Multicultural Health Awareness

and

Health Equity Education

for

EMS PROFESSIONALS

April 2024

DOH 530-091

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Objectives

COGNITIVE OBJECTIVES

At the completion of this lesson, the student will be able to:

- Practice attitudes and skills that will help when providing care to diverse populations.
- Examine the relationship between culture, language, and health.
- Discuss implicit bias and how bias, racism, and poverty manifest as health inequities.
- Evaluate strategies to help reduce bias during assessment and treatment.
- Recognize how social determinants of health impact individuals, and communities.
- Describe best practices of working with an interpreter.

AFFECTIVE OBJECTIVES

At the completion of this lesson, the student will be able to: (Case Studies and worksheets)

- Evaluate areas of personal knowledge, attitudes, and skills to help improve patient care to diverse populations.
- Formulate a plan to serve as a model for others when practicing cultural competency with patients, family, and bystanders.
- Develop awareness of one's own and others' biases and the implications in the healthcare setting.

PSYCHOMOTOR OBJECTIVES

- No psychomotor objectives identified.

Preparation

Purpose:

Washington State has a diverse and dynamic population. Here, and across the country, people of racial, ethnic, and cultural groups; immigrant and refugee communities; and economically and socially disadvantaged populations often receive less or lower quality health care.

While each state has unique causes that contribute to disparities, some states have been successful in addressing disparities in overall health indicators and may serve as examples for other states. Washington is a model state in addressing health disparities. Our State is committed to improving health and increasing access to care for all our communities and individuals living within our borders.

The COVID-19 pandemic has further exposed that health outcomes are experienced differently by different people based on discrimination and bias in the health care system. Research shows that health care resources are distributed unevenly by intersectional categories including, but not limited to, race, gender, ability status, religion, sexual orientation, socioeconomic status, age, and geography. These inequities have permeated health care delivery, deepening adverse outcomes for marginalized communities.

Training frequency:

Training must be completed during all initial EMS education EMR, EMT, AEMT, and Paramedic courses. RCW 43.70.615: Multicultural health awareness and education program—Integration into health professions basic education preparation curriculum.

Training must be completed once every four years by all credentialed EMS providers.
RCW 43.70.613: Health care professionals—Health equity continuing education. (wa.gov)
WAC 246-12-800: WAC 246-12-810: WAC 246-12-820: WAC 246-12-830:

Materials: Curriculum and companion PowerPoint presentation which include various audio-visual materials relating to multicultural health awareness and equity training. Educators can add additional materials to the presentation to ensure that the cultural needs of the community are met.

Personnel:

Primary instructor knowledgeable in:

- Roles and responsibilities of EMS professionals and prehospital EMS care
- Multicultural health disparities
- Demonstrated knowledge and experience related to health equity through lived experience or training

Length: Minimum Time to Complete: two hours, presentation can be separated into multiple modules.

Verification of Competency:

Complete an assessment at the end of an in-person or virtual continuing education training to determine knowledge gained during that training, or document attendance at the training.

Introduction

A. Washington State has a diverse and dynamic population. Here and across the country, health disparities exist.

1. Research shows that health care resources are distributed unevenly by intersectional categories including, but not limited to, race, gender, ability status, religion, sexual orientation, socioeconomic status, age, and geography; and these inequities have permeated health care delivery, deepening adverse outcomes for marginalized communities.
2. As health providers, understanding the full landscape and context of people.
3. Many people do not receive health care or if they do, it is not the same quality of health care that other people receive. These differences are experienced by racial, ethnic, gender and cultural groups, immigrant, and refugee communities and economically and socially disadvantaged populations.
4. Washington state is a model state in addressing health disparities. Our state is committed to improving health and increasing access to care for all our communities and individuals living within our borders.
5. The COVID-19 pandemic has further exposed inequities in health outcomes due to discrimination and bias in the health care system.

B. Providing care for multicultural populations:

1. US Census data indicates that by the year 2050, almost half the population will be from cultures other than white or non-Hispanic.
2. Washington will need to address the needs of its changing population.
3. We can help meet these health care needs by providing culturally and linguistically appropriate health care and by improving quality and access to care.

C. Data
1. Data sources can be found in Appendix 2.
2. Reviewing these sites provides an opportunity to access current and relevant data specific to your local area.
3. Add content to local presentation.

Building a foundation - Definitions

A. An understanding of terminology provides a strong foundation. In the process of reviewing definitions consider the relationship between culture, language, and health. Appendix 1: Terminology and definitions

1. Explicit and implicit bias
2. Race vs ethnicity
3. Sex vs gender
4. Culture - Cultural competence, cultural humility, cultural relativism, acculturation, culture shock, ethnocentrism, and racism
5. Health - Determinants of health, health disparity, and health equity
6. Socioeconomic considerations – Poverty and power

An Overview of Health Disparities

A. The Washington State Board of Health (SBOH) provides the following definition of health disparity:

1. Health disparities describe the disproportionate burden of disease, disability, and death among a particular population or group when compared to the general population.
2. This means there are differences in health outcomes for some groups when compared to outcomes for the greater population.

