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Health Disparities: Closing the Gap through Cultural Competencies

Doctor- Patient Relationship Course

Brookshield Laurent D.O.
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Do.
Make.
Heal.
Innovate.
Reinvent the Future.

Objectives

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- **Define Health Disparities**
- **Explain the contributing factors of health disparities**
- **Explain how social determinants of health affect health outcomes**
- **Explain how practices in healthcare contribute to health outcomes**
- Explain the role of cultural beliefs in influencing health
- Define and explain the frameworks of cultural competency
- Explain the role of cultural competence and humility in addressing the disparity gaps in health care

Expectations

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Life long commitment to grow in the discipline of cultural competency to provide quality health care to all persons and to lead communities holistically and with equity

HEALTH DISPARITIES

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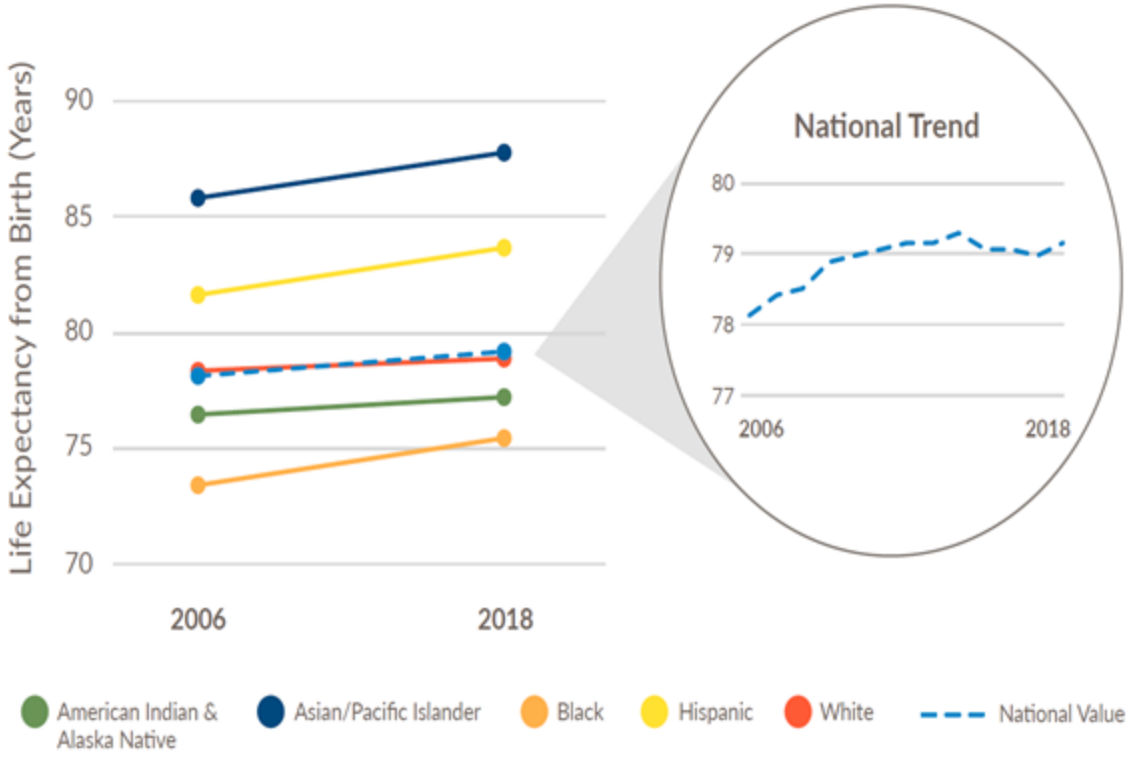
- Differences in the incidence, prevalence, mortality and burden of disease as well as other adverse health conditions or outcomes that exist among specific population groups

- Well documented in sub-populations based on socio economic status, education, age, race, ethnicity, geography, disability, gender, sexual orientation

National Trends in Life Expectancy and Gaps Among Racial & Ethnic Groups (Rankings 2010 to 2020)



countyhealthrankings.org

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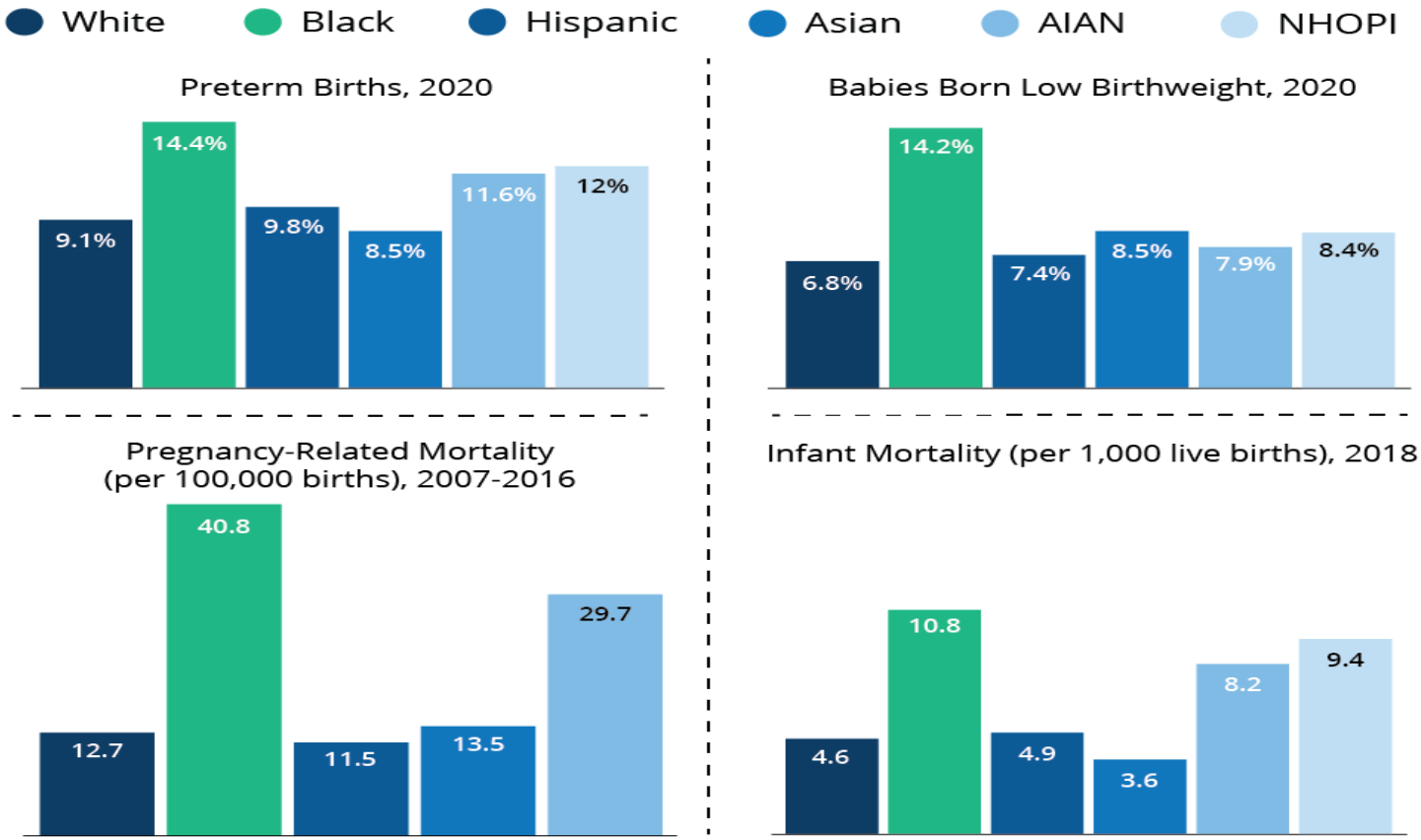
A Look at Key Maternal and Infant Health Disparities Among Black People



