

Instructor Lesson Plans

MULTICULTURAL AWARENESS FOR PREHOSPITAL EMS PROFESSIONALS



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Objectives

OBJECTIVES LEGEND

C=Cognitive P=Psychomotor A=Affective

1 = Knowledge level

2 = Application level

3 = Problem solving level

COGNITIVE OBJECTIVES

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

- 1-1.1 Recognize the knowledge, attitudes and skills that will help with providing care to diverse populations. (C-1)
- 1-1.2 Discuss the relationship between culture, language and health (C-1)
- 1-1.3 Identify resources to aid in skills building in providing services to diverse populations. (C-1)
- 1-1.4 Discuss the roles and responsibilities of the EMS Professional to practice cultural competency with patients, family and bystanders. (C-1)
- 1-1.5 Define quality improvement and discuss the EMS Professional's role in the process of improving cultural competency. C-1)

AFFECTIVE OBJECTIVES

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

- 1-1.6 Assess areas of personal knowledge, attitudes and skills to help improve patient care to diverse populations. (A-3)
- 1-1.7 Serve as a model for others when practicing cultural competency with patients, family and bystanders. (A-2)

PSYCHOMOTOR OBJECTIVES

No psychomotor objectives identified.

Preparation

Motivation:

Washington State has a diverse and dynamic population. Here, and across the country, people of racial, ethnic and cultural minorities; immigrant and refugee communities; and economically and socially disadvantaged groups 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 the health and increasing access to care for all of our communities and individuals living within our borders.

Prerequisites:

None.

MATERIALS

AV Equipment:

Utilize various audio-visual materials relating to multicultural awareness. The continuous design and development of new audio-visual materials requires careful review to determine which best meets the needs of the program. Materials should be edited to assure the objectives of the curriculum and the cultural needs of the community are met.

EMS Equipment:

None required.

PERSONNEL

Primary Instructor:

One instructor knowledgeable in:

- Roles and responsibilities of EMS professionals
- Prehospital EMS care
- Multicultural disparities.

Assistant Instructor:

None required.

Recommended Minimum Time to Complete:

One and one half hours

Presentation

Last revision 3/13/2008

Declarative (What)

I. Introduction

- A. Washington State has a diverse and dynamic population. Here and across the country, it is currently accepted that health disparities exist.
 - 1. Many people do not receive health care or if they do, it is not the same quality of health care that other people receive.
 - 2. These differences are experienced by racial, ethnic, gender and cultural minorities, immigrant and refugee communities and economically and socially disadvantaged groups.
 - 3. Washington State is a model state in addressing health disparities. Our state is committed to improving the health and increasing access to care for all of our communities and individuals living within our borders.
- 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.

II. 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.
 - a) Minority Americans frequently report higher rates of specific health problems, such as diabetes or obesity. The poorer health status of racial and ethnic minority Americans reflects higher death rates for chronic diseases.
 - b) Infant mortality rates, as well as overall mortality ratios at different age groups, are higher among African-Americans and American Indian/Alaska Natives than among other groups in Washington State. Infant mortality is a widely used indicator for health disparities. ([See Appendix 1 – Statistical Graphs](#))

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3. Health Disparities in Washington
 - a) The Department of Health (DOH) collects and uses health-related data to measure the quality and accessibility of healthcare in the state. ([See Appendix 1 – Statistical Graphs](#))
 - b) This data has started the process for addressing disparities.
 - c) Despite progress in improving the overall health of Washington residents, disparities still exist for some racial and ethnic minority groups. For example, compared to Caucasians:
 - (1) African Americans and American Indians/Alaska Natives are twice as likely to die in infancy.
 - (2) African Americans are three times more likely to die from diabetes; the rate of death from diabetes is nearly 2.5 times higher for American Indians and Alaska Natives and nearly 1.5 times higher for Hispanics.
 - (3) African Americans, Asian/Pacific Islanders and American Indians are nearly twice as likely to die from cervical cancer.
 - (4) Asians experience more than 15 times the rate of tuberculosis; the rate for American Indians is nearly seven times greater and the rate for African Americans and Hispanics is nearly six times greater.¹

III. Defining 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 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 have to 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 the world. If everyone is unique with different views and languages, then how do we get quality care that will address differences? This leads us to our definition of Cultural Competence:
 1. It is the ability to function effectively in the context of cultural differences
 2. It allows us to understand who we are so we can allow others the opportunity to share who they are with us.
- 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?