Culture and Cultural Competence

A. Culture is our way of life, the way we do things, the way we hear what others are saying and even the way we see and make meaning of what is around us. Culture is how we identify our experiences and give them meaning.

1. Many things shape our personal culture including gender, race, age, sexual orientation, nationality, ethnicity, religious and political associations, physical ability, socioeconomic class, current realities, and life experiences.
2. The scope of culture is so large, it would be impossible to learn about so many things for everyone that we meet. Being culturally competent does not mean that you must be an expert on every culture.
    a. It means that we use care and do not make assumptions about others.
    b. It means that we ask questions to get information that will help us in providing care to the patient.

B. Cultural competence is sharing respect for each other and accepting that there are many ways of viewing and experiencing the world. You might ask: How can I provide quality care if every person has different views, different experiences, and may speak a different language than me? This leads us to our definition of Cultural Competence:

1. It is the ability to function effectively in the context of cultural and social differences.
2. It asks us to be aware of our own cultural worldview and respectfully engaging others with cultural dimensions and perceptions different from our own and recognizing that none is superior to another.

C. Steps to Cultural Competency – Ask yourself the following questions:

1. Awareness – Awareness of self includes information sharing about issues, positions, interests, and needs.
    a. What are my values?
    b. What are my personal biases and assumptions about people who are different from me?
2. Acknowledgement – means exploring differing values, not making assumptions, and shaping uninformed expectations of others.
3. Honest validation – is a process of understanding that different perspectives are of value.
    a. Am I willing to learn more about a belief that is different from mine?

   b. Can I see the importance of a value that may be different from one I hold?
4. Negotiation – allows us to expand our outlook to see different options and different approaches.
   a. Are my values/viewpoints threatened by learning about a value/viewpoint that is different?
   b. Do I want to share information about my values with someone who does not share my experiences?
5. Acting is the final step – adapting practice skills to fit the cultural context of the patient/client.
   a. Can I challenge myself to see that different viewpoints/values contribute to my experiences and my self-awareness?
   b. Do I have enough information about my patient's experiences to understand my patient's health care needs?

Bias

What is bias? Understanding the difference between explicit and implicit bias. Suggestion to complete Implicit Bias test such as Take a Test (harvard.edu) or other, to gain awareness.

A. Tools to help a person identify implicit bias:
   1. Strengths and limitations of implicit bias tests
   2. Self-assessment examples (this could be pre-course work)

B. Relationship between bias, racism, and poverty, and health inequities:
   1. Common biases during assessment and treatment:
   2. Types of unconscious bias in clinical medicine
      a. Anchoring bias
      b. Availability bias
      c. Confirmation bias
   3. Bias created challenges
      a. Pain tolerance / Pain medication administration needs
      b. Misdiagnosis

C. Overcoming bias to provide better patient outcomes:
   1. Awareness of health disparities
   2. Awareness of provider's own biases
   3. Use of checklists / follow protocol
   4. Consideration of use of communication tools for patient (picture board, interpreter, other)

Cultural Competence in the Health Care Encounter

A. Without successful interactions between the patient, the provider, and the system where the encounter takes place; challenges to providing care increase.
B. How much cooperation and interaction are necessary to address barriers and provide culturally and linguistically appropriate services?

C. Cultural Understanding in Health Care Encounters:
Understanding the issues facing patients can help the provider improve effectiveness in providing quality health care to all patients. The following are some of the barriers to accessing quality health care that culturally diverse patients may experience. It is important to look at these issues to understand the impact of language and culture on health and health care and their connection to health disparities and wellbeing.