NOTE: AIAN refers to American Indian or Alaska Native. NHOPI refers to Native Hawaiian or Other Pacific Islander.
SOURCE: Original source information and data available at www.kff.org/report-section/key-facts-on-health-and-health-care-by-race-and-ethnicity-health-status-outcomes-and-behaviors/

KFF

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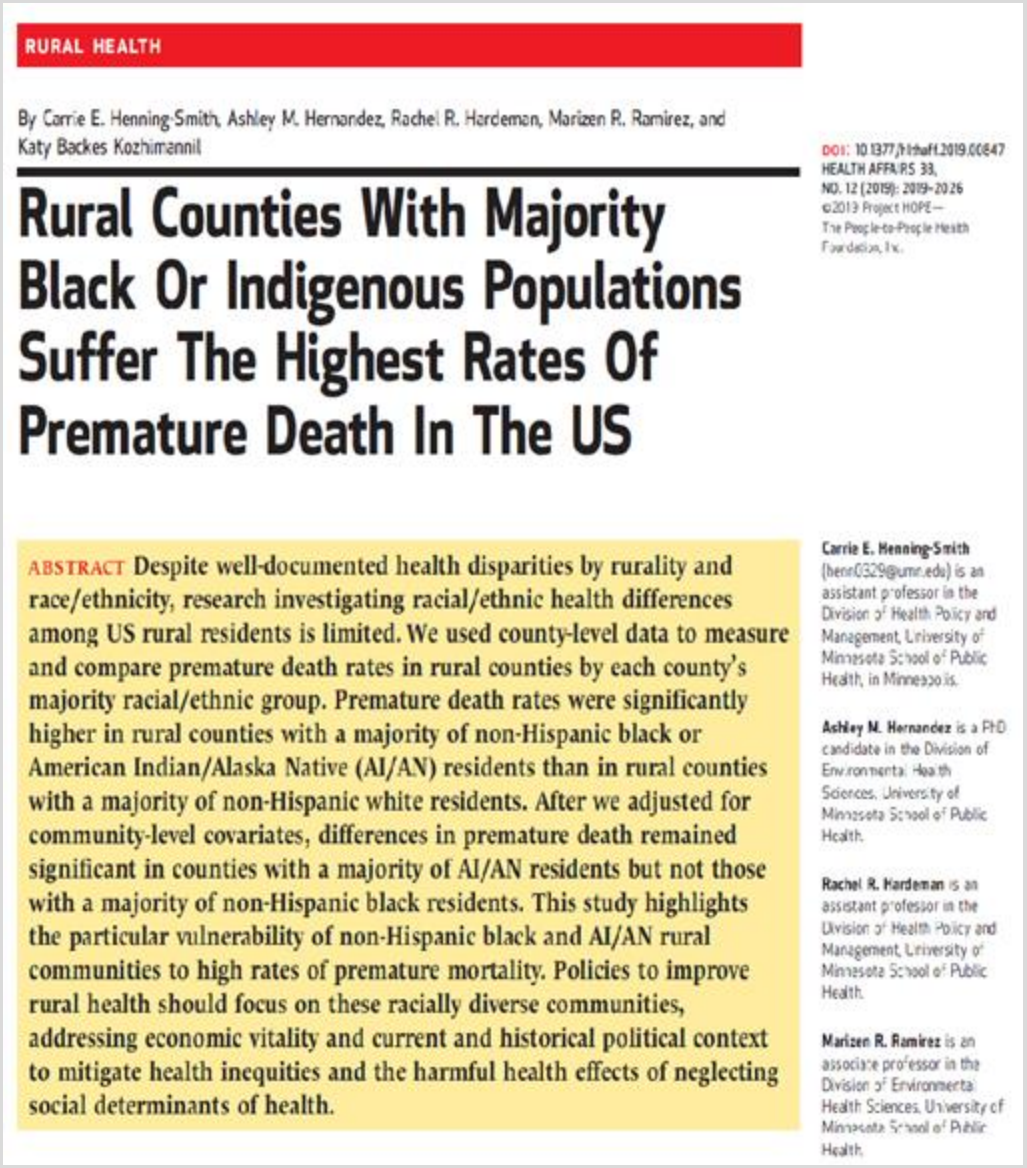

RURAL HEALTH

By Carrie E. Henning-Smith, Ashley M. Hernandez, Rachel R. Hardeman, Marizen R. Ramirez, and Katy Backes Kozhimannil

Rural Counties With Majority Black Or Indigenous Populations Suffer The Highest Rates Of Premature Death In The US

DOI: 10.1377/hlthaff.2019.00847
HEALTH AFFAIRS 38,
NO. 12 (2019): 2019–2026

ABSTRACT Despite well-documented health disparities by rurality and race/ethnicity, research investigating racial/ethnic health differences among US rural residents is limited. We used county-level data to measure and compare premature death rates in rural counties by each county's majority racial/ethnic group. Premature death rates were significantly higher in rural counties with a majority of non-Hispanic black or American Indian/Alaska Native (AI/AN) residents than in rural counties with a majority of non-Hispanic white residents. After we adjusted for community-level covariates, differences in premature death remained significant in counties with a majority of AI/AN residents but not those with a majority of non-Hispanic black residents. This study highlights the particular vulnerability of non-Hispanic black and AI/AN rural communities to high rates of premature mortality. Policies to improve rural health should focus on these racially diverse communities, addressing economic vitality and current and historical political context to mitigate health inequities and the harmful health effects of neglecting social determinants of health.

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Health Disparities within Populations in Rural Counties

Center for Disease and Control and Prevention

2017 Study found people of color and American Indian and Alaskan Native had worse health than Non- Hispanic White counter parts

Rural black residents have a higher premature mortality rates than their white or urban black counterparts

