



State Medical Board of

Ohio

Cultural & Linguistic Competency for Improved Health Outcomes in Ohio



INTRODUCTION

Thank you for dedicating your career to the health and wellbeing of Ohioans. The care and compassion you collectively provide to patients is appreciated by millions of people in our state each year. And while the practice of medicine is gratifying, the Board recognizes that your work is also highly demanding. This booklet is intended to be a practical guide, including new perspectives and resources to assist you in providing the very best care to each of your uniquely individual patients.

Effective services for minorities and individuals with disabilities are also part of a federal mandate under the National Culturally and Linguistically Appropriate Services (CLAS) Standards in Health and Health Care. According to US Health and Human Services (HHS) Office of Minority Health, these CLAS standards establish a blueprint for health care organizations to 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.

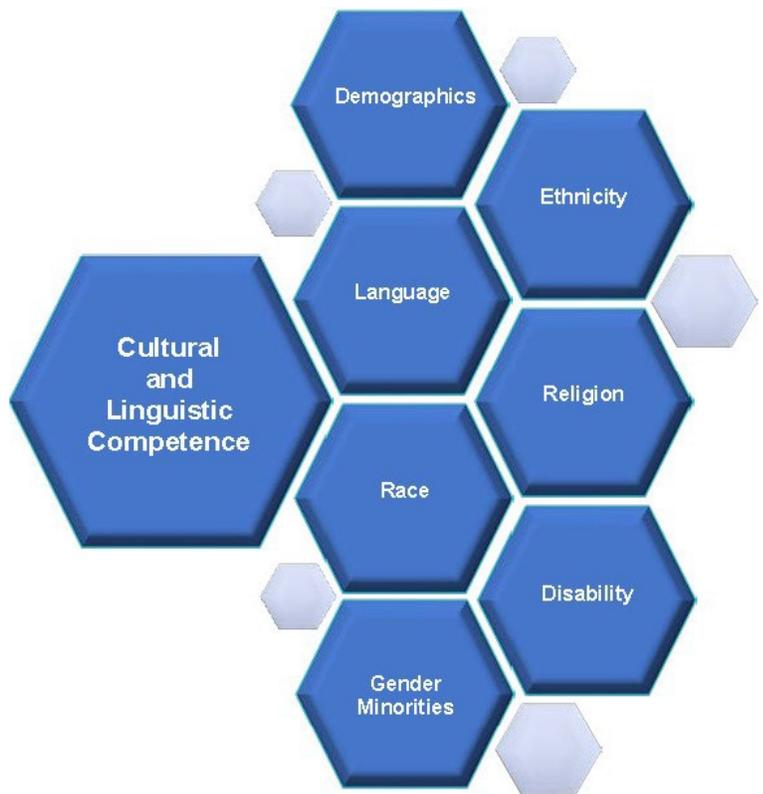
As we explore each aspect of cultural and linguistic competence, specific challenges will be noted for each area. Also included will be BEST PRACTICES that you can immediately incorporate into your health care services as well as RESOURCES where you can read more on each area of competency.

DIVERSITY IN OHIO

There are many aspects to consider such as demographics, language, race, disability, gender minorities, religion and ethnicity. While Ohio's total population may not appear diverse by race, it is important to recognize the additional factors influencing health care disparities, as presented in this guide.

Specific populations in Ohio experience disparate health outcomes regarding the incidence, prevalence and mortality of diseases and health conditions. These are commonly referred to as health disparities. People in such populations also tend to have less access to resources like healthy food, good housing, good education, safe neighborhoods, freedom from racism and other forms of discrimination. As long as health inequities persist, marginalized groups will not achieve their best possible health outcomes.

Bridging the gap between health disparities and health equity requires a mind-shift for health professionals. This is known as cultural and linguistic competence. The State of Ohio defines cultural and linguistic competency as a continuous learning process that builds knowledge, awareness, skills and capacity to identify, understand and respect the unique beliefs, values, customs, languages, abilities and traditions of all Ohioans in order to develop policies to promote effective programs and services.