D. What to know:
1. Differences in languages and non-verbal communication patterns.
    a. Communication about health often differs by ethnicity, age, socioeconomic status, geographic location, and sexual orientation.
    b. Differences in languages and non-verbal communication can lead to barriers that may impact the service being provided.
        1) Gestures, body movement, posture
        2) Facial expression
        3) Eye contact
        4) Paralinguistics – vocal tones, volumes, pitch, and inflections
        5) Positioning – being at eye level vs standing above the patient
2. Differences in perceptions of illness, disease, medical roles, and responsibilities.
    a. Western biomedicine has a distinct culture. Because of this, providers may discount different beliefs about the causation, diagnosis, and treatment of disease.
    b. Culturally based beliefs and traditions can affect the course and outcome of disease.
    c. Distrust in the medical system due to historical trauma.
3. Preferences for treatment of illnesses
    a. People often hold to the healing traditions taught by their culture and family.
    b. This does not mean that patients will not use Western medicine. Traditional medicine and modern medicine may coexist harmoniously.
    c. Health care providers, however, may face challenges in helping patients overcome doubts about Western medicine.
4. Socioeconomic status influences
    a. Access to health and health care. In 2021, 6.4% of Washington residents did not have health insurance. A larger number are underinsured according to US Census.gov.
    b. Access to education/literacy
    c. Economic stability
5. Geographical barriers to care
    a. Access to healthcare, specialty care, and other healthcare services.
6. Social and gender identity potential barriers to care
    a. Communication- ask questions, “How would you want to be addressed?”
    b. Having a gender-inclusive language expands our ability to communicate effectively.
    c. Patient centered care and communication improve healthcare outcomes across all patient populations.

E. How to address barriers:
1. Addressing barriers needs the cooperation of the patient, the care provider, and the organization or system where the encounter takes place. If a process is in place that includes

these three different participants, then the resource for removing or lessening the impact of the barrier is also in place.

2. Clear communication is the key to appropriate care. A communication approach that takes for granted a shared cultural background, gender orientation, and level of literacy may create instant barriers to care for many underserved communities.
3. Trust is important. If there is trust, the provider and patient can reach agreement about care.
4. Just as one size doesn't fit all, one program or service won't always work for all groups of a particular population.
5. Maintain awareness and respect.
6. Provide culturally appropriate materials and language resources. Materials appropriate for one group of clients may not convey important concepts to another group of clients. Materials provided in English and those translated into a single other language may simply be inadequate in conveying health care information.

Enhancing Your Communication

Skills as a Provider (Appendix 6 – Tools to Help Provide Culturally and Linguistically Appropriate Services).

A. Improving your interpersonal communication:
   1. Slow down.
   2. Use plain, non-medical language.
   3. Show or draw pictures or use Medical Visual Language Translator cards.
   4. Limit the amount of information provided and repeat it.
   5. Use the teach-back or show-me technique.
   6. Create a shame-free environment.

B. Obtaining information to help with patients and families from culturally diverse backgrounds (Appendix 5 – Tools to Help Provide Culturally and Linguistically Appropriate Services)
   1. The more accurate information we have about others, the more likely we will be able to assist them.
   2. How do we get the information we need? Do we know if it is proper to ask questions of our patients? We can start by asking permission.
   3. Questions to help in the process of getting information you need.
      a. So that I might be aware of and respect your cultural beliefs:
         1) Can you tell me what languages are spoken in your home and the languages that you understand and speak?
         2) Can you tell me about your beliefs and practices including special events such as birth, marriage, and death that you feel I should know?
         3) Do you use any traditional health remedies to improve your health?
         4) Is there someone, in addition to yourself, with whom you want us to discuss your medical condition?
         5) Are there certain health care procedures and tests that your culture prohibits?
         6) Are there any other cultural considerations I should know about to serve your health needs?
         7) Is there anything else you would like me to know?

8) Is there anything else you would like to know?
9) Do you have any questions for me? (Encourage two-way communication)

b. The first statement is letting the patient know that you need them to help you. It is a thoughtful way of asking permission.
c. The purpose of each question is to make communication respectful while establishing trust.

Addressing Language Barriers in Health Care

A. System Challenges:
   1. Health care has its own terminology and even if the provider and the patient speak the same language, there are still challenges to effective communication. However, the quality of medical care is closely linked to how well providers meet the language needs of the patient.
   2. When providers only speak English, treating patients who primarily or only speak a language other than English, it takes more time and additional resources to ensure they receive the same level of care as would English speaking patients. In addition, language barriers are often complicated by cultural differences between the provider and the patient.
   3. It is vital to ensure you use effective communication and you have supports in place that can overcome these challenges related to language barriers.

B. Patient Challenges:
   1. Patients often encounter the following basic types of problems:
      a. Lack of awareness of existing services and how to access them.
      b. Inability to communicate adequately with providers and ancillary staff at all points within the health care delivery system.
      c. Low patient satisfaction with cross-language encounters may lead to reluctance to return to the health care setting.
   2. Furthermore, research shows that even when patients who primarily or only speak a language other than English do access health care, health care quality may be diminished, and health outcomes may be poorer for them than for other patients.

C. Provider Challenges:
   1. Language barriers often cause health care providers challenges in the following tasks:
      a. In making an accurate diagnosis
      b. In meeting informed consent responsibilities
      c. While explaining care options (This may lead to more limited options for caring for the patient.)
      d. In encouraging patients to allow care they may not understand

D. Linguistic Competency:
   1. Patients who primarily or only speak a language other than English experience language barriers during every health care encounter. Gaining access to care, reading forms, and understanding questions and directions present barriers from the outset. If these encounters are not handled appropriately, patient care is interrupted.