¹ Committee on Health Disparities SBOH, *Final Report State Board of Health Priority: Health Disparities*, 13, 14.

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2. **Acknowledgement** - means exploring differing values, not making assumptions and shaping uninformed expectations of others.
 - a) Do I have one belief or value that everyone in the world shares?
 - b) What other values can I think of that may be different from a value I have?
 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. **Taking action** is the final step - adapting practice skills to fit the cultural context of the 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?
- D. Culturally and Linguistically Appropriate Services (**CLAS**)
1. A set of national standards called "Culturally and Linguistically Appropriate Services" (CLAS) were produced and published in 2001 ([See Appendix 2 – CLAS Standards](#)).
 - a) The standards establish goals, activities, and benchmarks for health care systems and organizations to improve the delivery of health care services for racial, ethnic, and all underserved groups.
 - b) The CLAS standards present a complete approach to providing care for diverse groups. It brings organizations, care providers, and communities together to work for a common goal – the best outcome for the patient.
 - c) Quality care organizations feel strongly enough about CLAS:
 - (1) They are including CLAS in their standards.
 - (2) This means that they believe everyone can benefit from CLAS.
- E. Influences on Health & Wellbeing
1. Issues influencing health care have been placed in four categories:
 - a) Differences in languages and non-verbal communication patterns
 - (1) Clear communication is the key to appropriate care.
 - (2) Differences in languages and non-verbal communication can lead to barriers that may impact the service being provided.
 - (3) Addressing such barriers needs the cooperation of the patient, the care provider, and the organization or system where the encounter takes place.

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- (4) 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.
 - b) Cultural differences in perceptions of illness, disease, medical roles and responsibilities.
 - (1) Western biomedicine has a distinct culture. Because of this, different beliefs about the causation, diagnosis and treatment of disease are not given importance or they are discounted.
 - (2) Culturally based beliefs and traditions can affect the course and outcome of disease.
 - c) Cultural preferences for treatment of illnesses
 - (1) People will hold to the healing traditions of their communities or that they bring with them to this country.
 - (2) This does not mean that patients will not use Western medicine. Traditional medicine and modern medicine may coexist harmoniously.
 - (3) Health care providers, however, may face challenges in helping patients overcome doubts about Western medicine.
 - (4) This is why trust is important. If there is trust then the provider and patient can reach agreement about care.
 - (5) While some individuals may adhere closely to the traditional beliefs and practices of a birthplace, others, born in the same locale, may fully acculturate into the U.S. way of life
 - d) Socioeconomic status influences health and health care because it limits choices and reveals general barriers to accessing care such as differences between patients and providers.
2. 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.

IV. 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 is necessary to address barriers and provide culturally and linguistically appropriate services?
- C. **Patient Perspective** - Understanding the issues facing racial and ethnic minority patients can help the provider improve effectiveness in providing quality health care to all patients. Following are some of the barriers to accessing quality health care that culturally diverse patients may experience.
 1. **Health insurance.** About 11% of Washington residents do not have health insurance. A larger number are underinsured.
 2. **Acculturation.** For first and second generation Americans, acculturation—the degree to which they learn the values, beliefs, and behaviors of the host culture is a major factor in health care decisions and use of preventive services. Common fears include language barriers and the cultural insensitivity. ([See Appendix 3 – Comparing Cultural Norms and Values](#))

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3. **Communication patterns.** Communication about health often differs by ethnicity, age, socioeconomic status, geographic location, and sexual orientation. 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.
4. **Inaccurate assumptions or generalizations.** Just as one size doesn't fit all, one program or service won't always work for all groups of a particular population. For example, within the Native Americans population there are differing languages, customs and histories, and attitudes toward health, illness, sexuality, and spirituality among different tribes.
5. **Differing history and community memory.** Because groups within an ethnic community have different histories and differing community memories, a single program will not meet the needs of everyone in the larger community.
6. **Lack of culturally appropriate materials and inadequate language resources.** Materials appropriate for one group of clients may not convey important concepts to another group of clients.
 - a) Prevention materials that are appropriate for use with some groups of Native Americans/American Indians could be inappropriate for use with Navajo people. Within traditional Navajo culture, speaking about disease is believed to bring it into existence.²
 - b) Materials provided in English and those translated into a single other language may simply be inadequate in conveying health care information.