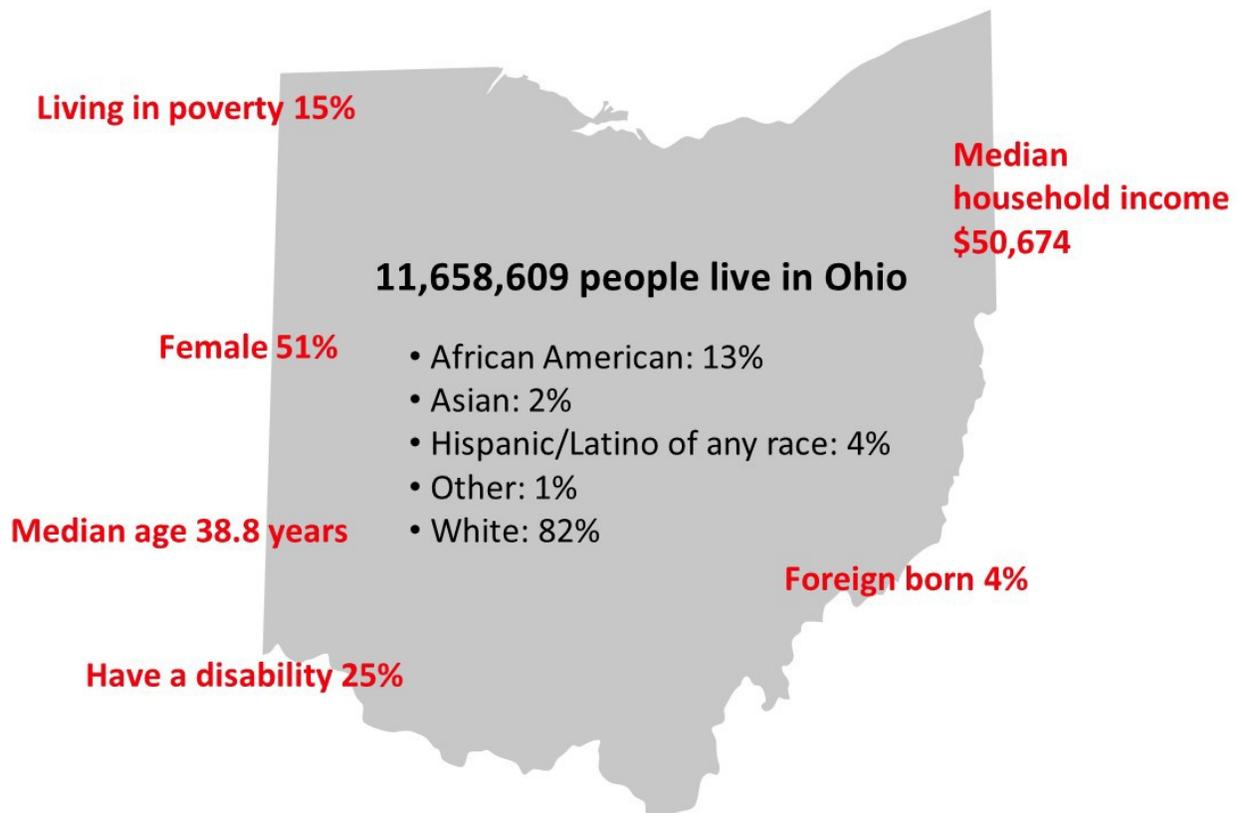
Incorporating cultural and linguistic competency strategies is especially important when designing and delivering programs.

- A culturally and linguistically competent staff is better able to discuss health care beliefs, needs, and preventative care without being hindered by cultural differences or barriers.
- When health care professionals are knowledgeable of and respectful towards the needs and beliefs of diverse patients, they can be more responsive to these needs to bring about positive health outcomes.
- Culturally competent communication is important to connect with and engage patients who may be distrustful of health care professionals after negative experiences within the health care system.

When service providers are more knowledgeable of and respectful towards the needs and beliefs of diverse patients they are able to be more responsive to these needs to bring about positive health outcomes such as:

- Fewer missed medical visits
- Improved patient understanding of treatment plans
- Increased patient engagement
- Increased participation from the local community
- Lower costs due to improved service delivery
- Reduction of costly inpatient and urgent care costs
- Increased preventive care by patients
- Increased cost savings from a reduction in medical errors, number of treatments and potential legal costs.

The state, and nation, are experiencing rapidly-shifting demographic patterns. According to the Ohio Department of Health's Office of Health Policy and Performance Improvement, the minority population in Ohio increased by 20 percent in just one decade (2000-2010).



10 UNIVERSAL GOOD PRACTICES

1

- Ask your patients what they need and how they would like you to refer to them

2

- Outline your commitment to being culturally competent and ask patients to let you know if you ever do something that is offensive in their culture

3

- Ask patients to repeat back to you their directions (teach-back)

4

- For some cultures, a personal relationship with the doctor is part of what health care means—you can acknowledge this limitation in the US system directly to the patient, but strive to create a trusting, professional relationship

5

- Advocate for hiring cultural specialists and patient navigators who can help patients understand the system and help you understand the patient

6

- Participate in a clinical intercultural collaboration to advocate and stay accountable together

7

- When your identity or background—race, age, gender, etc.— doesn't match the patient's, look for extra support within your staff, institution or beyond

8

- Develop accountability systems to check your conclusions and assumptions before, during and after treatment

9

- Provide a patient-centered environment. Upon scheduling, ask if the patient requires any reasonable accommodation for a better patient-centered experience

10

- Commit to ongoing professional development around disparities related to demographics, language, gender, race, ethnicity and religion

KEY RESOURCES

- [Ohio Resources for Health Equity, Ohio Department of Health \(ODH\)](#)
- [Office of Health Improvement & Wellness, ODH](#)
- [Unconscious Bias in Academic Medicine report from AAMC and The Kirwan Institute for the Study of Race and Ethnicity at The Ohio State University](#)
- [Office of Minority Health, HHS](#)
- [Standards for Culturally and Linguistically Appropriate Services \(CLAS\) in Health and Health Care, HHS](#)
- [United States Census Bureau, Ohio Data](#)
- [Trauma Informed Care Initiative from the Ohio Department of Mental Health and Addiction Services \(OhioMHAS\)](#)
- [MedlinePlus: Population Groups, National Institutes for Health \(NIH\)](#)

LANGUAGE

Communication breakdowns are common in any communicative endeavor; but within health care, precision is key. There are two focal points: provider communication, and patient communication. Providers should eliminate jargon, focus on what patients need to do, and check to see that the message has been delivered. When there is a language barrier—when the patient doesn't speak the same language as the provider—language supports must be employed to ensure messages are communicated accurately. This is federally mandated.

HEALTH LITERACY

Health literacy is the degree to which an individual has the capacity to obtain, communicate, process, and understand basic health information and services to make appropriate health decisions.

GOOD PRACTICES

- Slow down the delivery of information
- Ask patients to repeat back to you their directions (teach-back)
- Remove jargon from communication and define specialized terms
- Use 70 percent pictures to 30 percent text in written communications
- Focus on the patient's action steps and schedule
- Look at the signage and health literature in your facility—does it prioritize images or words?
- Look at the way medication dosages are recorded on prescriptions in your facility—dosages should show clearly the quantity and frequency, rather than ambiguous or complex instructions like “take two tablets biweekly”

RESOURCES

- [Centers for Disease Control and Prevention, Health Literacy Resources](#)
- [National Action Plan to Improve Health Literacy](#)

INTERPRETERS AND TRANSLATORS

Once you have established the patient's language, attempt to contact an appropriate interpreter service. It may be considered unethical for a provider with no interpretation training to try to communicate without an interpreter. Emergency departments may be challenged with this the most.

GOOD PRACTICES

- Speak directly to the patient, not to the interpreter
- Family members, especially children, should not be relied on to interpret for patients
- Avoid shortcuts, which can result in unfavorable outcomes, advocate for more interpretation resources
- Follow their lead in communication—their job is to direct communication traffic
- Aim for a normal rate of speech; deliver information in digestible chunks
- Speak in plain language; define terms and explain what they mean
- Have the patient or receiver “teach-back,” through the interpreter, any instructions you give; clarify misunderstandings and support with literature where appropriate
- If possible, have a quick feedback session with the interpreter— discuss what went well, what was challenging and provide feedback
- Have patient forms translated to the common languages in your area

RESOURCES

- [Community and Court Interpreters of Ohio](#)
- [American Translators Association](#)
- [HHS Civil Rights for Providers](#)

RURAL OHIO

About 20 percent of Ohio's population live rurally. On average, rural Ohio has a poverty rate of 9.8 percent. However, Appalachian Ohio's statistics are much higher. Appalachian Ohio is a band of 32 counties across the eastern and southern regions of the state. Appalachian Ohio has a 17.6 percent rate of poverty, compared to Ohio's average of 14.9 percent. Accessing health services is often an enormous barrier and they often find themselves isolated. A [2015 HRSA report](#) found that rural children are more likely than urban children to experience adverse childhood experiences (ACEs) such as child abuse, and lack of nutrition, making trauma-informed care important for better outcomes.

GOOD PRACTICES

- Cultivate trusting relationships with community members
- Participate in a local Regional Health Equity Coalition, if there is one in your area
- Look for your leverage to improve outcomes in systems: institutions, communities, organizations
- Advocate for resource sharing networks and use technology to close distance and resource gaps
- Apply principles of Trauma-Informed Care: prioritize a sense of safety which can form a foundation for trust; inquire about ACEs and look for ways to interrupt ACEs with parents and children

RESOURCES

- [State Office of Rural Health, Ohio Department of Health](#)
- [Health and Well-being of Children in Rural Areas report by HRSA](#)
- [Ohio Mental Health and Addiction Services, Trauma Informed Care Initiatives](#)
- [Ohio Development Services Agency, The Ohio Poverty Report](#)
- [Ohio Department of Health, Ohio Primary Care Workforce Data Compendium, September 2010](#)

RELIGION

Religious beliefs or faith traditions may lead a patient to disagree with your medical advice. Respectfully inquire about whether a patient's religion or beliefs contradict your advice. Remember that Ohio law allows competent adult patients to refuse medical care. Laws also allow parents to claim a non-medical exemption from vaccination requirements.

GOOD PRACTICES

- Take the extra time to connect with the patient and family, and admit what you don't know about specific faith practices; ask for support and guidance
- Be aware of significant holidays which could include religious practices
 - For example, during Ramadan, you can suggest taking medications at night
- Ask "Are you fasting?" and "Do you have any dietary restrictions, including alcohol?"
- Ask "Do you have any religious concerns related to your medical care?"

RESOURCES

- [Ohio's Non-medical, Religious Exemption for Vaccinations from the Department of Health](#)
- [Penn Medicine, Religious Diversity: Practical Points for Health Care Providers](#)
- [Interfaith Calendar](#)

GENDER MINORITIES

US constructions of gender and sex are often tied together— we understand women to be those generally physically capable of gestation, and men to be those generally physically capable of insemination. Shifts in gender conceptualization are cultural and on-going, but what distinguishes those committed to ending gender oppression are these baseline understandings: a person’s real gender is what they say it is; and “genitals do not equal gender” (a common saying within the trans-inclusive community).

In some health care situations, information about biological sex and/or hormone levels is important for assessing risk and/or drug interactions. But in many health care situations, gender identity is irrelevant. It is inappropriate to ask gender-related questions if it is unrelated to their care.

Health insurance forms can create systemic barriers. Forms usually require individuals to mark “male” or “female.” These categories can result in refusal of care when the needed care appears incompatible with the person’s gender. A billing code that allows for a gender/procedure mismatch has been endorsed by the Department of Health and Human services.