2. Resources to support this capacity may include, but is not limited to, the use of:
    a. Trained medical interpreters
    b. Family members
    c. Bilingual/bicultural or multilingual/multicultural staff
    d. Print materials in easy to read, low literacy, picture, and symbol formats, i.e. signage such as a Medical Visual Translator card.

E. People First Language:
1. People with disabilities are people first. People with disabilities are no more easily defined by their disability than they are by their gender, age, race, or national origin.
2. The way we refer to people with disabilities in our communication is important.
3. Lack of awareness about disabilities can lead to unintended stereotypes and discrimination.
4. The way we view and communicate with and about people with disabilities shapes our relationships.
5. People first language puts the emphasis on the person before the disability. Examples:

Preferred	Avoid
A person who uses a wheelchair.	Wheelchair bound/confined
A person who has a developmental disability	Mentally impaired
A person who is deaf.	Hearing impaired
A person with a disability.	Handicap, special needs

6. Refer to a person's disability only if it is relevant.
7. Avoid terms that lead to exclusion (e.g., "special" is associated with "separate" and "segregated" plans and services).

Using Interpreters

A. Good care means having good communication. Trained medical interpreters are the best resource to have available.
1. Providers need to know the proper way to work with interpreters in the medical encounter.
2. Review Appendix 7 - Tips on Working Effectively with Interpreters
3. Options
    a. Working with family members
    b. Teleservices
    c. Other options
4. Local community needs – how to engage for positive outcomes

B. Using family members, things to consider:
1. Potential for miscommunication of care, if used make sure person who is interpreting is asking the patient the question
2. Lack of neutrality and confidentiality
3. May cause embarrassment or strain on family relationship
4. May be inappropriate to involve minor children
5. Consider other options such as interpreting services

Systems and Organization Improvement

Institutions are designed to give a consistent level of service for the greatest number of people in the most cost-efficient manner. Many find that providing culturally and linguistically appropriate services not only improves patient care but can also improve business efficiency.

A. According to the Health Resources and Services Administration (HRSA) systems that successfully provide culturally, and linguistically competent services tend to:
   1. Define culture broadly
   2. Value clients' cultural beliefs
   3. Recognize complexity in language interpretation
   4. Facilitate learning between providers and communities
   5. Involve the community in defining and addressing service needs
   6. Collaborate with other agencies
   7. Recognize training in cultural competence and medical interpretation as equally important as training in other essential clinical skills
   8. Institutionalize cultural and linguistic competence

B. Engaging the community in their health care will help us create solutions to meet the challenges we face in providing culturally and linguistically appropriate care.

C. Culturally and Linguistically Appropriate Services (CLAS): The CLAS standards offer approaches to Governance, Leadership, and Workforce; Communication and Language Assistance; and Engagement, Continuous Improvement and Accountability (Appendix 3 – CLAS Standards).
   1. The CLAS standards present an approach that includes-
      a. Promoting culturally and linguistically appropriate services in policy and practices, recruitment and leadership, and workforce development.
      b. Offering language assistance and providing easy to understand materials in languages commonly used in the area.
      c. Assessing the organization's culturally and linguistically appropriate services through data collection and evaluation.

D. Provider Actions– Reducing disparities in health care and outcomes is a national and state priority.
   1. Various efforts are underway to improve-
      a. Cultural competency awareness through training in medical education programs
      b. Data collection and research methodologies among underserved communities
      c. The number and availability of culturally diverse health care providers and administrators
   2. Individuals involved at all levels of health care can take steps to improve the quality of care provided to culturally diverse patients (Appendix 5 – Tips for Improving the Patient-Provider Relationship Across Cultures).
      a. Patient-centered, individualized care is crucial to effective treatment.
      b. Asking the right questions can help facilitate the process.
   3. Patients who see positive characteristics in their providers (such as being thorough, understanding, responsive and respectful) are more likely to seek treatment and follow medical advice.

a. Patients with higher levels of trust are more satisfied with the patient-provider relationship.
b. This higher level of trust fosters:
    1) Increased patient participation in their care
    2) Reduced appointment cancellations and no-shows
    3) Improved health outcomes
    4) Improved patient safety

Summary and Review

A. Population data presented by race and ethnicity has contributed to making health disparities a priority in our state and the nation. Washington State data reveal that there are differences in health outcomes for racial, ethnic, and cultural groups when compared to Caucasians.