D. 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.

1. According to the Health Resources and Services Administration (HRSA)³, systems that successfully provide culturally and linguistically competent services tend to:
 - a) define culture broadly;
 - b) value clients' cultural beliefs;
 - c) recognize complexity in language interpretation;
 - d) facilitate learning between providers and communities;
 - e) involve the community in defining and addressing service needs;
 - f) collaborate with other agencies;
 - g) recognize training in cultural competence and medical interpretation as equally important as training in other essential clinical skills; and
 - h) Institutionalize cultural and linguistic competence.
2. 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.⁴

² Lori Alvord and Elizabeth Cohen van Pelt, *The Scalpel and the Silver Bear* (New York: Bantam 1999)

³ U.S. Department of Health and Human Services, Health Resources and Services Administration, *Study On Measuring Cultural Competence in Health Care Delivery Settings*, <http://www.hrsa.gov/culturalcompetence/measures> (Release Date: September 2001, accessed April 2007)

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3. **Provider Actions** - Reducing disparities in health care and outcomes is a national and state priority.
 - a) Various efforts are underway to improve:
 - (1) cultural competency awareness through training in medical education programs
 - (2) data collection and research methodologies among underserved communities
 - (3) the number and availability of culturally diverse health care providers and administrators.
 - b) Individuals involved at all levels of health care can take steps to improve the quality of care provided to culturally diverse patients ([See Appendix 4 – Tips for Improving the Patient-Provider Relationship Across Cultures](#)).
 - (1) patient-centered, individualized care is crucial to effective treatment;
 - (2) asking the right questions can help facilitate the process.
 - c) 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
 - (1) Patients with higher levels of trust are more satisfied with the patient-provider relationship.
 - (2) This higher level of trust fosters:
 - (a) Increased patient participation in their care.
 - (b) Reduced appointment cancellations and no-shows.
 - (c) Improved health outcomes.
 - (d) Improved patient safety.
- E. **Enhancing Your Cultural Communication Skills as a Provider** ([See Appendix 5 – Tools to Help Provide Culturally & Linguistically Appropriate Services](#)).
 1. **Improving Your Interpersonal Communication**
 - a) Slow down.
 - b) Use plain, non-medical language.
 - c) Show or draw pictures or use Medical Visual Language Translator cards.
 - d) Limit the amount of information provided and repeat it.
 - e) Use the teach-back or show-me technique.
 - f) Create a shame-free environment.
 2. **Obtaining information to help with patients and families from culturally diverse backgrounds** ([See Appendix 5 – Tools to Help Provide Culturally & Linguistically Appropriate Services](#)).
 - a) The more accurate information we have about others, the more likely we will be able to assist them.
 - b) How do we get information we need? Do we know if it is proper to ask questions of our patients? We can start by asking permission.
 - c) **Questions to help in the process of getting information you need.**
 - (1) So that I might be aware of and respect your cultural beliefs ...
 - (a) Can you tell me what languages are spoken in your home and the languages that you understand and speak?

⁴ Centers for Disease Control: Public Health Practice Program Office, *Principles of Community Engagement*, www.cdc.gov/phppo/, (Release Date: 1997, accessed April 2007).

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- (b) Please describe your usual diet. Also, are there times during the year when you change your diet in celebration of religious and other ethnic holidays?
 - (c) Can you tell me about your beliefs and practices including special events such as birth, marriage and death that you feel I should know?
 - (d) Do you use any traditional health remedies to improve your health?
 - (e) Is there someone, in addition to yourself, with whom you want us to discuss your medical condition?
 - (f) Are there certain health care procedures and tests that your culture prohibits?
 - (g) Are there any other cultural considerations I should know about to serve your health needs?
 - (h) Is there anything else you would like me to know?
 - (i) Is there anything else you would like to know?
 - (j) Do you have any questions for me? (Encourage two-way communication)
- (2) The first statement is letting the patient know that you need them to help you. It is a thoughtful way of asking permission.
 - (3) The purpose of each question is to make communication respectful while establishing trust.

