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About Cultural Competency in Nevada, 4 units (342)

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Contact hours: 4
Cost: $29
Expires: July 31, 2027
NV BON Approval: Approved by the Nevada State Board of Nursing

Overview

The intention of this training is to more effectively treat and care for patients or residents and better understand patients or residents who have different cultural backgrounds. This includes patients or residents who fall within one or more of the categories included in Nevada Resource Code 449.103.

Target Audience

This 4-hour course is required for all nurses, advanced practice nurses, and other health professionals.

Course Objectives

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

1. Describe 5 ways in which culture influences healthcare providers.
2. Describe the difference between implicit and explicit bias.
3. Define power, privilege, and oppression.
4. List 5 social determinants of health.
5. State 3 common myths about marginalized peoples.
6. Relate 3 practices that support reproductive justice.
7. Describe the first step in providing culturally religious care.
8. State 3 barriers faced by lesbian, gay, bi-sexual, transgender, questioning, intersex, asexual people when seeking healthcare.
9. Provide 1 example each of culturally competent practice in veteran services, mental health services, and services for older adults.
10. Provide 3 examples of ableist language.
11. Relate one of the most important barriers to accessing healthcare in the United States.
12. Describe 3 ways in which healthcare providers can avoid discriminatory language with their patients.
13. State 3 best practices that can improve cultural competence in healthcare.
14. Understand 3 ways in which cultural competence and good communication are linked.
15. Describe 3 aspects of a welcoming and safe healthcare environment.

1. Cultural Competence in Healthcare

Cultural competency is a set of behaviors, attitudes, and policies that 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 that helps healthcare providers manage prejudices and stereotypes that can affect their behavior when interacting with someone from a different culture (Gradellini et al., 2021).

Cultural competence means you are "culturally humble"—understanding that you are not the expert in all cultural matters. It is a lifelong process during which healthcare providers integrate knowledge into standards, policies, practices, and attitudes aimed at improving the quality of services and the ability to work 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).

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.

1.1 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.

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

Source: CDC. Public Domain

A key finding was that people in racial and ethnic minority groups received lower-quality healthcare than whites, 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. Additionally, clients in minority groups were not getting their mental health needs met. The report provided a primary impetus for the cultural competence movement in healthcare (Stubbe, 2020).

1.2 Cultural Sensitivity, Awareness, Safety, and Humility

Cultural sensitivity, awareness, safety, and humility are important aspects of cultural competence. **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. **Competence** means you integrate knowledge into specific standards, policies, practices, and attitudes (Shepherd et al., 2019).

Self-awareness and self-assessment of cultural concepts helps us understand that values often assumed to be universal can be relative in nature. Working to understand the influences of diverse but interrelated determinants of health offers new models of care that account for more than just biology and medicine.

Healthcare providers who are unaware or insensitive to the process by which cultural identity develops can—regardless of their own race or ethnicity—minimize the importance of racial and ethnic experiences. They may fail to identify cultural needs or recommend appropriate treatments and may unwittingly 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 Characteristics of Culture

Culture is commonly 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 can help a provider personalize patient care and understand where patients and family members fall within their cultural continuum (Canadian Paediatric Society, 2024).

Understanding the difference between collectivistic and individualist cultures helps providers understand a person's cultural and personal background and how this influences their perceptions of health, illness, death, and beliefs about causes of disease. This creates a cultural sensitivity that helps us understand cultural influences, how illness and pain are experienced and expressed, where patients seek help, and the types of treatment patients prefer (Canadian Paediatric Society, 2024).

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 and acknowledging their dignity. It 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).

Respect is demonstrated in practice by incorporating the perspectives of patients and community members into policies and practices. 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 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 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.

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).

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. 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).

Gender diversity is key to 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).

1.6 Health Equity

Health equity is the state in which everyone has a fair and just opportunity to attain their highest level of health. Achieving this requires focused and ongoing societal efforts to address historical and contemporary injustices; overcome economic, social, and other obstacles to health and healthcare; and eliminate preventable health disparities (CDC, 2022, December 16).

Heart disease, cancer, diabetes, and stroke are the most common causes of illness, disability, and death in the United States. Many of these chronic conditions are more common, are diagnosed later, and result in worse outcomes for some groups, such as people of color, people in low-income neighborhoods, and people who are members of marginalized communities.

Despite efforts to reduce health disparities, they persist. Such disparities do not have a single cause: they are created and maintained through multiple, interconnected, and complex pathways, including social determinants of health, environment and community conditions, behavioral factors, and availability and quality of medical services.

Achieving health equity requires healthcare organizations and personnel to provide culturally competent care, valuing everyone equally, addressing avoidable inequalities, acknowledging historical and contemporary injustices, and eliminating healthcare disparities (CDC, 2022, December 16).

Achieving health equity requires addressing social determinants of health and health disparities. It involves acknowledging and addressing racism as a threat to public health and the history of unethical practices in public health that lead to inequitable health outcomes (CDC, 2022, December 16).

2. Bias, in All Its Forms

Humans have developed many automatic responses that can help us move through our daily lives efficiently and without conscious thought. We don't think about how our bodies maintain balance, when to withdraw our hand from a hot stove, or why it is important to avoid rotten food. We have developed automatic and reflexive responses that allow us to function efficiently, without conscious thought.

Implicit biases might be viewed in this light. They occur below the level of consciousness, using information developed from our life experiences and habits. They help us to make sense of the world, allowing us to classify individuals into categories quickly and automatically. Although efficient and easy, biases have caused considerable harm to people who are their target, leading to discrimination and lack of access to the benefits available to members of society who do not experience these biases.

Expressions of explicit bias may have declined, but implicit, unconscious bias has remained unrelenting. Healthcare providers often still hold negative biases against many marginalized groups of people. Implicit bias permeates the healthcare system and affects patient–clinician communication, clinical decision making, and institutionalized practices (Vela et al., 2022).

Higher education systems, including medical schools and academic hospitals, have been affected by the discrimination and bias that have long permeated healthcare. A complex system of discrimination and bias causes devastating health inequities that persist despite a growing understanding of its root causes. These biases hinder improvement in healthcare provider diversity, which has long been recognized as an important mechanism for reducing disparities (Vela et al., 2022).

2.1 What is Implicit Bias?

Implicit bias affects a person's perception, action, or decision-making in an unconscious manner. It can contribute to unequal treatment based on characteristics such as race, ethnicity, nationality, gender, gender identity, sexual orientation, religion, socioeconomic status, age, or disability.

Decades of research has demonstrated that discrimination, driven by implicit bias, impacts healthcare access, trust in clinicians, care quality, and patient outcomes (Dirks et al, 2022). The troubling thing for healthcare professionals is the possibility that biased judgment and biased behavior can affect patient care (FitzGerald et al., 2019).

Implicit bias is widespread, even among individuals who explicitly reject prejudice. It persists through structural and historical inequalities that have been slow to change (Payne et al., 2019).

2.2 What is Explicit Bias?

Explicit or **conscious** bias, unlike implicit bias, occurs when we are aware of our prejudices and attitudes, which can lead to positive or negative preferences for a particular group. Explicit bias can lead to unequal treatment, lack of access to care, and influence diagnostic and treatment decisions.

Explicit forms of bias include preferences, beliefs, and attitudes of which people are generally consciously aware, personally endorse, and can identify and communicate (Vela et al., 2022).

2.3 What are Stereotypes?

Stereotypes are fixed, oversimplified beliefs about a particular group or culture. They occur when we categorize people by age, gender, race, or other criteria (Brusa et al., 2021). In the healthcare setting, stereotyping occurs when a provider categorizes a patient in a certain way, whether or not the individual fits the stereotype (Galanti, 2019).

When people are exposed to or are invited to think about traits or behaviors that counter their stereotypes, they became less prejudicial toward that social group. Equality of status, social and institutional support, pleasant contact, and intergroup cooperation often produce positive results (Brusa et al., 2021).

Recognizing stereotypical thoughts can have a powerful impact on bias. Putting yourself in the shoes of the other person, creating a non-stereotypical alternative to a particular stereotype, and seeing the person as an individual can reduce bias.

2.4 What is Perception Bias?

> 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

Perception bias is a type of unconscious or implicit bias that occurs when a person's perception is skewed based on inaccurate and overly simplistic assumptions about a group a person "belongs" to. This may include biases or stereotypes about age, gender, ethnicity, and appearance.