B. Personal culture is active and is ever changing. Cultural competence begins with the individual. It includes respect, awareness, and acceptance of differences in worldviews. It is also important not to make assumptions about people and situations, but to look for accurate information from the patient or family or community member.

C. Language and culture influence how we approach health and provide care. Successful health care systems work to put in place tools and processes that will benefit all patients. The CLAS Standards developed by the Office of Minority Health are an excellent road map to providing culturally and linguistically appropriate services.

D. Providers and patients/clients bring their unique cultural backgrounds and expectations to the medical encounter. Cultural competence becomes a part of the process when information is successfully shared. This means that 3 different entities must interact in a seamless manner: patients, providers, and systems.

E. There must be effective communication between patients and providers for quality care to result. Providers and organizations must have systems, policy, and processes in place to meet the challenges of patients who primarily or only speak a language other than English or who have low literacy.

F. Using trained medical interpreters reduces risk. Providers also need to know how to work effectively with interpreters.

Appendices – Instructor References/Student Handouts

Appendix 1: Terminology / Definitions

Acculturation: The process that takes place when contact between two societies is so prolonged that one or both cultures change substantially. Regarding immigrant groups, acculturation is the process of incorporating values, beliefs, and behaviors from the host culture into the immigrants' cultural worldview.

Anti-racist / Anti-racism: Anti-racist describes ideas and policies that produce and sustain racial equity among racial groups.

Bias: Attitudes, behaviors, and actions that are prejudiced in favor of or against one person or group compared to another.

Explicit biases: A form of bias that occurs intentionally and affects the attitudes and assumptions that we acknowledge as part of our personal belief systems, can be assessed directly by means of self-report.

Implicit biases: A form of bias that occurs automatically and unintentionally, that nevertheless affects judgments, decisions, and behaviors. Including attitudes and beliefs about race, ethnicity, age, ability, gender, or other characteristics that operate outside our conscious awareness and can be measured only indirectly.

Culture: A set of values, beliefs, customs, norms, perceptions, and experiences shared by a group of people. Age, cognitive ability, country of origin, degree of acculturation, education level, environment, family and household composition, gender identity, health practices, health beliefs, or religious practices. An individual may identify with or belong to many different cultural groups.

Cultural Competence: An ongoing process of increasing awareness of oneself, increasing knowledge of others, and developing skills to have positive interactions and relationships with others. Including:

- awareness and valuing diverse perspectives
- awareness of one's own cultural values
- understanding of the dynamics of difference
- development of cultural knowledge
- questioning generalizations and stereotypes
- being aware of the role biases play in perspectives
- ability to adapt practice skills to fit the cultural context of others

Cultural Humility: Approach to respectfully engaging others with cultural identities different from your own and recognizing that no cultural perspective is superior to another. The practice of cultural humility acknowledges systems of oppression and involves critical self-reflection, lifelong learning and growth, a commitment to recognizing and sharing power, and a desire to work toward institutional accountability.

Cultural Relativism: Judging and interpreting the behavior and belief of others in terms of their traditions and experiences.

Cultural Self-Awareness: Understanding the assumptions and values upon which one's own behavior and worldview rests. The appreciation and acceptance of differences.

Culture Shock: A form of anxiety that results from an inability to predict the behavior of others or act appropriately in a cross-cultural situation.

Determinants of Health: Factors that influence health status, including biological factors, like age; behavioral factors, like tobacco use; environmental factors, like housing quality; social factors, like neighborhood segregation; economic factors, like income; and access to healthcare.

Ethnicity: Cultural factors that influence a person or community such as nationality, culture, ancestry, language, and beliefs.

Ethnocentrism: The interpretation of the beliefs and behavior of others in terms of one's own cultural values and traditions with the assumption that one's own culture is superior.

Gender/Gender identity: the behavioral, cultural, or psychological traits typically associated with one sex or a person's internal sense of being male, female, some combination of male and female, or neither male nor female.

Health Disparity: A difference in health outcomes across populations groups. The definition indicates that a difference exists, but it doesn't consider whether the difference is caused by something preventable.

Health Equity: This exists when all people have the same opportunities and equal access in order to attain their full health potential regardless of the color of their skin, ancestry, ethnicity, level of education, gender identity, sexual orientation, age, religion, socioeconomic status, the job they have, the neighborhood they live in, or their ability status.

Health Inequity: Inequity means lack of fairness or justice and describes differences that result from a lack of access to opportunities and resources. Inequities are avoidable and different than disparities, which are differences that do not imply unfairness.

LGBTQ+: An abbreviation for Lesbian, Gay, Bisexual, Transgender, and Queer/Questioning. The + allows space for other diverse sexual orientation, gender identity, and gender expression groups.

Poverty: Poverty refers to the lack of adequate financial resources such that individuals, households, and entire communities do not have the means to subsist or acquire necessities.

