MEDICAID

Cultural Competency and Patient Engagement

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Footnote:
The content for the above sections was provided by the Health Industry Collaboration Effort. www.iceforhealth.org/home.asp.

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- Culturally and linguistically appropriate services (CLAS) standards
- Healthy Blue provider website

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Cultural Competency

We Are Committed to Cultural Competency

- As a contracted Healthy Blue provider with Blue Cross and Blue Shield of North Carolina (Blue Cross NC), our expectation is for you and your staff to gain and continually increase your knowledge of and ability to support the values, beliefs and needs of diverse cultures.

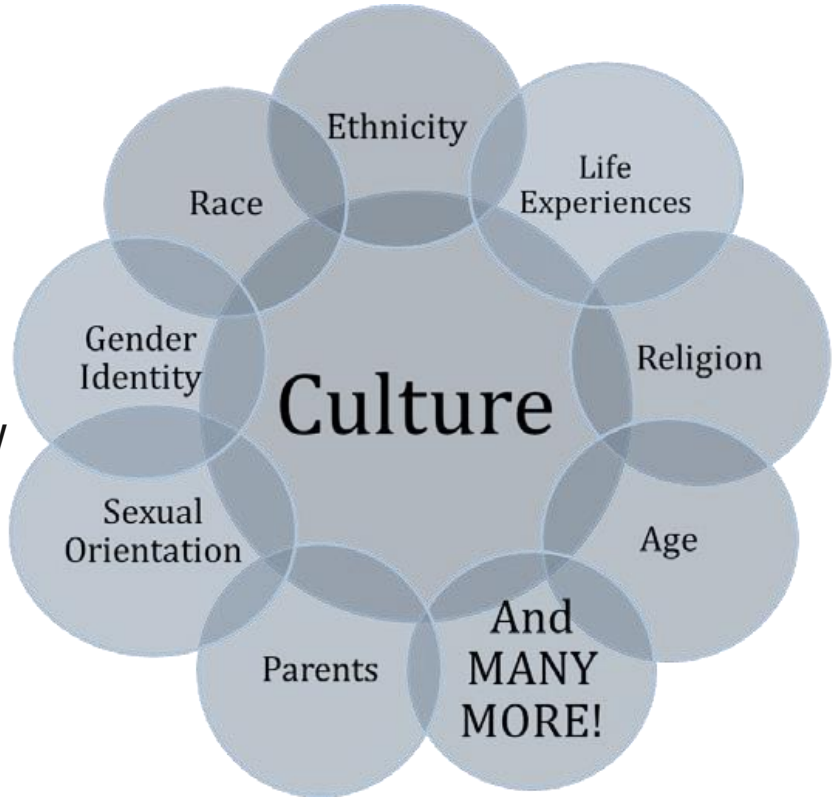
- This results in effective care and services for all people by taking into account each person's values, reality conditions and linguistic needs.

What is Culture?

Culture refers to integrated patterns of human behavior, including language, thoughts, actions, customs, beliefs, values and institutions, that unite a group of people.

We use culture to create standards for how we act and behave socially.

Culture is not only learned; it is shared, adaptive and constantly changing.



Footnote:
Source: http://minorityhealth.hhs.gov and The Cross Cultural Health Care Program

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Individual Cultural

An individual's culture:

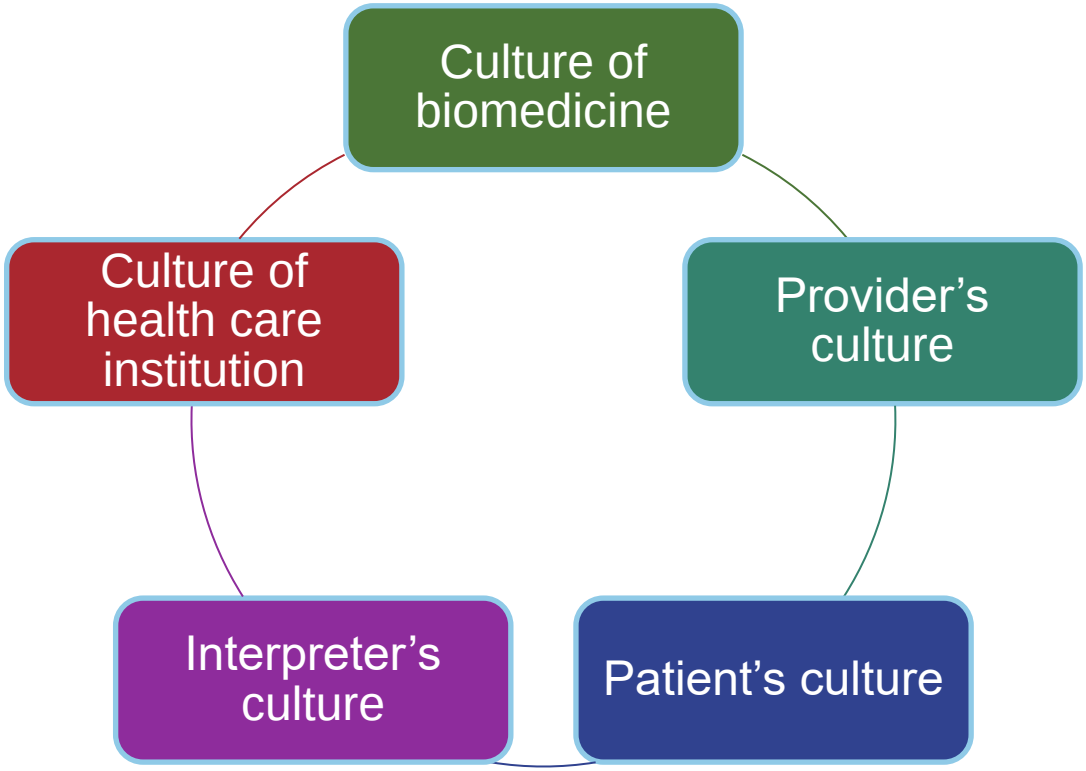
- Is a unique representation of the variation that exists within a larger culture
- Is learned as one grows up
- Is shaped by the power relations within one's social context
- Changes over the lifetime of the individual

Because people are a unique cultural package, cross-cultural encounters need strategies to open the door to discover an individual's cultural preferences and frame of reference.

An individual's culture is present in every health care encounter, including but not limited to:

- Our view of illness and what causes it
- Our attitudes toward doctors, dentists and other health care providers
- When we decide to seek our health care provider
- Our attitudes about seniors and those with disabilities
- The role of caregivers in our society

The Health Care Encounter



Because each individual brings their cultural background with them, there are many cultures at work in each health care visit.

How Does Culture Impact the Care Provided?

Culture informs us of:

- Concepts of health and healing.
- How illness, disease and their causes are perceived.
- The behaviors of patients who are seeking health care.
- Attitudes toward health care providers.

Importance of Cultural Differences in Health Care Settings

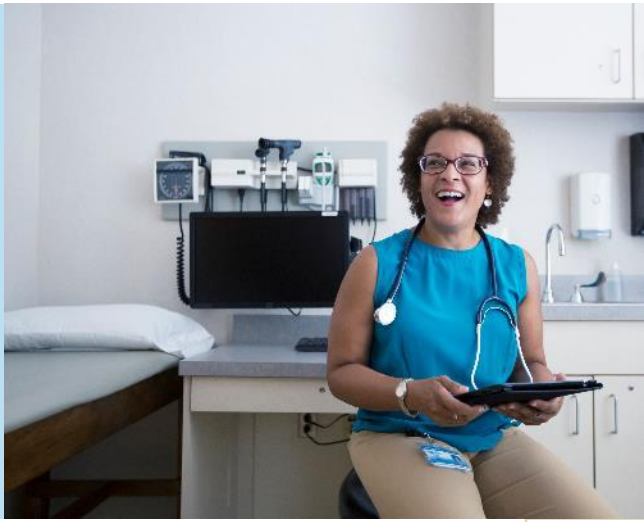
Cultural factors may influence the way individuals:

- Define and evaluate situations.
- Seek help for problems.
- Present their problems, situations and information to others.
- Respond to interventions and service plans.

Cultural awareness helps you modify your behaviors to respond to the needs of others while maintaining a professional level of respect and objectivity.

Reasons to Increase Your Cultural Awareness

- The perception of illness, disease and their cause varies by culture.
- The belief systems related to health, healing and wellness are as diverse as the populations we serve.
- Culture and socioeconomic concerns influence help-seeking behaviors and attitudes toward health care providers and services.
- Individual preferences affect traditional and nontraditional approaches to health care.
- Health care providers from culturally and linguistically diverse groups are under-represented in the current delivery system.



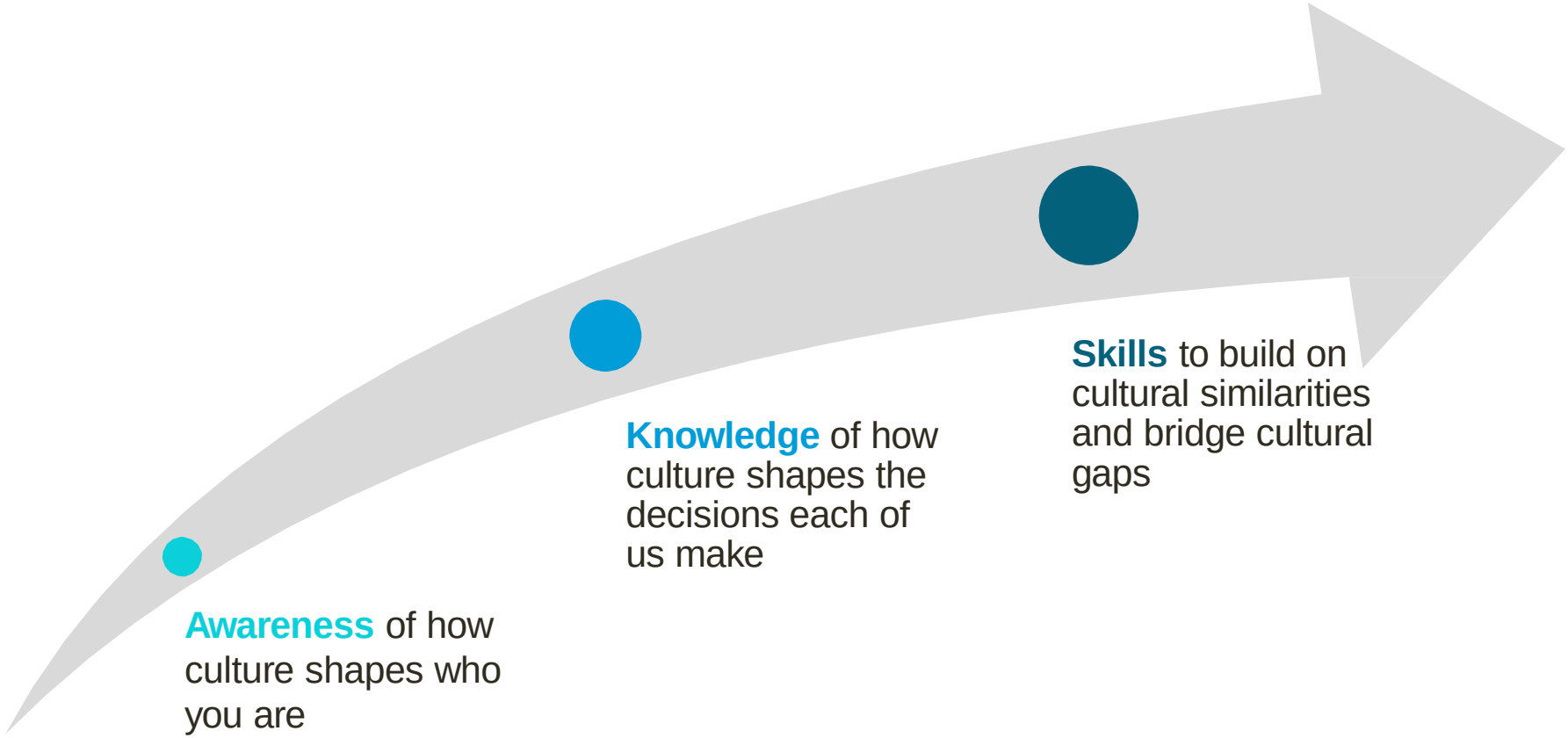
Impact of Increasing Your Cultural Awareness

You have a profound, positive impact on the quality of interactions with your patients by:

- Acknowledging their varied behaviors, beliefs and values.
- Incorporating these variables into their assessments, interactions and treatments.

Each patient's ability to communicate symptoms and adhere to recommended treatments improves in direct relation to your level of cultural competency and awareness.

Building Cultural Engagement with Your Patients is a Process



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Cultural Competency Continuum: For each row, circle where you are now

Area of competency	Stage 1: Culturally unaware	Stage 2: Culturally resistant	Stage 3: Culturally conscious	Stage 4: Culturally insightful	Stage 5: Culturally versatile
Knowledge of patients	Doesn't notice cultural differences in patients' attitudes or needs	Denigrates differences encountered in racial/ethnic patients	Difficulty understanding the meanings of attitudes/ beliefs of patients different from self	Acknowledges strengths of other cultures and legitimacy of beliefs, whether medically correct or not	Pursues understanding of patient cultures; learns from other cultures
Attitude toward diversity	Lacks interest in other cultures	Holds as superior the values, beliefs and orientations of own cultural group	Ethnocentric in acceptance of other cultures	Enjoys learning about culturally different health care beliefs of patients	Holds diversity in high esteem; perceives as valuable contributions to health care, medicine and patient well-being from many cultures
Practice-related behaviors	Speaks in a paternalistic manner to patient; doesn't elicit patient's perspectives	Doesn't recognize own inability to relate to differences; tends to blame patient for communication or cultural barriers	May overestimate own level of competent communication across linguistic or cultural boundaries	Able to shift frame of reference to other culture; can uncover culturally based resistance, obstacles to education and treatment	Flexibly adapts communication and interactions to different cultural situations; can negotiate culture-based conflicts in beliefs and perspectives
Practice perspective	Believes one approach fits all patients; no special treatment	Has lower expectations for compliance of patients from other cultural groups	Recognizes limitations in ability to serve cultures different from own; feels helpless to do much about it	Incorporates cultural insights into practice where appropriate	Incorporates cultural insights into practice where appropriate

Footnote:
Source: J. L. Mason, M. P. Benjamin, & S. A. Lewis (1993). The cultural competence model: Implications for child and family mental health services.

Clear Communication

The foundation of culturally competent care

Did You Know?

- One in six people living in the United States is Hispanic (almost 57 million). By 2035, this could be nearly one in four. (CDC 2015)
- Doctors interrupt patients every 11 seconds on average. (General Internal Medicine 2018)
- In the United States, 21% of people speak a language other than English at home. (Census 2013)
- The Latino population in the United States grew by 43% between 2000 and 2010. (Census 2011)
- Of the foreign born population in the United States, 17% are classified as newly arrived (arriving in or after 2005). (Census 2011)
- As of 2013, almost half of states in the United States had an increase in foreign language speakers. (CIS 2014)

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Benefits of Clear Communication

Increase in:

- Safety and adherence
- Physician and patient satisfaction
- Office processes

Decrease in:

- Time and money
- Malpractice risk
- Error, which reduces cost

Barriers to Communication

Linguistic barriers

- Speech patterns, accents or different languages may be used.

Limited experience (health care concepts and procedures)

- Many people are getting health care coverage for the first time.

Cultural barriers

- Each person brings their own cultural background and frame of reference to the conversation.

Systematic barriers

- The health care system has specialized vocabulary and jargon.

Our personal culture includes what we find meaningful — beliefs, values, perceptions, assumptions and explanatory framework about reality. These are present in every communication.

Clear Communication

What patients wish their health care providers knew:	What you can do:
• When I tell you I forgot my glasses, it is because I am ashamed to admit I don't read very well. • I don't know what to ask, and I am hesitant to ask you. • When I leave your office, I often don't know what I should do next. • I'm very good at concealing my limited reading skills.	• Use a variety of instruction methods. • Encourage open-ended questions and use Ask Me 3®. • Use the **Teach Back** or **Show Me** method. • Use symbols, color, large print directions or instructional signs. • Create a shame-free environment by offering assistance with materials.

Clear Communication (cont.)

What patients wish their health care providers knew:	What you can do:
• I put medication in my ear instead of my mouth to treat an ear infection. • I am confused about risk and information given in numbers like percent or ratios and don't know what I should do.	• Explain how to use the medications that are being prescribed. • Use specific, clear and plain language on prescriptions. • Use plain language to describe risks and benefits, and avoid using only numbers.

Clear Communication (cont.)