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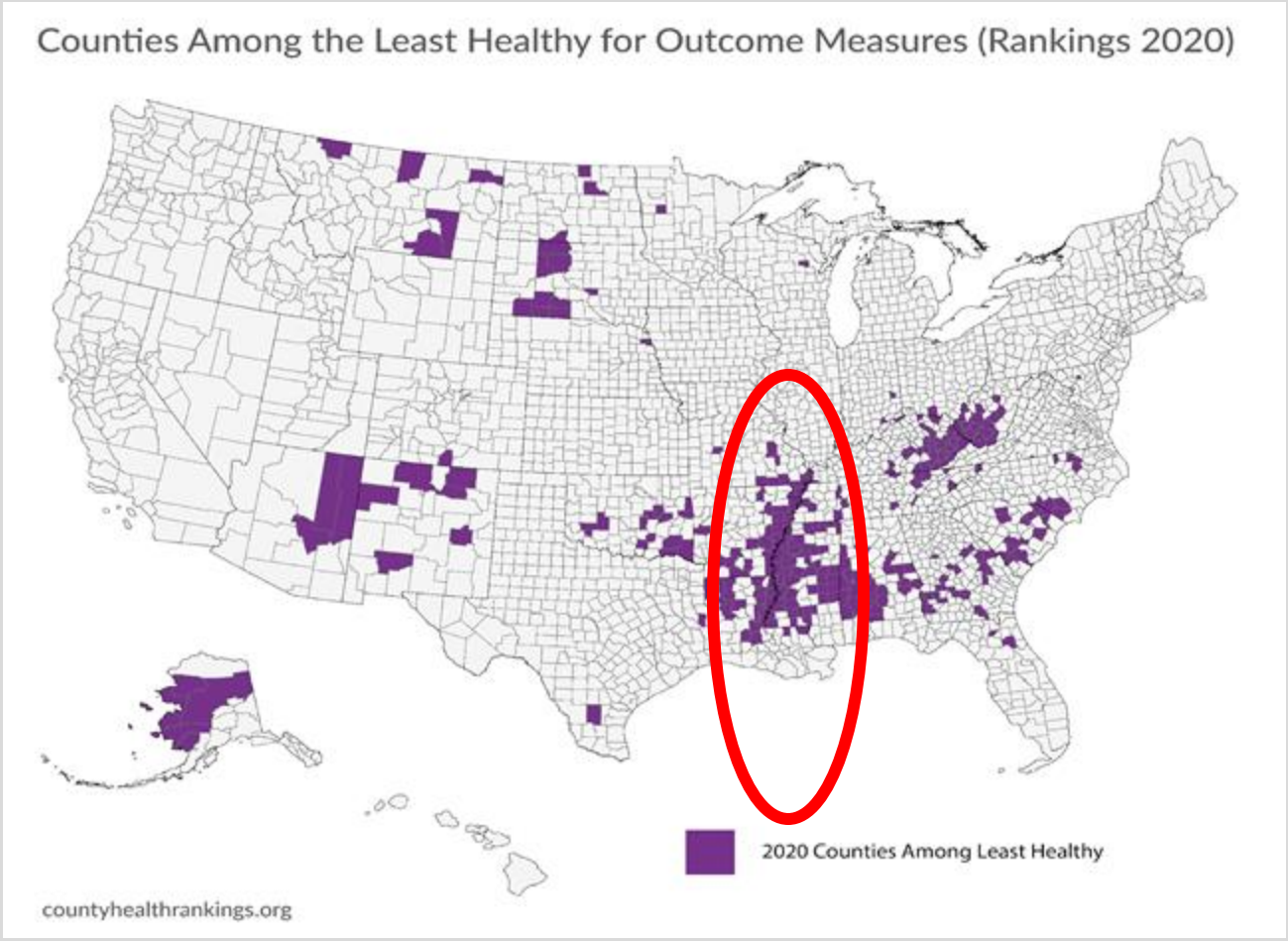

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Zip Codes Matter

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Figure 1

Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	
Medical bills	Playgrounds	Higher education		Stress	Quality of care
Support	Walkability				
	Zip code / geography				

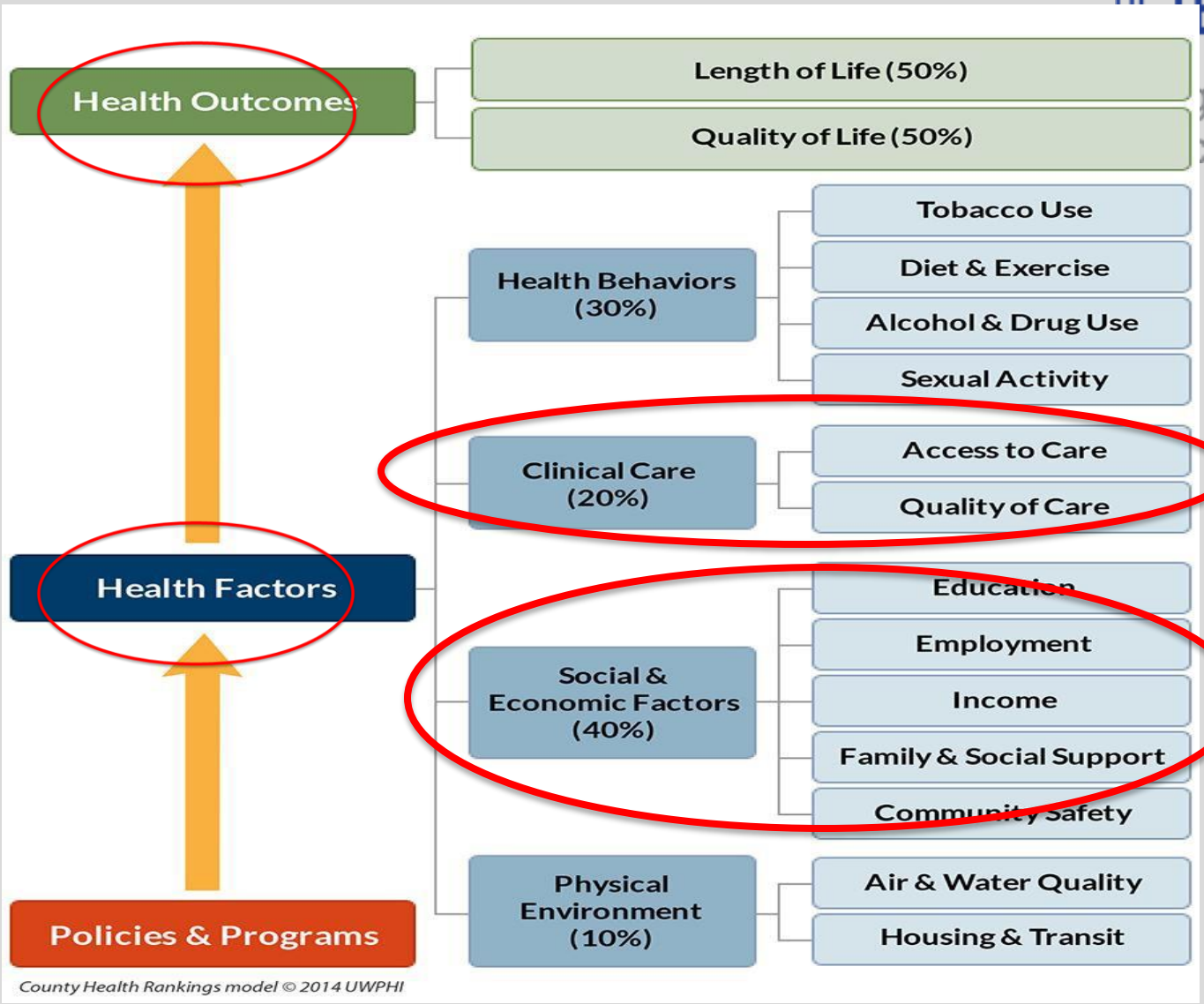
Health Outcomes

Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

KFF

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.