Power: The ability to produce intended effects on oneself, on other people, and on things or situations.

Race: Socially constructed system of organizing people into groups based on characteristics such as cultural affiliation, physical appearance, language, national heritage, religion, or ancestral geographical base. Race/ethnicity has no genetic basis— no characteristic, trait, or gene distinguishes members of one racial/ethnic group from another. The single term race/ethnicity emphasizes how the words are non-precise and socially constructed.

Racism: prejudice, discrimination, or antagonism by an individual, community, or institution against a person or people based on their membership in a particular racial or ethnic group, typically one that is a minority or marginalized.

Sex/Biological Sex: Either of the two major forms of individuals that occur in many species and that are distinguished respectively as female or male especially based on their reproductive organs and structures.

Social Stratification: The division of members of a society into strata (or levels) with an unequal access to wealth, prestige, power, opportunity, and other valued resources.

Sexual Orientation: is an enduring emotional, romantic, sexual, or affectional attraction or non-attraction to other people. People use a variety of labels to describe their sexual orientation.

Socio-Structural Factors: The way social ideologies influence individual access to services and opportunities provided by institutional systems, for example, political, legal, education, health care, housing, and economic systems.

Spirituality: One's orientation or total response to oneself, others, and the universe. It reflects the human capacity to see, to feel, to act in terms of a transcendent dimension, to perceive meaning that is more than merely mundane.

Transgender: Describes identities and experiences of people whose gender identity and/or expression differs from conventional expectations based on assigned sex at birth.

Data Sources to Explore Health Disparities in Washington

Appendix 2: Data Sources

A. The Washington State Department of Health (DOH) collects and uses health-related data to measure the quality and accessibility of healthcare in the state. Current data can be found in several locations. Reviewing these sites provides an opportunity to access current and relevant data specific to your local area.

1. Washington Tracking Network (WTN) | Washington State Department of Health
   WTN is a public facing data and dashboard portal intended to aid a variety of audiences in program planning, evaluation, surveillance, and many other public health efforts. Tools are supported by the Environmental Health Division and managed by individual programs overseeing the data topic areas specific to each dashboard.

   a. Dashboards: Data dashboards provide an interactive way to explore public health and environmental data. Most dashboards have filters for easily selecting the measure, geography, and timeframe of interest. Data can be viewed as a map or as trends over time and are available for download.
   b. The data portal allows you to select data according to topic and by time and geography (county, census tract, state). Data are available as tables, charts, or maps, and are available for download. The data portal allows you to select and view multiple measures at the same time.
   c. The IBL mapping tool lets you explore and compare your community with those around you. It displays information for a variety of topics by presenting a community's rank between 1 (lowest) and 10 (highest). Each rank represents about 10% of the communities. For example, if your community is ranked 7 for health disparities, it means that 60% of the communities in Washington State have a lower level of health disparity and 30% have a greater level of disparity.
   d. The Washington Tracking Network's (WTN) Community Report tool allows you to see a variety of health measures for a given geography. You can select which county(s) you would like data for, and which data you would like to see. Data can be viewed as a map or as trends over time and are available for download.
   e. Tool number five is the mobile app: WTN On The Go

2. CDC Wonder: The CDC Wonder tool is a data and report query system run by CDC. Data is available down to the state, county and sometimes census tract level. Data sources and demographic variables may vary by topic.

3. DOH Opioid and Drug Overdose Dashboard: This DOH run dashboard includes opioid and other drug overdose information related to deaths, hospitalizations, and EMS incidents. Currently the Death and Hospitalization tabs include age, sex, and race/ethnicity data.

Appendix 3: CLAS Standards

National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:

Principal Standard:

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership, and Workforce:

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance:

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability:

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the public.

Appendix 4: Comparing Cultural Norms and Values

Aspects of Culture	U.S. Health Care Culture	Other Cultures
1. Sense of self and space	Informal Handshake	Formal Hugs, bows, handshakes
2. Communication and language	Explicit, direct communication Emphasis on content - meaning found in words	Implicit, indirect communication Emphasis on context - meaning found around words
3. Dress and appearance	"Dress for success" ideal Wide range in accepted dress More casual	Dress seen as a sign of position, wealth, and prestige Religious rules More formal
4. Food and eating and habits	Eating as a necessity - fast food	Dining as a social experience Religious rules
5. Time and time consciousness	Linear and exact time consciousness Value on promptness Time = money	Elastic and relative time consciousness Time spent on enjoyment of relationships
6. Relationship, family, friends	Focus on nuclear family Responsibility for self Value on youth, age seen as handicap	Focus on extended family. Loyalty and responsibility to family Age given status and respect
7. Values and norms	Individual orientation Independence Preference for direct confrontation of conflict Emphasis on task	Group orientation Conformity Preference for harmony Emphasis on relationships
8. Beliefs and attitudes	Egalitarian Challenging of authority Gender equity Behavior and action affect and determine the future	Hierarchical Respect for authority and social order Different roles for men and women Fate controls and predetermines the future
9. Mental processes and learning style	Linear, logical Problem-solving focus Internal locus of control Individuals control their destiny	Lateral, holistic, simultaneous Accepting of life's difficulties External locus of control. Individuals accept their destiny
10. Work habits and practices	Reward based on individual achievement Work has intrinsic value	Rewards based on seniority; relationships Work is a necessity of life