V. 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. Treating non-English speaking (NEP) patients, those with low English proficiency (LEP) or low literacy takes more time and additional resources to ensure patients receive the same level of care as would English speakers. In addition, language barriers are often complicated by cultural differences.
- 3. The bottom line is to have effective communication and supports in place that can overcome these challenges.

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, which may lead to reluctance to return to the health care setting.
- 2. Furthermore, research shows that even when LEP patients are able to 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.

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- c) While explaining care options to NEP/LEP patients. (This may lead to more limited options for caring for the patient.)
- d) In convincing NEP/LEP patients to allow patient care they may not understand.

D. Linguistic Competency

- 1. A non-English speaking or LEP patient experiences 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) bilingual/bicultural or multilingual/multicultural staff;
 - c) print materials in easy to read, low literacy, picture and symbol formats; i.e. signage such as a Medical Visual Translator

E. Using Interpreters

- 1. 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. ([See Appendix 6 for Tips On Working Effectively With Interpreters](#))⁵.

VI. Summary & 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, 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 & 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 speak different languages, are non English speaking (NEP) low English Proficiency (LEP), or have low literacy.
- F. Using trained medical interpreters reduces risk. Providers also need to know how to work effectively with interpreters.

⁵ Cynthia Roat, Maria Francesca Braganza, *Communicating Effectively Through An Interpreter*, (CCHCP 1998).

Application

Procedural (How)

None identified for this lesson.

Contextual (When, Where, Why)

The student will use this information throughout the course to enhance his understanding and awareness of multicultural disparities within the health care field. After completion of the lesson, the student will use this information to understand cultural disparity, as well as being aware of federal and state legislation affecting the profession. A positive, helpful attitude presented by the instructor is essential to assuring a positive, helpful attitude from the student.

STUDENT ACTIVITY

Auditory (Hear)

1. Students will hear specifically what they can expect to receive from the lesson.
2. Students will hear the specific expectations of the lesson.
3. Students will hear actual federal and state legislation relative to cultural awareness.

Visual (See)

1. Students will see audio-visual aids or materials explaining cultural diversity in the health care field.
2. Students will receive a copy of the cognitive, affective and psychomotor objectives for the lesson.

Kinesthetic (Do)

1. Students will discuss situations where being culturally competent would assist in providing better patient care.

INSTRUCTOR ACTIVITIES

Reinforce student progress in cognitive and affective domains.

Redirect students having difficulty with content (complete remediation form).

Evaluation

Written:

Develop evaluation instruments, i.e., quizzes, verbal reviews and handouts, to determine if the students have met the cognitive and affective objectives of this lesson.

Practical:

None

Remediation

Identify students or groups of students having difficulty with this subject content. Complete remediation sheet from the instructor's course guide.

Enrichment

What is unique in the local area concerning this topic? Complete enrichment sheets from instructor's course guide and attach with lesson plan.

Appendices – Instructor References/Student Handouts

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Appendix 1: Statistical Graphs

Figure 1: Infant Mortality Rate (Deaths per 1,000 Live Births) by Race/Ethnicity, 2001-2003 Linked Files: Kaiser State Statistics; Washington DOH

