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Contact Hours: **4**

Cultural Competency Training

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LEARNING OUTCOME AND OBJECTIVES: Upon successful completion of this continuing education course, you will be prepared to provide effective and respectful care for patients belonging to different populations. Specific learning objectives to address potential knowledge gaps include:

- Examine the intersection of oppression, discrimination, and implicit biases in order to provide nondiscriminatory care.
- Discuss elements of culturally competent care for patients of all races, ethnicities, and religions, including how a patient's race, ethnicity, or religion may contribute to various healthcare-related considerations.
- Discuss elements of culturally competent care for LGBTQ+ patients, including physical space, informational materials, patient communication, and staff training.
- Discuss elements of culturally competent care for children and older adults, including best practices for communicating effectively.
- Discuss elements of culturally competent care for veterans, including trauma-informed care.
- Discuss elements of culturally competent care for patients with mental illness, including common stigmas about people with mental illness.
- Discuss elements of culturally competent care for patients with a disability, including the use of people-first language.

INTRODUCTION

According to the National Institutes of Health (2021), culture involves a combination of elements that are often specific to ethnic, racial, religious, geographic, or social groups. Some of these

elements include personal identification, language, thoughts, communications, actions, customs, beliefs, values, and institutions. These elements influence beliefs and belief systems surrounding health, healing, wellness, illness, disease, and delivery of health services. Cultural competence is a group of compatible behaviors, attitudes, and policies that combine together to allow healthcare professionals to work successfully in cross-cultural situations (Dillard et al., 2021).

In order to provide culturally competent care, nurses and other healthcare providers must be understanding and sensitive to the cultural characteristics common to certain populations, such as:

- Persons from various gender, racial, and ethnic backgrounds
- Persons from various religious backgrounds
- Lesbian, gay, bisexual, transgender, and questioning (LGBTQ+) persons
- Children and older adults
- Veterans
- Persons with a mental illness
- Persons with an intellectual, developmental, or physical disability

Providing care that adequately meets the diverse needs of patients from various cultural backgrounds is a necessary component of providing equitable healthcare for all individuals. Healthcare professionals can provide improved care to diverse patients through education and training, increased knowledge and skills, and changes in attitudes and behaviors (Dillard et al., 2021).

OPPRESSION, DISCRIMINATION, AND CULTURAL BIAS IN HEALTHCARE

A person's experience is influenced by the intersection of their sex, gender identity, race, ethnicity, sexual orientation, socioeconomic status, ability, and other social determinants. All these factors have an impact on a patient's access to healthcare, health risks, and health outcomes. Any past and present discrimination, oppression, or fear related to these factors can greatly influence an individual's actions to actively seek care when needed or, conversely, to defer their healthcare needs until a crisis occurs.

Providing whole-person, patient-centered care requires a healthcare professional to proactively consider the intersection between each person's diverse identities and broader cultural factors. Such an "intersectionality" perspective should not lead to assumptions about an individual based on the minority groups with which they identify but should inform the clinical experience in a positive manner in order to respect and address each person's unique needs (Medina-Martinez et al., 2021).

Cultural Bias and the Provision of Care

When working with patients, it is especially important for clinicians to build a positive rapport as a way to counteract the exclusion, discrimination, and stigma their patients may have experienced previously in the healthcare environment. However, despite their best intentions, healthcare professionals may hold internalized cultural biases that affect their interaction with patients. For example, a clinician, case manager, or other staff member may say something or use body language that communicates a stereotype or negative message about a patient.

These biases can lead to unequal care and affect a patient's decision to follow medical advice or return for follow-up care. Negative messages can also become internalized in the patient, adding to a person's stress and contributing to negative mental and physical health outcomes (Medina-Martinez et al., 2021).

A review of a number of research studies shows that bias in the healthcare community has far-reaching consequences for healthcare recipients.

- A literature review from 2018 showed that some medical professionals were more likely to view **women** experiencing chronic pain as emotional, hysterical, or sensitive.
- Results from a 2019 study showed that more than 80% of medical students had an implicit bias against **lesbian and gay people**.
- A 2017 study found that healthcare professionals were more likely to assume that **older adult patients** are offensive, helpless, demanding, and unwilling to receive treatment.
- A 2020 study showed that 83.6% of respondents implicitly preferred people without disabilities and viewed **people with disabilities** as having a lower quality of life due to their disabilities.
- Results from a 2015 study indicated that healthcare professionals can view **people with obesity** as lazy, weak-willed, lacking self-control, and unlikely to adhere to treatment regimens.
- Research from 2017 indicated that some physicians may be more likely to think that **people from low socioeconomic backgrounds** are less intelligent, independent, responsible, and rational than people from higher socioeconomic backgrounds. (Smith Haghighi, 2023)

Studies have shown that no matter how individuals may feel about prejudiced behavior, everyone is susceptible to biases based on cultural values and stereotypes that were embedded in their belief systems from a young age. To increase one's own awareness of internal bias, it is helpful to notice times when biased attitudes and beliefs may arise. Such internal awareness is the first step in making changes. Internal questions to ask may include:

- How do my current beliefs help me?
- What might I lose if I change my beliefs?
- How might my current beliefs harm others?

- How might it benefit me and others to change my beliefs?
  (NCCC, n.d.)

It is important for clinicians and case managers to focus on remaining open and compassionate by consciously intending to set aside assumptions and get to know a patient as an individual. For example, when first meeting a new patient who is a transgender man, the clinician can imagine what it might be like for this person to see a new provider for the first time. Instead of focusing on the patient's gender identity and when or if he has transitioned, the clinician or case manager can focus on getting to know him as a person, such as understanding where he lives and works and more about his family support.

IMPLICIT BIAS

The term *implicit bias* (also referred to as *unconscious bias*) refers to the idea that human beings are not neutral in their judgment and behavior and that unconscious experience-based associations and preferences/aversions occur outside our control. Such biases may lead to unequal treatment of others based on race, ethnicity, nationality, gender, gender identity, sexual orientation, religion, socioeconomic status, age, disability, or other characteristics (LERU, 2018).

Researchers have designed tests that make implicit biases visible. For instance, Harvard University's Project Implicit has developed implicit association tests that can identify preconceived in-group preferences and implicit biases in individuals. (See "Resources" at the end of this course.)

Institutional Nondiscrimination Statements

AMERICAN NURSES ASSOCIATION (ANA)

The ANA (2018) advocates for continued efforts to eliminate discrimination in healthcare, as described in the following statement:

> The American Nurses Association (ANA) recognizes progress in most national efforts to eliminate discrimination associated with race, gender, and socioeconomic status through improving access to and attainment of health care, and quality of health care. However, concerted efforts must continue for discrimination to be eliminated in all of its forms. ANA recognizes impartiality begins at the level of the individual nurse and should occur within every health care organization. All nurses must recognize the potential impact of unconscious bias and practices contributing to discrimination, and actively seek opportunities to promote inclusion of all people in the provision of quality health care while eradicating disparities. ANA supports policy initiatives directed toward abolishing all forms of discrimination.

AMERICAN PHYSICAL THERAPY ASSOCIATION (APTA)

The APTA (2019) published the following nondiscrimination statement:

> The American Physical Therapy Association opposes discrimination on the basis of race, creed, color, sex, gender, gender identity, gender expression, age, national or ethnic origin, sexual orientation, disability, or health status.

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA)

The AOTA's vision statement (2021) affirms its commitment to diversity, equity, and inclusion, as follows:

> AOTA is committed to creating an environment where all people within our professional community are valued and able to give their best in the communities where they live and work. AOTA strives to recognize and uplift the diversity of our profession and is committed to creating opportunities to foster inclusivity, participation, and representation. We will act with intention and live our values to be inclusive, equitable, just, and accountable in this work.

THE JOINT COMMISSION (TJC)

Joint Commission ambulatory care standards address discrimination and a patient's right to have an advocate: "As a patient, you have the right to be informed about and make decisions regarding your care. You also have the right to care that is free from discrimination as well as the right to have a patient advocate" (TJC, 2019).

CULTURALLY COMPETENT CARE FOR PATIENTS OF ALL RACES, ETHNICITIES, AND RELIGIONS

Health Disparities and Health Risk Factors

Racial minority groups in the United States have higher rates of morbidity and mortality and a greater range of health conditions such as diabetes, hypertension, obesity, asthma, and heart disease compared to White people. In fact, the life expectancy of a White American is 4 years longer than that of a non-Hispanic Black American (CDC, 2023a). Black, Hispanic, and Asian Americans experience a greater number of chronic comorbidities than their White counterparts and have more limited access to healthcare (Lopez et al., 2021).

Examples of these specific health disparities include:

- Black individuals between the ages of 51 and 55 are 28% more likely to have a chronic health condition than White people in the same demographic.
- Black males have a four times greater risk of being diagnosed with schizophrenia than White males.
- Results from a study showed that providers are more likely to diagnose a White person with alcohol use disorder than an Asian American even though both have the same symptoms.
- A study conducted in 2020 concluded that Black people were 1.26 times more likely than White people to die in the emergency room or hospital.
- A Black woman is far more likely to die in childbirth than a White woman, and in 2021, non-Hispanic Black women died 2.6 times more often from pregnancy-related complications than non-Hispanic White women in the United States.
- Black infants were more than twice as likely to die compared to White infants in 2021.
- In 2021, Black, Hispanic, and Asian adults were less likely to use mental health services than White adults.
- American Indian, Alaskan Native, and Hispanic people were more than twice as likely to be uninsured in 2021 as White people.
- In the 2021–2022 flu season, approximately 60% of Hispanic, Black, American Indian, and Alaskan Native adults did not receive a flu vaccination, while less than half of White adults did not receive a flu vaccination.
- Between 2019 and 2021, American Indian, Alaskan Native, Hispanic, and Black people encountered greater declines in life expectancy compared to White people.
(CDC, 2023b; Rees, 2020; Hill et al., 2023)

RACIAL DISCRIMINATION AND THE COVID-19 PANDEMIC

The recent COVID-19 pandemic highlighted the disproportionate health outcomes that marginalized groups experience. Compared with White people, Black, Hispanic, and Asian people experienced increased rates of infection with the virus, hospitalization, and death. The mortality rate for Black patients and Hispanic patients from COVID-19 on July 20, 2020, was 5.6 per 10,000, while the mortality rate for White patients was less than half that, at 2.3 per 10,000.

Approximately 1.6 million Hispanic individuals in the United States lost their healthcare insurance in 2020 during the beginning months of the pandemic. Insurance status, comorbidities, and geographic location of care all play a part in the disparities between care of racial minorities. Studies have shown that patients who are not proficient in English also experience worse health outcomes (Lopez et al., 2021).