Perception biases can create a conflict between what a person believes and what they want to do (FitzGerald and Hurst, 2017). Perception bias can affect a provider's ability to make sound medical decisions.

Providers may feel they can overcome biases through sheer will power. They may feel that bias does not occur among professionals and experts, or they may believe that they are impartial and immune to bias. They may perceive bias as only associated with corrupt or malicious people or with "bad apples" rather than systemic issues. Although research has shown this to be incorrect, they often feel that bias can be eliminated by technology, instrumentation, automation, or artificial intelligence (Dror, 2020).

2.5 What is Diagnostic and Treatment Bias?

> The use of racial terms to describe epidemiologic data perpetuates the belief that race itself puts patients at risk for disease, and this belief is the basis for race-based diagnostic bias. Rather than presenting race as correlated with social factors that shape disease or acknowledging race as an imperfect proxy for ancestry or family history that may predispose one to disease, the educators we observed portrayed race itself as an essential—biologic—causal mechanism.
>
> Amutah, et al., 2021
> New England Journal of Medicine

Patient-provider interactions, treatment decisions, patient adherence to recommendations, and patient health outcomes can be influenced by bias. This can lead to an unintentional form of discrimination that affects decision-making structurally and systematically and is hard to identify and uncover (Nápoles et al., 2022).

Studies have shown that implicit racial bias profoundly influences clinical decision-making. Its affects nonverbal behaviors such as eye contact and posture and has been shown to influence the quality of physicians' interpersonal communication with African American patients and, in turn, patients' trust and perceptions of their physicians (van Ryn et al., 2015).

2.6 Indirect Discrimination

Indirect discrimination happens when there is a policy that applies in the same way for everybody but disadvantages a group of people sharing a protected characteristic. * You are disadvantaged if you are a member of that group. A “policy” can include a practice, a rule, or an arrangement. It makes no difference whether anyone intended the policy to disadvantage you or not (EHRC, 2019).

*** Protected characteristic**: Also referred to as a protected class. A category of a group of people who have historically been discriminated against.

Indirect discrimination often operates under the guise of legitimacy and fairness. It can be related to sex, gender reassignment, sexual orientation, race, belief, age, disability, marriage or civil partnership, or religion. While direct discrimination is often evident, indirect discrimination can be subtle and difficult to prove.

If you are affected by indirect discrimination, the person or organization applying the policy must show that it is in place for a good reason. A “policy” can include a practice, a rule, or an arrangement. It makes no difference whether anyone intended the policy to disadvantage you or not (EHRC, 2019).

To prove that indirect discrimination is happening or has happened, a person must be able to show that the policy has disadvantaged them personally or that it *will* disadvantage them. Additionally, indirect discrimination can occur if the organization is unable show that there is a good reason for applying the policy despite the level of disadvantage to people with a protected characteristic (EHRC, 2019).

Examples of indirect discrimination include:

- Prohibiting certain types of hairstyles.
- Requiring patients to be given care by someone of the same gender—some people may prefer certain caregivers of the opposite gender or transgender people may want to be seen by the gender with which they identify.
- Providing protective clothing that is too small or large for an employee.
- Establishing height requirements for jobs where height is irrelevant or refusing a job to someone because the company’s equipment is not designed for people of a certain height.
- Providing generic toiletries that may not be suitable for some skin and hair types could constitute indirect discrimination for those, for example, with curly or coily hair.

In hospital organizations owned by religious organizations, indirect discrimination—although well-intentioned can include:

- Refusing to pay for an employee’s required training on Saturday because of the employer’s religious beliefs.
- Requiring prayer at the start of staff meetings.
- Promoting only members who share the religious beliefs of the hospital’s owners or managers.
- Serving lunch at a certain time each day without consideration for religious requirements such as fasting.

It is important to carry out impact assessments on all the protected characteristics when creating and reviewing policies, procedures, or rules.

Several tools have been developed to help an organization prevent policies and assumptions that can lead to indirect discrimination. For example, the *Equality Pay Act of 1963* requires employers to pay each employee equally for the same role regardless of gender identity and disability. It also ensured that Black Americans had equal access to public accommodations and material goods. (Also see the module 12, Best Practices for Improving Health Equity.)

3. Historic Inequalities—Power, Privilege, and Oppression

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).

These social and structural inequities 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. These complex and interconnected issues can contribute to chronic disease due to physiological and psychological stress from repeated daily inequities (Culhane-Pera et al., 2021).

Definitions: 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.

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).

3.1 Colonization and Colonial Medicine

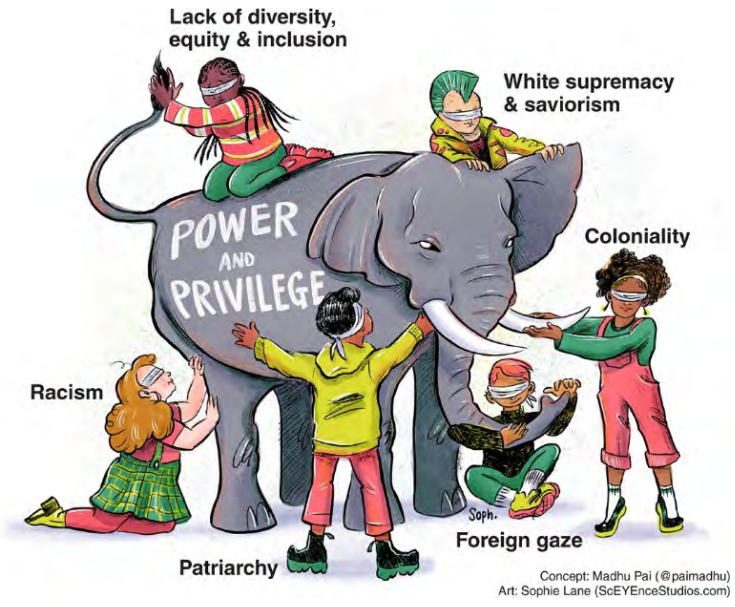
> Colonization is the process of assuming control of someone else's territory and applying one's own systems of law, government, and religion.
>
> Stolen Lives: The Indigenous Peoples of Canada and the Indian Residential Schools / Historical Background

Colonization has had—and continues to have—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.

3.2 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

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).

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.

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 11).

4. Social Determinants of Health

Marginalized groups experience poorer mental and physical health outcomes than the general population due to health inequities largely driven by social determinants of health—the conditions in which people live throughout their lifespan. There is a causal, vicious cycle between disadvantages due to social determinants of health and the poor health outcomes (Marjadi et al., 2023).

Poor health status creates additional disadvantages by limiting a person's ability to obtain education or engage in work. In addition, those who are disadvantaged often have limited access to healthcare services. This lack of access means that healthcare services may not be inclusive of the diverse populations who need them the most. Healthcare services which are not inclusive for diverse populations further contribute to these avoidable health inequities (Marjadi et al., 2023).

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.

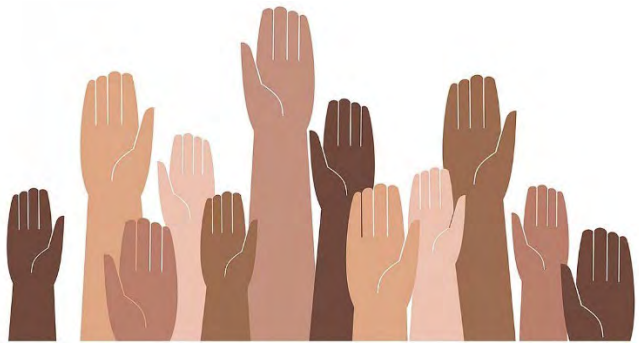
Most Americans are unaware of these health gaps, do not understand what causes them, and do not necessarily find them to be unfair. A survey conducted in 2008–2009 based on a national sample showed that most respondents (73%) were aware of health differences between the poor and middle-class people, 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).

5. Assumptions and Myths

> 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

To provide culturally responsive healthcare services, clinical staff, and organizations need to become aware of their own attitudes, beliefs, biases, assumptions, and myths 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).

Assuming an understanding of other people and cultures can lead to stereotyping a person based on your lack of knowledge about cultural differences. Cultural competence training can shine a light on the assumptions and myths we hold about marginalized peoples and unfamiliar cultures.



Source: NIH, public domain.