County Health Rankings Model



Example of Structural Inequities: REDLINING

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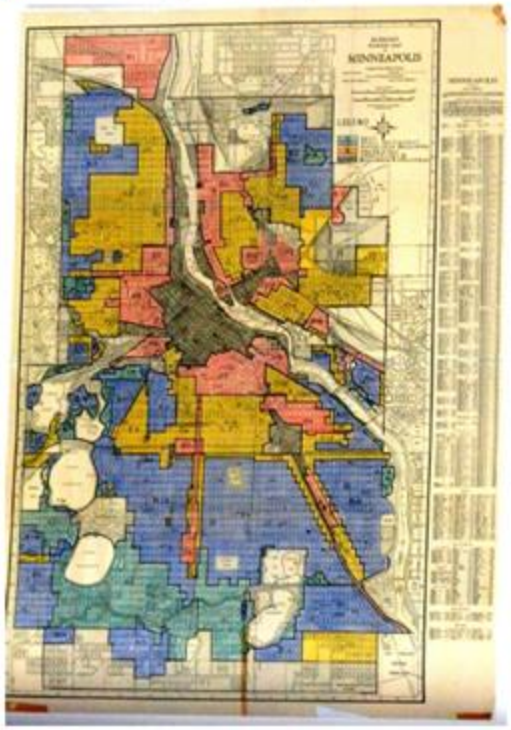
Appendix D: Redlining and Infant Mortality in Minneapolis, Minnesota

Historical map of Minneapolis showing redlining

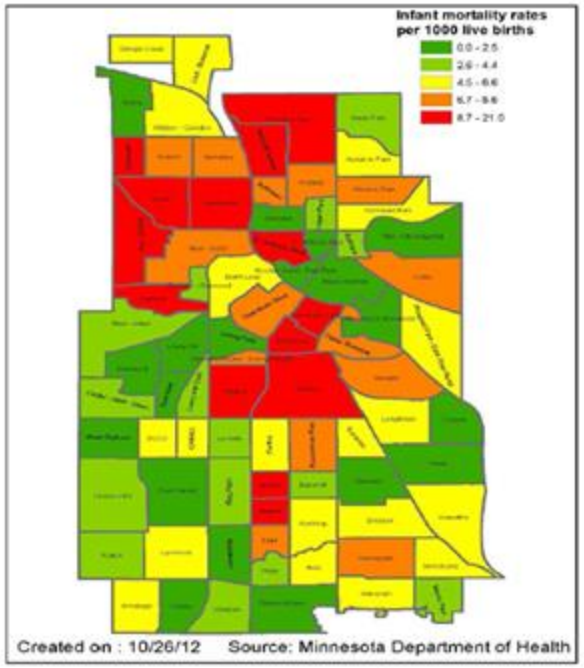
Redlining was used across the U.S. from the 1930s to the 1970s. It is "the practice of arbitrarily denying or limiting financial services to specific neighborhoods, generally because its residents are people of color or are poor."[143] Color-coded maps indicated which neighborhoods were considered lesser (green=best; blue=still desirable) or greater (yellow=declining; and red=hazardous), investment risks, which included the practice of mortgage lending. This historical map of Minneapolis is an example of this practice of redlining.[144]

The consequences of financial disinvestment are closely linked to social and economic decline in neighborhoods across the country, which in turn is associated with poorer health outcomes. The map on the next page shows the infant mortality rate in Minneapolis in 2010. Higher infant mortality rates correspond very closely with the neighborhoods that were coded yellow and red.



Infant mortality rates in Minneapolis by neighborhood, 2001–2010

This map shows infant mortality rates by neighborhood in the City of Minneapolis. The areas with the higher rates of infant mortality correspond closely with the areas marked red and yellow on the previous "redlined" Minneapolis map.[145]



[145] Map provided by the Minneapolis Health Department Research and Evaluation Division, January 29, 2014.

Impetus for Research on Health and Race/Ethnicity

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Patterns of racial/ethnic inequities in health and why need to learn more

- Rates of disease and death elevated for historically marginalized racial group, blacks, Native American, Native Hawaiians other Pacific Islanders

- Persistent of racial difference in health even after adjustment for socio economic status

- Research indicates that across virtually every type of diagnostic and treatment intervention blacks and other minorities receive fewer procedures and poorer-quality medical care than do whites

Williams et al. Racism and Health: Evidence and Needed Research. Annual Review of Public Health 2019.40:105-25

LGBTQ+ Health

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75%
of lesbians report delaying healthcare

Over 50%
of LGBTQ+ people report some form of healthcare discrimination

18%
of LGB youth report experiencing dating violence

1/5
of transgender people are refused healthcare services

25%
of LGBTQ+ adults report not having enough money to pay for health services, compared to 17% of the U.S. population

12x
the number of transgender individuals (48%) report suicidal thoughts compared to the U.S. population (4%)

3x
the number of LGB people experience a psychiatric comorbidity compared to the U.S. population

Gates, Gary J. (2014, August 26). "In U.S., LGBT More Likely Than Non-LGBT To Be Uninsured." Gallup. Retrieved from: https://news.gallup.com/poll/175445/lgbt-likely-non-lgbt-uninsured.aspx
"HIV Among Gay and Bisexual Men." CDC. n.d. Retrieved from: https://www.cdc.gov/nchhstp/newsroom/docs/factsheets/cdc-msm-508.pdf
"LGBTQ+ Communities and Mental Health." Mental Health America. 2020. Retrieved from: https://www.mhanational.org/issues/lgbtq-communities-and-mental-health
"Substance Abuse and SUDs in LGBTQ+ Populations." NIH. n.d. Retrieved from: https://www.drugabuse.gov/drug-topics/substanceuse-suds-in-lgbtq-populations
"10 Statistics You Need To Know About LGBTQ+ Healthcare." Lighthouse. n.d. Retrieved from: https://blog.lighthouse.lgbt/10-statslgbtq-healthcare/

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WHAT CAUSES LGBTQ+ HEALTH DISPARITIES?

- Minority stress theory: additional stress a marginalized person experiences due to society's discrimination and stigma against them on the basis of their identity
- Lack of access to adequate health services due to bias and discrimination on the system, policy, and provider level
- Biased and inadequete public knowledge, attitude, and systems
- Health promotion messages tailored to the LGBTQ+ comunity fail to realize that sexual orientation identification is not the same as sexual behavior

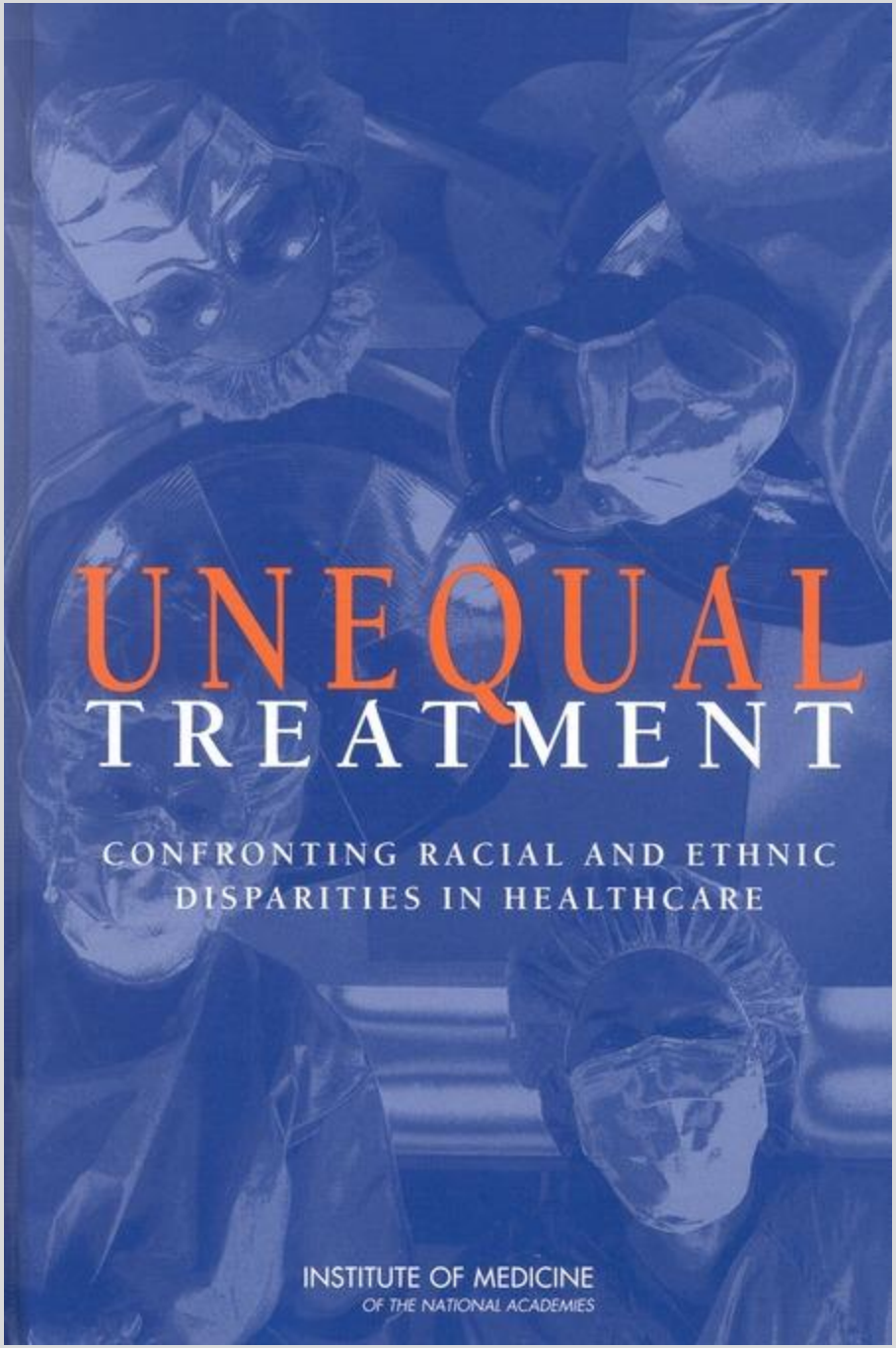
Gates, Gary J. (2014, August 26). "In U.S., LGBT More Likely Than Non-LGBT To Be Uninsured." Gallup. Retrieved from: https://news.gallup.com/poll/175445/lgbt-likely-non-lgbt-uninsured.aspx