Best Practices for Culturally Competent Care for Patients of All Races, Ethnicities, and Religions

Best practices for culturally competent care include screening and providing resources to address needs related to health disparities, learning about racial and ethnic differences among diverse populations, being more inclusive of alternative methods of healing, and being aware of how personal religious beliefs can impact care of the patient.

RACE AND ETHNICITY BIAS

Race and ethnicity bias is a form of bias that occurs when people make assumptions based on others' race or ethnicity. Example: One study showed that White medical students thought that Black people were more tolerant of pain than White people (Rees, 2020). This false belief may cause a provider to underprescribe pain medication to Black people. This type of bias can be explicit, implicit, or both.

SCREEN FOR SOCIAL NEEDS

Black and Hispanic households have had a lower median household income than White households since the U.S. Census Bureau began collecting data in 1967. In 2022, the median household incomes were:

- $52,860 for a Black household
- $62,800 for a Hispanic household
- $81,060 for a non-Hispanic White household
  (Guzman & Kollar, 2023)

Individuals in lower income households may have a harder time obtaining health insurance or paying for costly procedures and medications. They may also have reduced access to resources necessary to promoting a healthy quality of life, such as stable housing and fresh, unprocessed foods (ODPHP, n.d.).

Clinicians should screen all patients for needs related to healthcare, housing, food, and legal assistance, and then provide information and resources that can address these needs. Health disparities can be addressed through improved access to care and access to basic needs that can improve patients' health (Lopez et al., 2021).

LEARN ABOUT HEALTHCARE NEEDS FOR PATIENTS OF VARIOUS RACES AND ETHNICITIES

A patient's race, ethnicity, or religion may contribute to various healthcare-related considerations:

- Physiologic variations make some groups more prone to certain diseases and conditions, such as sickle cell anemia among non-Hispanic Black Americans or Tay-Sachs disease among Eastern European Jews.
- A patient's reaction to pain may be culturally prescribed; for example, Middle Eastern and Hispanic cultures encourage the open expression of emotions related to pain while Asian cultures value stoicism.
- Different ethnic groups have different norms of psychological well-being and acceptance of mental illness.
- Perceptions of appropriate personal space and physical contact, including between the sexes, vary among cultures.
- Different food preferences among cultural groups can be a factor in whether a patient is receiving adequate nutrition while in a hospital or other healthcare setting.
- Cultural views on sex roles, families, and relationships may impact areas such as decision-making, privacy, and information sharing among patients, loved ones, and healthcare providers.
- Most cultures use traditional herbal remedies, so it is important to ask a patient if they are taking anything in addition to prescriptions.
  (Taylor et al., 2019; Galanti, 2019)

Common Healthcare Considerations for Native American Patients

Native Americans, Native Hawaiians, and Pacific Islanders comprise a small part of the U.S. population, but it is important to recognize that they identify differently than the more common "White," "Black or African American," and "Hispanic or Latino" racial and ethnic categories. Clinicians need to educate themselves about diverse populations and learn how to respectfully inquire about a patient's cultural background (Dillard et al., 2021).

Healthcare considerations for Native American patients can include:

- A patient who avoids eye contact may be doing so as a sign of respect and not because they are not paying attention.
- Individual illness is often seen as a family matter, and family usually likes to be involved.
- During labor and delivery, the laboring person may be encouraged to be stoic.
- Long hair is often considered to be an indicator of a healthy child, and they may believe cutting it could lead to illness or death.
- Negative thoughts are believed to expedite death, so a patient may not want to talk about a terminal prognosis or do-not-attempt-resuscitation order (DNAR).
- Tobacco may be viewed as sacred, which can pose challenges when trying to counsel a patient to quit smoking.
  (Galanti, 2019)

Common Healthcare Considerations for Black Patients

Healthcare considerations for non-Hispanic Black patients can include:

- Certain types of cancer, such as prostate and cervical, have high mortality rates among African Americans. This may be due to general mistrust of hospitals and healthcare in general, which leads to delayed screening.
- Organ and blood donation may be considered taboo out of fear that it will expedite the donor's death.
- "High" blood could be confused with high blood pressure in some southern U.S. states. Red meat may be thought to cause "high" blood, and "low" blood may be thought to occur from too much vinegar, lemon juice, and garlic.
- A possible reluctancy to trust doctors and hospitals due to a long history of racial health disparities and being discriminated against.
  (Galanti, 2019)

Common Healthcare Considerations for White Patients

Healthcare considerations for White American patients can include:

- Husbands and wives typically share equal authority when making healthcare decisions for their child.
- There are usually no postpartum rituals.
- Some believe that childhood vaccines cause autism and may refuse to allow their children to be vaccinated.
- Stoicism is often expected after someone dies.
- Aggressive approaches to illness are usually preferred.
- Antibiotics are often asked for by patients because germs are considered to be the cause of disease.
- Patients frequently research health information online and may request treatments based on their own Internet search.
  (Galanti, 2019)

Common Healthcare Considerations for Hispanic Patients

Healthcare considerations for Hispanic patients can include:

- Large, extended families may visit the patient and show their love by spending as much time with the patient as they can.
- There may be a hesitancy to discuss emotional and psychological issues, especially by Hispanic males.

- Wives may prefer that their husbands make decisions for both their own health and the health of their children.
- The laboring person may be stoic during labor.
- Prenatal care may not be considered necessary since some believe that pregnancy is a normal condition.
- Room temperature or hot water to drink may be preferred when a person is ill due to beliefs about the hot/cold balance of the body.
- Hospice may be refused by family members who believe it will cause their loved one to give up hope and their will to live.
  (Galanti, 2019)

Common Healthcare Considerations for Southeast Asian Patients

Healthcare considerations for Southeast Asian (from Cambodia, Laos, and Vietnam) patients can include:

- Many are Buddhist and believe in reincarnation.
- Modesty is typically very important, and extra time may be needed to accommodate modesty concerns during procedures.
- Giggling at what would be considered an "inappropriate" time may indicate a patient is nervous or uncomfortable.
- It may be preferred that the eldest male relative is addressed first when a patient arrives with relatives.
- A baby may not be considered "human" until a few days after birth; this may have evolved as a defense mechanism from high infant mortality rates to keep mothers from bonding too early.
- Intravenous lines should not be put in an infant's scalp when possible because the head is often considered to be personal, vulnerable, and untouchable.
- Family members may request to wash the body after death and place a coin in the deceased family member's mouth.
- Surgery may be feared due to the belief that the soul is connected to different parts of the body and that surgery could sever the connection.
  (Galanti, 2019)

Common Healthcare Considerations for East Asian Patients

Healthcare considerations for Asian patients from China, Japan, Korea, and the Philippines can include:

- Respecting and providing for one's parents is highly valued.

- Hand gestures like gesturing to come with the index finger may be considered an insult to Filipinos and Koreans.
- It is considered polite to refuse at first, so interventions such as pain medication may need to be offered more than once before the patient agrees.
- Pronouns are nonexistent in most Asian languages, and the words *he* or *she* in English could be mixed up by the patient or misunderstood.
- Stoicism while in pain is valued; it is important to offer pain medication regularly based on the situation and using body language as an indicator that it may be needed.
- New birthing parents often do not bathe or exercise for the first month after giving birth.
- Some skin lesions (e.g., "Mongolian spots") are birthmarks that are more common for Asian infants; they can be mistaken for bruises.
- Cancer is often greatly feared and stigmatized, so it can be helpful to refer to cancer as a "growth" and chemotherapy as "medication."
- The words for the number "4" and "death" are pronounced the same way in many Asian languages, so Asian patients may want to avoid being admitted to rooms like 4 or 14. (Galanti, 2019)

BE MORE INCLUSIVE OF NON-WESTERN MEDICINE METHODS OF HEALING

Clinicians can broaden their perspectives and educate themselves about non-Western medicine and holistic methods of healing that patients may use in order to better care for such patients. Results from a cross-sectional survey of 144 healthcare professionals indicated that 80% of respondents knew how socioeconomic factors affect health, but only 9% of the same respondents indicated knowledge of various alternative healing traditions (Dillard et al., 2021).

LEARN ABOUT HOW A PATIENT'S RELIGION IMPACTS THEIR HEALTHCARE

A patient's religion/spirituality is often an important consideration in regard to medical decisions and culturally competent care. Therefore, healthcare providers must be aware of and respectful of a patient's religious beliefs as they relate to issues such as diet, medicines that may include animal products, modesty, the preferred gender of their health providers, prayer times that may interfere with treatment regimens, and more.

Examples of beliefs in specific religions that may need to be accommodated during the care of the patient include:

- Adherents of Buddhism may refuse mind-altering medication during the dying process.
- In the Church of Jesus Christ of Latter-day Saints (Mormon) religion, individuals are not supposed to drink alcohol, coffee, or tea.
- In Hinduism, the right hand is used to eat, and the left hand is used for hygiene and going to the bathroom.

- Muslims who practice Islam do not eat pork, and contact between genders is not allowed.
- Jehovah's Witnesses do not accept blood transfusions and do not eat food that has blood in it.
- Kosher laws that prescribe certain dietary restrictions are followed by some Jews. Likewise, in some Jewish religious movements, cremation is not allowed, and amputated limbs are buried in consecrated ground.
- Roman Catholics do not eat meat on Fridays, particularly during the season of Lent.
- Seventh-day Adventist members may refuse narcotics or stimulants.
- Adherents of Sikhism are not permitted to cut hair on any part of their body. (Swihart et al., 2023)

Similarly, many patients may turn to their religious faith in order to reduce their anxieties, respond to healthcare challenges, and make difficult healthcare decisions, including end-of-life care and preparations. Health professionals should therefore provide an opportunity for patients to discuss their religious and spiritual beliefs and tailor their evaluation and treatment to meet patients' specific needs.

In addition to an awareness of Protestant, Catholic, Jewish, and Muslim religions, providers should learn about the different religions and be aware of how their own personal religious beliefs could vary from those of the patient. Even though the primary religion in the United States is Christianity, education about other religions with which a portion of patients identify can improve the understanding of the clinician and help them to provide better care.

HOPE QUESTIONNAIRE

The HOPE Questionnaire is one tool that can be used to incorporate a spiritual assessment into an interview conducted by the healthcare professional. This type of resource can encourage providers to become more unbiased, more patient focused, and less judgmental regarding the religious choices of their patients (Dillard et al., 2021).

H – Hope

- What are your sources of hope, strength, comfort, and peace?
- What do you hold on to during difficult times?
- What sustains you and keeps you going?
- For some people, their religious or spiritual beliefs act as a source of comfort and strength in dealing with life's ups and downs; is this true for you?

O – Organized Religion

- Do you consider yourself part of an organized religion?

- How important is this to you?
- What aspects of your religion are helpful and not so helpful to you?
- Are you part of a religious or spiritual community? Does it help you? How?

P – Personal Spiritual Practice

- Do you have personal spiritual beliefs that are independent of organized religion? What are they?
- What aspects of your spirituality or spiritual practices do you find most helpful to you personally?
- Do you believe in God? What kind of relationship do you have with God?

E – Effects on Care

- Does your current situation affect your ability to do things that usually help you spiritually? (Or affect your relationship with God?)
- Is there anything that I can do to help you access the resources that usually help you?
- Are there any specific practices or restrictions I should know about in providing your care?
- (If the patient is dying) How do your beliefs affect the kind of medical care you would like me to provide over the next few days/weeks/months?

(Whitehead et al., 2022)

THE NATIONAL INSTITUTES OF HEALTH UNITE INITIATIVE

The UNITE Initiative was created by the National Institutes of Health (NIH) to promote racial equity and inclusion and eliminate structural racism. Structural racism is defined as "organizational structures, policies, practices, and social norms that perpetuate bias, prejudice, discrimination, and racism." Structural racism has led to health disparities, low health status, and premature mortality of marginalized groups. To address and eliminate structural racism, the UNITE Initiative is comprised of five committees with the following goals:

- U – Understanding stakeholder experiences through listening and learning
- N – New research on health disparities, minority health, and health equity
- I – Improving the NIH culture and structure for equity, inclusion, and excellence
- T – Transparency, communication, and accountability with our internal and external stakeholders

- E – Extramural research ecosystem: changing policy, culture, and structure to promote workforce diversity

(NIH, n.d.)

CULTURALLY COMPETENT CARE FOR LGBTQ+ PATIENTS

Even though social acceptance of LGBTQ+ individuals has been increasing, LGBTQ+ patients continue to face barriers to culturally competent care, including stigma and discrimination. For these patients, access to healthcare that is unbiased and culturally affirming remains a challenge in most parts of the United States (Butler et al., 2016).

LGBTQ+ ACRONYM

The acronym *LGBTQ+* is an umbrella term used to refer to the lesbian, gay, bisexual, transgender, and queer/questioning populations. The "+" designation is included to encompass additional populations (e.g., intersex [I], asexual [A], genderfluid, and others) that are not explicitly referred to by the acronym *LGBTQ* alone.

It is not uncommon for a person who identifies as lesbian, gay, bisexual, transgender, or questioning/queer (LGBTQ) to have had negative experiences in the healthcare environment due to discrimination and/or stigmatization based on their sexual orientation and/or gender identity. Such encounters may occur due to cultural bias or a lack of awareness and understanding by the provider of the healthcare needs and goals of such individuals.

Negative encounters immediately affect the patient's trust of the healthcare system and marginalize their needs. Continuing stigma makes many patients reluctant to reveal their sexual orientation or gender identity to healthcare providers even though this information can be important to receiving individualized care.

Even though social acceptance has been increasing and laws and policies are changing, LGBTQ+ individuals continue to face barriers, stigma, bias, and discrimination. Access to healthcare that is unbiased and culturally affirming remains a challenge in most parts of the United States.

People within the LGBTQ+ population are extraordinarily diverse, representing every social class and ethnicity in every geographical area and every profession (HRC, 2020). Healthcare professionals who practice cultural sensitivity in working with LGBTQ+ patients can have a positive impact and increase trust as they continue to understand the individual needs of their patients.

Terms and Definitions

To better understand the LGBTQ+ population and their unique health concerns, it is important to define and clarify some basic concepts of gender identity and sexual orientation. Terms and definitions are ever evolving, and clinicians must update their knowledge regularly to provide effective and respectful care for all patients. It is also important that clinicians have the comfort and sensitivity to ask their patients how they would like to be addressed in terms of identifiers of gender identity and sexual orientation in a respectful, honest, and open-minded manner.

(Terminology described in this course is taken from recognized sources at the time the course was written. These terms may not reflect every individual's personal preference, may become outdated even as they are mentioned in current clinical references, and may not reflect all local and regional variations.)

- **Anatomical sex:** the presence of certain female or male biologic anatomy (including genitals, chromosomes, hormones, etc.); also referred to as ***assigned sex at birth (ASAB)***
- **Asexual (A):** people with no or little sexual attraction to other people
- **Bisexual (B):** men and women who are sexually attracted to people who are both the same as and different than their own gender
- **Cisgender:** people whose gender identity aligns with the sex they were assigned at birth, i.e., the opposite of *transgender* or *gender diverse*
- **Gay (G):** a person who is attracted to someone of the same gender; historically, the term referred to men who are attracted to men, but it may also be used by women to refer to themselves
- **Gender diverse (also *gender nonconforming, gender variant,* and *gender creative*):** a person who embodies gender roles and/or gender expression that do not match social and cultural expectations
- **Gender expression:** the way a person presents their gender in society, through social roles, clothing, makeup, mannerisms, etc.
- **Gender identity:** a person's internal sense of being a male/man, female/woman, both, neither, or another gender
- **Genderfluid or genderqueer (also called *nonbinary*):** people who do not strictly identify as male or female; a mix of male and female (genderqueer/genderfluid); neither male nor female (nonbinary); or no gender at all
- **Intersex (I):** people with an indeterminate mix of primary and secondary sex characteristics, such as a person born appearing to be female "outside" who has mostly male anatomy "inside," a person born with genitals that are a mix of male and female types (a female born with a large clitoris or without a vaginal opening, or a male born with a small penis or a divided scrotum that has formed like labia); may identify as either cisgender or gender diverse
- **Lesbian (L):** women who are attracted to women

- **MSM:** men who have sex with men
- **Queer:** an umbrella term for all who are not heterosexual or who are not 100% clear of their sexual orientation and/or gender identity
- **Questioning (Q):** a person who is in the process of discovery and exploration of their sexual orientation, gender identity, or gender expression
- **Sexual orientation:** how a person identifies their sexuality, including who they are physically and emotionally attracted to and with whom they choose to have sex; a person may not have a sexual attraction to others (asexual)
- **Transgender (T):** People with gender identities that do not align with their assigned sex at birth; some transgender individuals may alter their physical appearance and often undergo hormonal therapy or surgeries to affirm their gender identity. However, medical intervention is not required for a person to identify as transgender. Some transgender people do not undergo the medical transition process for a variety of reasons, including cost or other health concerns. Gender identity terms that may be used by transgender people to describe themselves include:
    - Demiboy: a person who feels their gender identity is partially male, regardless of assigned sex at birth
    - Demigirl: a person who feels their gender identity is partially female, regardless of assigned sex at birth
    - Transgender female/woman, trans woman: a transgender person who was assigned male at birth (AMAB) but who identifies as female; formerly referred to as *male-to-female (MTF)*
    - Transgender male/man, trans man: a transgender person who was assigned female at birth (AFAB) but who identifies as male; formerly referred to as *female-to-male (FTM)*
- **WSW:** women who have sex with women

(AECF, 2021; APA, 2022; PFLAG, 2022)

CULTURE AND TERMINOLOGY

Terms for sexual orientation and gender identity vary according to culture. For example, *two-spirit* is a non-Western term used by some Indigenous populations to describe gender identity, sexual identity, and/or spiritual identity. Some Indigenous languages do not have terms such as gay, lesbian, or bisexual and instead describe what people do rather than how they identify (Researching for LGBTQ2S+ Health, n.d.).

TERMS AND CONCEPTS THAT MAY BE MARGINALIZING

Terms that marginalize and stigmatize people who are LGBTQ+ are still common. Also, some words previously used and accepted in the medical community may no longer be in common usage or considered acceptable/respectful today. Examples include:

- Homosexual
- Sexual preference
- Transvestite
- Male-to-female (MTF) transgender
- Female-to-male (FTM) transgender
(PFLAG, 2022; GLAAD, n.d.)

Examples of concepts that may contribute to societal stigmas for LGBTQ+ patients include:

- Heterosexism: the general presumption that everyone is straight or the belief that heterosexuality is a superior expression of sexuality
- Homophobia: negative attitudes and feelings toward people with nonheterosexual sexualities; may include discomfort with expressions of sexuality that do not conform to heterosexual norms
- Internalized oppression: the belief that straight and cisgender people are "normal" or better than LGBTQ+ people, as well as the often-unconscious belief that negative stereotypes about LGBTQ+ people are true
- Transphobia: negative attitudes and feelings toward transgender people or discomfort with people whose gender identity and/or gender expression do not align with traditionally accepted gender roles
(PFLAG, 2022; Ni, 2020)

Health Disparities and Health Risk Factors

The LGBTQ+ population is diverse in terms of race, ethnicity, disability, and socioeconomic status. Therefore, risk factors and disparities in each patient will vary depending on these individual factors. (See discussion below on specific population groups.)

Research has uncovered that LGBTQ+ individuals often face health disparities related to societal stigma, discrimination, and denial of civil and human rights in some manner. Discrimination has been linked to higher rates of psychiatric disorders, substance abuse disorders, and suicide. Violence and victimization are also more common and have lifelong consequences to the individual and the community as a whole. Personal, family, and social acceptance of an individual's sexual orientation and gender identity often affects these individuals' mental health and personal safety (Medina-Martinez et al., 2021).

Individuals who identify as LGBTQ+ may also experience minority stress. Minority stress theory connects health disparities among individuals to stressors induced by a hostile, homophobic culture in society as a whole. This often results in experiences of prejudice, internal expectations of rejection, and internalized homophobia. Aspects of minority stress, including the perception of

prejudice, stigma, or rejection, are associated with higher rates of depression and dysfunctional coping strategies (Hoy-Ellis, 2021).

LGBTQ+ populations experience a greater prevalence of mental health distress and diagnosis, such as:

- Anxiety and depression
- Suicidal ideation and attempts
- Other forms of emotional, physical, and sexual trauma (such as intimate partner violence) (Hoy-Ellis, 2021; Coleman et al., 2022)

Gay, lesbian, and bisexual adolescents and young adults have higher rates of tobacco and alcohol use, substance abuse, eating disorders, and risky sexual behaviors. This may be due to a higher level of psychological distress (CDC, 2022d; The Trevor Project, 2020, 2022).

MEN WHO HAVE SEX WITH MEN (MSM)

The most researched health disparity among MSM is HIV/AIDS incidence and prevalence. In 2018, 81% of new HIV cases among men occurred in MSM (CDC, 2020a). Gay, bisexual, and other MSM have also been found to be at increased risk of other sexually transmitted infections (STIs) (CDC, 2022a), including:

- Syphilis
- Gonorrhea
- Chlamydia
- Human papillomavirus (HPV)
- Hepatitis A and B

Gay men are also at an increased risk of cancers, including prostate, testicular, anal, and colon, which may be related to limited cancer screening and prevention services for this population (Domogauer et al., 2022). Moreover, MSM are also at higher risk for tobacco and drug use and depression (CDC, 2022b).

Clinical Implications

When providing care for MSM, clinicians and case managers should not assume that the individual is engaged in actions that increase the risk for certain disorders; a history should first be performed to understand the individual's risk (HEC, 2021). Understanding the risk factors and health disparities for MSM, it is important to address the unique clinical concerns for this population through:

- Regular assessment and screening for STIs and HIV

- Routine vaccination for hepatitis A, hepatitis B, and HPV
- Prevention and screening for prostate, testicular, anal, oral (head and neck), and colon cancers
(CDC, 2022a)

WOMEN WHO HAVE SEX WITH WOMEN (WSW)

Lesbian and bisexual women are more likely to be obese and to use tobacco and alcohol than heterosexual women. Stress may be a contributing factor to the increased substance use or abuse in this population. WSW are also at increased risk for depression and anxiety disorders and are less likely to receive routine reproductive care. Lesbian women are also less likely to access cancer screening and prevention services (Office on Women's Health, 2020; Open Access Government, 2020; ACS, 2021).

Lesbian women may be at a higher risk for uterine, breast, cervical, endometrial, and ovarian cancers for some of the factors listed above (ACS, 2021). Also, lesbians have traditionally been less likely to bear children, and hormones released during pregnancy and breastfeeding are believed to protect women against breast, endometrial, and ovarian cancers (WebMD, 2020).

Clinical Implications

Clinicians and case managers working with WSW should carefully assess and address the multiple risks that this population faces by providing:

- Preventive and wellness care to prevent or treat tobacco use/abuse and alcohol use/abuse
- Screening and early identification of behavioral health concerns such as depression or anxiety
- Regular preventive care and screening for uterine, breast, cervical, endometrial, and ovarian cancers
- Programs for healthy weight and exercise
(WebMD, 2020)

TRANSGENDER AND GENDER DIVERSE

Transgender individuals often face victimization, violence, and minority stress, and they are less likely to have access to health insurance for a variety of reasons. Transgender individuals have a higher prevalence of:

- HIV
- Sexually transmitted infections (STIs)
- Behavioral health disorders
- Suicide

(CDC, 2022c; CDC, 2021; NAMI, 2022)

Clinical Implications

Caring for transgender patients therefore includes screening for the following risks, as appropriate:

- Access to appropriate health insurance
- Violence
- Minority stress
- HIV
- STIs
- Suicide
- Behavioral health disorders
  (Caughey et al., 2021; Eder et al., 2021; Goldsmith & Bell, 2022)

GENDER-AFFIRMING MEDICAL INTERVENTIONS

Some transgender individuals desire to undergo medical interventions to alter their outward appearance and secondary sex characteristics in order to feel aligned in their body with their gender, while others do not desire this intervention. It is important to recognize the unique needs of these patients as they make decisions about transition-related care and treatment.

Some surgical treatments can take years, with multiple procedures needed to complete a gender-affirming transition. Education on preparation, treatment, supportive care, and follow-up care are essential to support transgender patients in this process. In many cases, gender-affirming surgeries are done at specialty centers, so it is important to understand where this care can be obtained and how to refer patients to these services, while also tending to their healthcare needs before, during, and after treatment for transition (Coleman et al., 2022).

ADOLESCENTS AND YOUNG ADULTS

Many concerns may impact the health and well-being of an LGBTQ+ individual. This is especially true for adolescents, who are in the process of navigating developmental milestones along with sexual orientation and gender identity.

Young adults who “come out” may be faced with bullying from their peers or family rejection. LGBTQ+ youth have high rates of substance abuse, STIs, and homelessness (Hao et al., 2021). They have an increased risk of depression, suicidal ideation, and substance use, including tobacco, alcohol, cannabis, cocaine, ecstasy, and heroin (The Trevor Project, 2020, 2021).

Research has shown that LGBTQ+ adolescents and young adults with family acceptance have greater self-esteem, more social support, and better health outcomes. This acceptance also reduces the risk of substance abuse, depression, and suicide (Delphin-Rittmon, 2022).

Clinical Implications

Clinicians and case managers working with this population should pay careful attention to subtle clues and risk factors of each individual, as adolescents and young adults may be especially reticent to discuss their concerns. Careful assessment focuses on:

- Evidence or risk of bullying
- Dysfunctional family dynamics
- Substance abuse risks
- Depression screening
- Suicide risks
- STI screening
- HPV vaccination
- Home living conditions
  (Hao et al., 2021; Eder et al., 2021)

CASE

Mark is a 38-year-old presenting to the urgent care clinic with UTI symptoms. The nurse practitioner, Jocelyn (she/her), asks Mark about pronouns, and Mark responds with "they/them." Mark describes to Jocelyn their concern about having three UTIs in the past three months.

According to the medical record, Mark is male and currently taking testosterone and bupropion. The nurse practitioner confirms this information, stating "I see on your intake form that you marked your gender identity as trans man. Is that correct?" Mark nods and replies, "Thank you for acknowledging this. Most providers ignore my gender identity." Jocelyn then asks about sexual orientation, and Mark responds, "I am gay and have a male partner." She documents Mark's responses so that the medical record accurately reflects sexual orientation and gender identity.

It could be easy to assume that Mark's genitals and organs match their outward male appearance and gender identity. But due to Mark's medication history and in order to clarify, Jocelyn asks which organs Mark has. She explains that asking Mark about their organs is important to determine whether there may be another medical reason Mark is having repeated UTIs. Mark reports having ovaries, a uterus, and a vagina. Jocelyn then explains to Mark that UTIs are common in people with frontal genital openings or vaginas.

Aware that using public restrooms can be uncomfortable or unsafe for some transgender people, Jocelyn asks if Mark is always able to empty their bladder when it is full or if there are times or situations where they are not able to do this. Mark responds that they are able to empty their bladder now but that prior to top surgery (six months ago), they did not feel comfortable or safe using either female or male public restrooms due to a large chest.

Ruling this out as an issue that might be contributing to Mark's UTIs, Jocelyn explains how testosterone can lead to vaginal atrophy and that the urethra is estrogen responsive. Since Mark is having repeated UTIs, it may be helpful to treat them with a course of vaginal estrogen.

Since Jocelyn has normalized the discussion of Mark's UTIs and gender identity, Mark leaves the office not only feeling very affirmed in their gender, but also relieved to understand that there is a medical reason for their continued infections.

BEST PRACTICES REGARDING PATIENT INFORMATION

Appropriate data collection and privacy policies can lead to improved access, quality of care, and outcomes (Medina & Mahowald, 2022). All healthcare institutions are encouraged to integrate data related to sexual orientation and gender identity into medical records. Data collection on intake and other forms should allow for appropriate responses that are inclusive of LGBTQ+ patients. Best practices when collecting data include asking questions about gender first, then sexual orientation, followed by relationship status (Grasso et al., 2021; National LGBT HEC, 2022).

Best Practices for Culturally Competent Care

LGBTQ+ patients, particularly those who identify as transgender or nonbinary, often face barriers to accessing healthcare services due to the lack of provider understanding of their gender identities. Providing high-quality, culturally competent, patient-centered care is a complex process that requires ongoing learning and awareness of the various factors that affect the LGBTQ+ population.

Even healthcare organizations that have taken positive steps toward improving cultural competency for LGBTQ+ patients will find new ways to address barriers to care and engage staff in improvement initiatives. Improving skills and knowledge among healthcare leaders, providers, and staff should be looked at as opportunities rather than as organizational or individual weaknesses.

PHYSICAL SPACE

Best practices start at the front door and extend into the provider's office and treatment areas. Everything from the hospital website to the front desk and waiting areas should reflect a healthcare setting that is welcoming, open, and inclusive.

- Include gender-neutral restrooms and signage.
- Post signage to affirm nondiscrimination policies that include sexual orientation, gender identity, and gender expression.
- Evaluate environmental factors of potential concern for LGBTQ+ patients and families, such as bathroom designations, artwork, posters, educational brochures, etc. (Reynolds, 2020)

INTERNET AND WEBSITE

Informational, educational, and support materials should be designed to help LGBTQ+ patients feel comfortable and supported in the healthcare setting.

- Include inclusive language on any websites and marketing materials that describes a commitment to high-quality, culturally competent, patient-centered care.
- Ensure that marketing, advertising, and informational materials reflect diverse populations, including same-sex couples and families.
- Create a separate webpage or portal for information and resources related to LGBTQ+ care.
  (National LGBTQIA+ HEC, 2021)

SUPPORTIVE COMMUNICATION

An individual may delay or avoid accessing care due to the fear that their provider may not take their gender identity and pronouns seriously or be entirely dismissive of them, causing them to feel "invisible." There are many ways that a healthcare provider and support staff can communicate with patients to help them feel respected and comfortable.

- Avoid the use of gendered titles such as "Sir" or "Ma'am." Instead of Mr. or Ms., patients may also wish to be addressed as Mx. (pronounced with a "ks" or "x" sound at the end).
- Introduce yourself with your pronouns. Ask patients for information such as their pronouns, preferred name, and gender identity. Pronouns may include: he/his/him, she/hers/her, or a range of options for nonbinary transgender patients, such as they/their/them, ve, xe, ze, per, and ey. Always respect the patient's pronouns and apologize if the wrong pronouns are used by mistake.
- Always ask for clarification when not clear what a patient would like to be called or how the patient would like to be addressed. Apologize if you refer to a patient in a way that seemed offensive.

- Ask patients what terms they use to refer to their anatomy, and mirror those terms during the patient interaction. Transgender patients may experience gender dysphoria and/or may not be comfortable with traditional terms for body parts.
- Ask the patient to clarify any terms or behaviors that are unfamiliar, or repeat a patient's term with your own understanding of its meaning to make sure you have a good understanding of what it means to them.
- Do not make assumptions about patients' sexual orientations, gender identities, beliefs, or concerns based on physical characteristics such as clothing, tone of voice, perceived femininity/masculinity, etc.
- Do not be afraid to tell a patient about one's own inexperience working with LGBTQ+ patients. Honesty and openness will often stand out to a patient from their previous healthcare experiences.
- Do not ask patients questions about sexual orientation or gender identity that are not material to their care or treatment.
- Do not disclose patients' sexual orientations or gender identities to individuals who do not explicitly need the information as part of the patients' care.
- Keep in mind that sexual orientation and gender identity are only two factors that contribute to a patient's overall identity and experience. Other factors—including race, ethnicity, religion, socioeconomic status, education level, and income—also contribute to the patient's experiences, perceptions, and potential barriers to healthcare.
  (Reynolds, 2020; LGBTQ+ Resource Center, 2024; Garrett, 2022)

INSTITUTIONAL POLICIES AND PRACTICES

In order to provide culturally competent care, institutions must assess current organizational practices and identify gaps in policies and services related to care and services for LGBTQ+ patients. This also includes ensuring that policies comply with all federal and state regulations.

