FLEX CEUs

Cultural Competency

Introduction

Within the healthcare realm, cultural competence refers to utilizing knowledge, skills, and tools to provide equitable care to patients of different cultures. Culture refers to the language, beliefs, values, communication, race, ethnicity, religion, or social influences that make up an individual's life. Healthcare disparities are inequities of care and outcomes and occur in the African American, Latino/Hispanic, Native American, Asian American, Alaska Native, and Pacific Islander communities in the United States. In this course, physical therapists and physical therapist assistants will explore the concept of cultural competence, discover which populations are historically and contemporarily marginalized, offer effective communication strategies, and ultimately strive to improve healthcare outcomes.

Cultural Competence - Knowledge

Culture forms a person's belief system about how they view the world around them. This includes how they view when to utilize healthcare, the severity of symptoms, and why they may have symptoms. To understand cultural competence as it applies to healthcare, a few concepts need to be explored. One's level of cultural competence affects how one interacts with and provides care to people of different backgrounds. The concepts of diversity, marginalized populations, oppression, privilege, power, and ethics will be discussed in this section. Being culturally competent begins with self-awareness of beliefs and continually educating oneself on the knowledge and skills needed to provide culturally competent health care to patients from all backgrounds.

Why is Education Needed on Cultural Competence? [1]

The United States and the rest of the world have become more diverse places as it has been easier than ever for people of different cultures and countries to migrate to other countries. It is a documented fact from surveys that the ethnic minority in a country receives worse healthcare and poorer outcomes compared to the ethnic majority population. In addition, people in ethnic minorities report less satisfaction with contact with their healthcare providers. These factors are due to multiple reasons such as language barriers, socioeconomic status, health insurance coverage, and barriers to understanding the priorities within different cultures. The goal of culturally competent health care is to provide a person-centered approach and partner with the patient to

provide the best possible care within their goals and cultural beliefs. Healthcare providers must know the health challenges that people of different cultures face and have the skills to communicate effectively. This may mean the use of an interpreter and multiple checks for mutual understanding. There are many ways to detect one's level of cultural competence and bias, which will be reviewed in this course. The first step to providing culturally competent healthcare is to acknowledge that every provider sees patients through a specific lens, which can be transformed over time. There are steps providers should take to provide culturally competent care.

Providers should expand their awareness, develop knowledge of different cultural beliefs in the patient populations that they see, and provide equitable care to every patient as an individual.

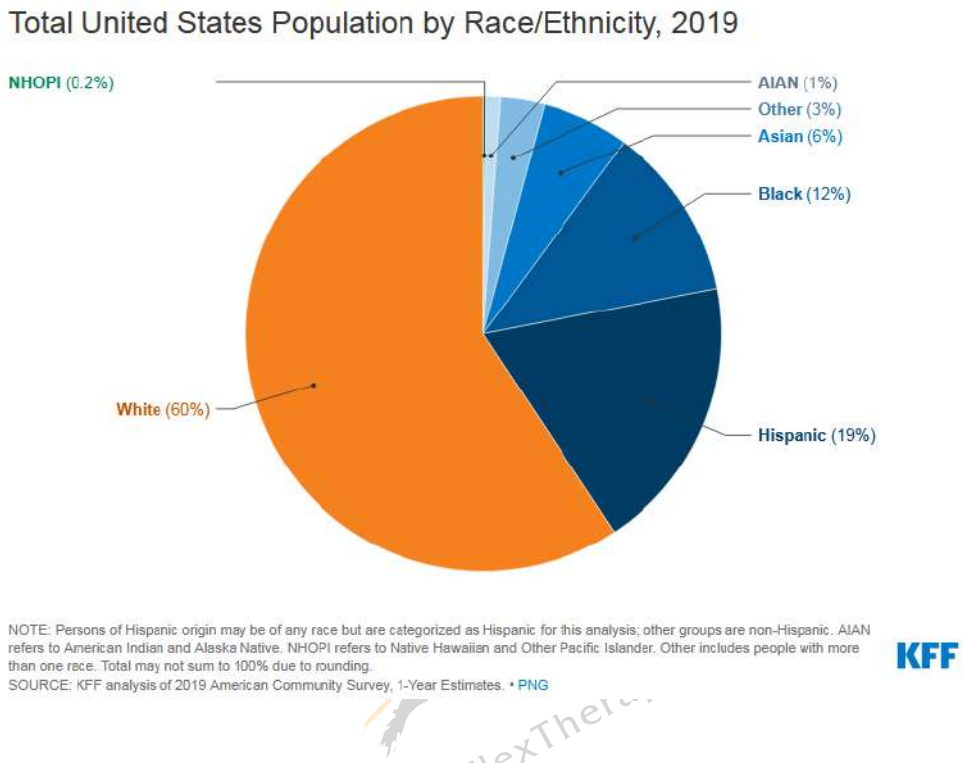
Diversity [2–5]

The definition of diversity is the practice or quality of including persons from a variety of social and ethnic backgrounds, genders, sexual orientations, and other factors that make a person unique. In the context of healthcare, more successful, inclusive care occurs when the organization's staff itself is made up of a diverse group of individuals. Research shows that if the healthcare staff is more diverse than the patient population they serve, the outcomes are better than if they are equal or less diverse. Healthcare fields are increasingly diverse, but still do not match the percentage of people in the United States for each ethnic group, gender, and sexual orientation. From the year 2016 to 2017, physical therapists in the United States were not a diverse group. Eighty-five percent of PTs in that year identified as white, one percent as Black, five percent as Asian, and three percent as Hispanic/Latino. This compares to the United States population as a whole, where fifty-eight percent are White, nineteen percent are Hispanic and/or Latino, seven percent are Asian, and twelve percent are Black.

Diversity speaks to the characteristics of people, while inclusion is the development of systems and procedures that provide equality to all groups of diverse people. Inclusive healthcare means that all populations are treated with equitable, culturally competent care, and therefore have similar health outcomes to nondiverse populations.

The United States has the highest immigrant population in the world. Around forty million people in the US are immigrants and represent nearly every country in the world. Twenty-five percent of US immigrants come from Mexico, six percent come from China, six percent come from India, and the remainder from other countries. Only half of the

immigrants residing in the US speak proficient English. This highlights the need for healthcare providers to know these facts, especially within the geographical area they treat, to effectively communicate with and care for people with limited English proficiency.



Marginalized Populations [6,7]

People in the United States (and across the world) have different levels of advantage, privilege, and power based on several factors. These factors include being born into wealth, being white, having a high educational status, being male, and many other individual characteristics. These specific characteristics put an individual ahead of others because success in society is systematically set up for people who are White, wealthy, and have the ability and expectation to pursue higher education. For example, a White male living in an affluent neighborhood with a college fund will have a better chance of going to college and achieving a high socioeconomic status and health equity than a Black female living in a low-income neighborhood would. This is due to a multitude of

factors – the systemic discrimination of nonwhite people and the access to educational resources that wealth and high socioeconomic status bring, to name two. This brings up the concept of privilege. Privilege is generally defined as having an advantage over another person or group of people due to virtually any factor. It is undeniable that an ethnic or racial group that is the majority will always be privileged over minorities. Also, groups with higher educational status, socioeconomic status, and other resources will have privilege over other groups with less of these advantages. Privilege is often blind to those who experience its benefits, but frankly apparent to those oppressed by another group's privilege. An example of oppression by privilege is people of color being perceived as dangerous or as criminals more often than their White peers.

Marginalization means that certain groups have limited social and financial resources and power as a result of their societal status. Populations that have been historically marginalized in the United States are ethnic minorities who are nonwhite, immigrants, females, those with disabilities, and those who are not heterosexual. These marginalized populations have to exude much more effort than non-marginalized populations to achieve similar outcomes because ultimately their skills, abilities, and values are undervalued and even judged by society at large. Although slavery has ended, females can vote, and people who are homosexual can get legally married, these marginalized populations experience fewer advantages than others. Well-documented evidence of this exists, such as Blacks being perceived as dangerous, females not being paid as much as male peers for the same work, and discrimination based on sexual orientation. People with disabilities, whose first language is not English, and those with religious beliefs that are not Christian in the United States also experience marginalization and less opportunity.

Social Determinants of Health [6]

The World Health Organization defines social determinants of health (SDH) as the situation that an individual is born into, lives, works, and structures in place to treat illness. They are factors that influence health and do not involve direct medical care. The following are all different social determinants of health:

- Income and social status
- Employment
- Education and literacy

- Childhood experiences
- Social support
- Access to healthcare services
- Healthy behaviors
- Biology and genetics
- Gender
- Culture
- Race

Research has found that socioeconomic status directly influences health; the lower one's socioeconomic status, the worse their health is. Studies have also shown that SDHs are responsible for up to fifty percent of health outcomes. This means that all of the social, financial, access to healthcare, culture, race, and other factors influence health just as much as medical care itself! There is a nearly twenty-year lower life expectancy in third-world countries compared to first-world countries.

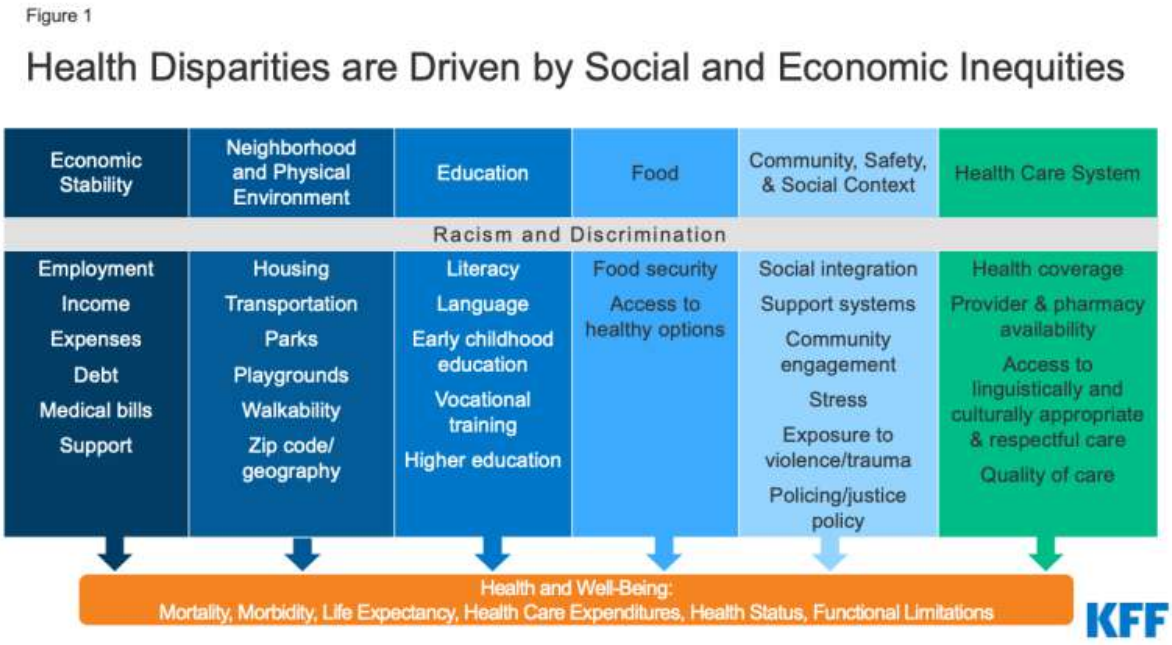
Healthcare Disparities [8]

Health disparities, or healthcare disparities, are factors that affect disease and health but are preventable and experienced among disadvantaged groups of people. They affect groups of people that have experienced systematic obstacles to accessing healthcare, such as minority groups. Health disparities are often a result of disadvantages due to aspects of social determinants of health. For example, a person in poverty (SDH) is likely to have a delay in care or not receive healthcare at all for heart disease. This is due to the disparity of prioritizing making ends meet financially and not pursuing healthcare.

The COVID-19 pandemic highlighted the disparities among different racial, ethnic, and other groups in the United States. American Indian, Alaska Native, Black, and Hispanic groups were affected with a three times higher premature death rate than White populations. This is hypothesized to be due to a higher risk of contracting the virus due to transportation, living, and working situations, having a higher rate of comorbid conditions, and poor access to treatment and care once exhibiting symptoms. In addition to this, a disproportionate amount of Hispanic and black adults lost a job during the pandemic, at a ten to twenty percent higher rate than Whites. The toll of a

pandemic and other extreme situations will affect those with disparities more than others – financially, socially, psychologically, and physically. When a group of people or an individual from a group that is marginalized experiences a specific disease, financial burden, or otherwise stressful event, they will be much more affected than the same event happening to someone who has resources, social support, and good access to healthcare.

Figure 1



https://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-5-key-question-and-answers/

Protection and Legality Surrounding Culturally Competent Care

Patient Rights and Responsibilities [9]

Every patient, regardless of diversity, has rights when receiving healthcare treatment. The first bill of rights for patients was passed in 1973 by the American Hospital Association. There is variation between countries and US states of specific legality around patient rights. The basic patient rights principles adopted in the US include informed consent, treatment refusal, emergent medical treatment, confidentiality, continuity of care, and the ability to speak against it if treatment is unfair. These principles are expected to be present throughout medical care and permeate the lens of

diversity and inclusion. For example, treatment could be unfair if a person of a certain culture, race, or gender, is treated differently than another.

Patient's Rights and Responsibilities in Oregon [10]

Oregon's summary of patient rights is similar to these US principles, with a few variations. Rule 333-700-0115 details the patient's rights, responsibilities, and family education. The following is adopted from this rule to ensure PTs and PTAs are informed of patient rights while providing care in Oregon.

1. "The governing body of the facility shall adopt written policies regarding the rights and responsibilities of patients and, through the chief executive officer, shall be responsible for the development of, and adherence to, procedures implementing such policies.

2. These policies and procedures shall be made available to patients and any guardians, next of kin, the Division, and to the public. The staff of the facility must be trained in and involved in the execution of such policies and procedures. The patients' rights policies and procedures must ensure all patients in the facility:

    a. Are informed of these rights and responsibilities, and of all rules and regulations governing patient conduct and responsibilities;

    b. Are informed of services available in the facility and of related charges;

    c. Are informed by their healthcare provider of their medical conditions unless medically contraindicated (as documented in their medical records);

    d. Are afforded the opportunity to participate in the planning of their medical care (either through direct involvement or if the patient chooses, through family or a representative);

    e. Are afforded the opportunity to refuse to participate in experimental research;

    f. Are transferred or discharged only for medical reasons, for their own welfare or that of other patients or for nonpayment of fees. Patients discharged for these reasons shall be given a written notice before transfer or discharge. A patient exhibiting violent, abusive, or threatening

behavior may be discharged immediately if necessary to protect themselves, other patients, or employees. A written notice shall be given to these patients within ten days of transfer or discharge;

g. Are treated with consideration, respect, and full recognition of their individual and their personal needs, including maintenance of confidentiality;

3. The facility shall have written documentation from the patient that he/she has had his/her rights and responsibilities explained.

4. The facility shall provide the patient and his/her family with the opportunity for education including, but not limited to the following topics:

5. Grievance mechanism: The facility must inform patients (or their representatives) of the facility's grievance process and the procedures for appeal. All patients are encouraged and assisted to understand and exercise their rights. Grievances and recommended changes in policies and services may be addressed to facility staff, administration, the Network, and agencies or regulatory bodies with jurisdiction over the facility, through any representative of the patient's choice, without restraint or interference, and without fear of discrimination or reprisal."10

The Americans with Disabilities Act [11]

The Americans with Disabilities Act (ADA) was passed to give United States citizens with disabilities the same opportunities as those without disabilities. Examples of this are handicapped parking, voting rights, communication technology, and the right to service animals. The law was passed in 1990 and prohibits discrimination against those with disabilities. Domains that provide protection are within employment, public services, public accommodations, and others. In healthcare, this means providing communication and accommodations for ease of access to understanding material and for accessing clinics.

National Standards for Culturally and Linguistically Appropriate Services (CLAS) [12]

CLAS standards exist to uphold the highest possible standards of healthcare, reduce healthcare disparity, and increase healthcare equity for patients of different cultures and native languages. CLAS is comprised of fifteen steps and was developed in 2004. The

overall goal of CLAS is to create a systematic standard through policy change and enforcement of excellent communication, and cultural understanding, and to create a diverse workforce in healthcare that is representative of the patient population.

The Joint Commission [13]

The Joint Commission is an organization to uphold standards for patient safety and was founded in 1951. Its role is to accredit and certify healthcare organizations and programs across the United States. The organization has recognized healthcare equity as a top priority due to its impact on the quality of care. A resource center is available at the link below, which has information on successful ways to address disparities at an organizational level.

https://www.jointcommission.org/our-priorities/health-care-equity/accreditation-standards-and-resource-center/

Oregon Specific Resources [14,15]

The Oregon Health Authority Office of Equity and Inclusion (OEI) is a great resource to note progress and work yet to do to become a healthcare system that provides equitable care to all. The OEI's mission is to reduce health disparities by working with diverse communities. They have developed programs, policies, partnerships with the government, and continuing education requirements for healthcare providers and help to increase workplace diversity among healthcare organizations. Their program called Developing Equity Leadership through Training and Action (DELTA) aims to systematically promote diversity and equality by training leaders in healthcare with a forty-hour comprehensive course.

The Oregon Health Authority is also responsible for mandating cultural competence training for all clinicians to maintain their licensure. Resources on which courses are appropriate and which elements are necessary and information on how to recertify as a Health Care Interpreter are also available at this site. An outline of the historical context, policies, data, and process of becoming culturally competent healthcare providers is available here: https://www.oregon.gov/oha/OEI/Pages/About-Us.aspx

Section 1 Key Words

Diversity – the practice or quality of including persons from a variety of social and ethnic backgrounds, genders, sexual orientations, and other factors that make a person unique.

Marginalization - Certain people of social, ethnic, or otherwise diverse groups have limited social and financial resources and power

Social Determinants of Health – The situation that an individual lives, works, and is born into; educational, financial, and social status, race, gender, and access to healthcare are examples

Section 1 Summary

Understanding the concepts of diversity, marginalization, health disparities, and social determinants of health is crucial to be a culturally competent healthcare provider. Oregon physical therapists and assistants should be well-versed in this background information to understand the complexity of providing care to patients who have experienced healthcare inequity. Legislation exists to protect patients who experience disparities, such as the ADS, CLAS, and other federal and state protection to promote equity in care.

Self-Awareness

To provide culturally competent healthcare, physical therapists and assistants must be aware of their own biases, expectations, and other factors that influence the care of diverse populations. Self-awareness and self-assessment are crucial for determining one's level of cultural competence and therefore, which beliefs may permeate into patient care. This section will discuss how to ethical expectations of PTs and PTAs and how to be aware and assess for biases and one's level of cultural competence.

The Influence of Culture on Behavior [16]

Several factors may influence both the behaviors of providers and patients. Beliefs shaped by culture undoubtedly create behavior. In the context of healthcare, this means that patients of various cultures may not believe in the methods of treatment or take the advice of a provider if it goes against their cultural experiences. Culture influences

behavior due to the following factors: family and community, religion, perspectives on health, gender roles, and medication beliefs.

Family and Community

Certain cultures rely on their community and family more than others. For example, those from Hispanic and Asian cultures often are closer to their extended family than their White peers. This means that patients of these ethnicities and cultures may need to make healthcare decisions considering the perspective of their family and community rather than independently.

Religion

Religious beliefs undoubtedly affect healthcare decisions. For some, religion permeates every decision because it is a lifestyle. Religious beliefs may impact healthcare by patients refusing to eat certain foods or accepting an injury or medical problem as an act of God. They may feel it is not within their right or control to act against it. This of course would affect compliance with physical therapy exercises and PTs should be aware that many people of religious beliefs in this way delay seeking care as well.

Perspectives on Health

Cultures vary in their historic pain tolerance, belief in “quick fixes” to solve pain, and belief in the ability of healthcare providers to help. People of different ethnicities than Caucasian have documented higher pain tolerances for the same injury coupled with disbelief in prescriptions as a quick fix. They may not trust Western remedies like surgery and pain pills to help them heal. This may result in minority groups being noncompliant with medications and treatments by stopping them before recommended by a healthcare provider. They may not see the value in PT care either, preferring their culture’s methods of healing. Cultures also have different perspectives on death, influencing how providers should approach making patients comfortable in end-of-life care.

Gender Roles

Gender roles vary immensely in cultures. In cultures where males are the primary decision maker, women may not express their opinion in care. In addition to this, women in cultures where they are seen as less dominant, may not accept invasive treatment to stay comfortable. For PTs and PTAs, it is imperative to ask if one feels comfortable with

services where the patient is touched, like soft tissue mobilization, joint mobilization, and dry needling.

Ethics and Cultural Competence [17]

Ethical standards of care within western medicine exist to give patients altruistic, patient-centered, honorable care. Ethical principles that are expected of physical therapists are outlined in the APTA Code of Ethics for the Physical Therapist. These principles are listed below.

Principle 1: “Physical therapists shall respect the inherent dignity and rights of all individuals”

Principle 2: “Physical therapists shall be trustworthy and compassionate in addressing the rights and needs of patients and clients”

Principle 3: “Physical therapists shall be accountable for making sound professional judgments”

Principle 4: “Physical therapists shall demonstrate integrity in their relationships with patients and clients, families, colleagues, students, research participants, other healthcare providers, employers, payers, and the public”

Principle 5: “Physical therapists shall fulfill their legal and professional obligations”

Principle 6: “Physical therapists shall enhance their expertise through the lifelong acquisition and refinement of knowledge, skills, abilities, and professional behaviors.”

Principle 7: “Physical therapists shall promote organizational behaviors and business practices that benefit patients and clients and society”

Principle 8: “Physical therapists shall participate in efforts to meet the health needs of people locally, nationally, or globally” [17]

The collective message of these principles in the context of diversity and cultural competence is treating every single patient altruistically, with patient-centered care, and working to meet the needs of specific populations with open-mindedness, compassion, and with the mindset to seek resources for them as needed.

Self-Assessment 18

Implicit Association Test [19]

The implicit association test is available at https://www.projectimplicit.net/. Anyone, whether within an organization or an individual, can take a test that screens for biases against many diverse characteristics. These include weight, race, gender, religion, sexuality, transgender, and disability. The test compares words with diverse characteristics (for example good and bad compared with dark and light-skinned images of people) and requires test takers to quickly sort the images and characteristics with word associations. The free tests allow the test taker to see their biases for each test in an easily digestible percentage. Healthcare providers will find value in awareness in this self-assessment as it informs biases they may have for certain groups they often treat. There are tests on races including Asian, Native American, Arab, Black, and skin tone, a test on weight, and a test on disabilities. After taking these tests, a provider will be aware of their biases, which is the first step in seeking culturally and bias-informed practice methods. It has been found that groups of both healthcare professionals and a control (society sample) have similar levels of bias against Black and Hispanic populations, associating negative words with these populations. Rehabilitation professionals in Oregon (and other health professions) must strive to combat their biases against other cultures, which is a continual learning process. This way, stereotypes, and associations like laziness, poor responsibility, and lack of compliance, will not be made based on someone's race, culture, or education level.

Cultural Self-Efficacy Scale (CSES) and Cultural Awareness Scale (CAS) [20]

The CSES and CAS assess the cultural awareness of practitioners by asking a sliding scale of questions regarding cultural competence. These scales were originally developed for nurses but may be used on an organizational or individual level to gain an understanding of any provider's skill set around cultural competence.

The CSES consists of twenty-five questions to determine the considerations in this table.

Items
1. Understanding the international patients' cultural characteristics or customs.
2. Having additional information needed for caring for international patients.
3. Being aware of the precautions when nursing international patients.
4. Acknowledging the specifics of cultural differences between international patients and myself.
5. Using any methods to intercommunicate with international patients.
6. Endeavoring to ease awkwardness and give enough time to adapt to a new environment.
7. Openly expressing my interest toward international patients by taking such actions like initiating a new conversation or greeting them.
8. Asking what my international patients' need.
9. Helping any new international patients, though without interpreters.
10. Adequately explaining all necessary information regarding nursing international patients to my team member.
11. Keeping any special favors asked by international patients in my mind for better care.
12. Not completely relying on interpreters, but trying my best to search for good ways to improve problems for patients.
13. Making an effort to explain Korean medical treatment system and remedies to international patients.
14. Describing any treatments that may be misconstrued (e.g. physical contact) in advance
15. Trying to nurse not only international patients, but also their families.
16. Not feeling troublesome treating international patients.
17. Patiently listening to the words spoken by international patients, even if I find them hard to comprehend.
18. Trying to understand exceptional situations that international patients go through.
19. Taking international patients' extraordinary actions or attitude as being 'different,' rather than 'wrong.'
20. Appreciating international patients' traditional belief on nursing.
21. Working hard to respect international patients' culture.
22. Understanding that international patients may refuse certain treatments due to cultural beliefs.
23. Accepting international patients' philosophy toward their life and the world.
24. Not discriminating against international patients for their race nor nation.
25. Not considering international patients' causal actions or response peculiar.

The CAS consists of thirty-six questions (sample provided below) to determine cultural knowledge, sensitivity, and skill.

Item	Strongly Disagree 1	Disagree 2	Neutral 3	Agree 4	Strongly Agree 5
1. This hospital provides opportunities for educational activities related to multicultural issues in nursing.					
2. Since joining this hospital, my understanding of multicultural issues has increased.					
3. My experiences at this hospital have helped me become knowledgeable about the health problems associated with various racial and cultural groups.					
4. I think my beliefs and attitudes are influenced by my culture.					
5. I think my behaviors are influenced by my culture.					
6. I often reflect on how culture affects beliefs, attitudes, and behaviors.					
7. When I have an opportunity to help someone, I offer assistance less frequently to individuals of certain cultural backgrounds.					
8. I am less patient with individuals of certain cultural backgrounds.					
9. I feel comfortable working with patients of all ethnic groups.					
10. I believe individual's own cultural beliefs influence their nursing care decisions.					
11. I typically feel somewhat uncomfortable when I am in the company of people from cultural or ethnic backgrounds different from my own.					
12. During group discussions or exercises on the unit or in educational sessions, I have noticed the session leaders make efforts to ensure no individual is excluded.					
13. I feel comfortable discussing cultural issues with nursing colleagues on my unit.					
14. I think individuals' cultural values influence their interactions with others (e.g., asking questions, participating in groups, offering comments).					
15. The nursing staff on my unit seem comfortable discussing cultural issues.					
16. I think the cultural values communicated at this hospital influences nursing staff's behaviors in the clinical setting.					
17. I believe the patient care experiences at this hospital help nursing staff become more comfortable interacting with people from different cultures.					
18. If I need more information about a patient's culture, I would use resources available onsite (e.g., books, videotapes, internet).					
19. If I need more information about a patient's culture, I would feel comfortable asking people with whom I work.					
20. If I need more information about a patient's culture, I					

An organization needs to promote the use of self-assessment in an overall plan to achieve cultural competence among employees.

The Georgetown University National Center for Cultural Competence is also a great resource that is updated based on current evidence to support self-assessment surrounding cultural competence. There are various self-assessments and learning tools available here: https://nccc.georgetown.edu/assessments/.

How to Foster an Inclusive, Non-Judgmental Environment [21]

After building awareness through self-awareness and self-assessment, healthcare providers should realize where they have biases and knowledge gaps in providing care to other diverse cultures. This creates the need for inclusive care, to make those of all cultures and backgrounds feel accepted in a healthcare environment. This often starts at a leadership level, such as hiring managers and leaders who are women and minority groups. Of course, the rest of the organization should be diverse as well but starting at the leadership level helps to change the mindset around the capabilities and achievements of diverse populations. Leadership and individuals should strive to have open communication that values engaging a diverse culture, transparency, and having difficult conversations about inequalities when necessary. At a patient and provider level, physical therapists and assistants should also foster an open communication line with patients and prioritize providing patient and culture-centered care. Providers can do many things to prevent the patient from being overlooked or misunderstood due to their culture. These include researching customs and traditions, cultural beliefs, gender roles, beliefs about healthcare, and anything else that may impact care. These should never be judgments, they should simply inform practice. Practitioners should foster open communication at the beginning of the evaluation and treatment by asking permission before palpating or assessing movements (informed consent). A provider and patient should always be fluent in the same language or a health care interpreter (not a family member or friend) should be present to translate.

Section 2 Key Words

Ethics – in a context of cultural competence ethical care is providing equal, patient-centered care to all regardless of diversity

Implicit Association Test – a test for implicit bias that is based on word association with a picture representation of diverse characteristics

Section 2 Summary

Self-awareness and self-assessment are critical components in the greater context of culturally competent healthcare. Physical therapists and assistants should individually seek out assessments, such as the Implicit Association Test and a cultural competence scale to determine their level of cultural competence and what areas to improve.

Skills

Certain skill sets need to be developed in addition to traditional physical therapy care when providing care to those with a different language and of a different culture. Skills in this area should be developed over time, and a good place to start is with patient populations that a provider sees most often. This section will discuss tools, assessment strategies, communication, discovering patient preferences, the use of community resources, and the use of healthcare interpreters.

Assessment Strategies

A culturally informed and self-aware provider knows that assessments vary among patients based on what is important to the patient. PTs and PTAs should always utilize patient and family-centered communication and discover the patient's perception of their health, and preferences in recovery. Assessment strategies themselves may need to be adjusted to accommodate comfort levels with being physically touched or having areas exposed to see muscle, for example.

Patient and Family-Centered Communication [22]

PTs and PTAs should always utilize principles of patient-centered care to facilitate the assessment of all patients. The following principles highlight this concept: respect and dignity, information sharing, participation, and collaboration. Providers should respect a patient's and family's healthcare choices and preferences, and ask what elements are important to be mindful of in a care plan. PTs and PTAs should include only unbiased, useful information when providing information like exercise handouts or education. For example, if a patient shares that they are not able to work on exercises on Sundays for religious reasons, an exercise handout should state "excluding Sundays". In addition, providers need to derive from patients and families how much they would like to be involved in the care plan and decision-making. Some cultures value the professional

opinion of what the provider states while others value contribution. Lastly, patients and families should be allowed to give feedback to the provider. This enhances quality of care

Patient and family-centered communication also mean communicating in a patient's native language (or fluent learned language). They should be offered exercise handouts, patient information forms, appointment reminders, and other material in their preferred language. This practice will reduce miscommunication and ensure they are receiving the provider's intentional message.

Certified Healthcare Interpreter (HCI) [23]

A certified healthcare or medical interpreter should be used in all circumstances where the provider does not speak the patient's language fluently. Ideally, an organization would have an in-person interpreter, but sometimes a video or phone live interpreter is only available. All options are sufficient and supportive of culturally competent healthcare. In a study, for nearly sixteen percent of patients admitted to a hospital with limited English proficiency, around four percent received a healthcare interpreter, which means seventy-five percent of patients received care in a language they do not fully understand. This makes it incredibly difficult for patients to prioritize or understand what they were instructed to do by the healthcare team.

Patient's Health Perception [24]

Patient perception of one's injury or health problem is crucial to understand from a provider's perspective. Factors that may affect recovery time involve having an external locus of control or a sense that there are no options for improving symptoms. Religion and cultural beliefs may create an external locus of control, such as believing forces outside one's control, like higher power, will heal all injuries. Physical therapists and physical therapist assistants should always ask patients their beliefs on exercises and involve the patient to determine a patient-centered plan. If a therapistgives a patient a cookie-cutter treatment plan for shoulder impingement, for example, and the patient is of the mindset that exercises will not help, this patient will not improve. The physical therapist in this case may try to gain a sense of what may help and work movements into daily movements and activities such as cooking or cleaning. Here is a list of questions a PT or PTA should ask their patients to understand their health beliefs and perceptions:

1. What do you call your problem and what do you think caused it?

2. How does this problem impact your life?
3. What type of treatment do you think would help you recover?
4. What results are important to you to achieve from treatment?

These questions will help to gain an understanding of the value physical therapy services will add to a patient's recovery. If they do not believe in exercises or treatment, providers should still educate on the importance of and purpose of treatment to provide informed care. However, they should never infringe upon a patient's autonomy or cultural beliefs.

Advocacy [25]

Patient advocacy is included in the healthcare profession's definition of "professionalism". Advocacy is "the promotion of social, economic, educational, and political changes that ameliorate the suffering and threats to human health and well-being that he or she identifies through his or her professional work or expertise."[25] Treating underserved patients involves values of altruism, compassion and caring, and social responsibility. PTs and PTAs must have compassion for cultures, beliefs, and diverse characteristics and see that everyone deserves access to healthcare. Advocacy begins with education and exposure to diversity and inclusion before becoming a professional. Many educational programs are implementing opportunities to provide pro-bono care and have clinical rotations treating the underserved. This and other sought-out opportunities should help prepare student physical therapists and assistants to have the compassion and altruism to treat all patients with cultural competence.

Advocacy also involves reporting incidents of inequity, racism, sexism, or other discrimination to managers, supervisors, or other leadership. Hospital systems should have a protocol for reporting such events, and nothing should go unreported in the spirit of advocating for patient rights.

Community Resources [14]

Oregon's state health website, www.oregon.gov, has many valuable resources on racial and ethnic disparity and the general breakdown of diverse characteristics among the general population. It breaks down Oregon's population, social determinants of health, health equity analysis, and other details. PTs and PTAs should review these resources to

know which populations are at risk of inadequate care due to access, inequity, and disadvantages.

Use data to inform clinical practice related to health equity (recognize institutional cultural issues)

Section 3 Key Words

Patient-Centered Care – providing healthcare prioritizing the patient's needs, communicating about cultural influences, decision making, and other factors

Certified Healthcare Interpreter – a certified employee who has passed fluency examinations in two languages to translate healthcare services from provider to patient and vice versa

Section 3 Summary

Physical therapists, physical therapist assistants, and other Oregon healthcare providers should strive for continual education and skill development to provide patient-centered, culturally competent healthcare. Recognition of disparities, fostering an inclusive environment, and being mindful of cultural differences are just a few ways to embrace cultural competence.

Case Study

Sam is a physical therapist seeing patients in a rural outpatient clinic in eastern Oregon. He is evaluating Felicia, an immigrant from Mexico (Spanish is her native language) who can speak a few words in English only. Sam speaks intermediate Spanish. Felicia was not able to fill out the intake paperwork and Sam knows only that she is here for a car accident with resulting knee pain. Felicia arrives at the clinic with her daughter, Clarissa, who is learning English in school. Felicia had not shown up for two appointments already as she had transportation issues with a late bus schedule.

Reflection Questions

1. What are the priorities in setting up a successful evaluation for Felicia's physical therapy care?

2. What social determinants of health should Sam be aware of that may influence care?

3. What action should Sam take in providing culturally competent healthcare by assigning a plan of care and exercises?

Reflection Responses

1. The first priority is having a certified healthcare interpreter present for the evaluation. If Sam is unable to get one through their system (video, phone call, in-person), they should not proceed with the evaluation that day. Ideally, this is arranged ahead of time to save Felicia from coming back for another appointment especially considering transportation difficulties. Sam should not attempt to speak intermediate Spanish or rely on Clarissa for interpretation as crucial information will be lost in the exchange.

2. Socioeconomic status, limited English proficiency, educational status, access to healthcare, social support, and employment are all potential social determinants of health in Felicia's care. Sam should inquire about all of these factors before assuming they are at play, however, avoiding stereotypes of limited socioeconomic status because of a language barrier, for example.

3. Sam should ask (through the certified interpreter), how Felicia would be able to fit exercises and recommendations into her life. If she does not see the importance, Sam should educate on the purpose, keeping in mind that she may not have the background to understand the value of exercises. Sam should give exercises and patient education forms in Spanish and seek to change intake forms to Spanish for future patients.

Conclusion

Culturally competent healthcare involves utilizing knowledge, skills, and tools to provide equitable care to patients of different backgrounds, social groups, ethnicity, and other diverse characteristics. This requires a commitment to a lifelong learning process developing knowledge, self-awareness, and the skill set to provide equitable care to all patients. Physical therapists and physical therapist assistants in Oregon have the opportunity to lead the nation in education surrounding cultural competence and providing patient-centered, culturally-minded physical therapy care.

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