"HIV Among Gay and Bisexual Men." CDC. n.d. Retrieved from: https://www.cdc.gov/nchhstp/newsroom/docs/factsheets/cdc-msm-508.pdf

"LGBTQ+ Communities and Mental Health." Mental Health America. 2020. Retrieved from: https://www.mhanational.org/issues/lgbtq-communities-and-mental-health

"Substance Abuse and SUDs in LGBTQ+ Populations." NIH. n.d. Retrieved from: https://www.drugabuse.gov/drug-topics/substanceuse-suds-in-lgbtq-populations

"10 Statistics You Need To Know About LGBTQ+ Healthcare." Lighthouse. n.d. Retrieved from: https://blog.lighthouse.lgbt/10-statslgbtq-healthcare/



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Institute of Medicine. 2003. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Washington, DC: The National Academies Press. https://doi.org/10.17226/12875.

Are We Making Progress Toward Eliminating Healthcare Disparities?

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The Agency for Healthcare Research and Quality's (AHRQ) 2021 *National Healthcare Disparities and Quality Report* finds that since 2000, **disparities have narrowed for only about**

- 8% of measures of American Indian and Alaska Native populations,
- 2% of measures for Asian populations
- 3% of measures for Black populations
- 4% of measures for Hispanic populations
- 10% of measures of Native Hawaiian/Pacific Islander populations

Adapted from Smedley, PhD, Brian (The Urban Institute)
How can we accelerate progress toward Healthcare Equity. February 2023. PPT
National Academies Science Engineering Medicine

What Factors are Associated with Healthcare Inequity?

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- Separate and inequitable healthcare systems – due to residential segregation, the maldistribution of healthcare resources, health system policies (e.g., limited provider networks)
- "Tiered" health insurance and differences in provider reimbursement
- Clinician biases, stereotypes, and prejudice
- Race-based clinical decision support and algorithms
- A persistent lack of diversity among healthcare professionals

Adapted from Smedley, PhD, Brian (The Urban Institute)
How can we accelerate progress toward Healthcare Equity. February 2023. PPT
National Academies Science Engineering Medicine

"Medical Apartheid" – Separate and Inequitable Care for Patients of Color

(Gangopadhyaya, 2021)

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- Study investigated differences in Black and White patient safety measures using hospital discharge records from 27 states
- Black patients experienced higher rates of adverse patient safety events on 55% of patient safety measures
- For 82% of patient safety indicators, **Black patients were significantly less likely to be admitted into hospitals classified as "high quality"** (i.e., hospitals best at minimizing patient safety risks based on the median value of each patient safety indicator)
- This same research team found Black patients experience higher rates of hospital- acquired illnesses or injuries related to surgical procedures relative to white patients **treated in the same hospital**.
- Within-hospital differences in Black-white adverse patient safety rates remain when comparing Black and white patients with **similar coverage types**.

Adapted from Smedley, PhD, Brian (The Urban Institute)
How can we accelerate progress toward Healthcare Equity. February 2023. PPT
National Academies Science Engineering Medicine

Racial Bias Among Healthcare Providers

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- A systematic review of 15 studies measuring implicit bias and health outcomes confirmed that **healthcare professionals hold the same level of implicit bias** against Black, Latinx, and dark-skinned people as the general population, and that “implicit bias was significantly related to patient–provider interactions, treatment decisions, treatment adherence, and patient health outcomes” (Hall et al., 2015)

- A systematic review of 37 studies confirmed the substantial evidence of “pro-White or light-skin/anti-Black, Hispanic, American Indian or dark-skin bias” among a variety of healthcare professionals across multiple levels of training and disciplines (Maina et al. 2017)

Adapted from Smedley, PhD, Brian (The Urban Institute)
How can we accelerate progress toward Healthcare Equity. February 2023. PPT
National Academies Science Engineering Medicine

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Negative Patient Descriptors: Documenting Racial Bias in the Electronic Health Record

(Sun et al., 2022)

- Researchers analyzed a sample of 40,113 history and physical notes (January 2019– October 2020) from 18,459 patients for sentences containing a negative descriptor (for example, resistant or noncompliant) of the patient or the patient's behavior.
- Sought to determine the odds of finding at least one negative descriptor as a function of the patient's race or ethnicity, controlling for sociodemographic and health characteristics [e.g., "refused," "(not) adherent," "(not) compliant," "agitated"].
- Compared with White patients, Black patients had 2.54 times the odds of having at least one negative descriptor in the history and physical notes.
- "Our findings raise concerns about stigmatizing language in the EHR and its potential to exacerbate racial and ethnic health care disparities."

Adapted from Smedley, PhD, Brian (The Urban Institute)
How can we accelerate progress toward Healthcare Equity. February 2023. PPT
National Academies Science Engineering Medicine

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Being the **Difference** to **ADVOCATE AND SAVE Lives**

Adapted from Smedley, PhD, Brian (The Urban Institute)
How can we accelerate progress toward Healthcare Equity. February 2023. PPT
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Health Disparities: Closing the Gap through Cultural Competencies: PART II

Doctor- Patient Relationship Course

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Objectives

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- Define Health Disparities
- Explain the contributing factors of health disparities
- Explain how social determinants of health affect health outcomes
- Explain how practices in healthcare contribute to health outcomes
- **Define and explain the frameworks of cultural competency**
- **Explain the role of cultural beliefs in influencing health**
- **Explain the role of cultural competence and humility in addressing the disparity gaps in health care**

Defining Culture

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- Culture is considered a central concept in anthropology and sociology
  - encompassing the range of phenomena that are transmitted through social learning in human societies
- **Reflects the whole of human behavior**, including ideas, attitudes; ways to relate with one another, manners of speaking or expression
- **Systems** of belief, etiquette, law, morals, entertainment, and education **commonly shared among members of a particular group**
- Any individual can identify with one or more culture
- Culture is **NOT** synonymous with race

What is cultural competency?