Recommendations to build awareness within an organization about the LGBTQ+ community include:

- Hold an open discussion with healthcare professionals and staff about the difference between sexual orientation (lesbian, gay, bisexual, etc.) and gender identity (transgender, nonbinary, intersex, etc.), since this can be confusing to those who are not familiar with such concepts.
- If not already in place, establish a point person, office, or advisory group to oversee LGBTQ-related policies and concerns, ideally including members representing the LGBTQ+ community.
- For inpatient facilities, review visitation policies to empower patients to decide who can visit them and act on their behalf.

- Review codes of conduct and ethics to ensure they include expectations for respectful communication with all patients, visitors, and staff members and that they specify consequences for code violations.
- Provide training and orientation on a regular basis to professionals and staff on culturally competent care and organizational policies related to conduct, ethics, privacy, nondiscrimination, and antiharassment policies.
(National LGBTQIA+ HEC, 2021)

CULTURALLY COMPETENT CARE FOR CHILDREN AND OLDER ADULTS

The modern family is diverse, and culturally competent care for children involves an awareness of elements of culturally competent care for patients and caregivers of all races, ethnicities, religions, and sexual orientations. Similarly, patients of advanced age may face health disparities related to ageism, which is prejudice based solely on a person's age.

Best Practices for Culturally Competent Care of Children

Culturally competent care of children requires an awareness of cultural differences that may have an impact on growth/development as well as other healthcare-related concerns. For instance:

- Common diets and feeding practices differ among groups and may contribute to nutritional or weight status in children.
- Parenting styles and health promotion behaviors can vary significantly, such as encouraging or discouraging independence in infants and toddlers.
- Practices such as infants and small children sharing a bed with parents may be of significance for the comfort of pediatric inpatients.
- Emotional development, such as acceptance around crying, can be affected by cultural views.
- For adolescents, cultural values and attitudes toward sexuality vary.

Clinicians must consider these and other cultural habits, beliefs, language, and ethnicity in order to provide appropriate care for all children and families (Ricci et al., 2021).

In order to improve health equity, culturally competent care should be provided in primary care, particularly during well-child visits. Results from recent research indicated that care provided in pediatric primary care offices that is rated by caregivers as culturally sensitive is correlated with higher-quality well-child care (Okoniewski et al., 2022).

Examples of interventions that support culturally competent care include:

- Offering the use of language supports, such as professional medical interpreters or healthcare workers qualified to translate, to all patients
- Explaining health issues based on social or cultural values
- Providing evidence of a health issue's influence on a cultural group (Okoniewski et al., 2022)

CASE

Mali is a nurse who works at a pediatrician's office. She is providing an initial assessment for an infant named Hana Li, whose mother has brought her in for her one-month well-child visit. Mali asks the infant's mother to remove the diaper so they can take an accurate weight. Mali notices a blue mark on the infant's left buttock that she thinks may be a bruise. She assesses the area and notes that it is not swollen or tender. Mali points the mark out to the patient's mother, who tells Mali that the infant was born with it.

Mali completes her assessment and lets the mother know that the doctor will be in shortly. Before the pediatrician goes in to see the infant, Mali lets her know of the mark that she saw on the infant and expresses concern that it may be a bruise. The pediatrician looks in the chart to verify that the infant was born with the mark. She shows Mali the previous charting about the mark and explains that some infants, mostly commonly Asian and Native American, are born with a blue-colored skin lesion sometimes referred to as a *Mongolian spot*. She states that the mark usually dissipates as the child gets older and that it can often be mistaken for a bruise. Mali understands that the lesion does not indicate child abuse but is a congenital birthmark that is more common in Asian infants such as Hana (Galanti, 2019).

Best Practices for Culturally Competent Care of Older Adults

Older adults are generally considered to be those ages 65 years and older. In the United States, the population of older adults is expected to double to 83.7 million individuals by 2050 (IHI, 2023). Health disparities become magnified in the older adult population, and issues around race, ethnicity, sex, gender identification, sexual orientation, and disability continue to impact these patients' access to healthcare and outcomes (Taylor et al., 2019).

Older adults have different healthcare needs due to normal physiologic changes of aging, the increasing prevalence of age-related disease, and other psychosocial factors. Despite these differences, culturally competent care for older patients requires nurses to avoid bias and discrimination based on age (referred to as ***ageism***).

Stereotypes about aging, particularly in North America, are primarily negative—a time of ill health, loneliness, dependency, and poor physical and mental functioning (Donizzetti, 2019).

Such negative attitudes toward and discriminatory treatment of older adults are present throughout the healthcare community and affect the quantity and quality of care provided to older patients, putting them at increased risk for undertreatment or overtreatment. For example, if a nurse has the belief that older adults are less healthy, less alert, and more dependent, then their initial assessment of the patient will reflect this belief (Swan & Evans, 2024).

A few common myths and realities about older adults include:

- Myth: Old age means mental deterioration. In reality, neither intelligence nor personality normally decrease because of aging.
- Myth: Older adults are not sexually active. In reality, although less frequent, sexual activity lasts well into their 90s in healthy older adults.
- Myth: Bladder problems are a problem of aging. In reality, incontinence is not a part of aging; it generally has a root cause and requires medical attention.
  (Taylor et al., 2019)

AGEISM AND HEALTHCARE

Ageism arises when age is used to categorize and divide people in ways that lead to harm, disadvantage, and injustice. It can take many forms, including prejudicial attitudes, discriminatory acts, and institutional policies and practices that perpetuate stereotypical beliefs.

Ageism is ingrained in our culture. It remains socially acceptable and is a stubborn prejudice. Ageism messages indicate that being old is something to avoid, and people of all ages show bias against older adults.

In medical settings, stereotypes associated with aging may influence treatment decisions. In the mental health field in particular, age bias and stereotypes can influence attitudes and practices. Many in the mental health field, for example, exhibit a preference against working with older patients, assuming less favorable outcomes for older patients and believing that depression is a natural consequence of older adults (Weir, 2023; WHO, 2021).

“Dwelling on negative aspects of aging can have a measurable negative impact on physical health and the ability to respond to stress.” Negative self-perceptions of aging are associated with a higher prevalence for chronic health conditions, including hypertension, heart disease, lung disease, diabetes, musculoskeletal disorders and injuries, and loss of cognitive function (Rosbach, 2022).

Despite the growing need for more providers with geriatrics expertise, many medical and nursing students come to view the care of older adults as frustrating, uninteresting, and less rewarding overall. Attitudes are further shaped by the persistent misconceptions that older patients are demented, frail, and somehow beyond saving.

Other factors that increase the risk for under- and overtreatment include the decline in the number of providers with advanced geriatrics training. Secondly, more practitioners are opting

out of participation in the Medicare system. Thirdly, older adults are frequently excluded from clinical trials of medications that are meant to help them, resulting in data that are problematic when caring for those with multiple chronic illnesses (Gutterman, 2023).

AGE-FRIENDLY HEALTH SYSTEMS

The Age-Friendly Health Systems initiative recognizes that older adults in the United States deserve safe, effective, and patient-centered care that aims to follow an essential set of evidence-based practices, cause no harm, and align with what matters to the older adult and their family caregivers. Age-Friendly Health Systems include a framework referred to as *4 Ms*:

- What **Matters**: Know what matters to the older adult concerning specific outcome goals and care preferences, and align care with them across settings of care, including end-of-life issues.
- **Medications:** If medications are necessary, prescribe age-friendly ones that do not interfere with what matters to the older adult, their mentation, or their mobility across settings of care.
- **Mentation:** Prevent, identify, treat, and manage delirium across settings of care.
- **Mobility:** Ensure that each older adult moves safely and on a daily basis to maintain function.

(IHI, 2023)

BEST PRACTICES FOR COMMUNICATING EFFECTIVELY WITH THE OLDER ADULT

For the older adult, the ability to communicate effectively is central to self-esteem, identity, and quality of life. For the healthcare provider, effective communication is essential for understanding and assessing older adults and promoting their health.

Therapeutic communication is a person-centered interaction that involves using eye contact, open body language, and active listening. There are three separate subcategories to communication:

- Seeing the individual
- Being respectful
- Showing empathy and compassion

Older adults often report being treated with lack of respect and negative attitudes and receiving insufficient information. It is important to remember that older people are not a homogeneous group but have a wide range of life experiences that influence their perception of illness and their ability to communicate with healthcare professionals. Ineffective communication can cause older

people to feel inadequate, disempowered, and helpless. It is important for providers to treat older people as individuals and to monitor and adapt communication accordingly.

It is helpful for healthcare providers to recognize whether they are communicating by talking with the older adult or talking to them. Older people need and are entitled to be recognized when matters involve them. Even if a person has dementia or memory loss, attention and comments should be directed to the patient.

Following are examples of **practices to enhance communication** with the older patient:

- Addressing the patient face-to-face and by their last name, using the title the patient prefers (e.g., Mr., Ms., Mrs.) until told otherwise
- Avoiding familiar terms such as *Dear* and *Hon/Honey*
- Introducing oneself and showing an interest in wanting to hear the person's concerns
- Providing professional translation services and written material in different languages when needed
- Assessing and matching the person's communication style by listening to the volume, pace, pitch, and tonality (expressive or reserved) of their speech
- Being alert to and compensating for deficits in hearing or vision
- Not rushing and speaking more slowly so that the person will have time to process what is being asked for or said, since feeling rushed often leads to people believing they are not being heard or understood
- Avoiding interrupting, since once interrupted, an older adult is less likely to reveal all of their concerns
- Using active listening skills by facing the patient, maintaining appropriate eye contact, and using brief responses to indicate one has been listening
- Demonstrating empathy by watching for opportunities to respond to the person's emotions
- Avoiding medical jargon and using simple, common language
- Introducing information by first asking patients what they already know about their condition
- Asking if clarification is needed, such as having something written down
- Asking patients to state what they understand about their presenting problem and what they think needs to be done
- Using family history to gain insight into an older patient's social situation as well as risk of disease
- Asking about living arrangements, transportation, and lifestyle to help determine appropriate interventions

- Considering cultural differences and avoiding healthcare provider bias
- Giving clear and specific written notes or printed handouts about their medical conditions (Jack et al., 2019; NIA, 2023)

CASE

Sophia is a home health nurse who has just arrived at the home of a new patient. The patient is a 78-year-old man named Bruce Blankenship who is recovering from a hip replacement. Mr. Blankenship experienced a fall while in the hospital after surgery; he was discharged from the hospital the day before. He lives with his 76-year-old wife.

Sophia rings the door bell, and the wife answers. “Oh, I’m so glad you’re here!” she tells Sophia.

“Thank you, Mrs. Blankenship. It’s nice to meet you. How can I help?” Sophia replies.

“Well, I’ve been having such a hard time getting Bruce to wait for me to help him get up! He’s such a stubborn man, and he insists he doesn’t need my help going to the restroom,” Mrs. Blankenship says.

Sophia follows Mrs. Blankenship to where her husband is sitting in the living room. She sees that the walker is on the other side of the room.

“Hello, Mr. Blankenship,” Sophia says, and introduces herself. “I’m here to check on how you’re doing.”

“Huh?!” Mr. Blankenship replies. “I’m hard of hearing! You need to speak up!”

“Of course,” Sophia says, raising her voice and slowly repeating her greeting. She proceeds to ask him about how he is feeling and whether he has been using his walker to get up the way the physical therapist instructed him.

“I don’t need that dumb walker!” Mr. Blankenship replies. He starts talking about himself and his past career as a mechanical engineer. He expresses his frustration about having to use the walker and needing to rely on his wife to use the restroom. Sophia listens without interrupting and maintains appropriate eye contact. After a few minutes, Mr. Blankenship is done speaking.

“That sounds very frustrating,” Sophia says in a clear, raised voice. “Would you like to tell me more about it while I change your surgical dressing?” By the end of the visit, Sophia has listened to Mr. Blankenship’s concerns and patiently gone over the care plan in simple terms. She discusses the role of physical therapy to improve his mobility and the importance of using the walker every time he is up and moving around. Sophia places the walker next to his armchair after he agrees to use it and to ask for his wife’s help.

As she is getting ready to leave, Mr. Blankenship says, “Thanks for listening to me, kid. I feel like nobody likes to listen to us old people anymore.”

“It’s my pleasure, Mr. Blankenship.” Sophia replies. “I’ll see you in a few days at our next visit.”

CULTURALLY COMPETENT CARE FOR VETERANS

Military service members, their families, and veterans have unique needs that require a culturally competent approach to healthcare services. There are approximately 18 million veterans as well as 2.1 million military service members in the United States. Approximately 6% of Americans have been in or are currently in the military (Inoue et al., 2023).

Combat and military experiences directly and indirectly impact veterans’ health and well-being. It is important to recognize how military experiences may be associated with different adverse outcomes in order to provide quality interventions and support services.

The key elements of **military culture** include:

- Chain of command
- Strict routine and structure
- Respect for authority and oneself
- Strength (not asking for help)
- Honor (used to being trusted)
- Aggression (faster, harder, louder, meaner)

Health Disparities and Health Risk Factors

Health disparities unique to the veteran population include increased comorbidities and the mental and physical effects of trauma experienced during their service. Disparities can vary according to the sex, race, sexual orientation, age, and socioeconomic status of the veteran (Tran & Huang, 2022).

Results from a study conducted in 2019 found that 53% of 10,000 veterans who participated in the study had chronic physical health conditions. In the same study, 33% of veterans had chronic mental health conditions. The most common chronic health conditions included:

- Chronic pain
- Sleep problems
- Anxiety

- Depression
  (Horrom, 2020)

POSTTRAUMATIC STRESS DISORDER (PTSD)

Approximately 2% to 17% of veterans experience combat-induced PTSD, a mental health condition that may occur as a result of their military service. Some veterans may have difficulty being able to identify or talk about the emotional or cognitive characteristics of PTSD. Reports of insomnia may indicate the need to investigate whether the veteran is experiencing PTSD symptoms. It is important to take a thorough and detailed history, since the diagnosis of PTSD is reliant on the patient's history (Inoue et al., 2023).

SUICIDE

Over 6,000 veterans die by suicide in the United States each year. One study calculated that veterans comprise 17.8% of known suicide cases, and suicide rates for veterans are 1.5 times the rate of the general population. Veterans are at a particularly marked risk for suicide in their first year after being discharged from military service. Although the Department of Defense and the Veterans Administration (VA) have attempted to reduce the suicide rate for veterans through preventive programs, the suicide rate for veterans has remained the same since 2012 (Inoue et al., 2023).

SUBSTANCE USE DISORDERS

Alcohol use disorders are the most common substance use disorders among veterans and military service members, and more than half (56.6%) of veterans consume alcohol. An estimated 27% of veterans smoke tobacco, and 24% of veterans have opioid prescriptions. Mental health conditions such as PTSD and depression, as well as deployments, combat, and becoming a civilian after military service, may contribute to the development of substance use disorders in veterans and military service members (Inoue et al., 2023).

Best Practices for Culturally Competent Care for Veterans

Best practices for culturally competent care of veterans include avoiding common stereotypes about the veteran population, caring in a trauma-informed manner, understanding and being sensitive of the multiple comorbidities of veterans, and understanding the long-term effects that military culture may have had on the patient.

UNDERSTAND THE UNIQUENESS OF EACH INDIVIDUAL VETERAN

There is no conventional identity for a veteran. Not all veterans are older, served during wartime, were injured or have a disability, or are male. Likewise, not all those who served in the military self-identify as "veterans"; thus, healthcare professionals may ask, "Were you in the military?" instead of "Are you a veteran?"

Culturally competent care includes an awareness of **common stereotypes** about the veteran population, which include:

- All veterans are in crisis.
- All veterans have posttraumatic stress disorder and/or substance use issues.
- All veterans served in combat.
- All veterans have access to Department of Veterans Affairs (VA) healthcare.
- All veterans are homeless.
- All veterans want to be thanked for their service.
  (CalVet, n.d.)

PROVIDE TRAUMA-INFORMED CARE

Many veterans experience trauma before, during, and after their military service. This trauma can contribute to mental health conditions such as PTSD and military sexual trauma (MST). In addition, veterans have more anxiety, depression, and mental distress than nonveterans, and female veterans have higher rates of mental health conditions than male veterans. An estimated one third of female veterans have experienced MST. Veterans who have experienced trauma may act irritable and anxious.

Caring in a trauma-informed manner includes:

- Deflecting common triggers such as crowded areas, loud noises, or unanticipated physical touching that may lead to disturbing thoughts, extreme emotions, or flashbacks
- Obtaining consent at all times prior to making physical contact. Explain what you intend to do, such as "To take your blood pressure, I need to place this cuff on your arm. Is that okay?"
- Creating a relationship of trust through your actions. Be reliable, compassionate, and honest while providing care.
- Addressing the patient's comments, concerns, and questions in a way that does not rush
- Not appearing to confront the patient when talking about noncompliance. Do not say, "You could lose a foot if you don't get your blood glucose levels under control." Instead, say, "I understand that monitoring your blood glucose levels can be hard because [what the patient stated was their concern]. Let's work together to come up with a realistic plan to get your blood glucose levels on track because it's really important that they are controlled."
- Providing a safe environment in case a patient becomes distressed. State calmly, "Let's work on how to help you feel safe. How can I help?"
  (Tran & Huang, 2022)

USE SENSITIVITY WHEN ADDRESSING COMORBIDITIES

Veterans experience more comorbidities than the nonveteran population. Because of this, a veteran is more likely to have a complicated medical history that may include physical, psychological, or substance use disorder. Sensitivity is important when addressing the healthcare needs of a patient with comorbidities.

Addressing comorbidities in a sensitive manner includes:

- Using people-first language, which is a way of communicating with people with disabilities by focusing on the person first, instead of the disability. For example, a veteran who is in a wheelchair is not referred to as "handicapped" but instead as a person with a disability.
- Understanding that environmental exposures the veteran experienced could be contributing to the comorbidities. For example, veterans of the Vietnam and Korean wars may have been exposed to Agent Orange, a chemical linked to cancer, diabetes, ischemic heart disease, and Parkinson's disease.
  (Tran & Huang, 2022)

BE AWARE OF THE LONG-TERM EFFECT MILITARY CULTURE CAN HAVE ON THE PATIENT

A veteran may experience long-term effects of military culture throughout the rest of their life. In military culture, the needs of the group are prioritized over the needs of the individual. Military members are also taught to follow the "chain of command" leadership structure. Because of this, some patients who are veterans may not prioritize self-care, could have mixed feelings about the care they are receiving, and may not think their needs are as important as someone else's. To address this, the clinician must listen carefully to what the patient has to say without being judgmental, and must relay compassion in the eye contact and body language used when communicating. One example of this is to listen and make eye contact when the patient is talking about something that is bothering them instead of charting on the computer as they speak (Tran & Huang, 2022).

HOSPICE AND VETERANS

Hospice care is a benefit that the Veterans Administration offers to qualified veterans who are in the final phase of their lives, typically the final six months or less. This multidisciplinary team approach helps veterans live fully until they die. The VA also works very closely with community and home hospice agencies to provide care in the home.

The National Hospice and Palliative Care Organization in collaboration with the Department of Veterans Affairs offers a program called We Honor Veterans to benefit the vast majority of veterans who are not enrolled in VA and may not be aware of end-of-life services and other VA benefits available to them. We Honor Veterans collaborates with the VA to engage hospices in delivering quality end-of-life care for Vietnam-era and other combat veterans and those who have been impacted by trauma.

Men and women who have served in the military often carry experiences from their military service that present unique challenges at the end of life. We Honor Veterans is essential in helping hospices to:

- Educate staff and communities about the end-of-life needs of veterans
- Coordinate care with VA and other healthcare organizations
- Provide veteran-to-veteran volunteer programs
- Connect veterans and their families with community resources
- Offer the services of staff and volunteers who are trained to meet the unique challenges faced by veterans and their families

(WHV, 2024)

CASE

John is a 40-year-old combat veteran who is being seen for a physical at the local VA clinic. He tells his provider that he has been having trouble sleeping recently. The provider recognizes this as a potential symptom of PTSD and conducts a five-question PTSD checklist to screen John for the condition.

The results for the questionnaire indicate that, in the last month, John has:

- Had recurring nightmares about events that happened during his combat deployment
- Tried to avoid thinking about these events
- Felt detached from others and unable to feel positive emotions like love and happiness
- Experienced insomnia and hypervigilance

The provider recognizes that John has scored 4 out of 5 indicators for PTSD. He provides him with a referral to a mental health professional who specializes in treating patients with PTSD (Inoue et al., 2023).

CULTURALLY COMPETENT CARE FOR PATIENTS WITH MENTAL ILLNESS

A mental health condition is a mild to severe disorder that affects an individual's thinking, mood, and/or behavior (SAMHSA, 2023a). Close to 1 billion people worldwide have some form of mental illness, including 51.5 million in the United States. Of these, 36 million are estimated to

be hospitalized each year. Nearly 1 in 3 people with a long-term physical health condition also has a mental health condition (Monaghan & Cos, 2021; Perry & Dilks, 2022).

These numbers make it easy to see that no matter what the role or setting, healthcare professionals will encounter patients who exhibit signs, symptoms, and behaviors indicating mental illness, and will be involved in the provision of care for both physical and mental illness.

Examples of mental health conditions include:

- Antisocial personality disorder
- Anxiety disorders (such as obsessive-compulsive disorder and social anxiety)
- Attention-deficit hyperactivity disorder (ADHD)
- Bipolar disorder
- Borderline personality disorder (BPD)
- Depression
- Eating disorders (such as anorexia nervosa, binge eating disorder, and bulimia nervosa)
- Posttraumatic stress disorder (PTSD)
- Seasonal affective disorder (SAD)
- Self-harm
- Suicide and suicidal behavior
  (SAMHSA, 2023a)

Healthcare clinicians are expected to provide holistic care involving the whole person, which includes physical, mental, spiritual, and social needs, and is rooted in the understanding that all of these aspects affect overall health. Being unwell in one aspect affects the others. This means that the responsibility for providing mental health care needs to be shared across the multidisciplinary workforce, requiring skilled clinicians to deliver both physical and mental health services in diverse clinical settings.

Physical and mental health education, training, and services, however, have historically functioned independently from each other, and as a result those caring for patients with physical disorders report a lack of training and feeling inadequately prepared to care for their patients' mental health care needs. In addition, they report a lack of access to appropriate training and support in the workplace (McInnes et al., 2022).

Challenges for Integration of Physical and Mental Health Care

Frustrations reported by staff related to caring for patients experiencing mental illness seem to arise from knowledge gaps or skill deficits, and mostly relate to ineffective therapeutic interaction, leaving the caregivers with feelings of inadequacy and professional dissatisfaction.

Nonpsychiatric healthcare professionals often report having to struggle to provide care for patients with mental illness without having the sort of specialized training that is standard for those who work in psychiatric facilities, such as:

- De-escalation
- Communication skills
- Suicide prevention
- Addressing potential violence and aggression
- Maintaining a safe environment

In addition, negative attitudes toward mental illness by healthcare professionals have been reported. These attitudes can have adverse consequences for people with mental illness from delays in seeking care to decreased quality of care provided.

STIGMA AND MENTAL ILLNESS

One of the most significant challenges for the integration of physical and mental health care is stigma. Stigma refers to negative and biased beliefs that a society has about something or someone else (Merriam Webster, 2024). Stigma is disempowering. Stigma undermines health by preventing access to critical health-promoting resources and acting as a destructive stressor leading to harmful affective, cognitive, behavioral, and physiologic responses among individuals. Historically, people with mental illness have experienced discrimination in healthcare settings. In healthcare settings, provider stigma compromises access to diagnosis, treatment, and successful health outcomes.

Nonpsychiatric professionals identify negative attitudes, fear, and even hostility toward patients with mental illness. These patients are commonly misperceived to be dangerous, unpredictable, uncooperative, and frightening. Self-stigma, the process of internalizing these negative stereotypes and applying them to oneself, can also lead to lower rates of willingness to disclose one's psychiatric history and may prevent seeking healthcare altogether.

Clinician inexperience in caring for patients with mental illness can contribute to delays and misdiagnoses. Implicit bias may occur when a patient's physical symptoms are ascribed to mental illness, which can lead to delays in referrals and initiation of treatment (Ollila, 2021; Earnshaw et al., 2022).

Despite all that has been learned and the urgency surrounding the need for evidence-based treatment, mental illness continues to be highly stigmatized (see table below). Mental illness–

related stigma, including that which occurs in the healthcare system and among healthcare providers, creates serious barriers to access to healthcare and the quality of care a patient receives. The impact of provider stigma has been identified as the strongest barrier toward help-seeking behavior of individuals with mental illness.

MENTAL HEALTH MYTHS VS. FACTS	
Myth	**Fact**
Children do not experience mental health problems.	Even very young children may show early warning signs of mental health concerns. Half of those with mental health disorders show first signs before the person turns 14 years old.
People with mental health issues are violent, unpredictable, and dangerous.	The vast majority of those with mental health problems are no more likely to be violent than anyone else. Only 3% to 5% of violent acts can be attributed to individuals living with a serious mental illness. In fact, people with severe mental illnesses are over 10 times more likely to be victims of violent crime than the general population.
People with mental health issues, even those who are managing their illness, cannot tolerate the stress of holding down a job.	People with mental health problems are just as productive as other employees. Employers who hire people with mental health problems report good attendance and punctuality as well as motivation, good work, and job tenure on par with or greater than other employees.
Mental health problems are caused by a personality weakness or character flaws, and the individual can snap out of it if they try hard enough.	Mental health problems have nothing to do with being lazy or weak, and many people need help to get better. Many factors contribute to mental health problems, such as genes, physical illness, injury, brain chemistry, life experiences such as trauma or a history of abuse, or family history of mental health problems.
There is no hope for people with mental illness.	Studies show that people with mental health problems get better and many recover completely.
Therapy and self-help are a waste of time.	Treatment for mental health problems varies depending on the individual and could include medication, therapy, or both.
(SAMHSA, 2023b)	

Lack of cultural understanding by healthcare providers may also contribute to underdiagnosis and/or misdiagnosis of mental illness in people from racially/ethnically diverse populations. Factors that contribute to these kinds of misdiagnoses include language differences between patient and provider, stigma of mental illness among minority groups, and cultural presentation

of symptoms. While racial/ethnic minority groups overall have similar (or, in some cases, lower) rates of mental disorders than Whites, they often bear a disproportionately high burden of disability resulting from mental disorders. People from racial/ethnic minority groups are also less likely to receive mental health care (APA, 2017).

Best Practices for Culturally Competent Care of a Patient with a Mental Illness

The central element of responding to the patient is the development of a quality **therapeutic relationship.** A therapeutic relationship requires exceptional communication skills, which include:

- Trust: critical to the relationship and requiring continual effort to maintain it
- Respect: recognizing each individual has inherent dignity, worth, and uniqueness
- Professional intimacy: providing physical care while being privy to the patient's psychological, spiritual, and social history
- Empathy: understanding, validating, and confirming what the healthcare experience means to the patient
- Power: recognizing the unequal power relationship and not abusing it
(CNO, 2020)

Effective ways to interact with a patient with a mental illness include:

- Be patient when attempting to communicate; do not rush or pressure the patient to talk.
- Answer questions briefly, quietly, calmly, and honestly.
- Counter distractibility and poor concentration by giving the patient clear, simple, and concrete instructions.
- Attempt to educate patients about any inappropriateness of their behavior without criticizing or blaming them.
- Avoid judging the person, and do not give negative feedback.
- Avoid verbal confrontations with the person.
- Encourage the patient to respect the personal space of others.
- Provide consistent limits on behaviors and verbal abuse; make sure all staff are clear about these limits and that they reinforce them.
- Encourage and support any ideas the person has that are realistic and in keeping with their healthcare regimen. It is far more effective to suggest alternative strategies rather than to forbid an action.
- Encourage the person to organize and slow thoughts and speech patterns by focusing on one topic at a time and asking questions that require brief answers only.

- If a patient's thoughts and speech become confused, cease the conversation and help to calm the patient by sitting quietly together.
- Offer PRN medications and watch for adverse side effects.
- Encourage participation in relaxation exercises such as deep breathing.
- Acknowledge what patients are experiencing but remind them that they are not in danger, they will be okay, and you are there to help.
- Speak in short, simple sentences and encourage the patient.
- Remind patients to breathe; if they are hyperventilating, have them breathe into their hands cupped over the mouth and nose or a small paper bag.
- Guide the patient through a simple, distracting physical task, such as raising the arms over the head.
  (Townsend, 2018; Martin, 2023; Vera, 2023)

CASE

Yolanda, a physical therapist, is making her fourth visit to Loren, a male patient who lives in Forest Park, an assisted-living facility. Loren is 78 years old and recovering from a stroke affecting his left side. He has been progressing well and normally greets Yolanda with a smile, but today he simply opens the door for her without any greeting.

During the treatment session, Yolanda notes that Loren seems distracted and not his usual self. He appears to be tired and out of sorts. She begins a conversation with Loren in order to learn more about his condition.

Yolanda: "You don't seem to be your usual self today."
Loren: "Well, I'm kind of tired is all."

Yolanda: "Are you not sleeping well?"
Loren: "Oh, I don't know. Things get to me."

Yolanda: "You've been through a lot lately. Perhaps this is affecting your sleep."
Loren: "Oh, dear. I can't sleep at all lately."

Yolanda: "Tell me more about that."
Loren: "Well, I wake up during the wee hours of the morning and just can't get back to sleep."

Yolanda: "What do you think about when you're trying to get back to sleep?"
Loren: "Oh, I just lay awake, turn this way and that way, and think of all the mistakes I've made in my life."

Yolanda: "That sounds very distressing."
Loren: "Yes, it is."

Yolanda: "Tell me …"

Yolanda recognizes that sleep disturbances, especially early morning awakenings, are a major physical symptom of a depressive disorder and that Loren's negative ruminations are also a problem. Her next step will be to inquire about other signs and symptoms of depression (e.g., changes in appetite, feelings of hopelessness, etc.) and then to inform Loren's primary care provider about her findings. Yolanda will also watch for any indicators of suicidal thinking. This is especially important with older male patients like Loren who have comorbid health problems, since they have the highest rate of suicide.

CULTURALLY COMPETENT CARE FOR PATIENTS WITH A DISABILITY

A person with a disability has a condition that substantially limits one or more major life activities and makes it more demanding for them to interact with the world around them. A disability can be intellectual, developmental, or physical in nature (CDC, 2020b).

Disability impacts one or more of the individual's:

- Vision
- Activity
- Thought process
- Memory
- Learning ability
- Communication
- Hearing
- Social relationships
  (CDC, 2020b)

Approximately 25% of all adults in the United States state they have a disability (CDC, 2022e). The origin of disabilities can be genetic, acute, or progressive:

- A person can be born with a disability, such as Down syndrome.
- Disability can become evident during childhood development, such as autism spectrum disorder.
- An injury can lead to disability, such as traumatic brain injury or spinal cord injury.

- Chronic health conditions can lead to disability, such as vision loss or limb loss due to diabetes.
- Disability can be progressive, such as muscular dystrophy.
(CDC, 2020b)

ABILITY BIAS

Ability bias occurs when assumptions are made about people based on physical and mental capabilities. One such assumption is that a disability is a "bad" thing that must be overcome. Ability bias can be reflected in the language used by healthcare professionals. For example:

- "I have tragic news about your child." vs. "We are here to help your child develop her strengths."
- "She is wheelchair bound and dependent on Medicare." vs. "She uses a wheelchair and receives services and benefits to enable her to attend school."
- "The ultrasound results were poor because the patient's disability didn't allow them to get on the exam table." vs. "We inquired ahead about the patient's needs and arranged accommodations to allow for a quality ultrasound exam."

(UCSF, 2023)

Health Disparities and Health Risk Factors

People with disabilities experience barriers to obtaining the healthcare services they need. The barriers can be physical or psychological.

- A survey of physicians' attitudes towards people with disabilities found that patients using wheelchairs were told to go to supermarkets, zoos, or cattle processing plants for their weight measurement.
- Psychological barriers can include poor communication, inadequate knowledge related to disabilities, and biased attitudes. Clinicians can feel that patients with disabilities act "entitled" to accommodations that they need.
(Cascella, 2022)

The Americans with Disabilities Act of 1990 prohibits discrimination toward patients with disabilities. However, this does not mean that discrimination does not still occur. Discrimination, whether acknowledged or implicit, prevents people with disabilities from receiving proper care. In turn, this lack of care leads to health disparities (Cascella, 2022).

Health disparities for people with disabilities that have been outlined in recent studies include:

- Communication failure between healthcare professionals and the patient/caregiver

- Financial limitations
- Issues with attitude and behavior
- Scarcity of medical services
- Organizational and health system barriers
- Transportation barriers
- Lack of training for healthcare professionals
- Language barriers
- Lack of resources and technology
  (Clemente et al., 2021)

Best Practices for Culturally Competent Care of Patients with Disabilities

Examples of elements of culturally competent care for patients with disabilities include:

- Ensuring all facilities are accessible in compliance with ADA requirements
- Providing individuals with access to communication aids and services, such as medical interpreters, signers, audio recordings, etc.
- Using people-first language (see below)
- Practicing disability etiquette when interacting, such as:
    - Mobility impairments: Don't push or touch someone's wheelchair; bring yourself down to the person's eye level to speak to them.
    - Visual impairments: Identify yourself; don't speak to or touch a working service animal. Acclimate the patient to the layout of the facility as well as any accessibility features.
    - Hearing impairments: Speak directly to the person, not the interpreter; don't assume they can read lips; don't chew gum, wear sunglasses, or obscure your face.
    - Speech disorders: Don't finish the person's sentences; ask the person to repeat or repeat yourself to confirm you understood.
    - Developmental disabilities: Speak clearly using simple words; do not use "baby talk" or talk down to the person; do not assume they cannot make their own decisions unless you've been told otherwise.
- Learning about the Americans with Disabilities Act of 1990 to better understand a clinician's legal responsibilities for providing culturally competent care for people with disabilities
- Asking patients if they require an accommodation as soon as they make an appointment to make sure the accommodation is ready for them when they arrive

- Ensuring patient education materials are available in large type, Braille, or audio format
- Speaking to the patient directly instead of communicating only with the caregiver
- Requesting feedback from patients on how they feel they can be accommodated better in the future
- Using the words that the person with a disability has stated they prefer
(SHP, 2018; Cascella, 2022)

USE PEOPLE-FIRST LANGUAGE

People-first language is a way of communicating with people with disabilities by focusing on the person first instead of the disability. Terms that were used in the past are not acceptable to use now and can be considered to be archaic and insulting. For example, it is not using people-first language to say that an individual with Parkinson's disease is "afflicted by Parkinson's" or a "victim of Parkinson's." Instead, emphasize that they are a person first by saying they are a person with Parkinson's disease (Cascella, 2022; CDC, 2022e).

When using people-first language, it is important to remember that every patient is unique. Care should be individualized since the range of people with disabilities is diverse. Instead of highlighting the patient's disability, the patient's abilities should be the focus. Honing in on the individual disability of a patient could lead to stereotyping and depersonalization (Cascella, 2022).

GENERAL TIPS FOR PEOPLE-FIRST LANGUAGE		
Tips	**Use**	**Do Not Use**
Emphasize abilities, not limitations	• Person who uses a wheelchair • Person who uses a device to speak	• Confined or restricted to a wheelchair, wheelchair-bound • Can't talk, mute
Do not use language that suggests the lack of something	• Person with a disability • Person of short stature • Person with cerebral palsy • Person with epilepsy or seizure disorder • Person with multiple sclerosis • Person with cystic fibrosis • A person who is deaf/blind	• Disabled, handicapped • Midget • Cerebral palsy victim • Epileptic • Afflicted by multiple sclerosis • Victim of/suffering from cystic fibrosis • The Deaf/The Blind

Emphasize the need for accessibility, not the disability	• Accessible parking or bathroom	• Handicapped parking or bathroom
Do not use offensive language	• Person with a physical disability • Person with an intellectual, cognitive, or developmental disability • Person with an emotional or behavioral disability, a mental health impairment, or a psychiatric disability	• Crippled, lame, deformed, invalid, spastic • Slow, simple, moronic, retarded, defective, afflicted, special person • Insane, crazy, psycho, maniac, nuts
Avoid language that implies negative stereotypes	• Person without a disability	• Normal person, healthy person
Do not portray people with disabilities as inspirational only because of their disability	• Person who is successful, productive	• Has overcome his/her disability/is courageous
(CDC, 2022e; SHP, 2018)		

CASE

Tony is a licensed practicing nurse who works at a family medicine medical office. He is working with Dee, a medical assistant who has worked at the clinic for decades. Tony is walking by the receptionist desk when he sees Dee hanging up the phone. She looks at Tony, rolling her eyes.

"Mr. Hernandez just made another appointment. Ugh, he's so annoying," Dee says.

"What do you mean?" Tony replies.

"Oh, you'll see," Dee replies. "I know you just started so you don't know all the problem patients. He's *handicapped*. So, we have to make sure everything is ready for him and his wheelchair. I mean, it takes three of us just to get him from his wheelchair to the exam table."

Tony quickly realizes that Dee is discriminating against a person with a disability. He replies using culturally competent terminology, "My younger sister uses a wheelchair. She was born with cystic fibrosis. I know firsthand how she has had to deal with discrimination

her whole life because of her disability. In fact, she's the reason I became a nurse. People with disabilities are not annoying, and it's our job as healthcare workers to provide them with accommodations so they can experience the world the same way as a person who does not have a disability."

Dee says, "Thank you for sharing that with me, Tony. I think I need to learn more about people with disabilities so that I can provide better care to them."

CONCLUSION

Providing high-quality, culturally competent care to all patients involves understanding the cultural contexts of each individual. When considering best practices for providing culturally competent care, healthcare professionals should carefully evaluate their practice environment; examine, advocate for, and modify practice policies when needed; take detailed and nonjudgmental histories; educate themselves and/or update their knowledge on the health issues of all patients; and reflect on any personal attitudes or bias that may prevent them from providing the highest level of care to their patients. By taking these positive steps, healthcare providers can ensure that all patients they care for achieve the best possible health outcomes.

RESOURCES

American Psychiatric Association
https://www.psychiatry.org

Communicating with and about people with disabilities (CDC)
https://www.cdc.gov/ncbddd/disabilityandhealth/materials/factsheets/fs-communicating-with-people.html

GLMA: Health Professionals Advancing LGBTQ Equality
https://www.glma.org/

Lesbian, gay, bisexual, and transgender health (Centers for Disease Control and Prevention)
https://www.cdc.gov/lgbthealth/index.htm

LGBTQ healthcare laws and policies map
https://www.lgbtmap.org/equality-maps/healthcare_laws_and_policies

Mental Health America
https://www.mhanational.org

National Center for Transgender Equality
https://transequality.org/know-your-rights/health-care

National Coalition for LGBTQ Health
https://healthlgbtq.org/

National Institute on Aging
https://www.nia.nih.gov/health

Project Implicit
https://www.projectimplicit.net/

We Honor Veterans (National Hospice and Palliative Care Organization)
https://www.wehonorveterans.org/

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TEST

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1. Which action would a healthcare professional take to reduce their personal cultural bias?

a. Answer the question, "Is my current belief wrong or right?"
b. Take a test on knowledge of inclusive terminology
c. Answer the question, "How might my current beliefs harm others?"
d. Debate personal beliefs on discrimination with other clinicians

2. Which patient is **more** likely to receive inadequate care as a result of their race or ethnicity?

a. A Black female patient who gave birth 1 hour ago and is reporting a feeling of intense pain in her abdomen
b. A White male patient postop day 1 from a cholecystectomy who has not yet had a bowel movement
c. A Hispanic male patient with a diabetic ulcer who is asking for a turkey sandwich
d. A White female hospitalized with COVID-19 who has been prescribed dexamethasone IV

3. For which condition should an adolescent who is teased by peers for being transgender be assessed?

a. Obsessive-compulsive disorder
b. Attention deficit disorder
c. Bipolar disorder
d. Suicidal ideation

4. Which action should be taken when a newly admitted patient has the legal first name "Karl"?

a. Show the patient the men's restroom when orienting them to the clinic facilities
b. Refer to the patient as "sir" until a more relaxed relationship has been established
c. Ask the patient the name they use and their pronouns
d. Inquire if the patient is married in the event they will need help at home during recovery

5. Which practice is recommended to enhance communicating with an older adult?

a. Calling the person by their first name
b. Encouraging the person to speak more rapidly
c. Interrupting when the person talks too much
d. Avoiding using medical jargon

6. Which statement incorporates the principles of trauma-informed care for a veteran?

a. "You are at an increased risk of having a heart attack or stroke because you do not take your statin medication."
b. "I'm just taking your blood pressure; you don't need to pull your arm away."
c. "Even though an exercise program can be difficult, let's work together to plan a way to increase your activity so you can start to feel better."
d. "Please calm down; getting upset doesn't help your situation."

7. Which statement is a common "myth" regarding people with mental health problems?

a. People with mental illness experience discrimination and stigma in healthcare settings.
b. People with mental health issues are more likely to be violent and dangerous.
c. People with mental health problems are just as productive on the job as other employees.
d. People with mental illness often get better and recover completely.

8. Which statement is an example of people-first language?

a. "My uncle is a person who uses a wheelchair."
b. "My uncle is confined to a wheelchair."
c. "My uncle is wheelchair bound."
d. "My uncle is restricted to a wheelchair."