Oregon is Spanish, representing 9% of Oregon’s population. The next most-common non-English language is Chinese (Mandarin, Cantonese), followed by Vietnamese. As a comparison, New York City—with a population of over 8 million people—has more than 800 spoken languages (Data USA, 2023).

On August 11, 2000, the President signed Executive Order 13166, "*Improving Access to Services for Persons with Limited English Proficiency*". The Executive Order requires Federal agencies to examine the services they provide, identify the need for services for those with limited English proficiency, and develop and implement a system to provide meaningful access to those services for people with limited English proficiency (NIH, 2022, August 31).

5.3.1 Good Communication is a Two-Way Dialogue

The intimate and sometimes overwhelming nature of health concerns can make communication challenging. Nevertheless, patient-centered communication is fundamental to ensuring good health outcomes, reflecting long-held values that care must be individualized and responsive to patient health concerns (Kwame and Petrucka, 2021).

Effective communication is a two-way dialogue between patients and care providers. In that dialogue, both parties speak and are listened to without interrupting; they ask questions for clarity, express their opinions, exchange information, and grasp entirely and understand what the others mean (Kwame and Petrucka, 2021).

Cultural competence has been linked to increased patient satisfaction and treatment adherence. By contrast, cultural and linguistic differences between healthcare providers and patients can cause significant miscommunication, decreasing patient trust and satisfaction. (Jongen et al., 2018).

If a provider lacks cross-cultural communication skills or if interpretation and translation services are not provided, the impact on a patient can be dire. Poor communication contributes to an incomplete and inaccurate health history, misdiagnoses, and the failure of a patient to understand their health condition and recommended treatment. This can lead to misuse of medications, repeat visits, and lack of informed consent (NCCC, nd).

Effective communication means providing information to an individual in an understandable and accessible way. The goal is to increase knowledge about prevention and maintenance of good health while positively influencing health behaviors and attitudes. This involves verbal, written, and nonverbal communication (HHS, 2022).

Studies have shown that a consistent communication-related barrier in nurse-patient interactions is miscommunication, which often leads to misunderstandings between nurses, patients, and their families. Additional communication-related barriers include language differences, poor communication skills, and a patient's inability to communicate due to their health state, especially in ICU, dementia, or end-of-life care contexts (Kwame and Petrucka, 2021).

5.3.2 National CLAS Standards

Culturally and Linguistically Appropriate Services (CLAS) standards are a set of 15 action steps. The standards are intended to advance health equity, improve quality, and help eliminate healthcare disparities by providing a blueprint for individuals and healthcare organizations to implement culturally and linguistically appropriate services (OMH, 2022).

CLAS standards can improve the quality of services provided to all individuals, which will ultimately help reduce health disparities and improve health equity. CLAS standards encourage respect and responsiveness: respect the whole individual and respond to the individual's health needs and preferences.

To reduce barriers to accessing quality and appropriate care for priority populations and advance health equity, the Oregon Health Authority expects all Oregon Health Plan enrolled providers and coordinated care organizations to provide services in support of OHA's health equity goals, consistent with National CLAS Standards. This means all health services, including telemedicine services:

- Are culturally responsive.
- Provide meaningful access to language services.
- Are provided in an equitable and inclusive manner.

A bilingual doctor discussing health issues with a patient and her daughter. Source: HHS, public domain

5.3.3 TeamSTEPPS

The *TeamSTEPPS Limited English Proficiency* program provides hospitals with the tools to develop and implement a plan to train interpreter and clinical staff in teamwork skills, specifically within the context of working with patients with limited English. The program includes train-the-trainer resources and instructional guides that include short case studies and videos (PSNET, 2019).

The success of TeamSTEPPS is well-documented and field testing concluded it was easy to implement and fostered staff learning. In addition to implementing the TeamSTEPPS program, hospitals are encouraged to: 1) foster a supportive culture for the safety of diverse patients, 2) adapt current systems to better identify medical errors among patients with limited English proficiency, 3) improve reporting of medical errors for patients with limited English proficiency, 4) routinely monitor patient safety for patients with limited English proficiency, and 5) address root causes to prevent medical errors among patients with limited English proficiency (PSNET, 2019).

5.3.4 Language Assistance Services

In the United States, healthcare organizations are required by law to provide interpretation services at no cost. Notification of communication and language assistance services allows organizations to avoid legal ramifications from miscommunications between provider and patient, which could potentially lead to malpractice and legal action against a provider and their organization.

Language assistance services such as oral interpretation, translation of written documents, signage, and wayfinding symbols greatly improve communication for patients with limited English proficiency and those who are deaf or hard of hearing. Healthcare organizations should notify patients that communication and language assistance services are available when scheduling an appointment. This helps patients (and their families) make better use of services and also helps them become more informed consumers of healthcare (HHS, 2022).

Online Resource

Video: UC Davis nursing students reducing language barriers to improve health care [3:19]

https://www.youtube.com/watch?v=9pST-K1aS14

Source: Betty Irene Moore School of Nursing at UC Davis

Providers might try to “get by” with the limited English skills of patients, their own inadequate foreign language skills, or unqualified interpreters, such as patients’ friends or family members or untrained staff. Examples of documented patient safety events due to a lack of language assistance include performing an x-ray on the wrong part of the body, falls due to the patient not knowing to ask for assistance, and inability to treat emergency room patients due to failure to obtain medical history or medication list (PSNET, 2019).

5.3.5 Working with Interpreters

In 2021, the Oregon Legislature passed House Bill 2359, requiring that all publicly funded healthcare providers hire only credentialed healthcare interpreters listed on a state registry. To obtain accreditation and entry onto the state’s registry, interpreters must pass language proficiency testing and meet other requirements. The bill was intended to make access to healthcare more equitable (Lund Report, 2022).

Using interpreters and translation services reduces disparities by bridging the communication gap between providers and patients with limited English proficiency. These services ensure that all parties understand a provider’s medical instructions and diagnoses and can also provide a more comfortable and trusting environment for patients.

Examples of language assistance services include oral interpretation, translation of written documents, signage, and wayfinding symbols. Individuals with language needs include those with limited English proficiency and those who are deaf or hard of hearing. Language assistance services should be provided at no cost to the patient (HHS, 2022).

Healthcare organizations should not use family members, children, other patients or visitors, or untrained staff as interpreters. Interpreters are communication professionals who will interpret everything that is said, maintain confidentiality, and provide a cultural context.

Interpreters and translators differ in their jobs. A translator works with the written word, translating from one language to another while an interpreter translates spoken information.

Interpreters' and translators' roles are diverse and include being a cultural broker, patient advocate, co-therapist, team member. and institutional gate keeper. It is often the provider's responsibility to train interpreters and translators working under their supervision in procedures and ethics (Louw, 2016).

Healthcare providers are responsible for the actions of interpreters and translators, ensuring that they act ethically, which may not always be easy to implement. Interpreters and translators are required to show respect for all involved, respect confidentiality, interpret accurately, convey cultural information, and remain impartial (Louw, 2016).

Online Resource

Video: Working with Interpreters [4:57]

https://www.youtube.com/watch?v=pVm27HLLiiQ

Source: Legal Services New Jersey

5.3.6 Working with Cultural Brokers

Cultural brokers provide a link between a patient's traditional health beliefs and practices and the healthcare system. Interpreters, community health workers, and patient navigators can play the role of a cultural broker by providing context and by serving as a partner for both the patient and provider (PSNET, 2019).

While a cultural broker's role can vary depending on patient and provider need, cultural brokers must be knowledgeable about the cultural group they serve and be able to successfully navigate the healthcare system. An individual acting as a cultural broker should be a trusted and respected member of the community but does not need to be healthcare professionals (PSNET, 2019).

Incorporation of a cultural broker in the care team embraces the importance of cultural distinctions among patient groups. It also acknowledges that, particularly in very diverse communities, it is unrealistic for providers to have sufficient understanding of all the different cultures present in the patient population they serve (PSNET, 2019).

Test Your Knowledge

1. If a person asks for an interpreter, can I assume they won't understand if I say something to a colleague in front of the patient?

Answer: It is not uncommon that a person who asks for an interpreter understands English quite well. Any comments you make to other providers or to the interpreter might be understood by the patient.

2. Today, I had a patient who I thought might need translation assistance, but the patient declined this service. I didn't want to embarrass her by insisting—I assumed her refusal meant she would clearly understand everything we were going to discuss—so, I just dropped it.

Answer: If a patient refuses language assistance services, ask them to sign a form that says they understand that language assistance is available, and have chosen to decline these services. The form must be available and signed in the patient's native language or completed orally if he or she is unable to read in their native language.

Document that the individual was notified about these rights and include the patient's preferences for utilizing language services in the future. Written documentation is needed to communicate with other providers and to indicate that language services are available and were offered.

Modified from *Think Cultural Health: Working Effectively with an Interpreter*

5.3.7 Working with Traditional Health Workers

Traditional Health Worker roles were defined in the original bill that created Oregon's Coordinated Care Organizations (CCOs) in 2011, House Bill 3650. Now codified in ORS 414.665, there are five specialty types of Traditional Health Workers in Oregon:

1. Community Health Workers
2. Peer Wellness Specialists
3. Peer Support Specialists
4. Personal Health Navigators
5. Birth Doulas (Li, et al., 2023)

Traditional Health Workers are individuals from their local communities who provide person- and community-centered care by providing a bridge between communities and the health systems they serve. They can increase the appropriate use of care by connecting people with health systems, advocating for their clients, supporting adherence to care and treatment, and empowering individuals to be agents in improving their own health. As of October 2022, there were more than 4,400 Traditional Health Workers certified in Oregon (Li et al., 2023).

The effectiveness of Traditional Health Workers is enhanced when they have similar lived experience or are members of the same community as the patients they serve, have knowledge of health issues, and understand how to help patients navigate the health system. Traditional Health Workers help to assure the delivery of high-quality, culturally responsive care, which is instrumental in achieving the Oregon Health Authority's goal to eliminate health inequities in Oregon by 2030 (Li et al., 2023).

5.3.8 Working with Traditional Medicine/Healers

American Indian and Indigenous peoples utilize traditional medicine/healing for health and well-being. Modern, Western-trained healthcare practitioners receive minimal training and education on traditional these healing practices and their application and integration into healthcare settings. Lack of knowledge and practice guidelines on how to navigate these two healthcare perspectives creates uncertainties in the treatment of American Indian and Indigenous peoples. Such conflicts can undermine patient autonomy and result in culturally incongruent practice (Esposito and Kahn-John, 2022).

One challenge Western-trained healthcare a provider may face is respecting a person's autonomy by allowing them to choose and prioritize health and wellness interventions they feel best fit their physical, mental, emotional, and spiritual needs. These are valid concerns and must be considered, discussed, and explored to maintain optimal health and safety of patients (Esposito and Kahn-John, 2022).

For Western-trained healthcare providers, training in traditional medicine/healing and learning how to integrate Western medicine and traditional medicine is an important part of providing comprehensive, culturally inclusive, and effective care. Traditional medicine/healing education should be integrated on several levels of Western medical training (Esposito and Kahn-John, 2022).

5.4 Utilizing Data to Inform Clinical Practice and Health Equity

Collecting and utilizing data to inform clinical practice and improve health equity starts with defining the population and health equity issue you plan to address. The first step is to identify disparities by collecting and analyzing data on patient demographics, disease prevalence, and treatment outcomes.

Once disparities have been identified, the data is used to develop targeted interventions. For example, a healthcare organization may implement outreach programs to increase access to care for marginalized populations or create targeted treatment plans based on patient data.

Monitoring outcomes for effectiveness is the next step. This may involve collecting data on patient outcomes, patient satisfaction, and changes in health disparities over time. Engaging patients is a critical part of improving clinical practice. This can involve gathering patient feedback on their experiences with care and incorporating it into decision-making processes.

In Oregon, the Oregon Health Authority collects and analyzes data on health outcomes and health disparities, including race/ethnicity, language, income, and geographic location. The organization then identifies areas where health disparities exist and prioritizes interventions and initiatives aimed at reducing health disparities and improving health equity.

OHA has used this data to develop a series of culturally and linguistically appropriate outreach and education programs aimed at reducing disparities in chronic disease management among communities of color. They have also worked to increase the availability and use of health data in clinical practice, including implementing health information technology systems and training health providers in the use of data to inform patient care.

5.4.1 Institutional Culture and Health Equity

Institutional culture in healthcare refers to the shared beliefs, values, attitudes, and behaviors that are present within a healthcare organization. It encompasses all aspects of the organizational structure, from its mission and vision to its policies and procedures, to the interactions and relationships among staff members.

Healthcare organizations that prioritize health equity will typically have an institutional culture that emphasizes diversity and inclusivity, values patient-centered care, and supports ongoing training and education for healthcare providers. This type of institutional culture prioritizes community engagement and outreach, and supports policies and initiatives aimed at reducing disparities in health outcomes and access to care.

The governance structure of a healthcare organization can play a role in improving health equity. Addressing health inequities by recognizing and decreasing institutional racism and other forms of discrimination can have a significant impact on improving an organization's culture (Browne et al., 2018).

5.4.2 Implementing Health Equity Interventions

Health equity interventions can be implemented at multiple levels within health organizations and at the level of clinical practice. Specific interventions can vary but are characterized by a common goal of closing the health equity gap with the aim of 1) improving the health of populations, 2) enhancing patient experience and outcomes, and 3) reducing per capita cost of care (Browne et al., 2018).

5.4.3 Health Disparities and Social Inequities

Unequal social practices create gaps in health. One example is redlining, a practice where lenders deny mortgages to eligible buyers solely because of their race. These practices assured that Black people and other people of color are denied the right of home ownership and upward economic mobility that millions of White people enjoy. Redlining has been succeeded by gentrification, whereby middle-class people move into urban areas and displace others who have lived in a neighborhood for years (Julian, Hardeman, and Huerto, 2020).

Both redlining and gentrification perpetuate poverty in communities of color in America's cities. As such, many Black and low-income Americans live in communities where clean water isn't guaranteed, and social distancing is nearly impossible in crowded homes. In this way, redlining and gentrification have impacted the racial inequities seen during the COVID-19 pandemic (Julian, Hardeman, and Huerto, 2020).

5.5 Collaborating with Community Resources

Collaborating with other stakeholders, such as public health agencies and community-based organizations, is critical to improving clinical practice related to health equity. These organizations provide valuable insights into the needs of marginalized populations and help healthcare providers develop targeted interventions that are effective and sustainable.

Black and Latino individuals—especially women—comprise an essential part of the healthcare workforce, often serving in support roles such as nursing assistants and dietary service staff. Compared to physicians and nurses, they are underpaid and undervalued. In many cases, these healthcare workers have closer relationships with their communities than other healthcare professionals, representing an untapped opportunity to improve workforce cultural competence. These workers often live in the same communities that they serve and have strong ties with community members. Many times, they share ethnicity, language, socioeconomic status, and life experiences with the community (Rivera-Núñez et al., 2022).

5.5.1 Developing Community Partnerships

Developing partnerships with local community organizations helps healthcare providers understand and meet the needs of different cultural communities. These organizations provide valuable insight into the needs of their communities and can help develop programs that address social determinants of health.

5.5.2 Increasing Access to Care

Increasing access to care and services in underserved communities can reduce cultural disparities in healthcare. This is achieved by reducing transportation barriers, increasing affordability, and providing more convenient hours to accommodate different work and family schedules.

5.5.3 Developing Culturally Relevant Programs

Developing culturally relevant programs reduces healthcare disparities by helping patients learn about preventive care and other healthcare services. These programs should be tailored to the needs and cultures of the community and should be designed to address health issues in a culturally appropriate way.

Health literacy is closely related to culturally relevant programs. One aspect of health literacy is training providers to communicate health information in a way that is easy for patients to understand by using clear language, avoiding medical jargon, and developing well-designed visuals and written materials helps patients understand their health status and treatment options.

6. Concluding Remarks

In recent years, much has changed in the United States. War, climate change, and political disruptions have led to population upheavals with an influx of people from other countries into the United States. Many immigrants arrive with precarious health, often due to the conditions in which they made the trip. Living conditions and the stress of acculturation can cause a rapid deterioration of a person's health (Gradellini et al., 2021).

COVID-19 created immense inequities, widened income disparities, and fractured systems of global cooperation. The pandemic enabled those with money and power to expand their influence—making decoloniality, solidarity, and distribution of power, knowledge, and resources even more urgent. The fact that high-income countries reserved enough COVID-19 vaccine doses to vaccinate their own population multiple times over is a stark indication of power asymmetry in global health (Abimbola et al., 2021).

We have yet to truly understand of the impact of the COVID pandemic, which halted or reversed progress in health and shortened life expectancy. With 90% of countries reporting disruptions to essential health services, a decade of progress in reproductive health, maternal, and child health could be stalled or reversed. These problems are compounded by healthcare systems and healthcare providers who were stretched to their limits by the pandemic (UN, 2021).

It is important to understand the colonial conditionings of healthcare education. Practicing diversity and inclusion and localizing funding decisions can have a big impact on services. At both the individual and organizational levels, we must hold ourselves, our governments, and global health organizations accountable—especially for governance structures and processes that reflect a commitment to real change (Abimbola et al., 2021).

Cultural competency training provides tools that foster understanding and create respect for people from different cultures and lifestyles. This can help healthcare providers understand and relate to the differences and tailor care to best meet their needs. Implicit bias training helps providers identify and overcome their own unconscious biases and helps them understand how biases affect patient care.

Sustaining the effects of training requires changes in policy and visible support of organizational leaders. Rather than focusing exclusively on training others, leaders must look within their own approaches to equity and diversity. Leaders who model a more inclusive approach and integrate bias training with other initiatives to enhance inclusion and belonging within their organization will be more successful than those who rely on training alone (Sukhera, 2020).

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[Continue to next page to start quiz]

Quiz: Oregon: Cultural Competency (320)

1. Cultural sensitivity helps us manage prejudices and stereotypes that can affect interactions with people from different cultures and backgrounds.

a. True
b. False

2. Ways in which healthcare provides can demonstrate culturally sensitivity include:

a. Identifying cultural needs.
b. Practicing cultural humility.
c. Recognizing that cultural differences are not personal.
d. All of the above.

3. A collectivistic culture can differ from an individualistic culture by:

a. Valuing autonomy over interdependence.
b. Emphasizing individual achievement over obedience.
c. Focusing on “we” rather than “I”.
d. Minimizing groups values and views.

4. A variety of ethical issues can arise in clinical practice. They can appear as ethical challenges, conflicts, or dilemmas that influence the care and treatment of patients.

a. True
b. False

5. Strategies that can reduce racism and improve cultural competency in healthcare include:

a. Desegregating the healthcare system.
b. Diversifying the healthcare workforce.
c. Investing in surrounding communities.
d. All of the above.

6. Colonial medicine focused on protecting European health, maintaining military superiority, and supporting extractive industries.

a. True
b. False

7. Social injustices impact the health of many low income and minority communities, contributing to high disease burdens, difficulties accessing healthcare, and a lack of trust in the healthcare system.

a. True
b. False

8. For Indigenous people in North America, colonization:

a. Led to loss of cultural beliefs and traditional healing practices.
b. Exposed Indigenous people to racist reproductive policies.
c. Exposed Indigenous people to widespread environmental contamination.
d. All of the above.

9. Reducing pregnancy-related discrepancies in Black and American Indian/Alaska Native women can be accomplished by:

a. Identifying and addressing implicit bias and structural racism in healthcare.
b. Engaging communities in prevention efforts.
c. Supporting community-based programs that build social support and resiliency.
d. All of the above.

10. Reproductive justice is the fundamental right to be able to control the number and timing of childbearing.

a. True
b. False

11. Social determinants of health:

a. Do not significantly affect a person's health or quality-of-life.
b. Are conditions in the environment that affect a person's health, functioning, and quality-of-life.
c. In the U.S., are not generally responsible for health disparities.
d. Are related to income, but not to other factors such as education or health access.

12. Diversity training:

a. Helps healthcare providers make more money.
b. Helps providers understand the unique context of each person.
c. Discourages a provider from having an attitude of curiosity about each patient's experiences and culture.
d. Does not work in the healthcare setting.

13. The *Oregon Administrative Rules* state that the Oregon Health Authority shall not, either directly or through another entity, discriminate against any individual, or harass, exclude from participation, or deny the benefit of programs, services, or activities because the individual belongs to a protected class.

a. True
b. False

14. The Joint Commission requires healthcare organizations to examine and understand the root causes of health disparities and address them with targeted interventions.

a. True
b. False

15. The Oregon Health Authority has established an overarching strategic goal to eliminate health inequities in Oregon by 2030.

a. True
b. False

16. Cultural competence occurs:

a. When a healthcare provider takes a class in cultural bias.
b. When knowledge, attitudes, and skills are integrated into a person's daily actions.
c. When healthcare providers avoid people with different cultural backgrounds.
d. When you work in a hospital with a culturally diverse clientele.

17. Collaborative practice occurs when:

a. Doctors and nurses make decisions about patients together.
b. Family members receive follow-up phone calls after surgery.
c. Healthcare workers from diverse professional backgrounds work with patients and their families to deliver high quality care.
d. A patient files a complaint and workers from diverse professional backgrounds defend themselves.

18. The adverse impact on patients with limited English proficiency when interpretation and translation services are not provided can include:

a. Incomplete and inaccurate health history.
b. Misdiagnoses of health and mental health conditions.
c. Misuse of medications.
d. All of the above.

19. The adverse impact on patients with limited English proficiency when interpretation and translation services are not provided can include:

a. Incomplete and inaccurate health history.
b. Misdiagnoses of health and mental health conditions.
c. Misuse of medications.
d. All of the above.

20. Collecting and utilizing data to inform clinical practice and improve health equity involves:

a. Identifying disparities by collecting and analyzing data.
b. Using data to develop targeted interventions.
c. Monitoring outcomes for effectiveness.
d. All of the above.

21. Collaborating with other stakeholders involves:

a. Developing partnerships with local community organizations.
b. Increasing access to care and services in underserved communities.
c. Developing culturally relevant programs to reduce healthcare disparities.
d. All of the above.

[Continue to next page for answer sheet]

Answer Sheet: Oregon: Cultural Competency (320)

Name (Please print) _____

Date _____

Passing score is 80%

1. _____	11. _____
2. _____	12. _____
3. _____	13. _____
4. _____	14. _____
5. _____	15. _____
6. _____	16. _____
7. _____	17. _____
8. _____	18. _____
9. _____	19. _____
10. _____	20. _____
	21. _____

[Continue to next page for course evaluation]

Evaluation: Oregon: Cultural Competency

Please use this scale for your course evaluation. Items with asterisks * are required.

1 = Strongly agree 2 = Agree 3 = Neutral 4 = Disagree 5 = Strongly disagree

*Upon completion of the course, I was able to:

1. Describe 5 ways in which culture influences healthcare providers.	1 2 3 4 5
2. Define power, privilege, and oppression.	1 2 3 4 5
3. List 5 social determinants of health.	1 2 3 4 5
4. Explain the 3 main components of patient rights and responsibilities for healthcare facilities.	1 2 3 4 5
5. Understand the ways in which cultural competence and good communication are linked.	1 2 3 4 5
*The author(s) are knowledgeable about the subject matter.	1 2 3 4 5
*The author(s) cited evidence that supported the material presented.	1 2 3 4 5
*Did this course contain discriminatory or prejudicial language?	Yes No
*Was this course free of commercial bias and product promotion?	Yes No
*As a result of what you have learned, will make any changes in your practice?	Yes No

If you answered Yes above, what changes do you intend to make? If you answered No, please explain why.

*Do you intend to return to ATrain for your ongoing CE needs?

____Yes, within the next 30 days. ____Yes, during my next renewal cycle.

____Maybe, not sure. ____No, I only needed this one course.

*Would you recommend ATrain Education to a friend, co-worker, or colleague?

____Yes, definitely. ____Possibly. ____No, not at this time.

*What is your overall satisfaction with this learning activity? 1 2 3 4 5

*Navigating the ATrain Education website was:

____Easy. ____Somewhat easy. ____Not at all easy.

*How long did it take you to complete this course, posttest, and course evaluation?

____60 minutes (or more) per contact hour ____59 minutes per contact hour

____40-49 minutes per contact hour ____30-39 minutes per contact hour

____Less than 30 minutes per contact hour

I heard about ATrain Education from:

____Government or Department of Health website. ____State board or professional association.

____Searching the Internet. ____A friend.

____An advertisement. ____I am a returning customer.

____My employer. ____Social Media.

____Other_____

Please let us know your age group to help us meet your professional needs

____18 to 30 ____31 to 45 ____46+

I completed this course on:

____My own or a friend's computer. ____A computer at work.

____A library computer. ____A tablet.

____A cellphone. ____A paper copy of the course.

Please enter your comments or suggestions here:

[Continue to next page for registration and payment form]

Registration and Payment Form: OR: Cultural Competency (320)

Please answer all of the following questions (* required).

*Name: _____

*Email: _____

*Address: _____

*City and State: _____

*Zip: _____

*Country: _____

*Phone: _____

*Professional Credentials/Designations:

_____

*License Number and State: _____

Payment Options

You may pay by credit card, check or money order.

Fill out this section only if you are paying by credit card.

2 contact hours: $24

Credit card information

*Name: _____

Address (if different from above):

*City and State: _____

*Zip: _____

*Card type: Visa Master Card American Express Discover

*Card number: _____

*CVS#: _____ *Expiration date: _____