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- **Not** about being “really polite”; although you should be
- **Not** just about being able to speak the person’s language, although it can help
- **Not** about knowing the stereo types of different cultures

Demonstration of Cultural Competency

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According to the NIH

- "Cultural competency positively impacts care through service delivery that is "**respectful of and responsive** to the health beliefs, practices and cultural and linguistic needs of diverse patients"

Cultural Competence

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- **Understanding, adapting, and being responsive** to individuals from other cultures with different belief systems than own
- The ability of health professionals **to communicate and effectively provide high quality care to patients from diverse sociocultural backgrounds**

Betancourt et al. Academic Medicine 2010; Concha, M, Villar, M.E., & Azevedo, L, (2014) Health Attitudes and Beliefs Tool Kit, Technical Assistance Network for Children's Behavioral Health, University of Maryland, Baltimore, MD.

Emerging Terms

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"Cultural Competemility"

- Reconciling relationship between cultural competency and cultural humility
  - Critique: Cultural Competency can be seen as acquiring technical skill; potential for stereotype, lacks in addressing of social justice
  - Cultural humility: dynamic and life long process focusing on self reflection and personal critique

Josepha Campinha-Bacote, PhD, MAR, PMHCNS-BC, CTN-A, FAAN

Fisher-Borne, M, Cain, J.M., & Martin, S. L. (2015). From mastery to accountability: Cultural humility as an alternative to cultural competence. *Social Work Education, 34* (2), 165-181. doi:10.1080/02615479.2014.977244

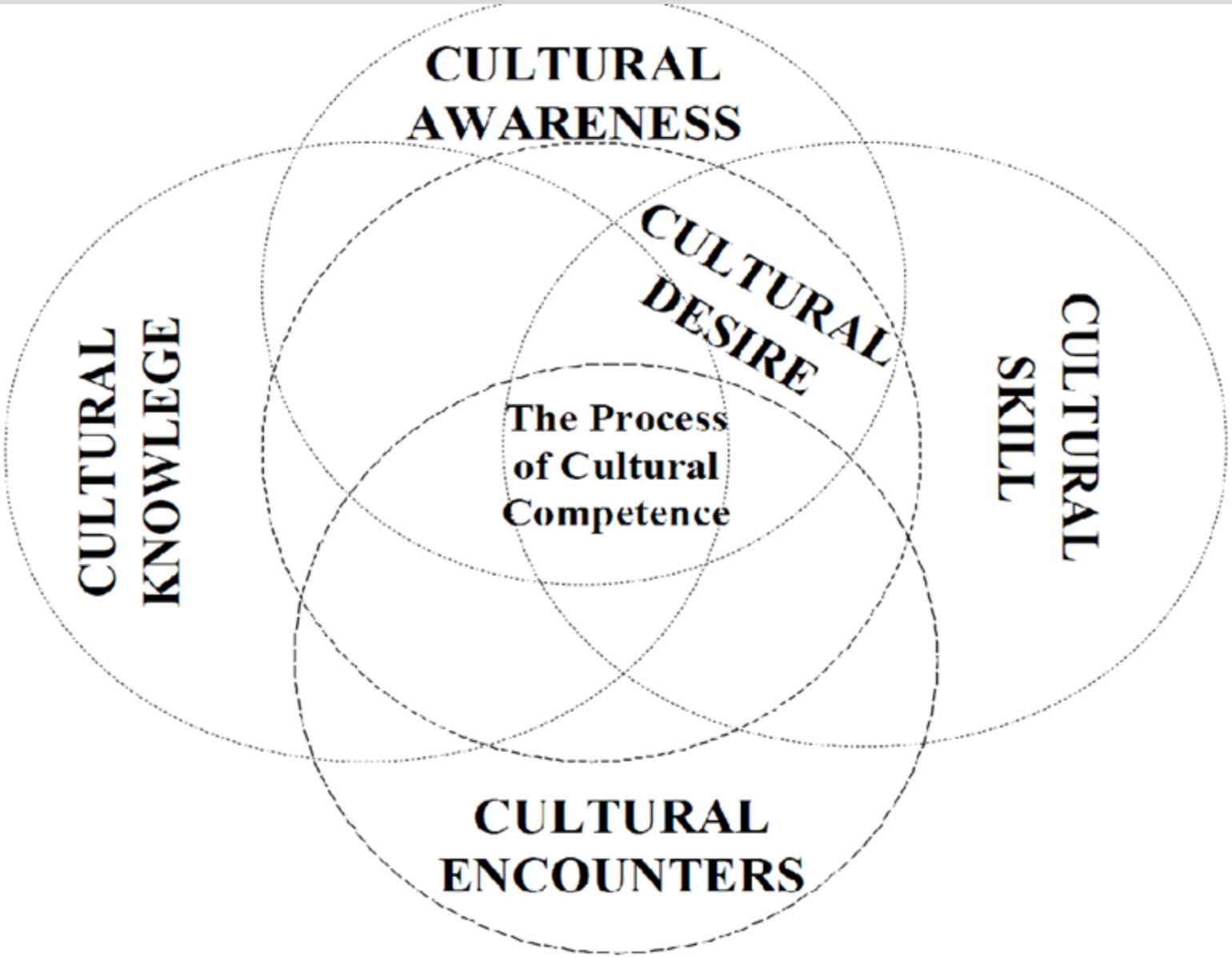

FIGURE 1. The Process of Cultural Competence in the Delivery of Health Care Services.
SOURCE: Transcultural C.A.R.E. Associates. Reprinted with permission.

Cultural Awareness

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- Self examination
- In depth exploration of one owns cultural/professional background
- Recognition of biases/prejudices/ assumptions

Cultural Knowledge

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- Process of seeking and obtaining sound educational foundation about diverse cultural and ethnic groups
- Intra cultural variation
  - Avoid stereotypes
  - Everyone in a culture adhere to various degree of culture

Cultural Knowledge

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Clinician must integrate

- Health related beliefs/cultural values
- Disease incidence/prevalence
  - Lack of epidemiological data will negatively affect care
- Treatment efficacy

Campinha-Bacote. The Process of Cultural Competence in the delivery of Health Care Service: A model of Care. Journal of Transcultural Nursing Vol. 13 No. 3 July 2002 181-184

Cultural Skill

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- Ability to collect relevant cultural data regarding the patient's presenting problem as well as accurately performing physical assessment with cultural context in mind

Campinha-Bacote. The Process of Cultural Competence in the delivery of Health Care Service: A model of Care. Journal of Transcultural Nursing Vol. 13 No. 3 July 2002 181-184

Cultural Encounters

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- Process that encourages the health care professional to directly engage in cross cultural interactions with patients from culturally diverse backgrounds
- Assessment of linguistic needs

Picture reference: http://www.answersandinsights.com/truxchange/

Text reference:. Campinha-Bacote. The Process of Cultural Competence in the delivery of Health Care Service: A model of Care. Journal of Transcultural Nursing Vol. 13 No. 3 July 2002 181-184

Cultural Desire

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- Motivations of health care provider “to want to”, rather than to “have to” engage in the process of being culturally aware, knowledgeable, skillful and familiar with cultural encounter

Campinha-Bacote. The Process of Cultural Competence in the delivery of Health Care Service: A model of Care. Journal of Transcultural Nursing Vol. 13 No. 3 July 2002 181-184

A guide to 'ASSESS' how to develop consistent cultural humility

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- **A**sk questions in a humble manner
  - (Only if it has something to do with the medical issue or care)
- **S**eek self-awareness
- **S**uspend judgment
- **E**xpress kindness and compassion
- **S**upport a safe and welcoming environment
- **S**tart where the patient is

Culture and Health

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- Culture matters in health care
- You may not learn about every culture, **but you should understand how culture affects communication and health outcomes**

Lack of Cultural Competence: Impact of Clinical Outcome

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Lead to barriers that may include, but are not limited to:

Stigmas
Mistrust
Discrimination
Poor health outcomes
Higher cost in health care

(NKI. Center for Excellence in Culturally Competent Mental Health, 2014).