Lee Gardenswartz and Anita Rowe, *Managing Diversity: A Complete Desk Reference and Planning Guide* (Burr Ridge, Ill.: Irwin, 1993), p. 57.

Appendix 5: Tips for Improving the Patient-Provider Relationship Across Cultures

1. Do not treat the patient in the same manner you would want to be treated. Culture determines the roles for polite, caring behavior and will formulate the patient's concept of a satisfactory relationship.
2. Begin by being more formal with patients who were born in another culture. In most countries, a greater distance between caregiver and patient is maintained through the relationship. Except when treating children or very young adults, it is best to use the patient's last name when addressing him or her.
3. Do not be insulted if the patient fails to look you in the eye or ask questions about treatment. In many cultures, it is disrespectful to look directly at another person (especially one in authority) or to make someone "lose face" by asking him or her questions.
4. Do not make any assumptions about the patient's ideas about the ways to maintain health, the cause of illness or the means to prevent or cure it. Adopt a line of questioning that will help determine some of the patient's central beliefs about health/illness/illness prevention.
5. Allow the patient to be open and honest. Do not discount beliefs that are not held by western biomedicine. Often, patients are afraid to tell western caregivers that they are visiting a folk healer or are taking an alternative medicine concurrently with western treatment because in the past they have experienced ridicule.
6. Do not discount the possible effects of beliefs in the supernatural effects on the patient's health. If the patient believes that the illness has been caused by embrujado (bewitchment), the evil eye, or punishment, the patient is not likely to take any responsibility for his or her cure. Belief in the supernatural may result in his or her failure to either follow medical advice or comply with the treatment plan.
7. Inquire indirectly about the patient's belief in the supernatural or use of nontraditional cures. Say something like, "Many of my patients from ____ believe, do, or visit____. Do you?"
8. Try to ascertain the value of involving the entire family in the treatment. In many cultures, medical decisions are made by the immediate family or the extended family. If the family can be involved in the decision-making process and the treatment plan, there is a greater likelihood of gaining the patient's compliance with the course of treatment.
9. Be restrained in relating bad news or explaining in detail complications that may result from a particular course of treatment. "The need to know" is a unique American trait. In many cultures, placing oneself in the doctor's hands represents an act of trust and a desire to transfer the responsibility for treatment to the physician. Watch for and respect signs that the patient has learned as much as he or she is able to deal with.
10. Whenever possible, incorporate into the treatment plan the patient's folk medication and folk beliefs that are not specifically contradicted. This will encourage the patient to develop trust in the treatment and will help assure that the treatment plan is followed.

Salimbene S. Graczykowski JW. 10 Tips for Improving The Caregiver/Patient Relationship Across Cultures.

Appendix 6: Tools to Help Provide Culturally and Linguistically Appropriate Services.

Six Steps to Community Engagement

1. Go into the community and establish relationships, build trust, work with formal and informal leadership, and seek commitment from community organizations and leaders to create processes for mobilizing the community.
2. Remember and accept that community self-determination is the responsibility and right of all people who comprise a community.
3. All aspects of community engagement must recognize and respect community diversity. Awareness of the various cultures of a community and other factors of diversity must be paramount in designing and implementing community engagement approaches.
4. Community engagement can only be sustained by identifying and mobilizing community assets, and by developing capacities and resources for community health decisions and action.
5. An engaging organization or individual change agent must be prepared to release control of actions or interventions to the community and be flexible enough to meet the changing needs of the community.
6. Community collaboration requires long-term commitment by the engaging organization and its partners.

Reasons to Develop Cultural and Linguistic Competency

1. Respond to current and projected demographic changes.
2. Eliminate health disparities.
3. Improve the quality of services and health outcomes.
4. Meet legislative, regulatory and accreditation mandates.
5. Decrease the likelihood of liability claims.

Six Steps to Enhancing Interpersonal Communication with Patients

1. Slow down.
2. Use plain, non-medical language.
3. Show or draw pictures.
4. Limit the amount of information provided and repeat it.
5. Use the teach-back or show-me technique.
6. Create a shame-free environment.