GOOD PRACTICES

- Ask people for their pronouns (he? she?), even people you think ‘don’t look’ trans or genderqueer; when in doubt, default to they/their/theirs and inform your staff to do so as well
- Never disclose a person’s gender status to anyone who does not explicitly need the information for care
- Apply principles of Trauma-Informed Care: seek out peer supports for the patient; prioritize a collaborative approach to patient-centered care; be transparent and admit areas of ignorance
- Familiarize yourself with common medications that patients might be using
- Become knowledgeable about health care issues related to evolving perceptions of gender

RESOURCES

- [World Professional Association for Transgender Health](#)
- [Transgender Law Center, 10 Tips for Working with Transgender Patients](#)

PEOPLE WITH DISABILITIES

People with disabilities can benefit from the same healthcare services as people without disabilities as long as clinical spaces and clinical practices are accessible and inclusive of people with disabilities. The accessibility of doctor’s offices, clinics, hospitals, and other healthcare facilities is essential in providing culturally competent medical care to people with disabilities.

Section 504 of the Rehabilitation act of 1973, and The Americans with Disabilities Act of 1990, are federal civil rights laws that were created to prohibit discrimination against people with disabilities in everyday activities, including medical services. Both Section 504 as well as Title II and Title III of the ADA require that medical care providers provide individuals with disabilities:

- Full and equal access to their health care services and facilities; and
- Reasonable modifications to policies, practices, and procedures when necessary to make health care services fully available to individuals with disabilities, unless the modifications would fundamentally alter the nature of the services

Despite these regulations, people with disabilities still face barriers in clinical settings. These barriers can be both

physical and attitudinal. For example, a lack of height-adjustable examination tables may lead to a person with disability being examined while sitting down, potentially leading to adverse health consequences or a missed diagnosis. Attitudinal barriers may result in the physician focusing on the person's disability rather than paying attention to the patient's concerns. Disability is not poor health, and physicians can play a large role in offering the best care possible to a growing population of people with disabilities.

GOOD PRACTICES

- Ask all patients if they require any accommodations when scheduling appointments
- Communicate directly with the patient, even if a caregiver, guardian, family member, or interpreter is present
- Focus on the patient's primary health concerns during the visit rather than their disability
- Avoid making assumptions about what a patient can or cannot do based on their disability; do not second-guess the patient on their stated abilities or needed accommodations
- Adjust the timing of office visits to allow for longer appointments if necessary
- Use the resources below to ensure your healthcare facility is accessible

RESOURCES

- [Free Trainings for Healthcare Providers to Better Serve People with Disabilities – CE Available!](#)
- [ADA.org – Tips for Accessible Health Care](#)
- [Short Accessibility Checklist for Clinical Spaces](#)
- [Communicating with People with Disabilities](#)
- [Access to Medical Care for Individuals with Mobility Limitations](#)
- [Hiring a Sign Language Interpreter](#)

IMMIGRANTS & REFUGEES

Immigrants, having left their home country willingly, are lawfully present have been granted the right by the US Citizenship and Immigration Services (USCIS) to reside in the United States and in most cases, they are permitted to work without restrictions. Refugees are unable or unwilling to return to their place of origin because of a disaster, persecution or a well-founded fear of persecution due to race, religion, nationality, membership in a social group or political opinion. Both immigrants and refugees may have a history of psychological trauma.

Undocumented persons are excluded from many health care access options and therefore may seek care at safety net clinics or at the emergency room. Providers often contend with fear around engaging with systems, and health conditions may go untreated. Ohio health care systems must provide emergency and other care regardless of the patient's language, nationality, or immigration status.

GOOD PRACTICES

- Understand that immigrant/refugee patients may not have a context for certain rules (such as a HIPAA form) and other rules may not fit their case
- If you will have an ongoing relationship with an immigrant/refugee, do historical research as soon as possible
- Apply principles of Trauma-Informed Care: recognize culture shock, learned helplessness, avoidance, dissociation, and other responses to traumatic events; and provide a patient-focused environment

RESOURCES

- [Internal Revenue Service: Immigration Terms and Definitions Involving Aliens](#)
- [Ohio Department of Job and Family Services, Refugee Resettlement Fact Sheet](#)

SOMALIS

Ohio has the second largest Somali population in the nation, with thousands residing in central Ohio. It is important to know that some Somali cultural norms are illegal in the United States. They should not, however, be made to feel that their beliefs and practices are not respected or valued. This can lead to mistrust of medical professionals and refusal of care.

One example is the use of qat, a leafy narcotic. The DEA classifies qat as an illegal drug that has no accepted medical use and a high potential for abuse. Thus, persons who use qat may hesitate to admit it. Long-term effects may include cancer of the mouth, depression and psychosis.

Somalia has the highest rate of tuberculosis (TB) in the world. Some may hesitate to initiate TB treatment because they believe they must discontinue chewing qat while undergoing treatment. Communicating the availability of legal medications to treat symptoms of health conditions can be a valuable, trust building clinician-patient opportunity.

Female circumcision, known as female genital mutilation (FGM) in the US, is a common cultural practice. Its illegal status in the United States has led to secrecy, and patients may feel uncomfortable discussing it with Western health care providers.

GOOD PRACTICES

- Explain how diseases are spread and address myths regarding Western medicine
- Muslim patients' privacy and modesty must be respected. Ideally, it is best if they are cared for by a clinician of the same gender
- Medical decisions for family members are often made by the male - this should not be immediately interpreted as a sign of abuse
- Do not assume the patient can read Somali - the Somali script was introduced only in the 1970s and social upheaval severely disrupted education
- Address language barriers, as a lack of qualified Somali interpreters still exists
- If no medication is prescribed, explain the reason why, as Somalis may expect medication for illnesses
- Educate about preventive care

RESOURCES

- [Center for Diseases and Control and Prevention, Somali Refugee Health Profile](#)
- [The Ohio State University, Guide to Resources and Information on Somali Language, Culture, and Traditions](#)

ETHNICITY & RACE

Patients of different ethnicities and races may have different experiences in the health care system. Practitioners should be careful to avoid any implicit bias, stereotypes or generalization.

In the US, ethnicity and race are often considered distinct categories. The US Census recognizes ethnicity as either Hispanic or non-Hispanic. Hispanic ethnicity can accompany any racial category. Race is defined as a person's self-identification with one or more social groups. An individual can report as White, Black or African American, Asian, American Indian and Alaska Native, Native Hawaiian and Other Pacific Islander, or some other race. Survey respondents may report multiple races. This updated definition is reflective of the understanding of race as a socially constructed concept, unrelated to biology.

AFRICAN AMERICAN

Many aspects of African American culture reflect the culture of the general US population. The following cultural patterns may represent many African Americans but should never be used as generalizations for populations. Each person is an individual, as well as a community member.

According to the CDC, the death rate for African Americans has declined about 25 percent over 17 years, primarily for those aged 65 years and older. However, new analysis shows that younger African Americans are living with or dying of many conditions typically found in white Americans at older ages. The difference shows up in African Americans in their 20s, 30s, and 40s for diseases and causes of death. When diseases start early, they can lead to death earlier. Chronic diseases and some of their risk factors may be silent or not diagnosed during these early years.

Health disparities among the African American population include life expectancy, heart disease, hypertension, infant mortality and morbidity rates, cancer, HIV/AIDS, violence, type 2 diabetes mellitus, and asthma.

GOOD PRACTICES

- Work with other sectors, such as faith and community organizations, education, business, transportation, and housing, to create social and economic conditions that promote health equity and address social determinants of health starting in childhood
- Older African Americans may be suspicious of clinicians, possibly believing their health is personal and up to God's will. Because they may be reluctant to share personal or family issues, building a trusting relationship is key

RESOURCES

- [ServingOhioBetter.org, Cultural Tip Sheets](#)
- [Ohio Commission on Minority Health](#)
- [CDC Vital Signs, African American Health](#)
- [NIH Medline Plus, African American Health](#)

ASIAN

Though the word Asian is globally understood to span immense geographic and cultural space, most Americans limit the term to Japanese, Indian, Chinese, Korean, Vietnamese, or Pacific Islanders. Though perceived as a single category, these groups have significant cultural differences. The degree to which US cultural values have been adopted has a dramatic impact on whether these values and any associated behaviors apply to a given individual.

GOOD PRACTICES

- Assess the language barrier. Ascertain whether the patient speaks English or not, their native dialect, and the degree of acculturation
- Ask about traditional beliefs as part of your cultural formulation. Patients may hold traditional values and concept of health and disease (e.g., Yin/Yang). They may seek traditional healers such as acupuncturists and herbalists. Their ideas about bodily symptoms may affect drug compliance
- Many Asian immigrants view physicians and other providers as authority, so encourage patients' participation in their care. Taking blood pressure, checking pulse, and giving advice about diet and foods/use of herbal products can promote rapport
- Involve the family in health care decisions. If interdependence among family members is valued, treat the family as a unit
- Be attentive to co-morbid medical problems
- Consider traditional interventions, in addition to medication and if indicated, diets, exercises, and other traditional methods (Tai Chi, Breathing exercises) of stress-reduction and relaxation
- Ask detailed clinical history with open-ended questions first and be attentive to non-verbal clues (facial expression, tearing, etc)

RESOURCES

- [ServingOhioBetter.org, Cultural Tip Sheets](#)
- [National Institutes of Health, US National Library of Health](#)
- [Working with Asian American Patients, American Psychiatric Association](#)

LATINO/HISPANIC

Latinos are a multiracial, multicultural group. Hispanic/Latino Americans are descended from Africans, American Indians, and Europeans, and include people of mixed ancestry who share historical backgrounds, cultural traditions, and the Spanish language. The US-government-created term “Hispanic” refers to the Spanish language, not place of origin. It is used by formal institutions, including Congress, government agencies, schools, nonprofit organizations, and the press. The term Latino is preferred by Latin American heritage groups and other community-based organizations to promote a community-oriented environment. Most Hispanics/Latinos prefer to be referred to by their immediate ethnic group name, such as Mexican, Puerto Rican, Cuban, etc.

GOOD PRACTICES

- Take the time to develop a cultural formulation, which includes a consideration for acculturation, community and family connection, immigration status/ history, education
- Be aware of self-remedies that could interact with medications
- Continue to explore and educate yourself about Latino experiences in your community
- Although this is generally a culture that respects authority, feeling misunderstood and not connected to a provider could compromise care

RESOURCES

- [Ohio Commission on Hispanic and Latino Affairs, Latino Community Report 2017](#)
- [ServingOhioBetter.org, Cultural Tip Sheets](#)

WHITE

The prevalence of this demographic allows marginalized intersections to be overlooked; for example, white immigrants from across Europe and Central Asia may be assumed to be “American” or speak English because they are “American looking.” Although white patients may not experience racial marginalization, they may experience other forms of discrimination.

While deadly drug overdoses impact all races and ethnicities, the rate of opioid overdose deaths for White Ohio residents occur at a rate of 37 per 100,000 people, compared to 21.5 for African American Ohioans and 15.9 for Hispanic Ohioans according to the Kaiser Family Foundation.

GOOD PRACTICES

- Examine assumptions of native language and home country
- Avoid stereotyping
- Commit to ongoing professional development around disparities as you would for any professional dimension

RESOURCES

- [Healthy People 2020, HHS Office of Disease Prevention and Health Promotion](#)
- [The Community Guide: What Works to Promote Healthy Communities, HHS Vital Signs Health Topics, CDC](#)

READY TO DO MORE?

The Multiethnic Advocates for Cultural Competence (MACC) was a great partner in the development of this guide. MACC is a statewide nonprofit membership agency aimed at the reduction of health disparities in Ohio's health systems. Ohio faces a number of disparate health outcomes that are the result of a lack of knowledge and understanding about the diverse racial and ethnic populations being served. MACC is equipping providers and systems with the necessary tools and best practices to enhance their delivery of care.

MACC offers the following services:

- Sponsoring Lectures, Conferences and Educational Sessions concerning issues of cultural competence
- Researching cultural competency practices, standards and providing this information throughour Resource Library
- Partnering with systems and organizations to help them assess and improve their level of cultural competence
- Identification and development of cultural competence: assessment tools, trainers, and training curricula throughout Ohio

Connect with the Multiethnic Advocates for Cultural Competence online at maccinc.net