Lack of Cultural Competence: Impact of Clinical Outcome

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1. Patients fear of being misunderstood or disrespected
2. Providers not familiar with the prevalence of conditions among certain minority groups
3. Providers may fail to take into account differing responses to medication
4. Providers may lack knowledge about traditional remedies, leading to harmful drug interactions
5. Patients may not adhere to medical advice because they do not understand or do not trust the provider
6. Providers may order more or fewer diagnostic tests for patients of different cultural backgrounds

The Influence of Cultural and Social Factors on Health Outcomes

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- Healthcare-seeking behavior
- Perceived causes of illness
- Understanding of disease process
- Treatment decisions

Table 1. Dimensions of the Health Belief Model

Dimensions	Definitions
Perceived Susceptibility	An individuals perception of his/her chances of getting the disease
Perceived Seriousness	An individuals knowledge related to the severity of the disease
Perceived Benefits	An individual's opinion of desirable behavioral health beliefs that need to be taken into consideration during treatment plans.
Perceived Barriers	An individual's opinion as to what will stop him/or her for seeking behavioral health services and returning for continued services.
Self Efficacy	An individual's belief that he or she can do something to improve current situation

Concha, M, Villar, M.E., & Azevedo, L, (2014) Health Attitudes and Beliefs Tool Kit, Technical Assistance Network for Children's Behavioral Health, University of Maryland, Baltimore, MD.

Figure 2.
Reflecting Behavioral Health Values and Beliefs: Guiding Questions using Health Belief Model

Perceived Susceptibility	Perceived Seriousness
• Please tell me why you came here today and what you hope to accomplish to improve your situation? • Were you taught about <reason you are here> growing up? • Does anyone among your friends and family also share the same issues as you? Did they seek help? What was the result? • What role do your spiritual beliefs play in regaining your health?	• When you hear the term "behavioral health", what does it mean to you? What about mental health? Mental illness? • What do you know about your current issue that brought you here today? • How do people in your community talk about mental illness? • How different is the perception of your health issue in the American culture compared tot he culture from your country of origin? • Do you think you could get better without professional help?

Perceived Benefits	Perceived Barriers
• How do you feel about getting the kinds of services we provide here? • Does your family support you in your decision to seek help for this situation? • What type of social and support networks do you have besides your family Explain. • I s religion important to you? If so, how? • Would you consider yourself a spiritual person? If yes, explain. • What things are meaningful in your life? • What role do your spiritual beliefs play in regaining your health? • Have you ever received services from natural healers (preachers, shamans, etc.) or other complementary health approaches? • Do you meditate? What else do you do to help your own spiritual and mental wellness? • Have you have any position experiences with a behavioral health? Explain.	• Do you think you will be able to resolve your situation and the problems that brought you here today? Can you do it on your own or do you feel you need professional help? • Does your family support you in your decision to seek help? • What type of social and support networks do you have besides your family? Explain. • What do people in your community think about your situation (probe for stigma, stereotypes and prejudice)? Do you think the community discriminates against people with similar issues as you? • How do people in your community talk about mental illness? • How old were you when you moved tot he U.S.? (only if not born in the U.S.) • Do you identify more with U.S. culture or the culture of your home country? • Have you ever been discriminated against for being different? How did you react? • Do you feel comfortable speaking only with your doctor or caseworker in English? Or would you feel more comfortable with an interpreter? • How do you want a behavioral health care specialist to treat you? • How do you want your mental health care provider to perceive you? • Have you had any negative experiences with a behavioral health? Explain. What about positive experiences?

Self Efficacy
• Do you think you will be able to resolve your situation and the problems that brought you here today? Can you do it on your own or do you feel you need professional help? • Does your family support you in your decisions to seek help? • What is most important to you and your family? Think of material things as well as family values • What role do your spiritual beliefs play in regaining your health? • What type of social and support networks do you have besides your family? Explain.

Concha, M, Villar, M.E., & Azevedo, L, (2014) Health Attitudes and Beliefs Tool Kit, Technical Assistance Network for Children's Behavioral Health, University of Maryland, Baltimore, MD.

Culture Awareness in Health Care

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- Cultural forces are powerful determinants of health-related behavior

- A lack of knowledge or sensitivity to health beliefs and practices of different cultures can limit one's ability to provide quality healthcare

Mrs. S

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33-year-old woman from Pakistan and is Muslim, she presents to the clinic for an evaluation. In her initial office screening, she notes that English is her second language and is proficient in English. She prefers to see female physicians. In the encounter, you come to find that she has a medical history of diabetes. She has not been taken medications for some time now .

She complains of vaginal discharge and frequency of urination.

After the encounter and lab tests, you discuss the importance of blood sugar control. Provide in-depth education You re-start her on Insulin.

Upon her return, her blood sugars remain elevated. She remains frustrated that her vaginal discharge has not resolved.

APPLICATION OF THE HEALTH BELIEF MODEL

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- Perceived Seriousness
  - Dysuria and vaginal discharge
- Perceived Benefits
  - Caring for Family
  - Not having to deal with the complications of diabetes
- Perceived Barriers
  - Shame in using insulin
  - Couldn't eat what she cooks for her family
- Self Efficacy
  - Can you do it on your own or do you need professional help?
  - Does the role of family and spirituality enable self efficacy?

Cultures' effects on Health

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- Culture
  - Influence how people make judgement or sense about the world and decisions about behavior
  - Defines: "good , bad, health, unhealthy"
    - Large body type in some cultures signifies wealth and well being
  - Affects daily habits of life
    - Food choice of people groups from the Mediterranean

Riegelman, Richard K., and Brenda Kirkwood. *Public health 101: healthy people - healthy populations*. Burlington, MA: Jones & Bartlett Learning, 2015. Print

TABLE 4-3 Examples of Ways that Culture Can Affect Health

Ways that culture may affect health	Examples
Culture is related to behavior—social practices may put individuals and groups at increased or reduced risk	Food preferences—vegetarian, Mediterranean diet Cooking methods History of binding of feet in China Female genital mutilation Role of exercise
Culture is related to response to symptoms, such as the level of urgency to recognize symptoms, seek care, and communicate symptoms	Cultural differences in seeking care and self-medication Social, family, and work structures provide varying degree of social support—low degree of social support may be associated with reduced health-related quality of life
Culture is related to the types of interventions that are acceptable	Variations in degree of acceptance of traditional Western medicine including reliance on self-help and traditional healers
Culture is related to the response to disease and to interventions	Cultural differences in follow-up, adherence to treatment, and acceptance of adverse outcome

TABLE 4-4 Examples of Ways that Religion May Affect Health

Ways that religion affects health	Examples
Religion may affect social practices that put individuals at increased or reduced risk	Sexual: circumcision, use of contraceptive Food: avoidance of seafood, pork, beef Alcohol use: part of religion versus prohibited Tobacco use: actively discouraged by Mormons and Seventh-Day Adventists as part of their religion
Religion may affect response to symptoms	Christian Scientists reject medical care as a response to symptoms
Religion may affect the types of interventions that are acceptable	Prohibition against blood transfusions Attitudes toward stem cell research Attitudes toward abortion End-of-life treatments
Religion may affect the response to disease and to interventions	Role of prayer as an intervention to alter outcome.