Enhancing Your Cultural Communication Skills as A Provider

The more accurate information we have about others, the more likely we will be able to develop appropriate opinions, feelings, and behaviors. How do we get the information we need? Do we know if it is proper to ask questions of our patients? We can start by asking permission.

Questions To Help with Patients and Families from Culturally Diverse Backgrounds:

The first statement is letting the patient know that you need them to help you. It is a thoughtful way of asking permission. The purpose of each question is to make communication respectful while establishing trust.

So that I might be aware of and respect your cultural beliefs …

1. Can you tell me what languages are spoken in your home and the languages that you understand and speak?
2. Please describe your usual diet. Also, are there times during the year when you change your diet in celebration of religious and other cultural holidays?
3. Can you tell me about your beliefs and practices including special events such as birth, marriage and death that you feel I should know?
4. Do you use any traditional health remedies to improve your health?
5. Is there someone, in addition to yourself, with whom you want us to discuss your medical condition?
6. Are there certain health care procedures and tests that your culture prohibits?
7. Are there any other cultural considerations I should know about to serve your health needs?
8. Is there anything else you would like me to know?
9. Is there anything else you would like to know?
10. Do you have any questions for me? (Encourage two-way communication)

Checklist for patient-friendly environment

During check-in procedures:

- ☐ Provide assistance filling out forms
- ☐ Provide forms in patients' languages
- ☐ Provide easy-to-read forms
- ☐ Routinely review important instructions
- ☐ Use non written modalities

Appendix 7: Tips on Working Effectively with Interpreters

12 Tips on Working Effectively with An Interpreter from Language Line Services, Inc.

Language Line Services hires the very best interpreters available. And then we test, train, and monitor them for the highest level of accuracy and professionalism.

With that said, though, language interpretation is a three-way conversation between yourself, your patient, and the interpreter.

You and your colleagues can make every interpreter call a more effective and pleasant one for you and your patient just by learning these few simple tips:

1. Brief the interpreter – Identify the name of your organization to the interpreter, provide specific instructions of what needs to be done or obtained, and whether you need help with placing a call. The interpreter can assist you in getting the call off to a good start by introducing you and your facility, and then relaying your initial question.

2. Speak directly to the patient – You and the patient can communicate directly with each other as if the interpreter were not there. The interpreter will relay the information and then communicate the patient's response directly back to you. Also, speak naturally (not louder) and at your normal pace (not slower).

3. Segments – Speak in one sentence or two short ones at a time. Try to avoid breaking up a thought. Your interpreter is trying to understand the meaning of what you're saying, so express the whole thought if possible. Interpreters will ask you to slow down or repeat if necessary. You should pause to make sure you give the interpreter time to deliver your message.

4. Clarifications – If something is unclear, or if the interpreter is given a long statement, the interpreter may ask you for a complete or partial repetition of what was said or clarify what was meant by the statement.

5. Ask if the limited English proficient (LEP) person understands – Please don't automatically assume that the LEP patient understands you. In some cultures, a person may say "yes" as you explain something, but it doesn't necessarily mean they understand. It may just mean they want you to keep talking because they are trying to follow the conversation. Also, keep in mind that a lack of English does not necessarily equate to a lack of education.

6. Do not ask for the interpreter's opinion – Avoid asking the interpreter for opinions or comments. The interpreter's job is to convey the meaning of the source language and not allow opinion to tinge the interpretation (see the Language Line Services "Code of Ethics").

7. Everything you say will be interpreted – Try to avoid private conversations with your colleagues. Whatever the interpreter hears will be interpreted.

8. Avoid jargon or technical terms – To help your patient and interpreter better understand you, don't use industry jargon, slang, idioms, acronyms, or technical terms. Clarify vocabulary that is unique to the situation and provide examples if needed to explain a term.

9. Length of interpretation session – Many concepts you express may have no equivalent in other languages. The interpreter may have to describe or paraphrase the terms you use. As a result, an interpretation might take twice as long as a conversation carried on in English only. Please avoid interrupting the interpreter while he or she is interpreting.

10. Reading scripts – Though we may not notice it, we often talk more quickly when reading a script. When reading a script, prepared text, or a disclosure, please slow down to give the interpreter a chance to keep up with your pace.

11. Culture – Professional interpreters are familiar with the culture, and customs of the limited English proficient speaker. During the interpretation session, the interpreter might identify and point out a cultural issue of which you may not be aware of. Also, if the interpreter feels that a particular question is culturally inappropriate, he or she may ask you to rephrase it.

12. Closing of the call – The interpreter will wait for you to initiate the closing of the call. When appropriate, the interpreter will offer further assistance and will be the last to disconnect from the call.

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