5.1 Common Myths About Marginalized People

Myths, stereotypes, racism, and sexism are closely linked. Throughout human history, myths and stereotypes have stigmatized marginal groups. Stereotypes and myths differ somewhat: as discussed earlier, stereotypes are fixed, oversimplified beliefs about a particular group or culture while a myth is a foundational belief, something that is not true but is shared by many people.

Years of discrimination, lack of teaching about the true history of marginalized communities, and films and media that perpetuate stereotypes have led many people to have commonly held myths about unfamiliar cultures and peoples.

Myths are usually based on stereotypes. For example, there is a pervasive belief that Asian Americans are good at math and music, they are generally more law-abiding and polite than other people, and that their moms force their children to work harder than other children.

Women often face myths and stereotypes that affect their ability to make independent choices about their lives. Myths and stereotypes affect how women live in the world, their ability to own property, hold jobs, and make decisions about child-bearing family planning. Common, incorrect myths about women state that they are irrational, not good at math, not good leaders, and invite sexual advances by dressing inappropriately.

In the United States, myths related to Native Americans abound. One overriding belief is the Native people are all the same, are all wealthy because of casinos, or contradictorily, are primitive and lack cultural laws and values. All these statements are myths based on ignorance and lack of cultural understanding.

In the United States, there are currently 574 federally recognized Indian Nations. Approximately 229 of these ethnically, culturally, and linguistically diverse nations are located in Alaska; the other federally recognized tribes are located in 35 other states. Additionally, there are state recognized tribes located throughout the United States recognized by their respective state governments (NCAI, 2020).

People of Asian descent are often lumped into one group that erases Asian peoples' vast diversity and cultural richness. The so-called "model minority myth" places pressure on children and adults to behave in a certain way and accomplish certain goals. It also perpetuates the myth of Asian Americans are foreigners in their own land.

For immigrants, certain myths are pervasive. As with Native Americans, many people believe that all immigrants are the same. A common myth is that all immigrants are in the U.S. illegally, don't want to learn English, take jobs from U.S. citizens, and don't pay taxes.

All these statements are false. Click here to learn more about these myths and stereotypes. To learn about overcoming myths and stereotypes, see section 13.9 Overcoming Perceptions (in this course).

Consider the following stereotypes and myths:

- Women are irrational.
- Women encourage sexual advances and rape by not dressing modestly.
- Girls and women are not good at math.
- Women are not good leaders.

6. Gender, Race, and Ethnicity

Racial, ethnic, sexual, and gender minoritized groups have historically been excluded from many benefits of society. Most recently, these groups were disproportionately affected by COVID-19 pandemic. This has shined a light on the disparities within our healthcare system and has led healthcare organizations and workers to examine attitudes and practices that affect the care and outcomes for these groups of people.

Central to the effective care of historically excluded communities is an appreciation for cultural responsiveness, sometimes called cultural competence. In the context of healthcare, culturally responsive communication refers to a provider's ability to engage with patients based on views of culturally diverse patients rather than the views of health care professionals (Xavier et al., 2023).

Cultural responsiveness centers unique patient experiences and understandings of health and illness, recognizes the individual biases that clinicians may hold, and seeks to work productively with patients who are not typically represented or valued in the Western understandings of care. This approach allows healthcare practitioners to work consciously and effectively toward cultivating health equity for historically marginalized groups (Xavier et al., 2023).

The influence of social determinants of health, including access to screening and treatment, and other systemic and structural factors are largely responsible for these disparities. Provider competence in culturally responsive screening practices will be critical to reducing the impact of systemic and structural factors serving as barriers to screening and treatment. Improving the capacity of providers to communicate with patients in a culturally responsive manner may influence improved screening and treatment outcomes for minoritized groups (Kalita et al., 2023).

6.1 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 norms, gender identity, and gender relations together encompass the socially constructed roles, relationships, behaviors, relative power, and other traits that societies routinely ascribe to women and men. Gender identities other than those of men and women (who can be either cisgender or transgender) include transgender, nonbinary, genderqueer, gender neutral, agender, gender fluid, and "third" gender, among others (Peters and Woodward, 2023).

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).

Sex and gender are integrally related and influence health in different ways. According to the World Health Organization, sex refers to “the different biological and physiological characteristics of females, males and intersex persons, such as chromosomes, hormones and reproductive organs”, while gender refers to “the socially constructed characteristics of women, men, girls, and boys” (Peters and Woodward, 2023).

6.1.1 Reproductive Justice

> 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

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).

The concept of reproductive justice represents a significant shift from traditional notions of reproductive rights. 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 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.

6.1.2 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).

6.1.3 Health Equity and Children

[Unless otherwise noted, the following section is from Rattermann et al., 2021].

Health equity is a major concern for pediatric and adolescent children. Despite the great gains made in access to healthcare since the passage of the Affordable Care Act, children from poor communities often lag behind their peers in more affluent communities in access to quality healthcare.

Over one quarter of poor children under 18 years of age in the U.S. have gone more than 6 months without having contact with a doctor or other healthcare professional, with 4.2% of those children having no contact with a doctor or healthcare professional in over five years.

Many schools are addressing the lack of access to healthcare through school nurse programs and school-based health centers. School-based healthcare provides access to primary and preventive healthcare services for students who are at risk for negative medical, social, and academic outcomes. For children of poverty, the school nurse and the school-based health center are often the only medical care that is available to them.

Training future generations of pediatricians to deliver culturally appropriate care and promote health equity has become a priority, especially in the context of COVID-19-related racial and ethnic disparities and the increased recognition of racism as a public health crisis. Recently, funding agencies have focused on defining key terms, introducing a definition of pediatric health equity reflecting a collective goal (Hernandez et al., 2022):

- Ensuring every child has a fair and just opportunity to be as healthy as possible.
- Removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs.
- Providing fair pay, quality education and housing, safe environments, and healthcare.
- Developing curricula that are accountable to community needs and that more comprehensively address health inequities.
- Creating competency among pediatricians that address racism, discrimination, and other contributors to inequities.

6.2 Race and Ethnicity

Implicit racism is a form of power and oppression that has 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.

6.3 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 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. Source: 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).

7. Religion and Spiritualty

A healthcare provider's religious or spiritual beliefs can have a profound effect on the patient's view of you as a provider. In many cases, overt religious views and iconography can alienate patients. Religious and spiritual beliefs cut both ways. Differing beliefs can cause a patient to wonder if the provider has their best interest in mind.

Religion as an organized system of beliefs, practices, rituals, and symbols designated to facilitate access to the sacred and the transcendent (God, Greater Force, and Supreme Truth). Religiosity corresponds to how much an individual believes, follows, and practices a religion (Borragini-Abuchaim et al., 2021).

Spirituality can be seen as a personal quest to understand issues related to the purpose of life, its meaning, as well as relations with the sacred or transcendent that may or may not lead to the development of religious practices or formation of religious communities (Borragini-Abuchaim et al., 2021).

Religion and spirituality are important to many patients seeking care. However, the diversity of religions around the world can create challenges for healthcare providers and systems related to providing culturally competent medical care. Healthcare providers may not take religious beliefs into account when they are dealing with difficult medical decisions for patients and their families (Swihart, Yarrarapu, Martin, 2023).

Historically—and in many parts of the world today—religious leaders and healthcare providers are one and the same. Only within recent times has medicine relied on a scientific approach to care. This has resulted in a separation between medicine and religion (Swihart, Yarrarapu, Martin, 2023).

The challenge is to understand that patients often turn to their religious and spiritual beliefs when making medical decisions. Religion and spirituality can impact decisions about diet, medicines based on animal products, modesty, and the preferred gender of their healthcare provider. Some religions have strict prayer times that may interfere with medical treatment (Swihart, Yarrarapu, Martin, 2023).

Acknowledging and understanding a patient's background and beliefs is the first step in providing culturally sensitive healthcare. Providing culturally religious care starts with developing an awareness of the uniqueness of each person's religion and their special needs. It means being respectful, avoiding judgements, and recognizing how values, behaviors, and beliefs may affect others.

Healthcare providers can develop religious competence by avoiding assumptions and asking the patient and family how you can help make their experience more comfortable. Although most healthcare workers are trained to observe body and facial language, it is important to frame these observations in a religious context. If a cultural mistake occurs, apologize, and ask the patient or family member for feedback (Swihart, Yarrarapu, Martin, 2023).