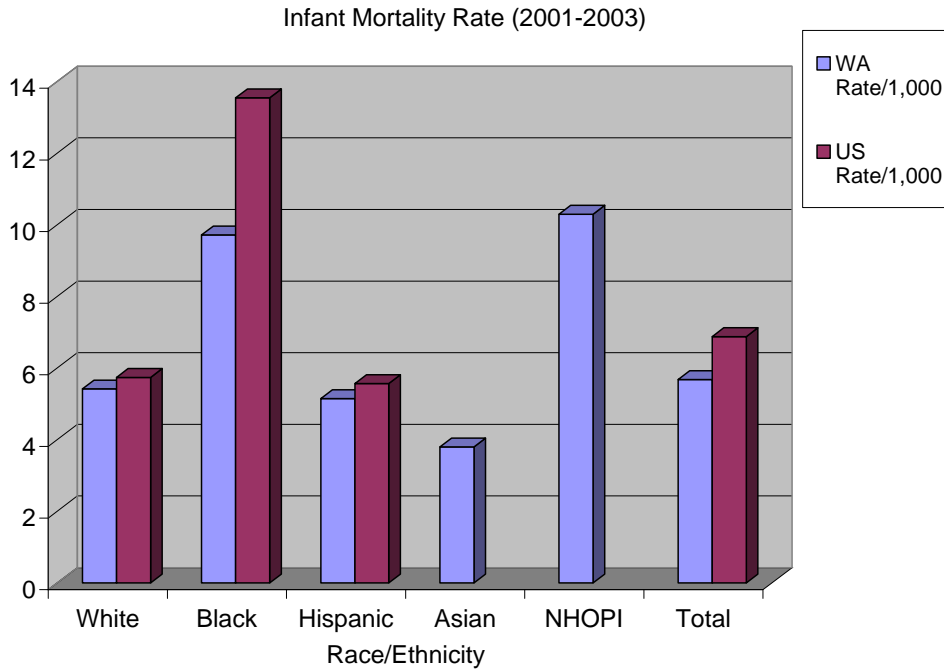
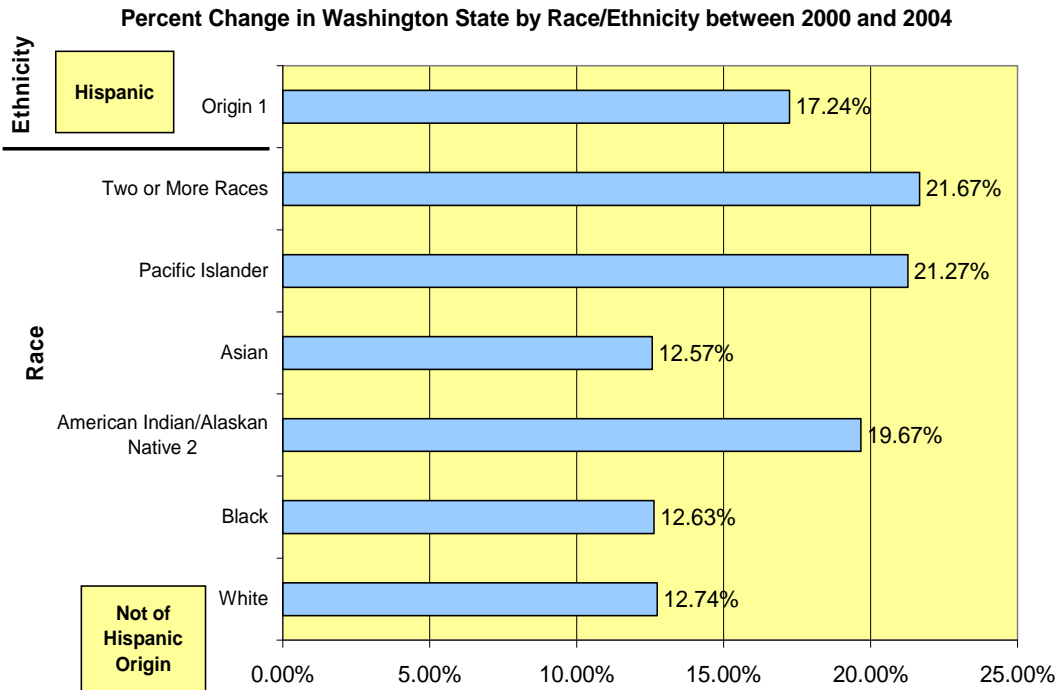


Figure 2: Percent Change in WA Population Groups 2000 to 2004



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Appendix 2: CLAS Standards

The CLAS standards are primarily directed at health care organizations; however, individual providers are also encouraged to use the standards to make their practices more culturally and linguistically accessible. The principles and activities of CLAS should be integrated throughout an organization and undertaken in partnership with the communities being served.