Consideration of Culture and Health

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- Religion may influence
  - Attitudes in social practices
    - Sexual practices
    - Food
    - Alcohol: part of religion or prohibited
    - Tobacco
  - Response to symptoms
    - Example: people groups may not prescribe to traditional western medical care as a response to symptoms

Riegelman, Richard K., and Brenda Kirkwood. *Public health 101: healthy people - healthy populations*. Burlington, MA: Jones & Bartlett Learning, 2015. Print

Consideration of Culture and Health

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- Religion/Faith/Spirituality may influence
  - Types of interventions that are acceptable
    - Blood transfusion
    - Attitudes toward stem cell research
    - Attitudes toward contraception/abortion
    - Certain aspects of end of life treatment
  - Response to disease
    - Role of prayer as an intervention to alter outcome

Riegelman, Richard K., and Brenda Kirkwood. *Public health 101: healthy people - healthy populations*. Burlington, MA: Jones & Bartlett Learning, 2015. Print

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Caveats to Culture

- There are various degrees to which individuals adhere to the norms of their culture
- Each person may belong to more than one type culture

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Five Essential Elements of Cultural Competence

- Assessing cultural knowledge (*avoid stereotypes)*
- Valuing diversity
- Managing the dynamic of difference
- Adapting to diversity
- Institutionalizing cultural knowledge

The Continuum. (n.d.). https://ccpep.org/home/what-is-cultural-proficiency/the-continuum/
Accessed August 6, 2023

Approach to Cultural Competency

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- Developing skill set and framework through a critical consciences of self, other, and the world

- Posturing oneself as a curious learner

Cultural Humility

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- Cultural humility in this context is defined as developing a *lifelong commitment* towards *self evaluation and critique* when engaging with patients and communities of a different culture

Tervalon and Murray- Garcia J Health Care Poor Underserved 1998

Cultural Proficiency Continuum

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1. **Cultural Destructiveness**
2. **Cultural Incapacity**
3. **Cultural Blindness**
4. **Cultural Pre-competence**
5. **Cultural Competence**
6. **Cultural Proficiency**

Source: *Cultural Proficiency, A Manual for School Leaders, 2nd Edition* by Randall B. Lindsey, Kikanza Nuri Robins, and Raymond D. Terrell

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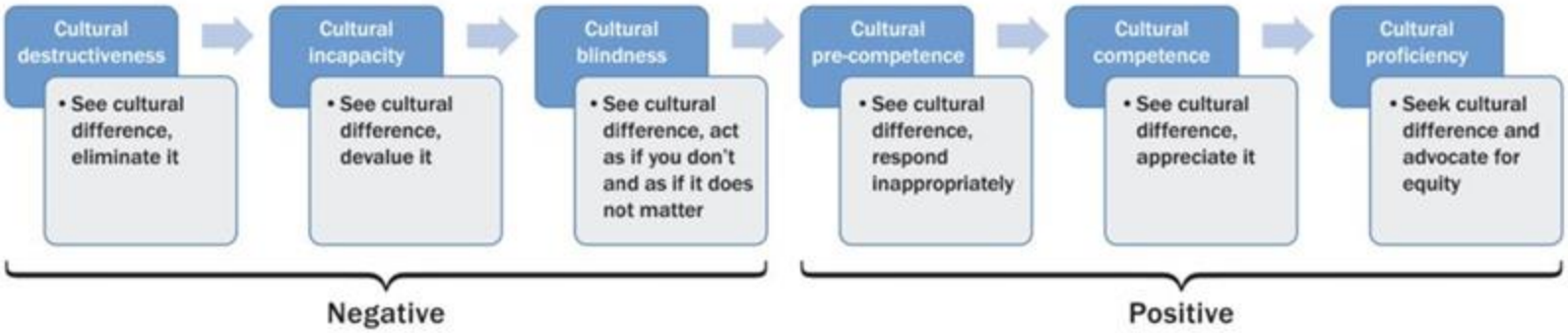
Figure 1. Organizational Cultural Competence Continuum



Burney and Paladko 2015

Cultural Proficiency Continuum

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1. **Cultural Destructiveness**. See the difference, stomp it out. Attitudes, policies, and practices that are destructive to cultures and consequently to the individuals within the culture

2. **Cultural Incapacity.** See the difference, make it wrong. System or individuals in a culture are extremely biased, believe in the superiority of the dominant group and assume a paternal posture toward the so called " lesser" groups. These systems or individuals are often characterized unrealistic fear of people who are different than the dominant group.

3. **Cultural Blindness**. See the difference, act as if you don't. Belief that culture make no difference and that all people are the same values and behaviors of the dominant culture are presumed to be universally applicable and beneficial.

Source: *Cultural Proficiency, A Manual for School Leaders, 2nd Edition* by Randall B. Lindsey, Kikanza Nuri Robins, and Raymond D. Terrell

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Cultural Proficiency Continuum (continued)

4. **Cultural Pre-competence**. See the differences, respond inadequately. An awareness of limitation in cross cultural communication and outreach. Individuals or organizations desire to provide fair and equitable treatment with appropriate cultural sensitivity without knowing what is possible or how to proceed

5.**Competence**. See the difference, understand the difference. There is acceptance and respect for difference, continuous expansion of cultural knowledge and resources and variety of adaptations to belief systems, polices, and practices that make it possible to be effective in many cultural contexts.

6. **Cultural Proficiency**. See the difference and respond. Holding culture in high esteem. Seeking to add to the knowledge base of cultural competent practice by conducting research, developing new approaches based on culture and formally and informally increasing the knowledge of others about culture and the dynamic of difference. Advocating for and championing cultural competent practices in all arenas.

Moving toward Cultural Competency

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- Elicit patient's understanding of illness and strategies for identifying different styles of communication
- Obtain decision making preferences/role of family members
- Acknowledge or use of complementary and alternative medicine
- Acquire skills for negotiating
- Use tools to increase awareness of mistrust, prejudice, impact culture in clinical decision making

Required Skills for Cultural Competency

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Understanding of your patient population

Understand acceptable social behaviors

Awareness of cultural health beliefs

Acquiring cultural sensitivity

Incorporating all of the above in the care of your patient.

PROJECT IMPLICIT SOCIAL ATTITUDES

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Take the Think Cultural Health Module: Culturally and Linguistically Appropriate Services (CLAS) (See CPG for instructions)

Take the IAT

Objectives

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- Define culture
- Define cultural competency
- Explain the role of culture in health
- Explain how cultural beliefs affect health
- Explain steps toward cultural proficiency

Seidel's Guide to Physical examination 8th edition Ch. 2 p 21-29 Cultural Competency

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Feedback Survey

https://comresearchdata.nyit.edu/redcap/surveys/?s=HRCY448FWYXREL4R

Lecture Feedback Form: