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Implicit Bias

Introduction

Research presented by the Centers for Disease Control and Prevention (CDC) suggests that implicit bias can impact patient care as well as a patient's health, overall well-being, and quality of life. The question is, what is implicit bias, and how can health care professionals mitigate implicit bias within their health care organization? This course will answer that very question, while providing insight into health equality.

Section 1: Implicit Bias

A health care professional overhears another health care professional use the following terms to describe a group of patients: addicts, poor, undesirables. The health care professional immediately considers implicit bias.

Unfortunately, much like in the scenario presented above, implicit bias does occur in health care settings. Therefore, health care professionals should be familiar with implicit bias, and methods to mitigate implicit bias within their health care organization. With that in mind, this section of the course will focus on implicit bias, methods to mitigate implicit bias, and cultural competency. The information found within this section of the course was derived from materials provided by the U.S. Department of Health and Human Services Office of Minority Health unless, otherwise, specified (U.S. Department of Health and Human Services Office of Minority Health, 2021).

What is implicit bias?

Implicit bias, otherwise referred to as subconscious bias, may refer to the attitudes or stereotypes that affect individuals' understanding, actions, and decisions in an unconscious manner.

Health care professionals should note the following: implicit bias, which encompasses both favorable and unfavorable assessments, is typically activated involuntarily and without an individual's awareness or intentional control; implicit bias suggests that much of an individual's social behavior is driven by learned stereotypes that operate automatically, and therefore unconsciously, when he or she interacts with other individuals in day-to-day life (note: the term stereotype may refer to a generalized belief about a particular category of individuals).

What are the major elements of implicit bias?

The major elements of implicit bias include: a distinctive psychological construct, such as an “implicit attitude,” which is assessed by a variety of instruments; individuals' thoughts and feelings; cognitive and affective processes; categorization judgment; cognitive load (note: categorization judgment may refer to the process of categorizing objects, events, behaviors, and people; cognitive load may refer to the amount of information that working memory can hold/process at one time) (Stanford Encyclopedia of Philosophy, 2019).

What is the difference between implicit bias and explicit bias?

Explicit bias may refer to an attitude or assumptions that an individual acknowledges as part of his or her personal belief system, which may be assed directly by means of self-report; implicit biases, on the other hand, are attitudes and beliefs about race, ethnicity, age, ability, gender, or other characteristics that operate outside of an individual's conscious awareness and can be measured only indirectly (note: implicit bias may influences judgment and can, without intent, contribute to discriminatory behavior; individuals can hold explicit egalitarian beliefs while harboring implicit attitudes and stereotypes that contradict their conscious beliefs) (Sabin, 2022).

How does implicit bias develop?

Implicit bias, typically, develops early in life from repeated reinforcement of social stereotypes.

Is implicit bias associated with "attitude?"

Implicit bias may be associated with an individual's attitude. Specific information regarding implicit bias and attitude may be found below. The information found below was derived from materials provided by the Stanford Encyclopedia of Philosophy (Stanford Encyclopedia of Philosophy, 2019).

- Attitude may refer to a feeling or way of thinking that impacts an individual's behavior.
- Psychology theories suggest that individuals hold two distinct attitudes in mind toward the same object, one implicit and the other explicit. Explicit attitudes are

typically identified when an individual communicates and engages in conversation, implicit attitudes are those that an individual is unwilling or unable to express in an open manner.

- Some philosophers propose that implicit measures assess a distinct kind of “action-oriented” attitude, which is different from ordinary attitudes, but not necessarily in terms of being unconscious.
- Implicit attitudes may be linked with behavioral impulses.
- Implicit attitudes are typically insensitive to the logical form in which information is presented.
- Implicit attitudes are often implicated in behaviors for which it is difficult to give a logical or reasonable explanation.
- Some philosophers propose that implicit bias and implicit attitudes are characterized by cognitive “schemas” (note: schemas may refer to clusters of culturally shared concepts and beliefs) and an approach that focuses on stereotypes that involve generalizing extreme or horrific behavior from a few individuals to groups.
- Implicit bias may be related to an individual's attitude about a specific situation (e.g., it is best to avoid men while walking alone in a city).

Is it possible to evaluate implicit bias?

Yes, an Implicit Association Test may be used to evaluate/measure implicit bias. The Implicit Association Test may refer to a process that measures the strength of associations between concepts (e.g., different types of people) and evaluations (e.g., good, bad) or stereotypes.

What is a historical example of the impact of implicit bias in health care?

The most well known historical example of implicit bias in health care is the U.S Public Health Service (USPHS) Syphilis Study at Tuskegee. Specific information regarding the USPHS study at Tuskegee may be found below. The information found below was derived from materials provided by the Centers for Disease Control and Prevention (CDC) (Centers for Disease Control and Prevention [CDC], 2021).

- The U.S Public Health Service (USPHS) Syphilis Study at Tuskegee was a clinical study conducted between 1932 and 1972 (note: the study was limited to Black men 25 years of age or older).
- The study was intended to observe the natural history of untreated syphilis (note: syphilis may refer to a bacterial infection typically transmitted through sexual contact). As part of the study, researchers did not collect informed consent from participants and they did not offer treatment.
- In 1932, the USPHS, working with the Tuskegee Institute, began a study to record the natural history of syphilis. It was originally called the "Tuskegee Study of Untreated Syphilis in the Negro Male" (now referred to as the "USPHS Syphilis Study at Tuskegee"). The study initially involved 600 Black men - 399 with syphilis, and 201 who did not have the disease. Participants' informed consent was not collected. Researchers told the men they were being treated for "bad blood," a local term used to describe several ailments, including syphilis, anemia, and fatigue. In exchange for taking part in the study, the men received free medical exams, free meals, and burial insurance.
- By 1943, penicillin was the treatment of choice for syphilis, but the participants in the study were not offered treatment.
- In 1972, an Associated Press story about the study was published. As a result, the Assistant Secretary for Health and Scientific Affairs appointed an Ad Hoc Advisory Panel to review the study. The advisory panel concluded that the study was "ethically unjustified;" that is, the "results [were] disproportionately meager compared with known risks to human subjects involved." In October 1972, the panel advised stopping the study. A month later, the Assistant Secretary for Health and Scientific Affairs announced the end of the study. In March 1973, the panel also advised the Secretary of the Department of Health, Education, and Welfare (HEW) (now known as the Department of Health and Human Services) to instruct the USPHS to provide all necessary medical care for the survivors of the study. The Tuskegee Health Benefit Program (THBP) was established to provide these services. In 1975, participants' wives, widows and children were added to the program. In 1995, the program was expanded to include health, as well as medical, benefits. The last study participant died in January 2004. The last widow

receiving THBP benefits died in January 2009. Participants' children (10 at present) continue to receive medical and health benefits.

- In 1997, President Bill Clinton issued a formal presidential apology, in which he announced an investment to establish what would become the National Center for Bioethics in Research and Health Care at Tuskegee University.
- After the USPHS Syphilis Study at Tuskegee, the government changed its research practices. In 1974, the National Research Act was signed into law, creating the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. The group identified basic principles of research conduct and suggested ways to ensure those principles were followed.
- In addition to the Commission's recommendations, regulations were passed in 1974 that required researchers to get voluntary informed consent from all persons taking part in studies done or funded by the Department of Health, Education, and Welfare (DHEW). They also required that all DHEW-supported studies using human subjects be reviewed by Institutional Review Boards, which decide whether research protocols meet ethical standards.
- An Ethics Advisory Board was formed in the late-1970s to review ethical issues of biomedical research. As a result of their work, the 1979 publication commonly known as The Belmont Report summarized the three ethical principles that should guide human research: respect for persons; beneficence; justice.
- In October 1995, President Bill Clinton created a National Bioethics Advisory Commission, funded and led by the Department of Health and Human Services. The commission's task was to review current regulations, policies, and procedures to ensure all possible safeguards are in place to protect research volunteers. It was succeeded by the President's Council on Bioethics, which was established in 2001, and then the Presidential Commission for the Study of Bioethical Issues established in 2009.

What are contemporary examples of the potential impact of implicit bias in health care?

Examples of the potential impact of implicit bias in health care include the following:

- Non-white patients receive fewer cardiovascular interventions and fewer renal transplants;
- Black women are more likely to die after being diagnosed with breast cancer;
- Non-white patients are less likely to be prescribed pain medications (non-narcotic and narcotic);
- Black men are less likely to receive chemotherapy and radiation therapy for prostate cancer and more likely to have testicle(s) removed;
- Patients of color are more likely to be blamed for being too passive about their health care (Joint Commission, 2022).

How may implicit bias impact individual patient care?

Implicit bias may lead to health disparities. Specific information regarding health disparities may be found below. The information found below was derived from materials provided by the Centers for Disease Control and Prevention (CDC) (Centers for Disease Control and Prevention [CDC], 2022).

- Health disparities may refer to preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by populations that are disadvantaged by their social or economic status, geographic location, and environment.
- Many populations experience health disparities, including people from some racial and ethnic minority groups, people with disabilities, women, people who are LGBTQI+ (lesbian, gay, bisexual, transgender, queer, intersex, or other), people with limited English proficiency, and other groups.
- Across the U.S., individuals in some racial and ethnic minority groups experience higher rates of poor health and disease for a range of health conditions, including diabetes, hypertension, obesity, asthma, heart disease, cancer, and preterm birth (e.g., the average life expectancy among Black or African American individuals in the U. S. is four years lower than that of other groups; these disparities sometimes persist even when accounting for other demographic and socioeconomic factors, such as age or income).
- Health disparities may be impacted by social determinants of health (note: social determinants of health may refer to conditions in the places where people live,

learn, work, play, and worship that affect a wide range of health risks and outcomes).

- Social determinants of health may be impacted by individuals' social and community context, which includes their interactions with the places they live, work, learn, play, and worship and their relationships with family, friends, co-workers, community members, and institutions. Interventions are critical to protecting the health and well-being of people who do not get the level of support they need to thrive from their social and community context (e.g., children of incarcerated or detained parents may gain from their parents' participation in reentry programs that assist with job placement or offer parenting support, and lesbian, gay or bi-sexual high school students who are bullied would benefit from school-based programs to reduce violence and prevent bullying).

- Social and community context also includes discrimination (note: discrimination may refer to the unfair treatment of people or groups based on characteristics, such as: race, gender, age, or sexual orientation). Discrimination exists in many systems in society including those meant to protect well-being or health such as health care, housing, education, criminal justice, and finance; discrimination often has a negative effect on the people and groups who experience it and some people who belong to groups that historically have experienced discrimination, such as people with disabilities, people experiencing homelessness, and people who are incarcerated or detained; people who have experienced discrimination may be affected by layered health and social inequities.

- Health disparities may be impacted by racism (note: racism may refer to a system, supported and maintained through institutional structures and policies, cultural norms and values, and individual behaviors). The three major types of racism include: structural, institutional, or systemic racism, personally-mediated or interpersonal racism, and internalized racism (note: structural, institutional, or systemic racism may refer to differential access to the goods, services, and opportunities of society by race; personally-mediated or interpersonal racism may refer to differential assumptions and differential actions by individuals towards others; internalized racism may refer to acceptance by members of the stigmatized races of negative messages about their own abilities and intrinsic worth).

- Racism determines opportunity based on the way people look or the color of their skin. It also shapes social and economic factors that put some people from racial and ethnic minority groups at increased risk for negative mental health outcomes and health-related behaviors, as well as chronic and toxic stress or inflammation.
- Individuals with disabilities and people from some racial and ethnic minority groups, rural areas, and White populations with lower incomes are more likely to experience implicit bias driven health disparities.
- Individuals who have been historically marginalized, such as people from racial and ethnic minority groups, people with disabilities, and people with lower incomes, are disproportionately affected by inequities in access to high-quality education and implicit bias driven health disparities; policies that link public school funding to the tax base of a neighborhood limit the resources available in schools of lower income neighborhoods; this results in lower-quality education for residents of lower income neighborhoods, which can lead to lower literacy and numeracy levels, lower high school completion rates, and barriers to college entrance; in addition to educational barriers, limited access to quality job training or programs tailored to the language needs of some racial and ethnic minority groups may limit future job options and lead to lower paying or less stable jobs. Individuals from some racial and ethnic minority groups and other historically marginalized groups also face greater challenges in getting higher paying jobs with good benefits due to less access to high-quality education, geographic location, language differences, discrimination, and transportation barriers. People with limited job options often have lower incomes, experience barriers to wealth accumulation, and carry greater debt. The historical practice of denying mortgages to people of color has also created a lack of opportunity for home ownership, and thus wealth accumulation, due to the inability to pass down property and build wealth. Such financial challenges may make it difficult to manage expenses, pay medical bills, and access affordable quality housing, education, nutritious food, and reliable childcare.

How can health care professionals identify implicit bias within their health care organization?

Health care professionals can identify implicit bias within their health care organization by utilizing the strategies found below. The information found below was derived from materials provided by the Joint Commission (Joint Commission, 2022).

- Evaluate the racial climate by evaluating employees' shared perceptions of the policies and practices that communicate the extent to which fostering diversity and eliminating discrimination are priorities in the organization.
- Investigate reports of subtle or overt discrimination and unfair treatment.
- Identify and investigate implicit bias incidents (note: an implicit bias incident may refer to an event characterized by discrimination, bullying, aggression, or harassment against an individual based on perception of race, color, creed, religion, national origin, citizenship, sex, pregnancy, age, marital status, sexual orientation, gender identity or expression, genetic information, disability, veteran status, or other preconceived notion).
- Identify and work to transform formal and informal norms that ignore and/or support racism.
- Establish monitoring systems in which processes and outcomes of care can be compared by patient race (note: collecting data on race and other indicators of social position can be used to self-assess, monitor and evaluate the effectiveness of the organization's strategies for eradicating inequities in care).
- Give care units and, where appropriate, individual clinicians, equity-specific targeted feedback; when inequities are found, support creative solutions for remediation and create accountability for improvement.
- Implement work policies and clinical procedures that protect health care professionals from high cognitive load and promote positive emotions (note: when health care professionals' cognitive capacity is low or overtaxed, memory is biased toward information that is consistent with stereotypes; high cognitive load can be created by: productivity pressures, time pressure, high noise levels, inadequate staffing, poor feedback, inadequate supervision, inadequate training, high communication load, and overcrowding).

- Promote racial diversity at all levels of the organizational hierarchy and support positive intergroup contact (note: intergroup contact can reduce intergroup prejudice and help reduce feelings of interracial anxiety; institutional support for interaction can increase the benefits of intergroup contact).
- Implement and evaluate training that ensures that health care professionals have the knowledge and skills needed to prevent racial biases from affecting the quality of care they provide (note: the training should cover self-awareness regarding implicit biases, and skills related to perspective-taking, emotional regulation, and partnership-building; training may be used to identify existing implicit bias).

How can health care professionals mitigate implicit bias within their health care organization?

Health care professionals can mitigate implicit bias within their health care organization by embracing cultural competency (note: cultural competency may refer to a developmental process in which one achieves increasing levels of awareness, knowledge, and skills along a continuum, improving one's capacity to work and communicate effectively in cross-cultural situations).

How can health care professionals achieve cultural competency?

Health care professionals can achieve cultural competency by following cultural competency recommendations. Cultural competency recommendations may be found below. The information found below was derived from materials provided by the U.S. Department of Health and Human Services Office of Minority Health (U.S. Department of Health and Human Services Office of Minority Health, 2021).

- Recognize that implicit bias does exist - first and foremost, health care professionals should recognize that implicit bias does exist; failing to recognize implicit bias can perpetuate implicit bias. Additionally, health care professionals should recognize that implicit bias can negatively affect clinical interactions and outcomes.
- Face implicit bias - after recognizing that implicit bias does exist, health care professionals should consider facing their own potential implicit bias. Methods that may be used to face implicit bias can be found below.

    - Stereotype replacement - stereotype replacement may refer to a process that enables an individual to become aware of the stereotypes he or she holds in order to create non-stereotypical alternatives to such stereotypes (note: stereotype replacement typically involves objective self-reflection).
    - Counter-stereotypic imaging - counter-stereotypic imaging may refer to remembering or imagining someone from a stereotyped group who does not fit the stereotype.
    - Individuating - individuating may refer to identifying each person as an individual, not a group member.
    - Perspective-taking - perspective-taking may refer to the act of considering the perspective of someone from a group different than one's own group (i.e., putting oneself in another person's shoes).
    - Cultural contact - cultural contact may refer to the process of building confidence in interacting with people who are different by seeking ways to get to know people from different social groups.
    - Emotional regulation - emotional regulation may refer to the process of reflecting on “gut feelings” and negative reactions to people from different social groups, while considering positive feelings.
    - Mindfulness - mindfulness may refer to the act of focusing attention on the present moment (note: mindfulness can help individuals identify and avoid stereotypic thoughts).
- Acknowledge the potential benefits of cultural competency - cultural competency may produce numerous benefits for health care organizations, patients, and the surrounding community. Such benefits may include the following: increases mutual respect and understanding between patient and organization; increases trust; promotes inclusion of all community members; increases community participation and involvement in health issues; assists patients and families in their care; promotes patient and family responsibilities for health; improves patient data collection; increases preventive care by patients; reduces care disparities in the patient population; increases cost savings from a reduction in medical errors, number of treatments and legal costs; reduces the number of missed medical visits; incorporates different perspectives, ideas, and strategies into the decision-making process; decreases barriers that slow progress; moves

toward meeting legal and regulatory guidelines; improves efficiency of care services; increases the market share of the health care organization.

- Practice cultural humility - cultural humility may refer to a reflective process of understanding one’s biases and privileges, managing power imbalances, and maintaining a stance that is open to others in relation to aspects of their cultural identity that are most important to them. Health care professionals should note the following strategies that can be used to help practice cultural humility: practicing self-reflection, including awareness of one's beliefs, values, and implicit biases; recognize what one does not know everything; being open to learning as much as one can; remain open to other people’s identities and empathizing with their life experiences; acknowledging that the patient is their own best authority; learning and growing from other people's beliefs, values, and worldviews.

- Engage in culturally and linguistically appropriate services (CLAS) - culturally and linguistically appropriate services (CLAS) may refer to services that are respectful of and responsive to individual cultural health beliefs and practices, preferred languages, health literacy levels, and communication needs. Health care professionals should note the following: CLAS should be employed by all members of a health care organization at every point of contact.

- Consider using the explanatory model - the explanatory model includes the patient's beliefs about their illness, the personal and social meaning they attach to their disorder, expectations about what will happen to them and what the provider will do, and their own therapeutic goals. Health care professionals can ask the following questions to effectively use the explanatory model during patient care: What do you call the problem?; What do you think has caused the problem?; Why do you think it started when it did?; What do you think the sickness does- how does it work?; How severe is the sickness - will it have a long or a short course?; What kind of treatment do you think you should receive?; What are the chief problems the sickness has caused?; What do you fear most about the sickness?

- Utilize the ADDRESSING framework - the ADDRESSING framework can help health care professionals remember some of the key social identities to consider when getting to know individuals' cultural identity. The elements of the ADDRESSING framework include the following:

    - Age and generational influences;
    - Disability status, focusing on developmental disabilities (note: the term developmental disability may refer to a condition that resulted from an impairment in physical, learning, language, or behavior areas);
    - Disability status, focusing on physical, cognitive, and psychosocial disabilities;
    - Religion and spiritual orientation;
    - Ethnicity and race;
    - Socioeconomic status;
    - Sexual orientation;
    - Indigenous heritage;
    - National origin;
    - Gender identity.
- Utilize the RESPECT model - the RESPECT model can help health care professionals remember what factors to consider in order to engage patients in a culturally and linguistically competent manner. The elements of the RESPECT model include the following:
    - Respect - health care professionals should understand how respect is shown within given cultural groups;
    - Explanatory model - health care professionals should devote time in treatment to understanding how patients perceive their presenting problems;
    - Sociocultural context - health care professionals should recognize how class, race, ethnicity, gender, education, socioeconomic status, sexual and gender orientation, immigrant status, community, family, gender roles, and so forth affect health care;
    - Power - health care professionals should acknowledge the power differential that may exist between patients and health care professionals;

    - Empathy - health care professionals should express, verbally and nonverbally, the significance of each patient's concerns so the patient feels that the health care professional understands.
    - Concerns and fears - health care professionals should elicit patients' concerns and apprehensions regarding help-seeking behavior and initiation of treatment.
    - Therapeutic alliance and trust - health care professionals should commit to behaviors that enhance the therapeutic relationship; recognize that trust is not inherent but must be earned by health care professionals; recognize that self-disclosure may be difficult for some patients; consciously work to establish trust.
- Utilize the LEARN model - the LEARN model suggests a framework for listening, explaining, acknowledging, recommending, and negotiating health care information and instructions. The elements of the LEARN model include the following:
    - Listen with empathy for the patient's perception of the problem;
    - Explain the issue at hand;
    - Acknowledge and discuss differences and similarities;
    - Recommend treatment - recommend a treatment plan that is developed with the patient's involvement, including culturally appropriate aspects;
    - Negotiate agreement (note: the final treatment plan should be determined as mutually agreeable by both the health care professional and the patient).
- Work to improve listening - to build on the previous recommendation, health care professionals should work to improve listening. Health care professionals can improve listening by utilizing the following methods: sit at the same level as the patient, look at them instead of the chart or screen, and let them speak with few or no interruptions; acknowledge the patient's expertise by saying, "You know your body better than I do" or "You're in the best position to judge;" ask questions to better understand how the patient views their health, health care needs, and priorities; invite questions from the patient; answer patient questions fully, clearly, and respectfully, without interrupting.

- Engage in partnership building and shared decision-making - partnership building may refer to the process of framing the patient-health care professional relationship as one between collaborating equals or as equal members of a team. Shared decision-making means treatment decisions are based on both the patient's and health care professional's expertise. Health care professionals should note the following five essential steps of shared decision-making: seek the patient's participation; help the patient explore and compare treatment options; assess the patient's values and preferences; reach a decision with the patient; evaluate the patient's decision.

- Work towards effective communication - health care professionals can work towards effective communication by utilizing the following methods:

    - Use plain, non-medical language - health care professionals should use common words that they would use to explain medical information to their friends or family, such as stomach or belly instead of abdomen;

    - Use the patient's words - health care professionals should take note of what words the patient uses to describe their illness, and use them in their conversation;

    - Slow down - health care professionals should speak clearly and at a moderate pace;

    - Limit and repeat messages - health care professionals should prioritize what needs to be discussed, and limit information to three to five key points and repeat them;

    - Be specific and concrete - health care professionals should not use vague and subjective terms that can be interpreted in different ways;

    - Show graphics - health care professionals should consider drawing pictures, using illustrations, or demonstrating with 3-D models; all pictures and models should be simple, designed to demonstrate only the important concepts, without detailed anatomy;

    - Demonstrate how it's done - whether doing exercises or taking medicine, a demonstration of how to do something may be clearer than a verbal explanation.

- Possess insight into different communication styles - possessing insight into how communication styles tend to vary across cultures can help health care professionals avoid misunderstandings and, ultimately, implicit bias. Examples of communication styles and how they may differ across cultures may be found below.

    - Tone, volume, and speed of speech - culture can influence how loudly it is appropriate to talk, the tone and level of expressiveness in the voice, and the speed of speech. Loud, fast, and expressive speech is common in some cultures but could be considered rude or aggressive in others (e.g., some American Indian cultures, Alaskan native, and Latin American indigenous cultures favor softer tones of voice and less expressive speech).

    - Eye contact - culture can influence whether it is considered polite or rude to make eye contact when addressing someone, and whether eye contact is necessary to indicate that one is listening (e.g., direct eye contact is considered rude in some Asian cultures).

    - Use of pauses and silence - culture can influence whether pauses and silence are comfortable or uncomfortable (e.g., pauses and silence are uncomfortable for many people who identify with dominant U.S. cultural norms; some American Indian cultures value silences and pauses as they provide time to process information and gather thoughts).

    - Facial expressiveness - culture can influence whether low facial expressiveness is considered normal or interpreted as a lack of understanding, a lack of interest, or even resistance (e.g., Latin American and the Caribbean cultures may value high facial expressiveness).

    - Emotional expressiveness - culture can influence how open people are in talking about their feelings. It is important to note that people from cultures that tend to be more emotionally expressive may still think that it is inappropriate to discuss emotions (particularly negative emotions) with people who are not close friends or family (e.g., East Asian cultures may consider it inappropriate to express strong emotions).

    - Self-disclosure - culture can influence whether talking to others about difficult personal situations is accepted or considered inappropriate. Individuals from cultures where self-disclosure is generally viewed negatively may disclose little about themselves and feel uncomfortable when asked to open up about personal problems (e.g., East Asian cultures may not feel comfortable with self-disclosure).

  - Formality - culture can influence whether personal warmth or respect and formality are more valued (e.g., East Asian cultures may embrace formality).
  - Directness - culture can influence whether verbal directness is valued or considered rude (e.g., the dominant cultural norm in the U.S. is to be relatively direct compared to many other cultures).
  - Context - culture can influence whether communication is high or low context. In low context cultures, words convey most of the meaning. In high context cultures, meaning is conveyed by more subtle verbal and non-verbal cues (e.g., the dominant culture in the U.S. is mostly low context, whereas many other cultural groups are higher context).
  - Orientation to self or others - some cultures are much more oriented to the self, while others are more oriented to others. This shows in communication styles through the use of mostly "I" statements versus the use of primarily third person and plural pronouns (e.g., the dominant cultural norm in the U.S. is individualistic; many other cultural groups are more collectivistic).
- Improve cultural and linguistic appropriateness - individuals can improve cultural and linguistic appropriateness by the following methods: understand that improving cultural and linguistic appropriateness is an ongoing process; understand the role that one's culture plays in interactions and delivery of care; understand the role culture plays in health beliefs and behaviors; become knowledgeable about the backgrounds of other individuals; be aware of language differences, and offer language assistance services; build trust and rapport with other individuals to facilitate learning about their needs, values, and preferences; be aware that some individuals may use various terms to describe medical issues (e.g., "sugar" for diabetes); be aware of barriers that can arise when expressions, idioms, or multi-meaning words are used; ask questions.
- Do not make assumptions - cultural assumptions can lead to implicit bias, thus, health care professionals should avoid assumptions. To avoid assumptions health care professionals should use simple language; avoid medical and health care jargon; avoid assuming they know an individual's literacy and health literacy

levels; check understanding and encourage questions; avoid assuming an individual understood what was communicated; adopt a positive, curious, nonjudgmental approach toward all individuals; avoid assigning meaning to an individual's nonverbal communication cues.

- Work to understand social identities - health care professionals can work to understand social identities by considering the following key factors for each patient:

    - Key historical events that influenced his or her culture (e.g., what lingering damage might American Indian communities face as a result of the history of compulsory boarding schools separating American Indian children from their families);

    - Sociopolitical issues (e.g., how may patients be affected by current changes in immigration enforcement);

    - Basic values and beliefs (e.g., how might values of independence and individualism, common in dominant groups in the U.S., contrast with values of collectivism and family predominant in many Asian, African, and Latin American cultures);

    - Cultural practices (e.g., what cultural practices are common among the dominant groups in the U.S. in contrast with cultural practices of other groups).

- Work effectively with an interpreter - some patients may require an interpreter. Therefore, to ensure effective communication and, ultimately, safe and effective health care, health care professionals should work effectively with an interpreter. Health care professionals may use the following methods to work effectively with an interpreter:

    - Use a trained interpreter (note: interpreters should be trained and certified in medical interpreting, especially when working in a patient setting);

    - Treat the interpreter as a respected health care professional;

    - Allow extra time for a visit;

- Ensure that there are no (or minimal) distractions, such as noises that may interrupt patient engagement;
- Give the interpreter a brief summary of the individual, goals, and/or procedures for the session;
- Document the name of the interpreter;
- Health care professionals should introduce themselves and have others in the room introduce themselves directly to the patient upon entering the room, allowing the interpreter to interpret the greeting (note: health care professionals should not address their introductions to the interpreter; introductions help set the tone and establish the health care professional as the one directing the interaction);
- Use the first person, and ask the interpreter to do the same;
- Face and speak directly to the patient (note: even if the patient maintains eye contact with the interpreter, health care professionals should maintain eye contact with the patient, not the interpreter);
- Observe and monitor all nonverbal communication;
- Speak clearly;
- Avoid shouting;
- Use simple language and avoid medical or health care jargon;
- Use sentence-by-sentence interpretation (note: multiple sentences may lead to information being left out);
- Allow the interpreter to ask open-ended questions, if needed, to clarify what a patient says;
- Observe what is going on before interrupting the interpreter (note: interruption may be warranted, for example, if the interpreter is taking a long time to interpret a simple sentence, or if the interpreter is having a conversation with the patient outside of their role);
- Ask interpreters if they are filling in details for the patient (note: the interpreter may have interpreted for the patient before and may be familiar with the patient's history, or the interpreter may be filling in based

  on assumptions; it is important that the interpreter maintains professionalism, and that health care professionals obtain an accurate and current history each time the patient is seen);

  - Allow time for the patient to ask questions and seek clarifications;

  - If patients decline language assistance services, ask them to sign a form that says they understand that language assistance is available and choose to decline these services;

  - Remember that some individuals who require an interpreter may understand English well; comments health care professionals make to others might be understood by the patient.

- Consider patients' beliefs regarding coronavirus disease 2019 (COVID-19) vaccination - due to personal, cultural, or religious beliefs, some individuals may not want to receive COVID-19 vaccination (note: COVID-19 may refer to a respiratory illness that can spread from person to person, which is caused by a virus known as the severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2]). Health care professionals should be aware of such individuals when working to prevent and treat COVID-19.

- Adhere to the laws that protect individuals from discrimination - specific U.S. laws protect individuals from discrimination. Health care professionals should be aware of such laws to help mitigate implicit bias and to help achieve cultural competency. Health care professionals should note that adhering to such laws can help achieve cultural competency when engaging with patients as well as fellow health care professionals. Specific laws that protect individuals from discrimination may be found below. The information found below was derived from materials provided by the U.S. Department of Health and Human Services (U.S. Department of Health and Human Services, 2021).

  - Title VI of the Civil Rights Act of 1964, as amended, prohibits discrimination on the basis of race, color, or national origin.

  - Section 504 of the Rehabilitation Act of 1973, as amended, prohibits discrimination against otherwise qualified individuals on the basis of disability.

- Title IX of the Education Amendments of 1972, as amended, prohibits discrimination on the basis of sex (including pregnancy, sexual orientation, and gender identity).
- The Age Discrimination Act of 1975, as amended, prohibits discrimination on the basis of age.
- Titles VI and XVI of the Public Health Service Act require health care facilities that received certain Federal funds ("Hill-Burton" funds) to provide certain services to members of its designated community.
- Section 1557 of the Patient Protection and Affordable Care Act provides that an individual shall not be excluded from participation in, be denied the benefits of, or be subjected to discrimination on the grounds prohibited under Title VI of the Civil Rights Act of 1964, (race, color, national origin), Title IX of the Education Amendments of 1972, (including pregnancy, sexual orientation, and gender identity), the Age Discrimination Act of 1975, (age), or Section 504 of the Rehabilitation Act of 1973, (disability), under any health program or activity, any part of which is receiving Federal financial assistance, or under any program or activity that is administered by an Executive Agency or any entity established under Title I of the Affordable Care Act or its amendments.
- Section 1553 of the Patient Protection and Affordable Care Act prohibits discrimination against individuals or institutional health care entities that do not provide assisted suicide services.
- Federal Health Care Conscience Protection Statutes prohibit recipients of certain Federal funds from discriminating against certain health care providers who refuse to participate in certain health care services on religious or moral grounds.
- Section 508 of the Rehabilitation Act of 1973, as amended, prohibits discrimination on the basis of disability in electronic and information technology.
- Section 533 of the Public Health Service Act prohibits discrimination on the basis of age, race, color, national origin, disability, religion, or sex (including pregnancy, sexual orientation, and gender identity) in Projects for Assistance in Transition from Homelessness.

- Section 1908 of the Public Health Service Act prohibits discrimination on the basis of age, race, color, national origin, disability, religion, or sex (including pregnancy, sexual orientation, and gender identity) in programs, services, and activities funded by Preventative Health and Health Services Block Grants.
- Section 1947 of the Public Health Service Act prohibits discrimination on the basis of age, race, color, national origin, disability, religion, or sex (including pregnancy, sexual orientation, and gender identity) in programs and activities funded by Community Mental Health Services Block Grant and Substance Abuse Prevention and Treatment Block Grants.
- The Family Violence Prevention and Services Act prohibits discrimination on the basis of age, race, color, national origin, disability, religion, or sex (including pregnancy, sexual orientation, and gender identity) in programs and activities funded under said Act.
- The Low-Income Home Energy Assistance Act of 1981 prohibits discrimination on the basis of race, color, national origin, or sex (including pregnancy, sexual orientation, and gender identity) in programs and activities funded under said Act.
- The Community Services Block Grant Act prohibits discrimination on the basis of race, color, national origin, or sex (including pregnancy, sexual orientation, and gender identity) in programs and activities funded under said Act.
- The Communications Act of 1934, as amended, has equal employment opportunity provisions that prohibit employment discrimination on the basis of race, color, religion, national origin, or sex (including pregnancy, sexual orientation, and gender identity) by Federally-funded public telecommunication entities.

How can cultural competency be applied to specific patients?

Case studies are presented below to explore how cultural competency can be applied to specific patients. When reading the case studies presented below, health care professionals should consider the application of cultural competency recommendations and how cultural competency may improve the outcome of each case study. Case study review questions are presented below the case studies to help promote further reflection about cultural competency. The information found within the case studies was derived from materials provided by the AIDS Education and Training Center-National Multicultural Center (AIDS Education and Training Center-National Multicultural Center, 2022).

Case Study 1

A 42-year-old woman of African descent presents to a health care facility for her monthly visit for HIV management. The patient missed several appointments in the past six months. When questioned about her missed appointments by a health care professional, the patient tells the health care professional that she was too busy to come in. Upon further questioning, the patient reports that she is feeling fine, but notices that her tongue looks white. Lab work reveals that the patient has a T-cell count of 34 and a viral load of 110,000. The health care professional provides the patient with information about antiretroviral therapy and recommends that the patient start antiretroviral therapy. The health care professional also asks the patient if she has a support system among family members or friends. The patient responds by saying she "does not know.” The patient goes on to explain that her family "probably won't help" her due to their belief system.

Case Study 2

Jill, a 32-year-old woman of African descent, presents to a health care facility for a follow-up visit after having an HIV test, which is positive. Upon receiving the HIV test results through a post-counseling interview, it is discovered that Jill is really James, a 32-year-old man. Questioning from a health care professional reveals that James routinely engages in unprotected intercourse with multiple partners. James also reveals that he cannot ask his family for help because "they will not accept" him. Additionally, James reports that he does not think he can stop engaging in intercourse with multiple patterns on a routine basis.

Case Study 3

Karen, a 34-year-old Native American woman from a small reservation, presents to a health care facility. The patient was married at age 17 and contracted HIV from prior drug use. The patient's husband, Carlos, a Central American immigrant, was HIV tested and is negative, although Karen admits they occasionally have unprotected intercourse. Additionally, the patient has a history of alcohol and crack use, as well as a history of abnormal Pap smears. The patient's family history and social history reveals childhood physical and sexual abuse, and chemical dependency. Upon questioning from a health care professional, the patient reveals that her family does not "know about her health." The patient also reports that she does not want her family to know about her health because they will blame her husband because he is an "outsider."

Case Study 4

The Infectious Disease (ID) team in a health care facility is called for a consult on the Pediatric floor for a 16 -year-old male patient, Juan, who tested positive for HIV. Juan was admitted to the hospital three days prior for a heroin overdose. Several family members are present in his room upon the ID team's arrival. Juan asks his family to leave the room and proceeds to explain, to the ID team, how he thinks he contracted HIV. Juan does not think he needs an interpreter. However, he reports that he is having some difficulty communicating with health care professionals. Upon questioning, Juan admits to using heroin for one year, but says he has not used heroin for the past three months. Juan also reports that he is homosexual, and engaged in intercourse with multiple "partners" over the past year. When asked how he thinks he contracted HIV, Juan says that he was recently injected with heroin against his will. Juan also says that he does not want to disclose his HIV diagnosis to his family.

Case Study 5

Joe is a 52-year-old African American man who was diagnosed with HIV four years ago. The patient does not have a history of opportunistic infections but is diagnosed with hypertension, hyperlipidemia, and obesity. The patient also has a history of crack cocaine addiction for which he received inpatient treatment. Upon questioning by a health care professional, the patient reports that his last drug use was four years ago at the time of his HIV diagnosis. Upon further questioning, the patient reports that he does not take antiretroviral medications for "cultural reasons."

Case Study 6

Pedro, a 32-year-old patient diagnosed with a bipolar disorder, presents to a health care facility for management of his condition. Pedro was initially seen by a health care professional. After engaging in an introductory conversation with the patient, the health care professional obtained a social history assessment by integrating cultural questions into the conversation with the patient. When asked what he thought caused his illness, Pedro readily explained, “I got it from my mother, and from all the other crazy things I did to get drugs.” Pedro was then asked what he thinks bipolar disorder does to him. Pedro stated that it "enhanced my relationship with God." Pedro added, “It makes me want to live and accomplish my goal of going back to college, before God takes me.” The health care professional then asked what level of severity Pedro thinks his bipolar disorder is at. Pedro stated that, at times, he becomes angry and depressed because he doesn’t know what is going to happen next. Pedro added, “I try to focus on my relationship with God to heal the illness.” The health care professional then asked what kind of treatments he thought he should receive. Pedro stated that he had a strong belief in herbs and vitamins as well as a strong spiritual belief system. When asked what were the most important results he hoped to achieve from these treatments, Pedro stated that he "hoped to maintain good health and avoid taking any more medications." Pedro further explained his reluctance in taking any more medication by saying, “it affects other organs in my body.” Pedro also reported the chief problem in having bipolar disorder was increased stress. When the health care professional asked Pedro what he feared most about his illness, Pedro responded, “going on another drug binge."

Case Study 7

Angela, a 22-year-old transgender Asian American, presents to a health care facility for a routine appointment. Upon questioning, Angela reports that, "she feels depressed all the time" because her family will not accept her "decisions." Angela also reports that she is stressed about starting estrogen hormone therapy because she is "not sure what it will do to her." Additionally, Angela is concerned that she will not be able to stop "binge drinking" or using cocaine when she "parties."

Case Study 8

A 79-year-old woman residing in a nursing home reports that she does not "feel like taking her medications any more" because she is tired of her "doctor's attitude," which she describes as "ill-tempered" and "impatient." The resident also reports that her doctor "does not seem to like old people" because "he is always making derogatory comments" about his patients. Additionally, the patient reports that she does not care if she "lives or dies anymore."

Case Study 9

A 74-year-old Asian American woman is rushed to the hospital by her children. The patient's chief complaint is that she is "extremely dizzy and cannot walk." Upon examination, a health care professional observes what appears to be red and purple circles on the patient's back. The health care professional immediately begins to consider older adult abuse.

Case Study 10

Emma, a 22-year-old woman presents to a health care facility. The patient reports that she is feeling "sick." Lab work reveals that the patient is positive for COVID-19. Questioning from a health care professional reveals that the patient is not vaccinated for COVID-19. Further questioning reveals that the patient does not want to receive vaccination because there "might be something in the vaccine" and because her family will not let her "get one" due to their belief system. The patient also reports that she does not like to "wear a mask" because it "messes up" her makeup.

Case Study 11

A 78-year-old Portuguese woman presents to a health care facility after a fall. A health care professional attempts to conduct a patient assessment - however, the health care professional cannot understand the patient because she is speaking in Portuguese. The health care professional calls an interpreter. Once the interpreter arrives, the health care professional begins the assessment. The health care professional speaks directly to the interpreter. Upon questioning, the patient reports that the fall was all her "son's fault" because he was "late picking her up." The patient goes on to say that the fall caused her to "miss Mass" and she wants to speak to a priest before she speaks to anyone else.

Case Study 12

A 44-year-old, Italian-American man presents to a health care facility with a hand injury. The patient reports that he "hurt" his hand while boxing. X-rays reveal the patient's right hand is broken. Upon questioning from a health care professional, the patient reports that his pain is "about a two out of ten." The patient also refuses pain medications. Upon further questioning, the patient asks if he can call his mother. Before a health care professional can answer, the patient attempts to stand up to retrieve his cell phone.

Upon standing, the patient falls. The patient immediately gets up on his own, and reports that he is "okay."

Case Study Review

Are there examples of implicit bias within the case studies; if so what are they?

How can cultural competency be applied to each patient in each case study?

How can health care professionals apply cultural competency recommendations to each case study?

How can cultural competency improve the outcome of each case study?

Section 1 Summary

Implicit bias, otherwise referred to as subconscious bias, may refer to the attitudes or stereotypes that affect individuals' understanding, actions, and decisions in an unconscious manner. Research presented by the CDC suggests that implicit bias can impact patient care as well as patient health, overall well-being, and quality of life. Therefore, health care professionals should work to mitigate implicit bias within their health care organization. Health care professionals can mitigate implicit bias within their health care organization by embracing and achieving cultural competency.

Section 1 Key Concepts

- Implicit bias, which encompasses both favorable and unfavorable assessments, is typically activated involuntarily and without an individual’s awareness or intentional control; implicit bias suggests that much of an individual's social behavior is driven by learned stereotypes that operate automatically, and therefore unconsciously, when he or she interacts with other individuals in day-to-day life.
- The major elements of implicit bias include: a distinctive psychological construct, such as an “implicit attitude,” which is assessed by a variety of instruments; individuals' thoughts and feelings; cognitive and affective processes; categorization judgment; cognitive load.

- Implicit bias may influences judgment and can, without intent, contribute to discriminatory behavior; individuals can hold explicit egalitarian beliefs while harboring implicit attitudes and stereotypes that contradict their conscious beliefs.
- Implicit bias may be associated with an individual's attitude.
- Health care professionals can mitigate implicit bias within their health care organization by embracing cultural competency.

Section 1 Key Terms

Implicit bias (otherwise referred to as subconscious bias) - the attitudes or stereotypes that affect individuals' understanding, actions, and decisions in an unconscious manner

Stereotype - a generalized belief about a particular category of individuals

Categorization judgment - the process of categorizing objects, events, behaviors, and people

Cognitive load - the amount of information that working memory can hold/process at one time

Explicit bias - an attitude or assumptions that an individual acknowledges as part of his or her personal belief system, which may be assed directly by means of self-report

Attitude - a feeling or way of thinking that impacts an individual's behavior

Schemas - clusters of culturally shared concepts and beliefs

Implicit Association Test - a process that measures the strength of associations between concepts and evaluations or stereotypes

Syphilis - a bacterial infection typically transmitted through sexual contact

Health disparities - preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by populations that are disadvantaged by their social or economic status, geographic location, and environment

Social determinants of health - conditions in the places where people live, learn, work, play, and worship that affect a wide range of health risks and outcomes

Discrimination - the unfair treatment of people or groups based on characteristics, such as: race, gender, age, or sexual orientation

Racism - a system, supported and maintained through institutional structures and policies, cultural norms and values, and individual behaviors

Structural, institutional, or systemic racism - differential access to the goods, services, and opportunities of society by race

Personally-mediated or interpersonal racism - differential assumptions and differential actions by individuals towards others

Internalized racism - acceptance by members of the stigmatized races of negative messages about their own abilities and intrinsic worth

Implicit bias incident - an event characterized by discrimination, bullying, aggression, or harassment against an individual based on perception of race, color, creed, religion, national origin, citizenship, sex, pregnancy, age, marital status, sexual orientation, gender identity or expression, genetic information, disability, veteran status, or other preconceived notion

Cultural competency - a developmental process in which one achieves increasing levels of awareness, knowledge, and skills along a continuum, improving one's capacity to work and communicate effectively in cross-cultural situations

Stereotype replacement - a process that enables an individual to become aware of the stereotypes he or she holds in order to create non-stereotypical alternatives to such stereotypes

Counter-stereotypic - remembering or imagining someone from a stereotyped group who does not fit the stereotype

Individuating - identifying each person as an individual, not a group member

Perspective-taking - the act of considering the perspective of someone from a group different than one's own group

Cultural contact - the process of building confidence in interacting with people who are different by seeking ways to get to know people from different social groups

Emotional regulation - the process of reflecting on "gut feelings" and negative reactions to people from different social groups, while considering positive feelings

Mindfulness - the act of focusing attention on the present moment

Cultural humility - a reflective process of understanding one’s biases and privileges, managing power imbalances, and maintaining a stance that is open to others in relation to aspects of their cultural identity that are most important to them

Culturally and linguistically appropriate services (CLAS) - services that are respectful of and responsive to individual cultural health beliefs and practices, preferred languages, health literacy levels, and communication needs

Developmental disability - a condition that resulted from an impairment in physical, learning, language, or behavior areas

Partnership building - the process of framing the patient-health care professional relationship as one between collaborating equals or as equal members of a team

Shared decision-making - treatment decisions are based on both the patient's and health care professional's expertise

Coronavirus disease 2019 (COVID-19) - a respiratory illness that can spread from person to person, which is caused by a virus known as the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)

Section 1 Personal Reflection Question

How can implicit bias lead to health disparities?

Section 2: Health Equality

In addition to cultural competency, health care professionals can mitigate implicit bias by ensuring health equality. In the current health care climate, health equality is especially important when caring for patients with disabilities and when working to prevent and treat COVID-19. With that in mind, this section of the course will review health equity, while highlighting how health care professionals can achieve health equality when caring for patients with disabilities and when working to prevent and treat COVID-19. The information found within this section of the course was derived from materials provided by the CDC unless, otherwise, specified (CDC, 2022).

Health Equity

- Health equity is the state in which everyone has a fair and just opportunity to attain their highest level of health.
- Achieving health equity requires focused and ongoing societal efforts to address historical and contemporary injustices; overcome economic, social, and other obstacles to best health and health care; and eliminate preventable health disparities.
- Health care professionals and health care organizations can work towards health equity by building a diverse workforce throughout levels, including leadership positions; considering the benefits of hiring people from the communities the health care facility serves, including those who are disproportionately affected; working with community partners to identify priorities and strategies, including the need to build community awareness and acceptance, before communication products are developed and released; avoiding jargon and using straightforward, easy to understand language; ensuring information is culturally responsive, accessible, and available; understanding that Information should represent people in the communities for whom the information is intended; ensuring that information is available in appropriate formats (e.g., audio, video, braille or large print formats, visual/graphic imagery).
- When working to achieve health equality, health care professionals should avoid the use of adjectives, such as: vulnerable, marginalized, high-risk. The aforementioned terms are vague and imply that a condition is inherent to a group rather than the actual causal factors. Health care professionals should consider using terms and language that focus on the systems in place and explain why and/or how some groups are more affected than others. Also, health care professionals should try to use language that explains the effect.
- When working to achieve health equality, health care professionals should avoid the following phrases: vulnerable groups, marginalized groups, hard-to-reach communities, underserved communities, underprivileged communities, disadvantaged groups, high-risk groups, at-risk groups, high-burden groups, and the needy.
- When working to achieve health equality, health care professionals should use the following terms/phrases (when applicable): groups that have been

economically/socially marginalized; groups that have been marginalized; communities that are underserved by/with limited access to [insert specific service/resource]; under-resourced communities (note: health care professionals should be specific about which resources are lacking); people who are not equitably served by [insert programs, initiatives, infrastructure, or systems]; groups experiencing disadvantage because of [insert reason]; groups placed at increased risk/put at increased risk of [insert outcome]; groups with higher risk of [insert outcome]; people living with increased risk of [insert outcome] because of [insert reason]; disproportionately affected groups; people [insert from area/ population] who are disproportionately affected by [insert outcome]; groups experiencing disproportionate prevalence/rates of [insert condition]; groups experiencing disproportionate risk of/impact from [insert factor].

- When working to achieve health equality, health care professionals should avoid dehumanizing language (e.g., referring to individuals as cases) and use person-first language instead.
- Health care professionals should describe people as having a condition or circumstance, not being a condition (e.g., diabetics versus people with diabetes).
- When working to achieve health equality, health care professionals should avoid using the following terms/phrases: diabetics; the diabetes population; the obese or the morbidly obese; the homeless; disabled person; handicapped; inmates; victims of abuse; cases (when referring to people affected by a disease or condition) or subjects (when referring to people participating in a study).
- When working to achieve health equality, health care professionals should avoid referring to people only as acronyms (e.g., MSM for "men who have sex with men").
- When working to achieve health equality, health care professionals should use the following terms/phrases: people/persons with [insert disease]; patients with [insert disease] (if referring to people who are receiving health care); people experiencing [insert health outcome or life circumstance]; people with obesity; people with severe obesity; patients or persons with COVID-19; reported cases of [insert disease/condition] (when referring to case reports, not people); study participants; people who are experiencing homelessness; people who are experiencing [insert condition or disability type]; person with mobility disability;

person with vision impairments; people who are incarcerated; survivors [of abuse, cancer, violence].

- When working to achieve health equality, health care professionals should remember that there are many types of subpopulations (e.g., people living with mobility/cognitive/vision/hearing disabilities).
- When working to achieve health equality, health care professionals should avoid saying target, tackle, combat, or other terms with violent connotation when referring to people, groups, or communities.
- When working to achieve health equality, health care professionals should use the following terms/phrases: engage/prioritize/collaborate with/serve [insert population of focus]; population of focus; consider the needs of [insert population of focus]; tailor to the needs of [insert population of focus]; communities/populations of focus; intended audience; eliminate/eradicate [insert issue/disease]; prevent/control spread of [insert disease].
- Health care professionals should note the following: metaphors can be helpful when communicating some types of information; health care professionals should use metaphors carefully because metaphors will note perfectly apply to everything or everyone; health care professionals should examine local, historical, and situational context to determine which metaphor is most appropriate.
- When working to achieve health equality, health care professionals should avoid unintentional blaming by using the following terms/phrases: people who refuse [insert vaccination/specific behavior]; workers who do not use face masks; people who do not seek health care.
- When working to achieve health equality, health care professionals should use the following terms/phrases: people who are unvaccinated; people who have yet to receive [insert vaccination/specific behavior]; people with limited access to [insert specific service/resource]; workers under-resourced with [insert specific service/resource].
- When working to achieve health equality, health care professionals should avoid the following terms/phrases: drug-users/addicts/drug abusers; alcoholics/ abusers; persons taking/prescribed medication assisted treatment (MAT); persons who relapsed; smokers.

- When working to achieve health equality, health care professionals should use the following terms/phrases: persons who use drugs/people who inject drugs; persons with a substance use disorder; persons with alcohol use disorder; persons in recovery from substance use/alcohol disorder; persons taking/ prescribed medications for an opioid use disorder (MOUD); persons who returned to use; people who smoke.

- When working to achieve health equality, health care professionals should avoid the following terms/phrases: poverty-stricken; the poor; poor people.

- When working to achieve health equality, health care professionals should use the following terms/phrases: people with lower incomes; people/households with incomes below the federal poverty level; people with self-reported income in the lowest income bracket (if income brackets are defined); people experiencing poverty.

- When working to achieve health equality, health care professionals should avoid the following terms/phrases: mentally ill; crazy; insane; mental defect; asylum.

- When working to achieve health equality, health care professionals should use the following terms/phrases: people with a mental illness; people with a pre-existing mental health disorder; people with a pre-existing behavioral health disorder; people with a diagnosis of a mental illness/mental health disorder/ behavioral health disorder; psychiatric hospital/facility.

- Health care professionals should note the following: mental illness is a general condition; specific disorders are types of mental illness and should be used whenever possible (e.g., people with depression; person with depression).

- Health care professionals should note the following: when referring to people who are experiencing symptoms (e.g., depression, anxiety) but a condition has not been diagnosed or the symptoms may not reach a clinical threshold, health care professionals should consider using the following phrases (when applicable): people experiencing mental distress; persons experiencing crisis or trauma; persons experiencing persistent high stress or anxiety.

- When working to achieve health equality, health care professionals should avoid the following terms/phrases: illegals; illegal immigrants; illegal aliens; illegal migrants; foreigners; the foreign-born.

- When working to achieve health equality, health care professionals should use the following terms/phrases: mixed-status households; immigrant; migrant; asylum seeker; people who are seeking asylum; refugee or refugee populations; non-U.S.-born persons; foreign-born persons.
- Health care professionals should note the following: use accurate and clearly defined terms when referring to foreign-born persons (e.g., do not use “refugee” when meaning “immigrant”); the term “alien” (person who is not a citizen of the United States) may be stigmatizing in some contexts and should only be used in technical documents and when referring to or using immigration law terminology; “refugee” and “migrant” are often used interchangeably; confusion in the use and understanding of these terms can impact the lives and safety of refugees and asylum-seekers; refugees who leave their homes may be entitled to a range of legal protections and aid to which migrants are not entitled; non-U.S.-born or foreign-born persons may also be used to refer to individuals born in a country other than the U.S., similar to the international migrant concept; the term “migrant farm worker” or “migrant agricultural worker” is often used to refer to persons who travel from their home base to another location within the same country, or from one country to another, to perform agricultural work; if combining subpopulations in writing, ensure American Indians and Alaska Natives from tribes located in what is now called the United States are not included in the “immigrant” category.
- When working to achieve health equality, health care professionals should avoid the following terms/phrases: elderly; senior; frail (when used to refer to or identify a person); fragile (when used to refer to or identify a person).
- When working to achieve health equality, health care professionals should use the following terms/phrases: older adults; persons aged [insert numeric age group]; elders when referring to older adults in a cultural context; elderly or frail elderly when referring to older adults in a specific clinical context.
- Health care professionals should note the following: American Indian and Alaska Native (AI/AN) urban communities, and federal agencies define AI/AN Elders as aged ≥ 55 years.
- When working to achieve health equality, health care professionals should use the following terms/phrases: American Indian or Alaska Native persons/ communities/populations; Asian persons; Black or African American persons;

Black persons; Native Hawaiian persons; Pacific Islander persons; White persons; Hispanic or Latino persons; people who identify with more than one race; people of more than one race; persons of multiple races.

- Health care professionals should note the following: when describing a combination of racial/ethnic groups, health care professionals should consider using “people from some racial and ethnic groups” or “people from racial and ethnic minority groups.”
- Health care professionals should note the following: American Indian and Alaska Natives are the only federally recognized political minority in the United States; tribes hold a unique government to government relationship with the United States; “American Indian or Alaska Native” should only be used to describe persons with different tribal affiliations or when the tribal affiliations are not known or not known to be the same; other terms, “tribal communities/ populations” or “indigenous communities/populations,” could also be used to refer to groups with multiple tribal affiliations; identify persons or groups by their specific tribal affiliation; the term “Indian Country” describes reservations, lands held within tribal jurisdictions, and areas with American Indian populations; “Indian Country” is generally used in context and is rarely used as a stand-alone - it typically is used in writing only after “American Indian or Alaska Native” (AI/AN) has already been used, and the writer wants to avoid continuing to repeat AI/AN or “tribes” and refer more broadly to the general wide community of AI/AN peoples and tribes; within context, there shouldn’t be any confusion about it referring to the Asian country, India.
- Health care professionals should note the following: health care professionals should consider using LGBTQ community (and not, for example, gay community) to reflect the diversity of the community unless a specific sub-group is meant to be referenced; health care professionals should consider using the terms “sexual orientation,” “gender identity,” and “gender expression;” use gender-neutral language whenever possible; consider using terms that are inclusive of all gender identities (e.g., parents-to-be; expectant parents); be aware that not every family is the same, and that some children are not being raised by their biological parents; build flexibility into communications and surveys to allow full participation.
- Health care professionals should note the following: stakeholders are persons or groups who have an interest or concern in a project, activity, or course of action;

the term “stakeholder” is used across many disciplines to reflect different levels of input or investment in projects or activities; this term can be used to reflect a power differential between groups and has a violent connotation for some tribes and tribal members; it also groups all parties into one term, despite potential differences in the way they are engaged or interact with a project or activity; consider using words other than “stakeholder” when appropriate for audiences and subject matter, recognizing it may not always be possible to do so; consider the audience when determining the appropriate term(s) to use; whenever possible, describe specific groups and/or individuals with interest in an activity using relevant names, categories, or descriptions of the nature of their influence or involvement (e.g., advisors, consultants, co-owners); if key groups are organizations or people directly involved in the project/activity, use terms that describe the nature of their influence or involvement.

- When working to achieve health equality, health care professionals should consider the following: long-standing systemic social and health inequities, including some that were introduced or exacerbated by federal, state, and local policies, put some population groups at increased risk of getting sick, having overall poor health, and having worse outcomes when they do get sick; health care professionals should avoid perpetuating these inequities in communication.

- When working to achieve health equality, health care professionals should consider how racism and other forms of discrimination unfairly disadvantage people and lead to social and health inequities; emphasize the value of ensuring that everyone has an equal opportunity for health and that reducing disparities contributes to the common good and benefits all; explain that policies, programs, practices, services, and environments that support health can reduce health inequity; recognize that access to information is not enough; people need information that they can understand, use, and that is culturally and linguistically appropriate; avoid implying that a person/community/population is responsible for increased risk of adverse outcomes; recognize that some members of disproportionately affected groups cannot follow public health recommendations; consider ways to improve the accessibility of content, such as using alternative communication formats and offering materials in other languages.

- Health care professionals should note the following: public health programs, policies, and practices are more likely to succeed when they recognize and reflect the diversity of the community they are trying to reach.

- When working to achieve health equality, health care professionals should use language that is accessible and meaningful to audiences of focus; tailor interventions and communications based on the unique circumstances of different populations; emphasize positive actions to be taken and ensure that community strengths and solutions are highlighted and drive local public health efforts; recognize that some members of an intended audience of focus may not be able to follow public health recommendations due to their cultural norms, beliefs, or practices; analyze structural barriers (present and historical) that need to be addressed to best serve different populations at different levels and within different contexts.

- Health care professionals should note the following: community engagement should be a foundational part of the process to develop culturally relevant, unbiased communication for health promotion, research, or policy making; community engagement can have varying levels of community involvement, from outreach to consultation, involvement, collaboration, and shared leadership.

- When working to achieve health equality, health care professionals should be clear about the populations and/or communities they want to engage and the purposes and goals of the engagement effort; remember that successful community engagement is a continuous process that builds trust and relationships through a two-way communication process, which starts with mindfulness and listening and continues with joint decision making and shared responsibility for outcomes; aim for co-developed, co-curated, and co-produced community content whenever possible; engage organizations, agencies, and people who represent the community throughout the stages of communication development; perform formative research to understand community health status, needs, priorities, assets, and key influences; listen to and learn from intended audiences before creating information products; consult community members on concept and message development in order to best understand what messages resonate and do not resonate with the intended audiences; invite people who represent intended audiences to review materials before finalizing and disseminating; enhance reach of the message through use of effective channels and formats that are appropriate for the intended audiences; learn what strategies and languages were most effective for audiences and apply that knowledge to future communication plans.

- Health care professionals should note the following: all of the members of an intended audience of focus may not have the same level of literacy.
- When working to achieve health equality, health care professionals should use active verbs and plain language so that all members of an intended audience can understand the information; recognize that while some people may not be literate, they possess other life skills that enable them to lead meaningful lives and contribute positively to society; acknowledge that many people with English as a secondary language are highly literate in a non-English language; recognize that people may not be literate in their primary language, and avoid assuming that people with English as a secondary language will understand written information when it's translated into their primary language; consider lack of digital access and literacy; consider that some people may not have access to technology, and others may not know how to use it.
- Health care professionals should note the following: insufficient consideration of culture in developing materials may unintentionally result in misinformation, errors, confusion, or loss of credibility; ideally, images should be created by communication professionals from a specific culture.
- When working to achieve health equality, health care professionals should consider the following when using health care imagery: show diverse representation within the intended audience; include diversity in terms of age, gender, race/ethnicity, culture, national origin, disability, sexual orientation, body size, and other factors; show appropriate use of cultural dress, activities or objects, and relevant settings; limit the use of traditional or cultural dress images unless appropriate to the audience and use, and show relevant home, work, or community locations; show positive portrayals and health behaviors; be aware of existing power or status inequities and counter those with positive portrayals; show diverse beauty standards; choose images that support broad standards of beauty; avoid stereotypical power or status inequities, as well as unintentional blaming; avoid negative stereotypes, including inappropriate humor, and avoid caricatures; avoid images that imply people are responsible for their own disparities; avoid a staged or artificial feeling; choose more natural groupings and settings to avoid appearing to "try too hard" to show diversity; include features that can be easily understood by people with disabilities; allow people with disabilities to access the information by inserting clear alt text; make sure images have enough color contrast for people with low visual acuity; ensure

communication products don’t rely on images as the main source of guidance; choose more literal illustrations, as people with intellectual limitations may struggle to understand abstract images; include depictions of people with disabilities as part of the general public; make sure people with disabilities are depicted in images portraying the general population, not only when communicating about disabilities; include accurate depictions of people with a disability and their assistive technology; do not forget that not all disabilities are visible, and there are many types of disabilities and assistive technologies.

- When working to achieve health equality, health care professionals should consider the following: are there words, phrases, or images that could be offensive or stereotypic of the cultural or religious traditions, practices, or beliefs of the intended audience; are there words, phrases, or images that may be confusing, misleading, or have a different meaning for the intended audience (e.g., if abstract images are used, will the audience interpret them as intended); are there images that do not reflect the look or lifestyle of the intended audience, or the places where they live, work, or worship; are there health recommendations that may be inappropriate for the social, economic, cultural, or religious context of the intended audience; are the toll-free numbers or reference web pages, when applicable, included in the document in the language of the intended audience; are resources such as teletypewriter or chat functions available; translating materials into the preferred language of the intended audience, and a native speaker should review materials once the material is translated; working with community members, leaders, and population-specific experts to develop content.

- Health care professionals should note the following: disparities in mental health outcomes are a public health issue that should be considered in addition to physical health outcomes; health care professionals should consider that people might experience poor mental health outcomes due to multiple factors, including limited access to appropriate, accessible, and affordable mental health care services; cultural and social stigma surrounding mental health care; experience with discrimination; and other factors; people may experience symptoms of poor mental health or mental illness that are undiagnosed, under-diagnosed, or misdiagnosed.
- Health care professionals should note the following: age and associated risk are often a continuum; risk for many diseases and severe outcomes increases with

age, with increasing risk among middle-aged adults, and older adults being at highest risk; guidance should be tailored to specific setting of interest within this age group (e.g., community dwelling, those living in multigenerational homes, those living in long-term care facilities or nursing homes, those living in retirement homes); signs and symptoms of many diseases and conditions may sometimes be atypical, delayed, or attenuated in older adults; health care professionals should consider risks to caregivers of older adults as well; caregivers themselves are often older adults or may have other risk factors; communication and outreach efforts should be tailored according to audience-preferred channels and platforms.

- Health care professionals should note the following: health equity is intersectional, which means that individuals belong to more than one group and, therefore, may have overlapping health and social inequities, as well as overlapping strengths and assets; the way people's social identities overlap should be considered to better understand, interpret, and communicate health outcomes; members of population groups are not all the same in their health and living circumstances; understanding and accurately articulating the particular needs and experiences of your audience of focus can determine the level of impact, success, or failure of an intervention; diversity exists within and across communities, with variations in history, culture, norms, attitudes, behaviors, lived experience, and many other factors; be cautious in generalizing about a community; race/ethnicity should not serve as a proxy for socioeconomic status, and vice versa.

Persons with Disabilities

When caring for patients with disabilities, health care professionals can achieve health equality by possessing insight into disabilities, and by following related recommendations. Specific information regarding disabilities and related recommendations may be found below.

- The term disability may refer to any condition of the body or mind that makes it more difficult for an individual with the condition to do certain activities and interact with the world around them.

- There are many types of disabilities, such as those that affect a person's: vision, movement, thinking, remembering, learning, communicating, hearing, mental health, and social relationships.
- Although "people with disabilities" sometimes refers to a single population, this is actually a diverse group of people with a wide range of needs; two people with the same type of disability can be affected in very different ways.
- According to the World Health Organization, disability has three dimensions:
  - Impairment (e.g., loss of a limb, loss of vision or memory loss);
  - Activity limitation (e.g., difficulty seeing, hearing, walking, or problem solving);
  - Participation restrictions (e.g., restrictions with working, engaging in social and recreational activities, and obtaining health care and preventive services).
- Disability can be related to conditions that are present at birth and may affect functions later in life, including cognition (e.g., memory, learning, and understanding), mobility (e.g., moving around in the environment), vision, hearing, behavior, and other areas.
- Disability can be associated with developmental conditions that become apparent during childhood (e.g., autism spectrum disorder and attention-deficit/ hyperactivity disorder [ADHD]).
- Disability can be related to an injury (e.g., traumatic brain injury or spinal cord injury).
- Disability can be associated with a longstanding condition (e.g., diabetes), which can cause a disability such as: vision loss, nerve damage, or limb loss.
- Disability can be progressive (e.g., muscular dystrophy), static (e.g., limb loss), or intermittent (e.g., some forms of multiple sclerosis).
- Impairment may refer to an absence of or significant difference in an individual's body structure or function or mental functioning (e.g., problems in the structure of the brain can result in difficulty with mental functions, or problems with the structure of the eyes or ears can result in difficulty with the functions of vision or hearing).

- Structural impairments may refer to significant problems with an internal or external component of the body (e.g., a type of nerve damage that can result in multiple sclerosis, or a complete loss of a body component, as when a limb has been amputated).

- Functional impairments may refer to the complete or partial loss of function of a body part (e.g., pain that doesn't go away or joints that no longer move easily).

- Individuals with disabilities experience significant disadvantages when it comes to health such as:

    - Adults with disabilities are three times more likely to have heart disease, stroke, diabetes, or cancer than adults without disabilities;

    - Adults with disabilities are more likely than adults without disabilities to be current smokers; and

    - Women with disabilities are less likely than women without disabilities to have received a breast cancer X-ray test (mammogram) during the past two years.

- Disability is associated with health conditions (such as arthritis, mental, or emotional conditions) or events (such as injuries).

- The functioning, health, independence, and engagement in society of people with disabilities can vary depending on several factors, such as: severity of the underlying impairment; social, political, and cultural influences and expectations; aspects of natural and built surroundings; availability of assistive technology and devices; family and community support and engagement.

- Health care professionals should encourage disability inclusion. Disability inclusion may refer to the act of including individuals with disabilities in everyday activities and encouraging them to have roles similar to their peers who do not have a disability.

- Disability inclusion involves more than simply encouraging people; it requires making sure that adequate policies and practices are in effect in a community or organization.

- Disability inclusion should lead to increased participation in socially expected life roles and activities, such as: being a student, worker, friend, community member, patient, spouse, partner, or parent.

- Socially expected activities may also include engaging in social activities, using public resources (e.g., transportation and libraries), moving about within communities, receiving adequate health care, having relationships, and enjoying other day-to-day activities.

- Disability inclusion allows for people with disabilities to take advantage of the benefits of the same health promotion and prevention activities experienced by people who do not have a disability (e.g., education and counseling programs that promote physical activity, improve nutrition or reduce the use of tobacco, alcohol or drugs; and blood pressure and cholesterol assessment during annual health exams, and screening for illnesses such as cancer, diabetes, and heart disease).

- Including individuals with disabilities in activities begins with identifying and eliminating barriers to their participation.

- Disability inclusion means understanding the relationship between the way people function and how they participate in society, and making sure everybody has the same opportunities to participate in every aspect of life to the best of their abilities and desires.

- Barriers may prevent disability inclusion. The term barriers, when used in the context of disability inclusion, may refer to factors in an individual's environment that, through their absence or presence, limit functioning and create disability (note: barriers may prevent an individual access to health care and health equality; implicit bias may cause barriers).

- Examples of barriers include the following: a physical environment that is not accessible; a lack of relevant assistive technology; negative attitudes of people towards disability; services, systems, and policies that are either nonexistent or that hinder the involvement of all people with a health condition in all areas of life.

- Attitudinal barriers are the most basic and contribute to other barriers. For example, some people may not be aware that difficulties in getting to or into a place can limit a person with a disability from participating in everyday life, common daily activities, and health care. Examples of attitudinal barriers include the following: stereotyping, stigma, prejudice, and discrimination.

- Individuals sometimes stereotype those with disabilities, assuming their quality of life is poor or that they are unhealthy because of their impairments (note: stereotyping often leads to implicit bias).
- Stigma, prejudice, and discrimination may come from individuals' ideas related to disability. Individuals may see disability as a personal tragedy, as something that needs to be cured or prevented, as a punishment for wrongdoing, or as an indication of the lack of ability to behave as expected in society (note: stigma, prejudice, and discrimination often leads to implicit bias).
- Communication barriers are experienced by individuals who have disabilities that affect hearing, speaking, reading, writing, and or understanding, and who use different ways to communicate than people who do not have these disabilities.
- Examples of communication barriers include:
    - Written health promotion messages with barriers that prevent people with vision impairments from receiving the message (e.g., use of small print or no large-print versions of material);
    - Auditory health messages may be inaccessible to people with hearing impairments, including videos that do not include captioning, and oral communications without accompanying manual interpretation (e.g., American Sign Language);
    - The use of technical language, long sentences, and words with many syllables may be significant barriers to understanding for people with cognitive impairments.
- Physical barriers are structural obstacles in natural or manmade environments that prevent or block mobility (moving around in the environment) or access (e.g., steps and curbs that block a person with mobility impairment from entering a building or using a sidewalk; mammography equipment that requires a woman with mobility impairment to stand; and absence of a weight scale that accommodates wheelchairs or others who have difficulty stepping up).

- Policy barriers are frequently related to a lack of awareness or enforcement of existing laws and regulations that require programs and activities to be accessible to people with disabilities.
- Examples of policy barriers include:
    - Denying qualified individuals with disabilities the opportunity to participate in or benefit from federally funded programs, services, or other benefits;
    - Denying individuals with disabilities access to programs, services, benefits, or opportunities to participate as a result of physical barriers; and
    - Denying reasonable accommodations to qualified individuals with disabilities, so they can perform the essential functions of the job for which they applied or were hired to perform (note: accommodations may refer to alterations made to items, procedures, or systems that enable an individual with a disability to use them to the maximum extent possible; a modification to an existing environment or process to increase the participation by an individual with an impairment or activity limitation).
- Programmatic barriers may refer to barriers that limit the effective delivery of a public health or health care program for people with different types of impairments (e.g., inconvenient scheduling; lack of accessible equipment [e.g., mammography screening equipment]; insufficient time set aside for medical examination and procedures; little or no communication with patients or participants; and health care professional’s attitudes, knowledge, and understanding of people with disabilities).
- Social barriers are related to the conditions in which people are born, grow, live, learn, work and age; social determinants of health that can contribute to decreased functioning among people with disabilities (e.g., individuals with disabilities are far less likely to be employed; adults age 18 years and older with disabilities are less likely to have completed high school compared to their peers without disabilities; children with disabilities are almost four times more likely to experience violence than children without disabilities).
- Transportation barriers are due to a lack of adequate transportation that interferes with an individual's ability to be independent and to function in society (e.g., lack of access to accessible or convenient transportation for people who are

not able to drive because of vision or cognitive impairments, and public transportation may be unavailable or at inconvenient distances or locations).

- Health care professionals should work to remove barriers to health care in order to mitigate the impact of implicit bias and to ensure health equality.

- Health care professionals can remove barriers to health care by working towards inclusion.

- Inclusion involves: getting fair treatment from others (nondiscrimination); making products, communications, and the physical environment more usable by as many people as possible (universal design); modifying items, procedures, or systems to enable a person with a disability to use them to the maximum extent possible (reasonable accommodations); and eliminating the belief that people with disabilities are unhealthy or less capable of doing things (stigma, stereotypes) (note: disability inclusion involves input from individuals with disabilities, generally through disability-focused and independent living organizations, in program or structural design, implementation, monitoring, and evaluation).

- Universal design may refer to the act of designing buildings, products, or environments to make them accessible to all individuals, regardless of age, disability, or other factors.

- Universal design can include the following elements:

    - Equitable use - the design is useful and marketable to people with diverse abilities (e.g., power doors with sensors at entrances that are convenient for all users);

    - Flexibility in use - the design accommodates a wide range of individual preferences and abilities (e.g., a palm rest to aid those with arm mobility or strength limitations);

    - Simple and intuitive use - use of the design is easy to understand, regardless of the user’s experience, knowledge, language skills, or current concentration level (e.g., including an instruction manual with clear drawings and no text);

    - Perceptible information - the design communicates necessary information effectively to the user, regardless of the current light, visual, or sound conditions or the person’s abilities to read, see, or hear (e.g., alarm systems that can be both seen and heard; and routinely making captioning available in all television or video presentations).

  - Tolerance for error - the design minimizes hazards and the harmful consequences of accidental or unintended actions (e.g., ground-fault interrupter (GFI) electrical outlet that reduces risk of shock in bathrooms).
  - Low physical effort - the design can be used efficiently and comfortably with minimum fatigue (e.g., easy-to-use handles that make opening doors easier for people of all ages and abilities).
  - Size and space for approach and use - appropriate size and space is provided for approach, reach, manipulation, and use regardless of a person’s body size, posture, or mobility (e.g., counters and service windows are low enough for everyone to reach, including people who use wheelchairs; and curb cuts or sidewalk ramps, essential for people in wheelchairs, but are used by all people, and also convenient for people pushing baby strollers).

- Accessibility occurs when the needs of individuals with disabilities are specifically considered, and products, services, and facilities are built or modified so that they can be used by people of all abilities (e.g., parking spaces are close to entrances; floor spaces and hallways are free of equipment and other barriers; health care professionals and health care staff can use sign language or have access to someone who can use sign language).
- As previously mentioned, accommodations may refer to alterations made to items, procedures, or systems that enable an individual with a disability to use them to the maximum extent possible; a modification to an existing environment or process to increase the participation by an individual with an impairment or activity limitation (e.g., Braille, large print, or audio books are examples of accommodations for people who are blind or who have visual limitations otherwise) (note: communication accommodations do not have to be elaborate, but they must be able to convey information effectively).
- Assistive technologies (ATs) may refer to devices or equipment that can be used to help an individual with a disability fully engage in life activities (e.g., a computer that talks and helps someone communicate, wheelchairs, walkers, and scooters) (note: smartphones have greatly expanded the availability of assistive

technology for people with vision or hearing difficulties, or who have problems with effectively communicating their thoughts because of mental or physical limitations).

- Health care professionals should note that: independent living is being able to take care of oneself without being dependent on another individual (e.g., an individual is able to clean the house, cook, shop, and pay bills, or be able to use public transportation).

- Health care professionals should note that: assisted living is for adults who need help with everyday tasks (e.g., individuals may need help with dressing, bathing, eating, or using the bathroom, but they don't need full-time nursing care).

- Health care professionals can work towards inclusion by effectively communicating with patients with disabilities. To effectively communicate with patients with disabilities, health care professionals should follow the recommendations found below.

    - Emphasize abilities, not limitations.

    - Do not use language that suggests the lack of something.

    - Emphasize the need for accessibility, not the disability.

    - Do not use offensive language.

    - Avoid language that implies negative stereotypes.

    - Do not portray individuals with disabilities as inspirational only because of their disability.

    - Avoid the following phrases: confined or restricted to a wheelchair, wheelchair bound; can't talk; mute; disabled, handicapped; midget; cerebral palsy victim; epileptic; handicapped parking or bathroom; crippled, lame, deformed, invalid, spastic; slow, simple, moronic, defective, afflicted, special person; insane, crazy, psycho, nuts.

    - Use the following phrases (when applicable): person who uses a wheelchair; person who uses a device to speak; person with a disability; person with cerebral palsy; person with epilepsy or seizure disorder; accessible parking or bathroom; person with a physical disability; person with an intellectual, cognitive, developmental disability; person with and emotional or behavioral disability, a mental health impairment, or a psychiatric disability.

- Health care professionals can work towards inclusion by following applicable laws, requirements and regulations. Three federal laws protect the rights of people with disabilities and ensure their inclusion in many aspects of society, including health care. These laws include: Section 504 of the Rehabilitation Act of 1973; the Americans with Disabilities Act (ADA) of 1990, which was followed by the ADA Amendments Act of 2008 in an attempt to restore the original intent of the legislation; and the Patient Protection and Affordable Care Act in 2010.
- Section 504 of the Rehabilitation Act of 1973 is a federal law that protects individuals from discrimination based on disability. The nondiscrimination requirements of the law apply to employers and organizations that receive financial assistance from federal departments or agencies. Section 504 forbids organizations and employers from denying individuals with disabilities an equal opportunity to receive program benefits and services. It defines the rights of individuals with disabilities to participate in, and have access to, program benefits and services.
- Section 504 of the Rehabilitation Act of 1973 may be found below. The information found below was derived from materials provided by the United States Department of Health and Human Services (United States Department of Health and Human Services, 2021).

Section 504 of the Rehabilitation Act of 1973

(a) Promulgation of rules and regulations

No otherwise qualified individual with a disability in the United States, as defined in section 705 (20), shall, solely by reason of his or her disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance or under any program or activity conducted by any Executive agency or by the United States Postal Service. The head of each such agency shall promulgate such regulations as may be necessary to carry out the amendments made by the Rehabilitation, Comprehensive Services, and Development Disabilities Act of 1978. Copies of any proposed regulations shall be submitted to appropriate authorizing committees of the Congress, and such regulation may take effect no earlier than the thirtieth day after the date of which such regulation is so submitted to such committees.

(b) "Program or activity" defined

The term "program or activity" means all of the operations of --

(1)(A) a department, agency, special purpose district, or other instrumentality of a State or of a local government; or

(B) the entity of such State or local government that distributes such assistance and each such department or agency (and each other State or local government entity) to which the assistance is extended, in the case of assistance to a State or local government;

(2)(A) a college, university, or other postsecondary institution, or a public system of higher education; or

(B) a local educational agency (as defined in section 8801 of Title 20), system of vocational education, or other school system;

(3)(A) an entire corporation, partnership, or other private organization, or an entire sole proprietorship

(i) if assistance is extended to such corporation, partnership, private organization, or sole proprietorship as a whole; or

(ii) which is principally engaged in the business of providing education, health care, housing, social services, or parks and recreation; or

(B) the entire plant or other comparable, geographically separate facility to which Federal financial assistance is extended, in the case of any other corporation, partnership, private organization, or sole proprietorship; or

(4) any other entity which is established by two or more of the entities or (3); any part of which is extended Federal financial assistance.

(c) Significant structural alterations by small providers

Small providers are not required by subsection (a) to make significant structural alterations to their existing facilities for the purpose of assuring program accessibility, if alternative means of providing the services is available.

(d) Standards used in determining violation of section

The standards used to determine whether the was violated in a complaint alleging employment discrimination shall be the standards applied under title I of the Americans with Disabilities Act of 1990 and the provisions of sections 501 through 504, and 510, of the Americans with Disabilities Act of 1990, as such sections related to employment.

Section 794a. Remedies and attorney fees

(a)(1) The remedies, procedures, and rights set forth in section 717 of the Civil Rights Act of 1964, shall be available, with respect to any complaint under section 791, to any employee or applicant for employment aggrieved by the final disposition of such complaint, or by the failure to take final action on such complaint. In fashioning an equitable or affirmative action remedy under such section, a court may take into account the reasonableness of the cost of any necessary work place accommodation, and the availability of alternative therefore or other appropriate relief in order to achieve an equitable and appropriate remedy.

(2) The remedies, procedures, and rights set forth in title VI of the Civil Rights Act of 1964 shall be available to any person aggrieved by any act or failure to act by any recipient of Federal assistance or Federal provider of such assistance under section 794.

(b) In any action or proceeding to enforce or charge a violation of a provision of this law, the court, in its discretion, may allow the prevailing party, other than the United States, a reasonable attorney's fee as part of the costs.

- The Americans with Disabilities Act (ADA) of 1990, as amended, protects the civil rights of people with disabilities, and helped remove or reduce many barriers for people with disabilities. The legislation required the elimination of discrimination against people with disabilities. The ADA expanded opportunities for people with disabilities by reducing barriers, changing perceptions, and increasing participation in community life. ADA guarantees equal opportunity for individuals with disabilities in several areas: employment; public accommodations such as restaurants, hotels, theaters, doctors’ offices, pharmacies, retail stores, museums, libraries, parks, private schools, and day care centers; transportation; state and local government services; telecommunications such as telephones, televisions, and computers.

- Patient Protection and Affordable Care Act is commonly referred to as the ACA. The ACA provides more health care choices and enhanced protection for Americans with disabilities; provides new health care options for long-term support and services; improves the Medicaid home- and community-based services option; provides access to high-quality and affordable health care for many people with disabilities; mandates accessible preventive screening equipment; and designates disability status as a demographic category and mandates data collection to assess health disparities. Specific information from the Affordable Care Act for Americans with Disabilities may be found below.
    - The Act states that health plans cannot limit or deny benefits or deny coverage outright for a child younger than age 19 simply because the child has a "preexisting condition."
    - The Act states that insurance companies cannot deny coverage or charge more to any person based on their medical history.
    - The Act prohibits health plans from putting a lifetime dollar limit on most benefits received. The Act also restricts and phases out the annual dollar limits a health plan can place on most benefits.
    - The Act helps make wellness and prevention services affordable and accessible to individuals by requiring health plans to cover many preventive services without charging individuals a copayment, coinsurance, or deductible.
    - The Act Allows individuals to stay on their parents' plan until age 26; health plans that cover
      children must make coverage available to children up to age 26. By allowing them to stay on a parent's plan, the Affordable Care Act makes it easier and more affordable for young adults to get or keep health insurance coverage.
    - The Act expands the Medicaid program to more Americans, including people with disabilities.
    - State-based health insurance exchanges will be established to provide families with the same private insurance choices that the President and Members of Congress have or had, to foster competition and increase consumer choice.

  - The exchanges will supply easy to understand, standard, accessible information on available health insurance plans, so people can compare and easily identify the quality, affordable option that is right for them.
  - Plans in the health insurance exchanges and all new plans will have a cap on what insurance companies can require beneficiaries to pay in out-of-pocket expenses, such as co-pays and deductibles.
  - The Act improves the Medicaid Home-and-Community-Based Services (HCBS) option.
  - The Act creates the Community First Choice Program.
  - The Act offer incentives for states to offer home and community-based services as a long-term care alternative to nursing homes.
  - The Act invests in prevention and public health to encourage innovations in health care that prevent illness and disease before they require more costly treatment.
  - The Act improves access to medical diagnostic equipment so people with disabilities can receive routine preventive care and cancer screenings by establishing exam equipment accessibility standards.
  - The Act improves data collection on health disparities for persons with disabilities, as well as training and cultural competency of health care professionals.
- Health care professionals can work towards inclusion by including all individuals in programs and activities, such as: education and counseling programs that promote physical activity, improve nutrition or reduce the use of tobacco, alcohol or drugs; and blood pressure and cholesterol assessment during annual health exams, and screening for illnesses such as cancer, diabetes, and heart disease. Health care professionals should note the following: individuals with disabilities require health programs and health care services for the same reasons anyone does, for overall health, well-being, and quality of life.
- Health care professionals should note the following: the CDC supports state-based disability and health programs dedicated to improving the health of people with disabilities. The CDC also supports and provides funding to National Centers

on Health Promotion for People with Disabilities also known as National Centers on Disability to prevent disease and promote health and wellness for people with disabilities. The goal of the National Centers on Disability is to improve the quality of life of individuals living with disabilities by providing health information, education and consultation to health care professionals, people with disabilities, caregivers, media, researchers, policymakers and the public. The National Centers on Disability accomplish the aforementioned goal by implementing the following activities:

  - Serve as a resource for increasing knowledge and changing attitudes and practices as it relates to people with disabilities;
  - Educate policymakers about differences in health among people with disabilities;
  - Build collaborations with consumers, local health organizations, CDC, and other relevant partners;
  - Share information about programs, methods, materials, and lessons learned;
  - Measure and document the National Centers on Disability impact using common methods of evaluation and reporting activities, such as the population reached by activities, and outcomes/impact indicators;
  - Identify the health needs of people with disabilities.

- Health care professionals can work towards inclusion by providing patient education. Examples of the type of patient education that should be provided, when applicable, may be found below.
  - Having a disability does not mean an individual is not healthy or that he or she cannot be healthy. Individuals with disabilities must get the care and services they need to help them be healthy. Individuals with disabilities should know their bodies, how they feel when they are well and when they are not; talk openly with their health care professional about their concerns; find health care professionals that they are comfortable with in their area of need; check to be sure they can physically get into their health care professional's office, such as having access to ramps or elevators if they use an assistive device like a wheelchair or scooter; check to see if their health care professional's office has the equipment they

need, such as an accessible scale or examining table; ask for help from their health care professional's office staff if they require help; think about questions and health concerns before they visit their health care professional so that they are prepared; bring health records, when applicable; take a friend or family member with them if they are concerned they might not remember all their questions or what is said by the health care professional; write down, or have someone write down, what is said by the health care professional.

- Adults of all shapes, sizes, and abilities can benefit from being physically active, including those with disabilities. For important health benefits, all adults should do both aerobic and muscle-strengthening physical activities. Regular aerobic physical activity increases heart and lung functions; improves daily living activities and independence; decreases chances of developing chronic diseases; and improves mental health.
- Adults with disabilities should try to get at least 2 hours and 30 minutes (150 minutes) a week of moderate-intensity aerobic physical activity (i.e., brisk walking; wheeling oneself in a wheelchair) or at least 1 hour and 15 minutes (75 minutes) a week of vigorous-intensity aerobic physical activity (i.e., jogging, wheelchair basketball) or a mix of both moderate- and vigorous-intensity aerobic physical activities each week. A rule of thumb is that 1 minute of vigorous-intensity activity is about the same as 2 minutes of moderate-intensity activity (note: adults with disabilities should avoid inactivity as some physical activity is better than none).
- Muscle-strengthening activities should include moderate and high intensity, and involve all major muscle groups on two or more days a week (i.e., working with resistance-band, adapted yoga) as these activities provide additional health benefits. All children and adolescents should do 1 hour (60 minutes) or more of physical activity each day.
- If a person with a disability is not able to meet the physical activity guidelines, they should engage in regular physical activity based on their abilities and should avoid inactivity. Adults with disabilities should talk to a health care professional about the amounts and types of physical activity that are appropriate for their abilities.

    - Individuals with disabilities should; engage in the amount and types of physical activity that are right for them; find opportunities to increase regular physical activity in ways that meet their needs and abilities; start slowly based on their abilities and fitness level (e.g. active for a few minutes at a time, slowly increase activity over several weeks, if necessary); include aerobic physical activities that make them breathe harder and their heart beat faster for important health benefits, such as reducing the risk of heart disease, stroke, diabetes, and some cancers; know that most aerobic physical activity may need to be modified, adapted, or may need additional assistance or equipment; and avoid being physically inactive.

    - Individuals with disabilities are at greater risk for abuse, violence, and harm than people without disabilities.

    - Individuals with disabilities are at greater risk for victimization. Victimization is harm caused on purpose. The two most common places where victimization occurs are in hospitals and homes.

    - Victimization includes: physical violence with or without a weapon; sexual violence of any kind, including rape; emotional abuse, including verbal attacks or being humiliated; neglect of personal needs for daily life, including medical care or equipment.

    - Overall mental health and well-being are important for everyone. Mental health is how an individual thinks, feels, and acts as he or she copes with life.

    - Everyone feels worried, anxious, sad or stressed sometimes. If these feelings do not go away and they interfere with daily life, individuals should talk with other people about your feelings, such as a family member or health care professional.

- Health care professionals can work towards inclusion by engaging all women in breast cancer screening. Health care professionals should note the following: all women between the ages of 50 - 74 should have a screening mammogram every two years.

- Health care professionals can work towards inclusion by possessing insight into secondary conditions (note: the term secondary condition may refer to any additional physical or mental health condition that occurs as a result of having a disability). Specific information regarding secondary conditions may be found below.

- Individuals with disabilities often are at greater risk for health problems that can be prevented. As a result of having a specific type of disability, such as a spinal cord injury, spina bifida, or multiple sclerosis, other physical or mental health conditions can occur.

- Examples of secondary conditions include the following: bowel or bladder problems, fatigue, injury, mental health and depression, overweight and obesity, pain, and pressure sores or ulcers.

- Some disabilities, such as spinal cord injuries, can affect how well a person's bladder and bowel works.

- Fatigue may refer to a feeling of weariness, tiredness, or lack of energy. Fatigue can affect the way a person thinks and feels. It can also interfere with a person's activities of daily living.

- Injuries, including unintentional injury and suicide, are the leading cause of death for people one through 44 years of age. The consequences of injuries can include physical, emotional, and financial consequences that can affect the lives of individuals, their families, and society.

- Mental health may refer to how individuals think, feel, and act as they cope with life. Individuals with disabilities report higher rates of stress and depression than people without disabilities. There are different ways to treat depression; exercise can be effective for some people; counseling or medication also might be required.

- Children and adults with disabilities are less likely to be of healthy weight and more likely to be obese than children and adults without disabilities. Overweight and obesity can have serious health consequences for all people.

- Pain is commonly reported by people with many types of disabilities. For some, pain can affect functioning and activities of daily living. The length of time a person experiences pain can be classified as either long term (also called chronic) or short term.

- Pressure ulcers, also known as bed sores, pressure sores, or decubitus ulcers, may refer to wounds caused by constant pressure on the skin. They usually develop on body parts such as the elbow, heel, hip, shoulder, back, and back of the head. Individuals with disabilities who are bedridden or use a wheelchair are at risk for developing pressure sores.

- Arthritis, or joint inflammation, is the most common cause of disability among adults residing in the United States.

- Individuals with certain types of disability have a higher risk of getting flu-related complications, such as pneumonia. Some physical disabilities can affect how well their body fights off infection; such individuals should discuss their risk of illness with a health care professional.

- Individuals with certain types of disability have a higher risk of getting COVID-19-related complications.

- Individuals with certain types of disability have a higher risk of getting MRSA-related complications. Methicillin-resistant Staphylococcus aureus (MRSA), is a type of bacteria that is resistant to certain antibiotics. MRSA, most often occurs among people in hospitals and health care facilities (e.g., nursing homes and dialysis centers) who have weakened immune systems. A person can get MRSA through direct contact with an infected person or by sharing personal items, such as towels or razors that have touched infected skin.

- Individuals with certain types of disability have a higher risk of getting RSV-related complications. Respiratory syncytial virus (RSV) is a virus common in childhood and important among older adults. RSV infects the lungs and breathing passages. Most otherwise healthy people recover from RSV infection in one to two weeks. However, infection can be severe among some people.

- Learning disabilities may refer to disorders that may affect an individual's ability to understand or use spoken or written language, do mathematical calculations, coordinate movements, or direct attention. Learning disabilities can be lifelong conditions and some people can have several overlapping learning disabilities.

  - Limb loss can occur due to trauma, infection, diabetes, vascular disease, cancer, or other diseases. Limb loss more often is the result, rather than the cause, of other health problems. However, the loss of a limb can result in decreased physical activity, skin problems associated with using a prosthesis, and phantom pain for the residual limb.

  - Musculoskeletal disorders include problems such as: back pain, joint injuries, tendinitis, and repetitive strain. Musculoskeletal injuries can cause temporary or even permanent disability, leaving some individuals unable to move around easily. Work-related musculoskeletal disorders are the leading cause of disability for people during their working years.

  - Alcohol, tobacco, illicit drugs, and prescription medications all can be substances of abuse. Individuals with disabilities might have multiple risk factors that can increase their chances for substance abuse (note: substance abuse may refer to the harmful or hazardous use of a psychoactive substance such as alcohol and illicit drugs).

  - Individuals with disabilities may develop suicidal ideation. Suicidal ideation may refer to thoughts of suicide and/or thoughts of planning suicide. Suicidal ideation may lead to a suicide attempt and/or suicide. A suicide attempt may refer to a non-fatal self-directed and potentially injurious behavior with any intent to die as a result of the behavior (note: a suicide attempt may or may not result in injury). Suicide may refer to a death caused by injuring oneself with the intent to die.

- Health care professionals can work towards inclusion by providing nutrition counseling to all patients. Health care professionals should note that adequate nutrition can help prevent some secondary conditions (e.g., obesity). Specific nutrition recommendations may be found below.

  - Fiber helps maintain digestive health and helps individuals feel fuller longer. Fiber also helps control blood sugar and lowers cholesterol levels. Fresh fruits and vegetables, whole grains, legumes, nuts, and seeds are good sources of fiber.

  - Individuals can increase fiber intake by eating vegetables, fruits, beans, lentils, and whole grain cereals.

  - Calcium and vitamin D work together to promote optimal bone health.

- Individuals can increase calcium and vitamin D intake by drinking fortified dairy beverages; eating salmon and/or sardines; eating spinach, collard greens, bok choy, mushrooms, and taro root.
- Potassium helps the kidneys, heart, muscles and nerves function properly. Not getting enough potassium can increase blood pressure, deplete calcium in bones, and increase the risk of kidney stones.
- Individuals can increase potassium intake by eating beet greens and lima beans; fruit (e.g., bananas); and by drinking 100% prune juice or 100% pomegranate juice.
- Too much added sugar in a diet can contribute to weight gain, obesity, type 2 diabetes, and heart disease. Some foods such as fruit and milk contain natural sugars. Added sugars are sugars and syrups that are added to foods and drinks when they are processed or prepared. Added sugars have many different names, such as cane juice, corn syrup, dextrose, and fructose. Table sugar, maple syrup, and honey are also considered added sugars. Individuals should limit added sugars.
- Eating too much sodium can raise the risk of high blood pressure, heart attack, and stroke. Individuals should work to limit the amount of sodium in their diet by avoiding salt and/or added salt.
- Replacing saturated fat with healthier unsaturated fats can help protect the heart.
- Individuals can replace saturated fat with healthier unsaturated fats by replacing whole milk in a smoothie with low-fat yogurt and an avocado; sprinkle nuts or seeds on salads instead of cheese; use beans or seafood instead of meats as a source of protein; cook with canola, corn, olive, peanut, safflower, soybean, or sunflower oil instead of butter or margarine.

COVID-19

The CDC developed COVID-19 equality recommendations to help reduce COVID-19 health disparities and achieve health equality. The principles of the COVID-19 equality recommendations include the following: reduce health disparities; use data-driven approaches; foster meaningful engagement with community institutions and diverse leaders; lead culturally responsive outreach; reduce stigma, including stigma associated with race and ethnicity; all individuals have the opportunity to attain the highest level of health possible. The goals of the COVID-19 equality recommendations include the following: reduce COVID-19-related health disparities; increased testing, contact tracing, isolation options, and preventive care and disease management in populations at increased risk for COVID-19; ensure equity in nationwide distribution and administration of future COVID-19 vaccines; implement evidence-based policies, systems, and environmental strategies to mitigate social and health inequities related to COVID-19; reduce COVID-19-associated stigma and implicit bias; expanded cultural responsiveness and the application of health equity principles among an increasingly diverse COVID-19 responder workforce. Specific COVID-19 equality recommendations may be found below. The information found below was derived from materials provided by the CDC (CDC, 2022).

- Build on plans for collecting and reporting timely, complete, representative, and relevant data on testing, incidence, vaccination, and severe outcomes by detailed race and ethnicity categories, taking into account age and sex differences between groups.
- Build on plans for collecting and reporting timely, complete, and representative data on testing, incidence, vaccination, and severe outcomes among other populations of focus.
- Develop plans for literature reviews and analyses using data available from the CDC and/or non-CDC sources to assess disproportionate impacts of COVID-19.
- Develop and implement plans for special studies related to social determinants of health to expand knowledge base, contextualize health disparities, and mitigate stigma and bias.
- Develop and implement plans to disseminate health equity-related data and related materials tailored to be culturally and linguistically relevant for diverse audiences.
- Develop key principles and resources for collecting, analyzing, reporting, and disseminating health equity-related data to inform action during a public health emergency.
- Develop Strengths, Weakness, Opportunities, Threats (SWOT) analysis on CDC program and practice investment plans focused on reducing health disparities and addressing negative consequences of mitigation strategies.

- Build community capacity to reach disproportionately impacted populations with effective culturally and linguistically tailored programs and practices for testing, contact tracing, isolating, vaccination and health care strategies across populations placed at increased risk and in place-based settings.
- Develop a health communications strategy with culturally and linguistically responsive materials and messengers, for disseminating accurate information in plain language, lessening adverse effects of mitigation strategies, and emphasizing importance of wellness visits and preventive care.
- Identify and establish collaborations with critical partners aligned with place-based settings that serve and support populations at increased risk for COVID-19.
- Identify and establish collaborations with critical partners affiliated with racial and ethnic populations placed at increased risk for COVID-19 to disseminate scientifically accurate, culturally and linguistically responsive information and facilitate access to health-related services.
- Identify and establish collaborations with critical partners affiliated with other populations of focus that are put at increased risk for COVID-19.
- Develop strategies to prevent adverse effects of mitigation strategies in future infectious disease outbreaks and other emergencies.
- Support capacity building for COVID-19 vaccine distribution and administration by establishing partnerships with organizations, including federal, state, local, tribal and territorial agencies, national non-governmental, private sector partners, and community-based organizations.
- Identify and establish partnerships with state and local policy organizations affiliated with other populations of focus to develop evidence-based strategies for preventing COVID-19 among populations at highest risk.
- Provide culturally tailored COVID-19 support to American Indian/Alaska Native tribal organizations.
- Develop SWOT analysis on CDC program and practice investment plans focused on reducing COVID-19-related health disparities among frontline and essential workers.

- Build capacity to reach essential and frontline workers with effective culturally and linguistically tailored programs and practices for testing, contact tracing, isolating, and care strategies.

- Develop health communications strategy with culturally and linguistically responsive materials and messengers, promoting scientifically accurate information on prevention of COVID-19 and importance of wellness visits tailored to frontline and essential workers.

- Establish partnerships with organizations that serve and support frontline and essential worker safety.

- Support capacity building for vaccine distribution and administration to frontline and essential workers by establishing partnerships with organizations, including federal, state, local tribal and territorial agencies, national non-governmental, private sector partners, and community-based organizations.

- Identify and establish partnerships with state and local policy organizations affiliated with other populations of focus to develop evidence-based strategies for reducing frontline and essential workers' exposure to the virus that causes COVID-19.

- Develop culturally and linguistically tailored COVID-19 responder trainings and resources.

- Build a diverse responder workforce (e.g., diverse racial, ethnic, and social backgrounds, multi-disciplinary, multi-lingual, and multi-generational).

- Provide support for CDC responders who may be experiencing loss and challenges due to the COVID-19 pandemic.

- Implement inclusive practices for team activities to assess and address the needs of an increasingly diverse U.S. population.

- Health care organizations should ensure that each employee receives training, in a language and at a literacy level the employee understands, and so that the employee comprehends at least the following: COVID-19, including how the disease is transmitted, the importance of hand hygiene to reduce the risk of spreading COVID-19 infections, ways to reduce the risk of spreading COVID-19 through the proper covering of the nose and mouth, the signs and symptoms of the disease, risk factors for severe illness, and when to seek medical attention;

employer-specific policies and procedures on patient screening and management; tasks and situations in the workplace that could result in COVID-19 infection; workplace-specific policies and procedures to prevent the spread of COVID-19 that are applicable to the employee’s duties (e.g., policies on Standard and Transmission-Based Precautions, physical distancing, physical barriers, ventilation, aerosol generating procedures); employer-specific multi-employer workplace agreements related to infection control policies and procedures, the use of common areas, and the use of shared equipment that affect employees at the workplace; employer-specific policies and procedures for personal protective equipment (PPE), including: when PPE is required for protection against COVID-19; limitations of PPE for protection against COVID-19; how to properly put on, wear, and take off PPE; how to properly care for, store, clean, maintain, and dispose of PPE; and any modifications to donning, doffing, cleaning, storage, maintenance, and disposal procedures needed to address COVID-19 when PPE is worn to address workplace hazards other than COVID-19; workplace-specific policies and procedures for cleaning and disinfection; employer-specific policies and procedures on health screening and medical management; available sick leave policies, any COVID-19-related benefits to which the employee may be entitled under applicable federal, state, or local laws, and other supportive policies and practices (e.g., telework, flexible hours); the identity of the safety coordinator(s) specified in the COVID-19 plan; and how the employee can obtain copies of employer specific policies and procedures, including the employer’s written COVID-19 plan, if required (Occupational Safety and Health Administration [OSHA], 2021).

- To help prevent COVID-19 transmission among individuals living in tribal communities, health care professionals should provide such individuals with the information found below.
    - Everyone has a role to play to reduce and slow the transmission of COVID-19. Social distancing is an essential step in preventing the spread of COVID-19. Social distancing is reducing physical interaction between people. Social distancing lowers the chances of spreading illness between people. If individuals are not fully vaccinated, they should practice social distancing by putting space (at least six feet) between themselves and others. It is especially important during the COVID-19 pandemic to protect individuals who are at higher risk for severe illness from COVID-19.

- Individuals who are at higher risk for severe illness from COVID-19 include older adults and people of any age who have serious underlying medical conditions. People can follow social distancing by reducing how often they are physically near others, reducing the overall number of people they are physically near, and by keeping at least six feet away from others when they do leave their homes. Staying physically apart is important, even in places like the workplace, school, when shopping, or in other places in the community. The goal of social distancing is to reduce the risk of spreading COVID-19.

- Social distancing may make some people feel socially or culturally isolated, and possibly lead to loneliness, depression, and poor health. It is important to use other non-physical ways to connect with family and friends, like sending a letter, phone calls, video calls, or social media. Exercising in or around the home or yard and sitting or working outside, close to home, can also help.

- Social distancing to stay healthy and safe may prevent individuals from following some traditional and ceremonial practices.

- American Indian/Alaska Native (AI/AN) communities with elders, parents, and children living together in households and in rural, tribal areas experience unique challenges with physical distancing and access to grocery stores, water, and health services.

- Consider wearing a mask in public (note: masks should not be placed on children younger than two years old, anyone who has trouble breathing or is unconscious, or anyone who is unable to remove the mask without assistance).

- Wash hands often following these steps: wet the hands with clean, running water, turn off the tap, and apply soap; lather the hands by rubbing them together with the soap; lather the backs of the hands, fingers, and under the nails; scrub the hands, palms, back, between fingers and around fingernails for at least 20 seconds or for the length of the “Happy Birthday” song from beginning to end twice; rinse the hands well under clean, running water; dry the hands using a clean towel or air dry them.

- Wash the hands for at least 20 seconds, with soap and water, before eating.

- Wash the hands for at least 20 seconds, with soap and water, after touching a surface or after returning home.
- Use an alcohol-based hand sanitizer that contains at least 60% alcohol, when needed. Place a dime-sized amount of hand sanitizer on the palm and rub hands together, covering all parts of the hand, fingers, and nails until they feel dry.
- If a household member has COVID-19, provide a separate bedroom and bathroom for the individual(s) who is sick. If that is not possible, try to separate the individual from other household members as much as possible.
- Remind everyone in the household to avoid touching their faces and cover their coughs and sneezes with the inside of their elbow or with a tissue and then throw the tissue away.
- Regularly clean frequently touched surfaces (e.g., tables, doorknobs, light switches, handles, desks, toilets, faucets, sinks, and electronics).
- If possible, send individuals that are not at higher risk for severe illness from COVID-19 to gather essentials for the home, such as food and medications.
- Monitor individuals for COVID-19 emergency signs, such as: trouble breathing; continual pain or pressure in the chest; new confusion; pale, gray, or blue-colored skin, lips, or nail beds.
- Tribal community members may need to regularly share personal vehicles with members outside of their own households; tribal organizations may provide medical transportation to their community members by using non-emergency vehicles (e.g., cars or vans).
- If washing the body, shrouding, or other important religious or cultural practices are observed in a specific tribal community, families are encouraged to work with their cultural and religious leaders and funeral home staff on how to reduce their exposure as much as possible.
- Individuals who died from COVID-19 can be buried or cremated. Individuals should check for any additional tribal, state, local, or territorial requirements that may dictate the handling and disposition of the body of

individuals who passed from certain infectious diseases (note: spouses and families of American Indian/Alaska Native veterans may be eligible for burial assistance; burial benefits can include opening and closing of the grave, perpetual care, a government headstone or marker, a burial flag, and a Presidential Certificate - at no cost to the family).

- Consider vaccination. To increase COVID-19 vaccination among individuals living in tribal communities, health care professionals should provide such individuals with the information found below.

    - COVID-19 can cause serious illness or death. All COVID-19 vaccines available in the United States are effective at helping prevent COVID-19. Even if individuals become sick after they are vaccinated, they should be protected from more serious illness. All three vaccines (Pfizer-BioNTech, Moderna, and Johnson and Johnson/ Janssen) are either authorized or approved for adults. In addition, the Pfizer-BioNTech vaccine is authorized for people 5 to 15 years of age and approved for those 16 and 17 years of age.

    - COVID-19 vaccination is recommended for all people five years and older, including people who are pregnant, breastfeeding, trying to get pregnant now, or might become pregnant in the future. Pregnant and recently pregnant people are at an increased risk for severe illness from COVID-19 when compared with non-pregnant people. There is currently no evidence that any vaccines, including COVID-19 vaccines, cause fertility problems in women or men.

    - All COVID-19 vaccines used in the United States were tested in clinical studies involving thousands of people, including American Indians and Alaska Natives. These studies were done to make sure the vaccines meet safety standards and protect people of different ages, genders, races, and ethnicities. All authorized COVID-19 vaccines meet the Food and Drug Administration's (FDA) rigorous scientific standards for safety, effectiveness, and manufacturing quality needed to support emergency use authorization (EUA). Approved COVID-19 vaccines meet the same safety standards as other vaccines used in the United States.

- Different types of vaccines work in different ways to offer protection, but COVID-19 vaccines, like any other vaccine, cannot affect DNA in any way.
- People with medical conditions like heart disease, lung disease, diabetes, and obesity are more likely to get very sick from COVID-19. Vaccination is especially important for people with these conditions. People with a weakened immune system may not get as much protection from COVID-19 vaccination as those with a functioning immune system. That is why the CDC recommends that people with moderately to severely compromised immune systems receive an additional dose of mRNA COVID-19 vaccine at least 28 days after a second dose of Pfizer-BioNTech COVID-19 vaccine or Moderna COVID-19 vaccine.
- The CDC advises against altering the HHS/CDC COVID-19 vaccination card in any way, which includes embedding tribal names or logos onto the cards. While the intent of doing so may be to promote vaccination among tribal members, COVID-19 vaccination cards that were altered may not be recognized as sufficient proof of vaccination to allow for entry into other countries. To ensure that the vaccination cards people receive will be accepted as valid proof of vaccination, the CDC recommends that tribes, tribal-serving organizations, and health care professionals use and distribute the original, unaltered HHS/CDC COVID-19 vaccination card.
- If individuals had a severe allergic reaction or an immediate allergic reaction, even if it was not severe, to any in an mRNA COVID-19 vaccine, they should not get either of the currently available mRNA COVID-19 vaccines (Pfizer-BioNTech and Moderna). If individuals had a severe allergic reaction or an immediate allergic reaction to any ingredient in the Johnson and Johnson/Janssen COVID-19 vaccine, they should not get the Johnson and Johnson's/Janssen COVID-19 vaccine.
- Individuals may still get vaccinated if they have severe allergies to oral medications, food, pets, insect stings, latex, or things in the environment like pollen or dust.

  - The United States government is providing the vaccine free of charge to all people in the United States. No one should be charged for the vaccine at this time.
  - Even if an individual had COVID-19 in the past, it is possible that he or she could get COVID-19 again. Experts do not yet know how long individuals are protected from getting sick again after having COVID-19; however, vaccination is the best protection from re-infection
  - COVID-19 vaccines cannot make people sick with COVID-19. They do not contain the virus that causes COVID-19. Getting vaccinated may also protect others.
  - After getting the shot, individuals will be asked to wait for 15 - 30 minutes to ensure that they are okay.
  - After receiving a COVID-19 vaccine some individuals may have pain, redness, and swelling in the arm where they received the shot. Individuals may also have tiredness, headache, muscle pain, chills, and fever for a few days. These are normal signs that the body is building protection against COVID-19.
  - Once individuals are up to date on COVID-19 vaccines, they can resume many activities that they did prior to the pandemic. To reduce the risk of being infected and possibly spreading it to others, individuals should consider wearing a mask indoors in public if you are in an area where the COVID-19 Community Level is high.
- Continuing homeless services during the community spread of COVID-19 is critical. Health care professionals should make plans to maintain services for all people experiencing unsheltered homelessness. Furthermore, clients who are positive for COVID-19 or exposed to someone with COVID-19 need to have access to services and a safe place to stay, separated from others who are not infected. To facilitate the continuation of services, community coalitions should identify resources to support people sleeping outside as well as additional temporary housing, including sites with individual rooms that are able to provide appropriate services, supplies, and staffing.

- Vaccination for people experiencing homelessness is important. Homeless services are often provided in congregate settings, which could facilitate the spread of infection, including infection caused by the virus that causes COVID-19. Because many people who are homeless are older adults or have underlying medical conditions, they may also be at increased risk for severe illness. The Advisory Committee on Immunization Practices (ACIP) recommends that, when supplies of COVID-19 vaccine are limited, vaccination should be offered in a phased approach.
- When implementing the vaccination phases, it is important to consider that people experiencing homelessness might have low levels of trust in the medical system and often have difficulty accessing vaccinations through traditional health care delivery methods, such as clinics or health departments. Lessons learned from hepatitis A outbreaks should show health care professionals that offering vaccination in homeless service sites and places where people experiencing homelessness visit, as well as using mobile units, are important strategies.
- Use the Department of Housing and Urban Development's most recent point-in-time count to estimate the number of people experiencing homelessness by state or region and help inform vaccine distribution planning.
- Review state and local vaccination plans to identify when homeless service staff and people experiencing homelessness are prioritized for COVID-19 vaccination.
- Work with case managers, health care agencies, and community organizations to identify people experiencing homelessness who might be eligible for vaccination in earlier phases due to belonging to another group prioritized by state or local vaccination plans (e.g., due to age, employment, or underlying medical conditions).
- Consider sub-prioritization by housing status if there is limited vaccine supply. Not all jurisdictions will need to sub-prioritize; however, some health departments might sub-prioritize homeless shelters with increased risk of transmission, such as those with increased crowding, shared rooms, or higher turnover.
- Plan which entities (e.g., health department, health care for the homeless clinic, retail pharmacy, or other health care entity) will be responsible for ordering, storing, distributing, administering, and documenting data pertaining to vaccines.

- Identify vaccination providers and staff who are known and trusted by historically marginalized communities to help build vaccination confidence among racial and ethnic minorities and lesbian, gay, bisexual, and transgender people experiencing homelessness.
- Identify strategies for surge staffing for vaccination events. When available, Medical Reserve Corps or volunteer associations for nurses, pharmacists, and emergency medical technicians can provide additional staffing capacity. Students in pharmacy, nursing, social work, and medical programs can serve as additional volunteers, if available.
- Involve people experiencing homelessness and homeless service provider staff in the decision-making process for vaccination planning.
- Ensure vaccines can be offered on a recurring basis; plan to offer repeat events in the same location to improve vaccine uptake among people experiencing homelessness. Work with homeless service providers to identify the most convenient days and times to reach the highest number of individuals.
- Communicate with clinics where people experiencing homelessness might be more likely to access services, such as Health Care for the Homeless, Federally Qualified Health Centers, and behavioral health clinics. Ensure that clinics are aware of when homeless service staff and people experiencing homelessness are prioritized for COVID-19 vaccination in state and local vaccination plans. Share vaccination provider requirements and enrollment procedures.
- Many pharmacies are already involved in providing vaccination to the public and can be accessible for people experiencing homelessness, especially in rural areas. Ensure that pharmacies are aware of when homeless service staff and people experiencing homelessness are prioritized for COVID-19 vaccination in state and local vaccination plans.
- Other social service organizations where a high proportion of clients might be experiencing homelessness, including harm reduction services or syringe services programs - consider these as additional venues for on-site clinics. Collaborating with these partners can help to reinforce messages on the importance of vaccination and ensure follow-up of a second dose when needed.
- Ensure that the vaccination provider can follow cold chain requirements for vaccine storage and use once thawed.

- Confirm that vaccine distribution locations have staff with capacity to perform safe delivery of vaccination services, who can adhere to clinical considerations for vaccine administration, and who can provide clinical care for potential adverse events, such as anaphylaxis.
- Review existing vaccination clinic planning checklists and ensure adequate supplies, including epinephrine.
- Reinforce to health care staff and vaccination recipients the core COVID-19 prevention measures (e.g., masks, physical distancing, avoiding crowds, hand washing) and provide masks as needed during vaccination events and post-vaccination observation periods. Reinforce that these prevention measures must be sustained for the coming months, even after people receive COVID-19 vaccination.
- Connect with trusted communicators, such as people with lived experience of homelessness, who can provide vaccination education and information to people experiencing homelessness. Engage these individuals in planning and implementation of vaccination events.
- Advertise vaccination events for people experiencing homelessness in advance. Use multiple communication strategies such as flyers at encampments, in shelters, and on public transportation; announcements at health care and other service programs; or messages via email, text messaging, social media, television, and radio.
- Provide opportunities for homeless service provider staff and clients to ask questions about the vaccines.
- Know the elements of effective vaccination conversations: start from a place of empathy and understanding, give strong recommendations, address misinformation by sharing key facts, and connect people with trusted health care professionals to answer questions.
- Ensure adequate space and staff for post-vaccination observation for potential adverse reactions.
- Consider providing medical respite care and shelter options for people experiencing vaccine side effects.

- Use multiple second-dose reminder methods simultaneously to improve completion of each vaccine's two-dose series.
- Record complete contact information at the time of vaccination to improve second-dose follow-up. Ask for back-up contact information or an alternate contact (with permission). Plan for who will be responsible for ensuring follow-up and what strategies they will use.
- Consider innovative strategies for second-dose reminders such as providing prepaid phone cards, prepaid cell phones with programmed reminders, or second-dose incentives.
- Review general strategies for vaccine documentation and reporting, including training qualified vaccination providers on use of the jurisdiction’s immunization information system (IIS) or other system connected to the IIS, if needed.
- Ensure that vaccination teams have sufficient vaccination record cards.

Section 2 Summary

Health equity is the state in which everyone has a fair and just opportunity to attain their highest level of health. Health care professionals can mitigate implicit bias by ensuring health equality. In the current health care climate, health equality is especially important when caring for patients with disabilities and when working to prevent and treat COVID-19. Finally, health care professionals should work to establish a culture of health equity within their health care organizations by following related recommendations.

Section 2 Key Concepts

- Health care professionals can mitigate implicit bias by ensuring health equality.
- Health equality is especially important when caring for patients with disabilities and when working to prevent and treat COVID-19.
- Achieving health equity requires focused and ongoing societal efforts to address historical and contemporary injustices; overcoming economic, social, and other obstacles to best health and health care; and eliminating preventable health disparities.

Section 2 Key Terms

Health equity - the state in which everyone has a fair and just opportunity to attain their highest level of health

Disability - any condition of the body or mind that makes it more difficult for an individual with the condition to do certain activities and interact with the world around them

Impairment - an absence of or significant difference in an individual's body structure or function or mental functioning

Structural impairments - significant problems with an internal or external component of the body

Functional impairments - the complete or partial loss of function of a body part

Disability inclusion - the act of including individuals with disabilities in everyday activities and encouraging them to have roles similar to their peers who do not have a disability

Barriers (when used in the context of disability inclusion) - factors in an individual's environment that, through their absence or presence, limit functioning and create disability

Physical barriers - structural obstacles in natural or manmade environments that prevent or block mobility (moving around in the environment) or access

Programmatic barriers - barriers that limit the effective delivery of a public health or health care program for people with different types of impairments

Accommodations - alterations made to items, procedures, or systems that enable an individual with a disability to use them to the maximum extent possible; a modification to an existing environment or process to increase the participation by an individual with an impairment or activity limitation

Universal design - the act of designing buildings, products, or environments to make them accessible to all individuals, regardless of age, disability, or other factors

Assistive technologies (ATs) - devices or equipment that can be used to help an individual with a disability fully engage in life activities

Independent living - being able to take care of oneself without being dependent on another individual

Victimization - harm caused on purpose

Mental health - how an individual thinks, feels, and acts as he or she copes with life

Secondary condition - any additional physical or mental health condition that occurs as a result of having a disability

Fatigue - a feeling of weariness, tiredness, or lack of energy

Pressure ulcers (also known as bed sores, pressure sores, or decubitus ulcers) - wounds caused by constant pressure on the skin

Methicillin-resistant Staphylococcus aureus (MRSA) - a type of bacteria that is resistant to certain antibiotics

Learning disabilities - disorders that may affect an individual's ability to understand or use spoken or written language, do mathematical calculations, coordinate movements, or direct attention

Substance abuse - the harmful or hazardous use of a psychoactive substance such as alcohol and illicit drugs

Suicidal ideation - thoughts of suicide and/or thoughts of planning suicide

Suicide attempt - a non-fatal self-directed and potentially injurious behavior with any intent to die as a result of the behavior

Suicide - a death caused by injuring oneself with the intent to die

Section 2 Personal Reflection Question

How can health equality improve patient care?

Conclusion

Implicit bias can impact patient care as well as a patient's health, overall well-being, and quality of life. Therefore, health care professionals should work to mitigate implicit bias within their health care organization. Health care professionals can mitigate implicit bias within their health care organization by embracing cultural competency and by ensuring health equality.

References

AIDS Education and Training Center-National Multicultural Center. (2022). *Case studies in cultural competency*. https://www.aetcnmc.org/studies/index.html

Centers for Disease Control and Prevention. (2022, May 18). *CDC COVID-19 response health equity strategy: Accelerating progress towards reducing COVID-19 disparities and achieving health equity*. https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/cdc-strategy.html

Centers for Disease Control and Prevention. (2022, July 25). *Disability and health promotion*. https://www.cdc.gov/ncbddd/disabilityandhealth/index.html

Centers for Disease Control and Prevention. (2022, September 2). *Health equality*. https://www.cdc.gov/healthequity/index.html

Centers for Disease Control and Prevention. (2022, August 2). *Health equality guiding principles for inclusive communication*. https://www.cdc.gov/healthcommunication/Health_Equity.html

Centers for Disease Control and Prevention. (2022, August 2). *Key principles*. https://www.cdc.gov/healthcommunication/Key_Principles.html

Centers for Disease Control and Prevention. (2022, August 2). *Preferred terms for select population groups and communities*. https://www.cdc.gov/healthcommunication/Preferred_Terms.html

Centers for Disease Control and Prevention. (2021, April 22). *The U.S. public health service syphilis study at Tuskegee*. https://www.cdc.gov/tuskegee/index.html

Joint Commission. (2022). *Quick safety 23: Implicit bias in health care*. https://www.jointcommission.org/resources/news-and-multimedia/newsletters/newsletters/quick-safety/quick-safety-issue-23-implicit-bias-in-health-care/implicit-bias-in-health-care/#.YxsTXr_MLIW

Occupational Safety and Health Administration. (2021). *1910. 502 - Healthcare*. https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.502

Sabin, J.A., (2022). Tackling implicit bias in health care. *New Engl J Med 387*:105-107. DOI: 10.1056/NEJMp2201180

Stanford Encyclopedia of Philosophy. (2019, July 31). *Implicit bias*. https://plato.stanford.edu/entries/implicit-bias/

United States Department of Health and Human Services (2021, November 21). *Laws and regulations enforced by OCR*. https://www.hhs.gov/civil-rights/for-providers/laws-regulations-guidance/laws/index.html

United States Department of Health and Human Services Office of Minority Health. (2021, December 30). *Think cultural health*. https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53