Culturally Competent Care:

1. Health care organizations should ensure that patients/consumers receive from all staff members' effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.
2. Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.
3. Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

Language Access Services:

4. Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.
5. Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.
6. Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).
7. Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

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Organizational Supports:

8. Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.
9. Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.
10. Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.
11. Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.
12. Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.
13. Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.
14. Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.⁶
 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. Gain a competitive edge in the market place; and
 6. Decrease the likelihood of liability claims

⁶ United States Department of Health and Human Services Office of Minority Health, *National Standards for Culturally and Linguistically Appropriate Standards in Health Care*, (IQ Solutions, March 2001), 5-18.

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Appendix 3: 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 4: 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.

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.

Appendix 5: Tools To Help Provide Culturally & Linguistically Appropriate Services.

Six Steps to Community Engagement

1. Go into the community and establish relationships, build trust, work with the 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. Gain a competitive edge in the market place; and
6. 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 information we need? Do we know if it is proper to ask questions of our patients? We can start by asking permission. Here are a few questions to help in the process of getting information you need:

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 ethnic 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 forms
- ✓ Provide forms in patients' languages
- ✓ Provide easy-to-read forms
- ✓ Routinely review important instructions
- ✓ Use non written modalities

Appendix 6: Tips On Working Effectively With Interpreters

Step 1: Conducting a pre-session

- Ask the interpreter if he/she is familiar with concepts involved
- Encourage interpreter to ask questions when uncertain of meaning of any word, concept or issue
- Request that the interpreter interpret(speak) in the first person (to avoid “he said, she said”)
- Tell interpreter what you hope to accomplish – alert to potential difficulties or bad news.

Step 2: The Interview

- Arrange seating so that you directly face the patient
- Speak directly to the patient
- Look at the patient to observe non-verbal signs
- Speak at an even pace in relatively short segments; pause so the interpreter can interpret.
- Be aware that many concepts you express have no linguistic, or even conceptual, equivalent in other languages. The interpreter may have to paint word pictures of many terms you use; this may take longer than your original speech.
- Avoid
 - Highly idiomatic speech
 - Complicated sentence structure
 - Sentence fragments
 - Changing your idea in the middle of a sentence
 - Asking multiple questions at one time
- Do not hold the interpreter responsible for what the patient says or doesn't say; the interpreter is the medium, not the source, of the message
- Encourage interpreter to alert you to potential cultural misunderstandings that may come up
- **Be patient.** Providing care across a language barrier takes time. However the time spent up front will be paid back by good rapport and clear communication that will avoid wasted time and dangerous misunderstandings down the line

Appendix 7: Terminology

Race/ethnicity: A social, not biological, category, referring to social groups, often sharing cultural heritage and ancestry, that are forged by oppressive systems of race relations, justified by ideology, in which one group benefits from dominating other groups, and defines itself and others through this domination and the possession of selective and arbitrary physical characteristics (for example, skin color) Krieger N. A Glossary for Social Epidemiology, J Epidemiology Community Health 2001; 55:693-700.

Multilevel analysis: Analyses that conceptualize and examine associations at many levels, e.g., employ individual- and area-based data in relation to a specified outcome. These analyses typically entail the use of variance components models to partition the variance at multiple levels, and to examine the contribution of factors measured at these different levels to the overall variation in the outcome

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

Cultural Competence: A set of practice skills, knowledge and attitudes that must encompass five elements:

- awareness and acceptance of difference
- awareness of one's own cultural values
- understanding of the dynamics of difference
- development of cultural knowledge
- ability to adapt practice skills to fit the cultural context of the client

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: The learned and shared knowledge, beliefs and rules that people use to interpret experience and to generate social behavior.

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.

Ethnicity: A group identity based on culture, language, religion, or a common attachment to a place or kin ties.

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.

Multicultural Awareness for Prehospital EMS Professionals

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

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.

Socio-Structural Factors: The manner in which social ideologies influence individual access to services and opportunities provided by particular institutional systems, e.g. 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