Most healthcare organizations provide interpreters who can help with language and cultural issues. To be effective, interpreters must be medically and culturally competent, and fluent in the patient's preferred language. Avoid using untrained employees, children, or untrained ancillary staff as interpreters in place of a trained interpreter (Swihart, Yarrarapu, Martin, 2023).

Overt expressions of religious beliefs are less common in hospitals today than in the past. Nevertheless, many healthcare organizations allow the display of religious statuary or other symbols.

Case: Proselytizing

The Situation: David is a social worker in a hospital who specializes in discharge planning and care coordination. In the course of his work, he may meet with patients and families at the bedside but might also bring a patent and/or family member to his office. He has significant social work experience of this type but is relatively new to the hospital where he now works.

David, who is Jewish, is not secretive about his faith with co-workers but does not promote or display this. Recently, leaflets or other postings with Christian scripture have been appearing at the entrance to his office and taped to the wall or door. Some of these are of a clearly proselytizing nature. He removes them, but they reappear quickly. It seems that his co-workers know who is doing this but have the message: "the person (who is doing this) is just like that; shrug it off."

David has several concerns.

1. One of the postings could offend or intimidate a patient or advocate; he is concerned that this has already caused some uncomfortable feelings. Someone could report the issue to the administrative head of the hospital.

2. David is feeling harassed. He thinks that the person leaving the messages may be following him and keeping track of his whereabouts. Why are new messages appearing so quickly?

3. Furthermore, he feels unsupported by his department head and co-workers and is wondering whether he has a future in his new position.

Next Steps: The employee, Ray, who was posting the messages moved to a different job in another location as the result of a reorganization—this appeared to be coincidental and not the result of a department action. With the tension lifted, David was able to feel more at home and gained some recognition of his good work. But he was still not comfortable with the lack of action he saw earlier, and he was now considering an unexpected job offer. David decided to set up a meeting with the department chair.

Discussion: At the meeting with the department chair, David was able to talk more openly about his background and the effect of the messages on his ability to feel welcomed in the department. He also asked for regular communication in the department collectively or individually to address issues for staff working conditions and to discuss policies and resources proactively.

Outcome: It was fortunate that David's manager was receptive to his ideas and agreed to start regularly scheduled discussions. She had not been fully aware of the effect of the proselytizing. David decided to stay on in the department at least for the time being.

Lessons: (1) David realized he could have taken the step of talking directly to the department chair earlier. (2) Important—to build a culture of inclusiveness, the "small things" count. (3) Any medical facility (or company for that matter) should treat its employees as it purports to treat its patients.

8. Sexual Orientation and Gender Identity or Expression

All of us have a sexual orientation and a gender identity. Sexual orientation is an inherent or immutable enduring emotional, romantic, or sexual attraction to other people. It is independent of a person's gender identity. Gender identity is one's innermost concept of self as male, female, a blend of both or neither—how individuals perceive themselves and what they call themselves. Gender identity can be the same or different from their sex assigned at birth (HRC, 2024).

When seeking healthcare, lesbian, gay, bi-sexual, transgender, questioning, intersex, asexual people (LGBTQ+) are impacted by significant barriers. This can take the form of disrespect, discrimination, inadequate understanding of needs, and an inability to provide appropriate care. Many patients delayed seeking healthcare because of their identity and fear of discrimination from healthcare providers (Prasad et al., 2023).

The experience of discrimination among LGBTQ+ people is linked to higher incidence of serious illness, poorer health outcomes, more risky health behaviors, and difficulties accessing healthcare. When seriously ill LGBTQ+ people feel unable to share important aspects of identity, the impact can be devastating (Braybrook et al., 2023).

Competent communication is vital for LGBTQ+ inclusive care, building trusting relationships, informed decision making, and person-centered care. Poor communication and assumptions made by clinicians about patients' gender and sexual orientation undermine clinical relationships, leading to disengagement and loss of trust. Specifically, heteronormativity* and cisnormativity** are pervasive and damaging (Braybrook et al., 2023).

***Heteronormativity**: the assumption that being heterosexual is the "normal" sexual orientation.

****Cisnormativity**: the assumption that having a gender identity that aligns with sex assigned at birth is the "normal" gender identity.

For intersex populations, there is limited research focused on their healthcare, but there is a tendency for intersexual adults to avoid healthcare due to traumatic healthcare experiences during childhood. These disparities in physical health and quality of care highlight the need to improve the healthcare experience for this population by providing focused training to healthcare professional students (Prasad et al., 2023).

The concept of intersectionality explains how LGBTQ+ individuals may be confronted with multiple interlinked forms of discrimination such as heteronormativity, ageism, ableism, and racism, that when combined, increase vulnerability to health inequities and lead to inferior clinical outcomes (Comeau et al., 2023).

The lived experiences of gender-diverse people can be respected using words that patients choose in their own terms, which may include gender-neutral terms or binary terms if preferred to affirm one's gender (Marjadi et al., 2023).

The Human Rights Campaign Foundation's Healthcare Equality Index (HEI) shows incredible growth in the number of healthcare institutions that are embracing and adopting LGBTQ+ inclusive policies and practices. An overview of the HEI 2022 indicates, diverse healthcare facilities across the U.S. are making tremendous strides toward LGBTQ+ patient-centered care. In unprecedented numbers, they are changing key policies, implementing best practices, and training their staff.

HEI includes four foundational elements of LGBTQ+ patient-centered care (HRCF, 2022):

1. An LGBTQ+ inclusive patient non-discrimination policy.
2. An LGBTQ+ inclusive visitation policy.
3. An LGBTQ+ inclusive employment non-discrimination policy.
4. Staff training in LGBTQ+ patient-centered care.

9. Cultural Competency in Veteran Services, Mental Health Services, and for Older Adults

For many healthcare providers, practicing culturally competent care can be challenging for certain groups of people, especially if a provider has limited personal experience with the difficulties faced by these groups. For members of the military and veterans, military culture is often little understood by the general population. This can be true also for people with mental health issues and for older adults.

9.1 Military and Veteran Cultural Competency

[Unless otherwise noted the information in section is from Isserman and Martin, 2022].

Military members, veterans, and their families belong to a unique American subculture. Military culture, which is acquired through training and experiences that are integrated into the service members' mind, body, and spirit, is comprised of implicit values and beliefs shared through time-honored rituals, customs, and organizational traditions.

While there is great diversity among the various sectors of the armed forces, there are implicit cultural values and beliefs shared across all components and service branches. For example, the concept of *service before self*, is a core military value that stresses integrity and requires service members to place their duty responsibilities before their own personal interests and desires. These values are ingrained early in military training and remain with military members and their families even after transitioning from military service to veteran status.

Numerous studies have identified the need for health professionals to acquire what is referred to as “military/veteran cultural competence” to effectively engage with this population. This allows clinicians to understand the importance of recognizing how a client’s life experiences and relationships have been impacted by military service and veteran status.

Military cultural competence includes developing an understanding of the basics of military life and language and the impact of military lifestyles and duties on behavioral and physical health, combat-related exposures, and family separations. Understanding workplace challenges confronting the armed forces—issues like sexual violence, addiction, and suicide are also important.

Service members, veterans, and their family members expect providers to have a basic cultural appreciation, understanding, and interest in their military-related experiences. This includes listening to their experiences, even when these stories may be horrific or painful. It is critical that healthcare providers not let their own personal biases interfere with an understanding of a client’s unique military duty or military life experiences.

Healthcare providers can break down military cultural barriers by initiating discussions about specific problems related to trauma, military sexual trauma, intimate partner violence, PTSD, and behavioral health issues. Be aware that a client may be affected by conditions such as moral injury, challenges faced during deployment, and military grief for children.

Key points about military/veteran cultural competence:

1. Screen clients for military or veteran status.
2. Become knowledgeable about military culture.
3. Understand the cultural stigma clients face in reaching out to therapists for counseling.
4. Understand any preconceptions you may hold about the military.
5. Learn about the values and factors that impact a military client’s behavioral and relational difficulties.

Test Your Knowledge

You have a client who was injured in the Afghanistan conflict who was referred to you for counseling. You haven’t had any other clients who fought in the war and aren’t sure whether to ask your client about her experience or not. What should you do?

Answer: Ask her about her military service and praise her for reaching out for help. Remember that many veterans are reluctant to seek mental health care and may feel ashamed or stigmatized.

9.2 People with Mental Health Issues

Although culture is a fluid concept, it is a central part of how we understand mental health. Culture influences what gets defined as a problem, how the problem is understood, and which solutions to the problem are acceptable. It has many layers, which interact with class, religion, language, nationality, and gender, each of which influences how an individual engages with and experiences mental health services (Salla et al., 2023).

Culture provides standards for normality and abnormality, and the definitions of what constitutes a mental disorder are socially and culturally negotiated. Culture determines the variations of normalcy in behaviors; while some cultures are tolerant of high levels of deviant behaviors, other cultures insist on conformity (Ogundare, 2020).

Cultural differences can affect the rates of diagnosis of certain mental disorders. For example, diagnosis of attention deficit hyperactivity disorder diagnosis varies widely across countries. These variations reflect the influence of culture on the tolerability of certain behaviors in children, and the perception and acceptance of the diagnosis (Ogundare, 2020).

Current diagnostic classifications of mental illness rely mostly on western worldviews of what constitutes abnormal behaviors and assume a universalist view of mental illness. In reality, however, there are many cultural variations in the phenomenology of mental illness and psychopathology. These variations affect the reliability and validity of the diagnostic instruments that are used to diagnosis mental illness (Ogundare, 2020).

The DSM-IV (to some extent) and DSM-V (to a larger extent) have recognized the importance of cultural considerations in the manifestation of illness, diagnosis, and treatment of mental disorders. The DSM-V includes a cultural formulation chapter that aims to help clinicians evaluate cultural aspects of the diagnostic procedure and added a *Cultural Formulation Interview* to aid the implementation (Ogundare, 2020).

When the social and cultural factors are neglected in the assessment of patients, misdiagnosis and perpetuation of clinical stereotypes based on race, ethnicity, gender, among other factors occur, leading to disparities in mental healthcare. For example, in the U.S., there is a long history of misdiagnosis of schizophrenia and other psychosis-related disorders among Black people, dating as far back as the early 1900s (Ogundare, 2020).

Clinical diagnosis of a mental disorder requires clinicians to fit patient information into existing diagnostic categories, and the weaker the fit between the available information about the patient and the diagnostic criteria, the greater the uncertainty regarding clinical diagnosis. In these situations, clinicians often make clinical judgments based on underlying assumptions about the patient within the context of the general population (Ogundare, 2020).

Failure to consider a patient's cultural context leads to misinterpretation of the patient's behaviors and leads to diagnostic inaccuracies. Conversely, cultural sensitivity and knowledge of the cultural context provides a more contextualized perspective, improves diagnostic accuracy, and helps identify a patient's severity and ongoing vulnerability (Ogundare, 2020).

Healthcare professionals are not immune to making racially biased decisions; ideas related to race and culture overlap. In relation to mental health, barriers to help-seeking are not simply a cultural nuance, they are infused with a fear among racial minorities about the care they will receive because of their identity. Cases of historical mistreatment of racial minorities by the state and by mental health services contribute to cultural beliefs and values about mental health services (Salla et al., 2023).

9.3 Cultural Competency and Older Adults

They are many aspects to cultural competence for older adults. A patient's culture and background often affect whether and where they seek healthcare, their understanding of medical information, and how they make healthcare decisions. Recognizing the different health issues your older patients are likely to face, as well as the factors that contribute to these differences, will help you provide the most effective care.

Adults from different cultures and traditions have varied attitudes about aging. In some cultures, older adults are customarily respected for their wisdom and experience. Other cultures tend to be more youth-centered, valuing the qualities of youth over those of old age (NIA, 2023 June 27).

For older adults, culturally competent, linguistically appropriate care is essential to meet the needs of what is becoming a larger and more diverse population. The value of cultural competence lies in understanding how cultural variables impact and inform the healthcare experiences of older adults (Chowdhury et al., 2022).

For older adults, many complex and interacting factors underlie disparities in health risk and disease burden. These factors include:

- unequal access to healthcare services
- availability of social support
- neighborhood and workplace environments
- food availability and accessibility
- wealth and income gaps
- racism, sexism, and other forms of discrimination (NIA, 2023 June 27)

Additional factors such a lack of geriatrics specialists, medical insurance issues, ageism, hearing and visual changes, chronic diseases, cognitive changes, limited English proficiency, and health literacy can lead to stigma and misunderstandings that contribute to inaccurate diagnoses, lack of followup care, and poor health outcomes.

9.3.1 Patient-Centered Care

There is increasing recognition of the importance of including patient perspectives on the quality of healthcare delivery, which has traditionally been driven solely by healthcare professionals and policy makers. Person-centered care prioritizes viewing older adults as partners in receiving, planning, and monitoring care. Ensuring patients are involved and central to their care is a key component of high-quality healthcare (Chowdhury et al., 2022).

Because older adults from culturally diverse backgrounds are often miscategorized as a homogenous group despite prominent sociocultural differences, moving away from a "one-size-fits-all" approach is critical. Person-centered care encourages providers to tailor care delivery to the participants' specific sociocultural backgrounds. As such, person-centered care is a crucial component of cultural competence in healthcare settings, and each informs the other (Chowisdhury et al., 2022).

To ensure care supports all older adults, healthcare providers need to be responsive to the many diverse characteristics influencing the health and care needs of older people. Five key principles of culturally competent include (Ogrin et al., 2022):

1. **Awareness of unconscious bias and prejudice**. Reduced healthcare involvement can occur because of unintentional judgments about older people by healthcare providers.
2. **Promotion of inclusion**. Focus on similarities between people rather than differences supports a sense of belonging. Language is critical, such as using "person with dementia," rather than the derogatory "demented patient."
3. **Access and equity**. Inclusive healthcare requires embedding access and equity in policy and practice. These components have wide-reaching effects for participation of older people in their healthcare. Any deficits in these aspects should be identified by healthcare workers who understand the diverse needs of older people.
4. **Appropriate engagement**. Participation supports involvement and sharing of decision-making. Building trust and rapport leads to open and meaningful discussions.
5. **Intersectionality**. This involves moving away from viewing people through a single lens, towards understanding the intersection of their various characteristics. For example, the interplay of characteristics, such as an older woman, from a culturally and linguistically diverse background, living in a remote community with few services, will inform this woman's ability to participate in healthcare in a meaningful way.

9.3.2 Ageism

Ageism is an often underrecognized form of discrimination that includes stereotypes and prejudices directed toward people on the basis of their age. Ageism has serious implications for the health of older people. Age-based discrimination has been associated with poorer physical and mental health, reduced quality of life, and even earlier death (NIA, 2023 June 27).

Effective communication builds satisfying relationships with older patients to best manage their care. It strengthens the patient-provider relationship, leads to improved health outcomes, reduces medical errors, and makes the most of limited interaction time (NIA, 2023 January 25).

Key points (NIA, 2023 January 25):

1. **Speak to the patient as a fellow adult**. Having physical, sensory, or cognitive impairments does not lessen the maturity of an adult patient. Establish respect right away by using formal language as a default (such as Mr. or Ms.). Avoid terms, such as "dear," which could be perceived as disrespectful. Ask patients how they prefer to be addressed.
2. **Make older patients comfortable**. Make sure patients have a comfortable seat in the waiting room and, if necessary, help with filling out forms. Check on them often if they have a long wait before being seen. Patients with impaired mobility may need extra help. They may require assistance with climbing on to the exam table or removing clothing or shoes.

3. **Avoid hurrying older patients**. Be mindful if you are feeling impatient with an older person's pace. Some people may have trouble following rapid-fire questioning or torrents of information. Try speaking more slowly to give them time to process what is being asked or said, and don't interrupt. Once interrupted, a patient is less likely to reveal all of their concerns.
4. **Speak plainly**. Use common language and ask if clarification is needed. Check to be sure your patient understands the health issue, what they need to do, and why it is important to act.
5. **Address the patient face-to-face**. Don't talk to patients with your back turned or while typing. Many people with hearing impairment understand better when they can read lips as well as listen. Watching a patient's body language can also help you know whether they understand what you're saying.
6. **Write down or print out takeaway points**. It can often be difficult for patients of any age to remember everything discussed during an appointment. Older adults with more than one medical condition or health concern benefit from having clear and specific written notes or printed handouts.
7. **Recognize that people from different backgrounds may have different expectations**. Be sensitive to cultural differences that can affect communication with your patients. When needed, provide professional translation services and written materials in different languages.

Test Your Knowledge

You have an older, Spanish-speaking client who is concerned about her declining health and has come to you for counseling. She tells you she has been very depressed for more than a year. Your Spanish is less than adequate but you decide it's good enough for this sweet old woman. Her granddaughter offers to translate but you decline and ask the granddaughter to wait outside. In terms of cultural competency, **what have you already done wrong?**

Answer Any person with limited English should be offered professional translation services. You have already made several inaccurate assumptions about this woman. You have stereotyped her as a sweet, old woman who probably just needs someone to talk to. You don't feel the need to completely understand her needs and issues and will very likely be unable to draw her out due to your lack of fluency and lack of understanding of this women's cultural background.

What Should You Do? Ask if she would like to have a translator or see another counselor with a cultural background similar to hers. Refrain from infantilizing older women as sweet, cute, lonely, and inoffensive. Speak to her as a fellow adult and provide Spanish-language and provide her with educational materials in Spanish.

10. Intellectual, Developmental, and Physical Disabilities

> The last decades have been marked by a shift in thinking. From viewing disability as a personal problem that needs to be cured (the medical model), we have come to see the source of the problem: the society's attitude towards persons with disabilities. This means that we have to act collectively as a society in order to remove the barriers that hinder persons with disabilities from living among us and contributing to our society, and to fight against their isolation in institutions or in the backrooms of family homes. Finally, there has been a shift from welfare policies and charity as the only tools for dealing with disability, to an approach based on human rights and equality.
>
> Lucy Series, 2020

The *United Nations (UN) Convention on the Rights of Persons with Disabilities* (CRPD) was the first human rights treaty to be developed by disabled people, for disabled people. Adopted by the UN in 2006, the Convention embodies and enshrines key tenets of contemporary disability scholarship and activism—from "nothing about us without us" to a social understanding of disability (Series, 2020).

The CRPD is a landmark achievement for disability advocacy and human rights. It represents an inflection point in our understanding of what it means to be a bearer of rights, and the role of states and the global community in promoting, protecting, and ensuring those rights (Series, 2020).

In the United States, 36% of healthcare expenditures are related to disability. In the healthcare system, explicit and implicit biases toward people with disabilities are pervasive. Significant health inequities exist for and among disabled people, which relate at least in part to discrimination, inaccessibility, and other barriers that disabled people experience throughout health systems and society (Lundberg and Chen, 2024).

Comorbidities can be complex and combined with insufficient research and lack of disability-specific content in medical curricula. Providers may lack the experience and training to adequately address the needs of people with disabilities. For healthcare providers, lack of experience and discomfort communicating with people are major barriers to the delivery of good healthcare.

Did You Know. . .

> In some cultures, a disability is attributed to spiritual or otherworldly forces, such as sorcery, parents' "sin", punishment, or a test of faith. Community awareness programs aimed at explaining real causes of disabilities can reduce stigma and prejudice against individuals and families (Jansen-van Vuuren and Aldersey, 2020).

10.1 Intellectual and Developmental Disabilities

People with intellectual and developmental disabilities experience a great deal of stigma that can limit social inclusion and increase disparities compared to the general population. Stigma involves discrimination, prejudice, and exclusion in various forms and often affects how one is accepted or can participate within a community (Jansen-van Vuuren and Aldersey, 2020).

Compared to the general population, people with intellectual disabilities have a higher prevalence of physical conditions, especially neurological disorders, sensory impairments, obesity, constipation, and congenital malformation. Low awareness of the disease epidemiology may expose this population to underdiagnosis, misdiagnosis, inappropriate pharmaceutical interventions, and missed opportunities for preventative healthcare (Liao et al., 2021).

Cultural values, beliefs, and practices influence how people with intellectual and developmental disabilities are treated. For healthcare providers, understanding the stressors that people with intellectual and developmental disabilities experience daily is important. Helping clients develop practical skills, such as accessing public transport, managing finances, and using assistive technology increases independence and reduces stigma.

Individuals with intellectual or cognitive disabilities such as dementia, autism, or other developmental conditions are often deemed to lack mental capacity. These people often experience decisions made by others regarding their residence, care, and other broad elements of their daily life (Reed-Berendt, 2022).

For anyone with a disability, developing social and personal skills, learning work skills, and building self-esteem, self-identity, and assertiveness reduces the feeling of “otherness” and enhances a person’s ability to function and participate within society (Jansen-van Vuuren and Aldersey, 2020).

10.2 Institutionalization

The term "institution" means any facility or institution which is owned, operated, or managed by, or provides services on behalf of any State or political subdivision of a State. This can include facilities for persons who are mentally ill, disabled, or retarded, or chronically ill or handicapped (DOJ, 2023).

The National Council for Disability (NCD) defines institutions as places that only include people with disabilities, include a facility more than 3 people who did not choose to live together, and do not permit residents to lock the door to their bedroom or bathroom. These institutions were, and remain, facilities operating for the purpose of housing people with disabilities (DeLano, 2023).

Additional features of an institution include:

- limiting visitors
- restricting entry and exit
- enforcing sleep and mealtimes
- restricting religious practices and beliefs
- restricting sexual preferences or activities
- restricting access to phone and internet (DeLano, 2023)

Deinstitutionalization and the development of a strong community-based system that helps people with intellectual or development disabilities live in the community is both morally and ethically the right thing to do. It is also a civil rights issue. The law supports the individual right to live in the community (NCD, 2012).

Source: CDC, Public Domain.

In crafting the Americans with Disabilities Act of 1990 (ADA), Congress found that "the Nation's proper goals regarding individuals with disabilities are to assure equality of opportunity, full participation, independent living, and economic self-sufficiency for such individuals" (NCD, 2012).

10.3 Ableism

Ableism is discrimination or prejudice against people with disabilities. It is based on the belief that non-disabled people have more value than disabled people and that "typical" abilities are superior. Ableism assumes that disabled people require "fixing" and defines people by their disability.

10.3.1 Avoiding Ableist Language

Words have power and ableist language is both harmful and unnecessary. Ableist words have become an established part of society's vocabulary and changing the use of these words will have to be an ongoing process that we will have to work together to change (NLM, 2022).

Using ableist language both internalizes and reveals our unconscious biases. Ableist language evolves just like slang, with phrases catching on and becoming widely accepted parts of our vocabulary. Making a "dumb" choice, turning a "blind eye", acting "crazy" or "falling on deaf ears" are widely used phrases. Using these kinds of terms and phrases reinforces negative attitudes and promotes inaccurate descriptions of what having a disability means (NLM, 2022).

Some tips about ableist language (NLM, 2022):

- Avoid using disability as an insult.
- Work with friends, family, and coworkers to recognize and replace ableist words.
- Avoid euphemisms such as differently abled, physically challenged, mentally challenged, handi-capable, or special needs.
- Avoid identifying a person based on the equipment they are using (the cane lady or the hearing-aid guy).

10.3.2 Examining the Use of Ableist Language

Although there is a need to continue to examine ableist language within healthcare, there have been some positive changes. A study involving 22 disabled participants highlighted the positive encounters they experienced during interactions with medical professionals. Participants reported feeling more empowered with healthcare experiences involving active listening, practitioners taking the time to understand and address their priorities, and the presence of accessible and inclusive environments (Feldner et al., 2022).

These experiences ranged from meeting individual access needs to creating universally designed spaces and interactions that benefit a wide variety of people. For example, one participant described the nuances of care in a provider-patient relationship and its impact on personal conceptualizations of health, noting:

> The biggest factor in a positive healthcare encounter that went well, was that I'm not only being cared for but that I'm cared about on an almost personal level with the doctor. I really like it when doctors are okay to just chat with me for a minute about anything or make jokes. …And, if I feel like I'm cared about, I feel better and I'm as healthy as I feel, right. And, I think it actually has positive impacts on whatever health issue that I'm dealing with at the time. (Eli, Undergraduate Student) (Feldner et al., 2022)

Other participants described positive interactions when providers (Feldner et al., 2022):

- Used direct communication, and acknowledgment of expertise.
- Provided access free parking, accessible scheduling services, and quiet examination and treatment spaces.
- Advocated for their needs.

10.4 Communicating with People with Disabilities

As with all interactions within the healthcare system, being respectful of the individual is critical. Use “people-first” language that emphasizes the person rather than the disability. Talk in the same way you would for a person without a disability while considering differences such as mobility limitations, visual or hearing loss, speech and language disabilities, cognitive changes, or mental health difficulties.

Tips	Use	Do NOT Use
Emphasize abilities, not limitations	Person who uses a wheelchair	Confined to a wheelchair Wheelchair-bound
	Person who uses a device to speak	Can't talk, mute
Avoid language that suggests the lack of something	Person with a disability	Disabled, handicapped
	Person of short stature	Midget
	Person with cerebral palsy	Cerebral palsy victim
	Person with epilepsy or seizure disorder	Epileptic
	Person with multiple sclerosis	Afflicted by multiple sclerosis
Emphasize the need for accessibility, not disability	Accessible parking or bathroom	Handicapped parking or bathroom
Avoid offensive language	Person with a physical disability	Crippled, lame, deformed, invalid, spastic
	Person with an intellectual, cognitive, developmental disability	Slow, simple, moronic, defective, afflicted, special person
	Person with an emotional or behavioral disability, a mental health impairment, or a psychiatric disability	Insane, crazy, psycho, maniac, nuts
Avoid language that implies negative stereotypes	Person without a disability	Normal person, healthy person
Do not portray people with disabilities as inspirational only because of their disability	Person who is successful, productive	Has overcome his/her disability, is courageous

Source: CDC, 2022, February 1.

11. Barriers to Care

Nevada is a diverse state that faces challenges in achieving health equity for all its residents. Although there are significant health disparities that need to be addressed, progress has been made in providing better healthcare outcomes for all (Cruda, 2023).

Inadequate health insurance coverage is one of the largest barriers to healthcare access, and the unequal distribution of coverage contributes to disparities in health. Out-of-pocket medical care costs can lead individuals to delay or forgo needed care (such as doctor visits, dental care, and medications), and medical debt is common among both insured and uninsured individuals. People with lower incomes are often uninsured, and minority groups account for over half of the uninsured population (OASH, nd).

Restricted access to healthcare for people with disabilities is a serious social problem. Many factors contribute to this limited access including stigmatization, misconceptions, negative attitudes toward people with disabilities, and a lack of knowledge or attention on part of healthcare providers (Skuban-Eiseler et al., 2023).

Transportation to medical appointments is costly and often difficult to arrange and once a person arrives at a facility, barriers to access still exist. Insufficient flexibility of the medical care system, overlooking specific needs of people with disabilities, poverty, and a lack of integration of the voices of people with disabilities in service design continue to plague healthcare organizations (Skuban-Eiseler et al., 2023).

While urban counties Clark, Washoe, and the municipality of Carson City account for the majority of the population, Nevada has prioritized improving healthcare access in rural, frontier, and tribal communities. In rural areas, healthcare delivery can be more challenging due to the longer travel times and distances from specialized medical facilities (Cruda, 2023).

Remote areas of the state also lack resources such as fresh foods, healthcare providers, and medical facilities. Long distances to emergency healthcare present a barrier, especially in extreme weather conditions. However, there are initiatives to address these barriers, for instance, by increasing access to telehealth services and expanding primary care options (Cruda, 2023).

12. Discriminatory Language and Behaviors

Language can marginalize and exclude people through “othering”, which is exclusionary speech or behavior towards those who are deemed as different to oneself. When providing care for diverse groups, healthcare professionals must be mindful of not speaking or behaving in a way that is perceived by those who are receiving that care as othering (Marjadi et al., 2023).

Ensuring inclusive language means respecting the power of self-identification for individuals and communities. At the heart of inclusive language is respect for all types of diversity. Terms such as “wheelchair bound” and “confined to a wheelchair” are dismissive of the *Social Model of Disability*; better terms include “wheelchair rider”, “wheelchair user”, or “a person who uses a wheelchair” (Marjadi et al., 2023).

Faced with instances of differing terminology preferences within a population group, it is recommended that healthcare workers: (a) consult each person for their preference, (b) be familiar with the relevant local guidelines, and (c) acknowledge other preferences when using one language for general communications (Marjadi et al., 2023).

Awareness of health inequities has led to the development of inclusive, person-centered healthcare practices, which are practices tailored to individual identities, beliefs, and needs. This starts with awareness of assumptions and stereotypes and the use of inclusive language.

13. Best Practices for Improving Health Equity

13.1 Collecting Data and Monitoring Outcomes

Collecting data and monitoring outcomes are best practices that can improve health equity by identifying disparities in care. Data can be used to develop outreach and education programs aimed at reducing disparities in chronic disease management among marginalized communities. Additional best practices include developing community partnerships, increasing access to care for people living in underserved communities, and developing culturally relevant programs.

13.2 Developing Partnerships

Developing partnerships with public health agencies and community-based organizations provides valuable insights into the needs of the people they serve and helps healthcare providers develop targeted interventions that are effective and sustainable.

Existing expertise within a healthcare organization's workforce can have a significant and positive impact of health equity. 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. 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 (Rivera-Núñez et al., 2022).

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. Compared to physicians and nurses, they are underpaid and undervalued (Rivera-Núñez et al., 2022).

13.3 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.

13.4 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 care. Providing health information in a way that is easy for patients to understand, using clear language, avoiding medical jargon, and developing well-designed visuals and written materials helps patients understand their health status and treatment options.

Existing law
https://dpbh.nv.gov/uploadedFiles/dpbh.nv.gov/content/Reg/HealthFacilities/dta/Training/R016-20AP.pdf.

13.5 Diversity Training

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.

13.6 Following National CLAS Standards

Culturally and Linguistically Appropriate Services (CLAS) standards are a set of 15 action steps 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 can 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 *Nevada Department of Health and Human Services* expects all healthcare organizations to provide services 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.

13.7 Following Nevada Regulations Against Discrimination

The Nevada State Board of Health has established regulations against discrimination that inform best practices in any of its programs in relation to protected classes as defined by State of Nevada law and Federal law. Protected classes include but are not limited to:

- race
- color
- religion
- national origin
- ancestry
- age
- gender
- physical or mental disability
- sexual orientation
- gender identity or expression
- human immunodeficiency virus status of the patient or resident or any person with whom the patient or resident associates (DBPH, 2020)

Nevada Resource Code 449.103 states that a facility that provides care to a patient of resident, shall conduct training relating specifically to cultural competency for any agent or employee of the facility who provides care to a patient or resident of the facility. The purpose is to better understand patients or residents who have different cultural backgrounds.

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

13.8 Becoming Familiar with The Equality Act and Predecessors

Introduced by Congresswoman Nancy Pelosi, *The Equality Act* would amend existing civil rights law—including the *Civil Rights Act of 1964*, the *Fair Housing Act*, the *Equal Credit Opportunity Act*, the *Jury Selection and Services Act*, and several laws regarding employment with the federal government—to explicitly include sexual orientation and gender identity as protected characteristics. The legislation also amends the *Civil Rights Act of 1964* to prohibit discrimination in public spaces and services and federally funded programs based on sex (HRC, 2023).

13.9 Overcoming Perceptions

Overcoming myths, stereotypes, and perceptions that adversely impact marginalized groups is not easy. In healthcare organizations, as in other business settings, the failure to address myths and stereotypes not only affects health outcomes for the people the organization is serving, but this failure can also lead to lawsuits.

In a report compiled by the *Corporate Research Project for Good Jobs First* found that most large corporations throughout the U.S.—including 99% of the Fortune 500 companies—have made payments to plaintiffs in at least one employment discrimination or harassment lawsuit since the beginning of 2000 (Mattera, 2019).

Addressing and overcoming harmful and negative perceptions about marginalized groups take a strong commitment by organizations and by individuals. The process begins by identifying bias, stereotypes, and myths that affect marginalized groups. In Power and Influence for Positive Impact, the author recommends the following (Gibson, 2022):

1. **Embrace diversity**: Don't put yourself in a bubble. Learn about individuals you admire from other genders or races. Read books authored by people who don't share the same beliefs. Listen to music from various cultures. This can gradually recondition your perceptions.

2. **Interact with individuals from other groups**: Hiring a diverse workforce doesn't guarantee that employees will converse. Take the time to talk to people from different backgrounds.

3. **Confront stereotyping**: If you see something, say something. Sometimes, the most impactful thing you can do is call out prejudice or stereotyping when it's happening.

Practice What You Preach

Make it a priority to apply best practices within your organization for the benefit of employees as well as patients and other associates. How can hospital staff be expected to treat patients and visitors with respect and understanding if they are not experiencing these conditions themselves.

14. 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 Nevada, nearly 25% of residents speak a language other than English. The largest non-English language spoken is Spanish, representing 20% of Nevada's population. The next most-common non-English language is Tagalog (3%), followed by Chinese (Mandarin, Cantonese, 1.1%). 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).

14.1 Good Communication

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).

14.2 Working with Interpreters

Federal law requires healthcare providers who receive federal funding to offer interpretation services to patients with limited English proficiency. 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.

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.

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.

Test Your Knowledge

Question 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.

Question 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*

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.

Also, 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

14.3 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).

14.4 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 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).

14.5 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).

15. Welcoming and Safe Environments

Many people find healthcare offices and buildings sterile, confusing, and unwelcoming. Unfortunately, this can lead to distrust, leaving the facility against medical advice, and disengagement. A survey of 11,500 people in 5 countries (U.S., France, UK, Japan, and Brazil) found that women, ethnic minorities, people with disabilities, and individuals who identify as LGBTQ+ are far more likely to distrust their healthcare providers and the healthcare system as a whole (Hudson and Williams, 2023).

Features of a safe and welcoming healthcare facility include culturally competent communication, language assistance services (including 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).

Findings included (Sanofi, 2022):

- Ethnic minorities and people of color are more likely to say they have had experiences that damaged their trust in healthcare compared to non-minorities (73% vs 57%).
- People who identify as LGBTQ+ report a similar experience (66% vs 58% of their straight peers).
- People with disabilities, a group who fundamentally rely on healthcare, expressed the largest trust gap compared to non-disabled people (73% vs 56%).

A positive, welcoming, and safe environment promotes good-quality care. It has been shown to reduce hospital-acquired infection rates, hospital mortality, re-admissions, and adverse events. Furthermore, for workers, a positive work environment is strongly associated with attracting and retaining healthcare professionals (Maassen et al., 2021).

15.1 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, and 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).

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).

15.2 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).

15.3 Health Equity and Seniors

For older adults, creating a safe and welcoming healthcare environment has often been overlooked by healthcare organizations and providers. The lack of geriatric specialists in the U.S., overworked primary care providers, polypharmacy and medication errors, and a failure to monitor medications creates a sense of distrust and dread among older adults. Most older adults do not have a knowledgeable advocate for their care.

Many older adults, especially women and other marginalized people, are treated as if they do not matter. Our healthcare system is complex, with short appointments, a lack of primary care providers, and multiple professionals who often do not communicate with one another. For a person with mobility issues, getting to an appointment can be a challenge. Although access to healthcare services is an equity issue, little research has been done globally to understand the impact of these issues on the lives of older adults.

It may be difficult for young healthcare providers to understand the issues faced by older adults. The cost of housing, food, gas, and electricity, cuts to social security and Medicare, poverty, inadequate savings for retirement, and health issues place a great deal of pressure on older adults.

What is already known about this subject (Carroll et al., 2022)?

- Age is a known factor predicting inequity of access to healthcare.
- Multiple factors affecting different groups of people, such as age, income, education, location, are known to be relevant in accessing healthcare.
- Individual factors such as literacy, ethnicity, minority status and location, have been explored in empirical and conceptual studies examining older people's access of services.

The equity or inequity of a system is determined by factors such as discrimination, minority status, and needs, based on individual physical, cultural, and financial circumstances. Factors such as these that might apply to one older person, might not apply to another, with different implications for equity of access (Carroll et al., 2022).

Studies of equity for older adults uncover the need for a more sophisticated understanding and acknowledgement of the differences in older people's experience of services. Institutional frameworks tend to homogenize older people into one group, omitting clear differences in healthcare needs based on factors such as age, comorbidities, minority status, financial, and familial resources (Carroll et al., 2022).

16. 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 people arriving from other countries are in precarious health, often due to the conditions in which they made the trip (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. 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 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 stalled or reversed. These problems are compounded by healthcare systems and healthcare providers who were stretched to their limits by the pandemic (UN, 2021).

Practicing diversity and inclusion and localizing funding decisions can have a big impact on healthcare 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).

[Continue to next page for references]

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[Continue to next page for quiz]

18. Quiz: Nevada: Cultural Competency, 4 units (342)

1. 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.

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

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. Health equity is the state in which everyone has a fair and just opportunity to attain their highest level of health.

a. True
b. False

5. Implicit bias is a conscious process based on intentional mental associations.

a. True
b. False

6. 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.

a. True
b. False

7. Studies have shown that implicit racial bias rarely influences clinical decision-making.

a. True
b. False

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

a. True
b. False

9. 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.

10. Social determinants of health are:

a. Do not significantly affect a person's health or quality of life.
b. 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.

11. A myth is a foundational belief, something that is not true but is shared by many people.

a. True
b. False

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

a. True
b. False

13. Providing culturally religious care:

a. Starts with developing an awareness of the uniqueness of each person's religion and their special needs.
b. Means being respectful, avoiding judgements, and recognizing how values, behaviors, and beliefs may affect others.
c. Avoiding assumptions and asking the patient and family how you can help make their experience more comfortable.
d. All of the above.

14. Members of the LGBTQ+ community can experience high levels of chronic stress brought on by stigmatization and discrimination.

a. True
b. False

15. Significant health inequities exist for and among disabled people, which relate at least in part to discrimination, inaccessibility, and other barriers that disabled people experience throughout health systems and society.

a. True
b. False

16. Numerous studies have identified the need for health professionals to acquire what is referred to as "military/veteran cultural competence" to effectively engage with this population.

a. True
b. False

17. Ableism is discrimination or prejudice against people with disabilities.

a. True
b. False

18. One of the largest barriers to healthcare access is:

a. Not wanting to go to the doctor.
b. Inadequate health insurance coverage.
c. Lack of hospitals.
d. Implicit bias.

19. Faced with instances of differing terminology preferences within a population group, it is recommended that healthcare workers:

a. Consult each person for their preference.
b. Be familiar with the relevant local guidelines.
c. Acknowledge other preferences when using one language for general communications.
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. Failing to provide adequate interpretation and translation services contributes to:

a. An incomplete and inaccurate health history.
b. Misdiagnoses.
c. Lack of informed consent.
d. All of the above.

22. In the United States, healthcare organizations are required by law to provide interpretation services at no cost.

a. True
b. False

23. A positive, welcoming, and safe environment:

a. Promotes good-quality care.
b. Can reduce hospital-acquired infection rates, hospital mortality, re-admissions, and adverse events.
c. Creates a positive work environment associated with attracting and retaining healthcare professionals.
d. All of the above.

24. For older adults, creating a safe and welcoming healthcare environment has often been overlooked by healthcare organizations and providers.

a. True
b. False

[Continue to next page for answer sheet]

Answer Sheet: NV Cultural Competency, 4 units (342)

Name (Please print)_____

Date_____

Passing score is 80%.

1. _____	13. _____
2. _____	14. _____
3. _____	15. _____
4. _____	16. _____
5. _____	17. _____
6. _____	18. _____
7. _____	19. _____
8. _____	20. _____
9. _____	21. _____
10. _____	22. _____
11. _____	23. _____
12. _____	24. _____

[Continue to next page for course evaluation]

19. Evaluation: Nevada: Cultural Competency, 4 units (342)

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. Describe the difference between implicit and explicit bias.	1 2 3 4 5
3. Define power, privilege, and oppression.	1 2 3 4 5
4. List 5 social determinants of health.	1 2 3 4 5
5. State 3 common myths about marginalized peoples.	1 2 3 4 5
6. Relate 3 practices that support reproductive justice.	1 2 3 4 5
7. Describe the first step in providing culturally competent religious care.	1 2 3 4 5
8. State 3 barriers faced by lesbian, gay, bi-sexual, transgender, questioning, intersex, asexual people when seeking healthcare.	1 2 3 4 5
9. Provide 1 example each of culturally competent practice in veteran services, mental health services, and for older adults.	1 2 3 4 5
10. Provide 3 examples of ableist language.	1 2 3 4 5
11. Relate one of the most important barriers to accessing healthcare in the United States.	1 2 3 4 5
12. Describe 3 ways in which healthcare providers can avoid discriminatory language with their patients.	1 2 3 4 5
13. State 3 best practices that can improve cultural competence in healthcare.	1 2 3 4 5
14. Understand the ways in which cultural competence and good communication are linked.	1 2 3 4 5
15. Describe 3 aspects of a welcoming and safe healthcare environment.	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]

Registration and Payment

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.

4 contact hours: $29

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: _____