What patients wish their health care providers knew:	What you can do:
• I am more comfortable waiting to make a health care decision until I can talk with my family. • Sometimes, I am more comfortable with a doctor of my same gender. • It is important for me to have a relationship with my doctor. • I use complementary, alternative medicine and home remedies, but I didn't think to tell you.	• Confirm decision-making references. • Office staff should confirm preferences during scheduling. • Spend a few minutes building rapport during each visit. • Ask about the use of complementary medicine and home remedies.

Clear Communication: Limited English Proficiency

What patients wish their health care providers knew:	What you can do:
• My English is pretty good, but I need an interpreter at times. • Some days, it's harder for me to speak English. • When I don’t understand, speaking louder in English intimidates me. • If I look surprised, confused or upset, I may have misinterpreted your nonverbal cues.	• Office staff should confirm language preferences during scheduling. • Consider offering an interpreter for every visit. • Match the volume and speed of the patient’s speech. • Mirror body language, position and eye contact. • Ask the patient if they're unsure.

Using Professionally Trained Interpreters

- When patients are stressed by illness, communication in their preferred language can improve understanding.
- Being prepared to use an interpreter when needed will keep the office flow moving smoothly.
- The next three slides contain recommendations for using professionally trained interpreters.

Using Professionally Trained Interpreters (cont.)

Do…

- Inform the patient that using family members and minors as interpreters is highly discouraged.
- Choose an interpreter who meets the needs of the patient; consider age, sex and background.
- Hold a brief introductory discussion with the interpreter to introduce yourself and give a brief nature of the call/visit.
- Reassure the patient about your confidentiality practices.
- Be prepared to pace your discussion with the patient to allow time for interpretation.
- Be aware that in some languages it may take longer to explain a word or a concept.

Using Professionally Trained Interpreters (cont.)

Do…

- Face and speak directly to the patient, not the interpreter, using a normal, clear voice.
- Speak in the first person and in concise sentences.
- Be sensitive to appropriate communication standards.
- Be aware of the cultural context of body language for yourself and the patient.
- Use the **Teach Back** method even during an interpreted visit; it will give you confidence that your patient understood your message.

Using Professionally Trained Interpreters (cont.)

Don’t…

- Interrupt during interpretation.
- Speak too loud or too fast.
- Ask or say anything you don’t want the patient to hear.

To find out what language assistance services are available for members, please refer to your provider manual or contact Healthy Blue Provider Services at **1-844-594-5072**.

Sources

***Cultural Competency* section:**

- U.S. Department of Health and Human Services, Office of Minority Health. Culture and Cultural Competency. https://www.minorityhealth.hhs.gov.
- J. L. Mason, M. P. Benjamin, & S. A. Lewis (1993). The cultural competence model: Implications for child and family mental health services.

***Clear Communication: The Foundation of Culturally Competent Care* section:**

- Health Industry Collaboration Effort, Inc. (2010, July). Better communication, better care: Provider tools to care for diverse populations. Retrieved from www.iceforhealth.org.

Sources (cont.)

***Clear Communication: The Foundation of Culturally Competent Care* section (continued):**

- U.S. Department of Health and Human Services, Office of Minority Health. Handouts: Theme 1: BATHE Model (1.3). In The facilitator's guide: Companion to: A physician's practical guide to culturally competent care (pp. 145-145). Retrieved from https://cccm.thinkculturalhealth.hhs.gov/PDF_Docs/Physicians_QIO_Facilitator_GuideMEDQIC.pdf.
- Weiss, B. D. (2007). Health literacy and patient safety: Help patients understand; Manual for clinicians (2nd ed.). Chicago, IL: American Medical Association Foundation.
- Institute for Healthcare Improvement. Ask Me 3: Good Questions for Your Good Health. Retrieved from http://www.ihi.org/resources/Pages/Tools/Ask-Me-3-Good-Questions-for-Your-Good-Health.aspx.

Disability Sensitivity and Awareness

Laws and Regulations

The Americans with Disabilities Act (ADA) is divided into five titles (or sections) relating to different areas of public life:

Section	Topic/area addressed
Title I	Employment practices of private employers with 15 or more employees, state and local governments, employment agencies, labor unions, agents of the employer, and joint management labor committees
Title II	Programs and activities of state and local government entities
Title III	Private entities that are considered places of public accommodation
Title IV	Telecommunications
Title V	Miscellaneous

Requirements for Health Care Providers

Title II and Title III of the *ADA* and Section 504 of the *Rehabilitation Act of 1973* require that medical care providers offer individuals with disabilities the following:

- Full and equal access to their health care services and facilities (additional details on the next slide)
- Reasonable modifications to policies, practices and procedures when necessary to make health care services fully available to individuals with disabilities unless the modifications would fundamentally alter the essential nature of the services

Providing Full and Equal Access

From the first time a member has contact with your office, staff should be knowledgeable about not refusing services, providing separate or unequal access to health care services to any individual with a disability, and giving the appearance of discrimination against **any** person.

Providing full and equal access to those with disabilities includes:

- Removing physical barriers
- Providing a means for effective communication with those who have vision, hearing or speech disabilities
- Making reasonable modifications to policies, practices and procedures

Accommodations for Those with Disabilities

You must **deliver services in a manner that accommodates the needs of members** by:

- Providing flexibility in scheduling.
- Providing interpreters or translators for members who are deaf or hard of hearing.
- Having an understanding of disability-competent care.
- Ensuring individuals with disabilities and their companions are provided with reasonable accommodations to ensure effective communication (including auxiliary aids and services).
- Having accessible facilities.
- Providing reasonable modifications/accommodations.

Reasonable Modifications and Accommodations

Reasonable modifications and accommodations depend on the particular needs of the individual and include:

- Ensuring safe and appropriate access to buildings, services and equipment.
- Allowing extra time for members to:
  - Dress and undress
  - Transfer to exam tables
  - Speak with the practitioner to ensure the individual is fully participating and understands the information

Linguistic Services

You must be responsive to the linguistic, cultural and other unique needs of members with disabilities and special populations.

This includes the capacity to communicate with members:

- Who are deaf, hard of hearing or blind.
- In languages other than English.

Guidelines around communicating with a member with a disability:

- You cannot rely on a minor to facilitate communication.
- You cannot require patients to bring another person to interpret.
- An accompanying adult can be relied on to facilitate communication if it is an emergency or the patient requests it and the accompanying adult agrees. This arrangement must also be appropriate for the circumstances (28 CFR, Section 36.303).

Alternative Formats are Required

- Under Title II of the *ADA*, Section 504, federally conducted and assisted programs along with state and local programs are required to make their programs accessible to those with disabilities, as well as provide effective communication.
- Effective communication means communicating with individuals who have disabilities as effectively as you communicate with others.
- Alternative communications that support a patient encounter include sign language interpreters, tactile interpreters, and captioning and assisted-listening devices.

Resources to Support Disability-Competent Care

Disability-Competent Care Self-Paced Training Assessment Review Tool (DCC-START) — a free resource to assist health plans, systems and provider organizations in strengthening their efforts to provide more integrated, coordinated care to members with disabilities by:

- Assessing the disability competence of training materials.
- Identifying opportunities for training augmentation and enhancement informed by the DCC-START model.
- Offering a tailored selection of additional resources to enhance the effectiveness and completeness of the organization's disability training materials.
- Visit https://resourcesforintegratedcare.com. to access the DCC-START and accompanying user, technical and resource guides.
- The Disability Etiquette publication from the United Spinal Association offers tips on interacting with people with disabilities
- For more information, visit https://www.unitedspinal.org/disability-etiquette.

Source

Resources for Integrated Care. Retrieved from https://resourcesforintegratedcare.com.

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Practicing Cultural Awareness with American Indian/Alaska Native Patients

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Practicing Cultural Awareness with American Indian/Alaska Native Patients

- The content in this section of the training provides introductory information on the American Indian/Alaska Native (AI/AN) population.
- It is not intended to be all-encompassing or a provider's only resource. The most valuable resources are the patients themselves.
- Please consider this important information to support the provider-patient relationship. However, it is still critical to treat each AI/AN patient as an individual and not make assumptions about their beliefs and needs.

Demographics

National Demographics

- American Indians and Alaska Natives (AI/AN) is the term used to identify the indigenous peoples from the regions of North America now encompassed by the continental United States and Alaska.
  - The term includes a large number of distinct tribes, pueblos, villages, rancherias and communities.

- Approximately 3 million people in the United States identify as AI/AN people. The number increases to over 5 million when including AI/AN people of more than one race.

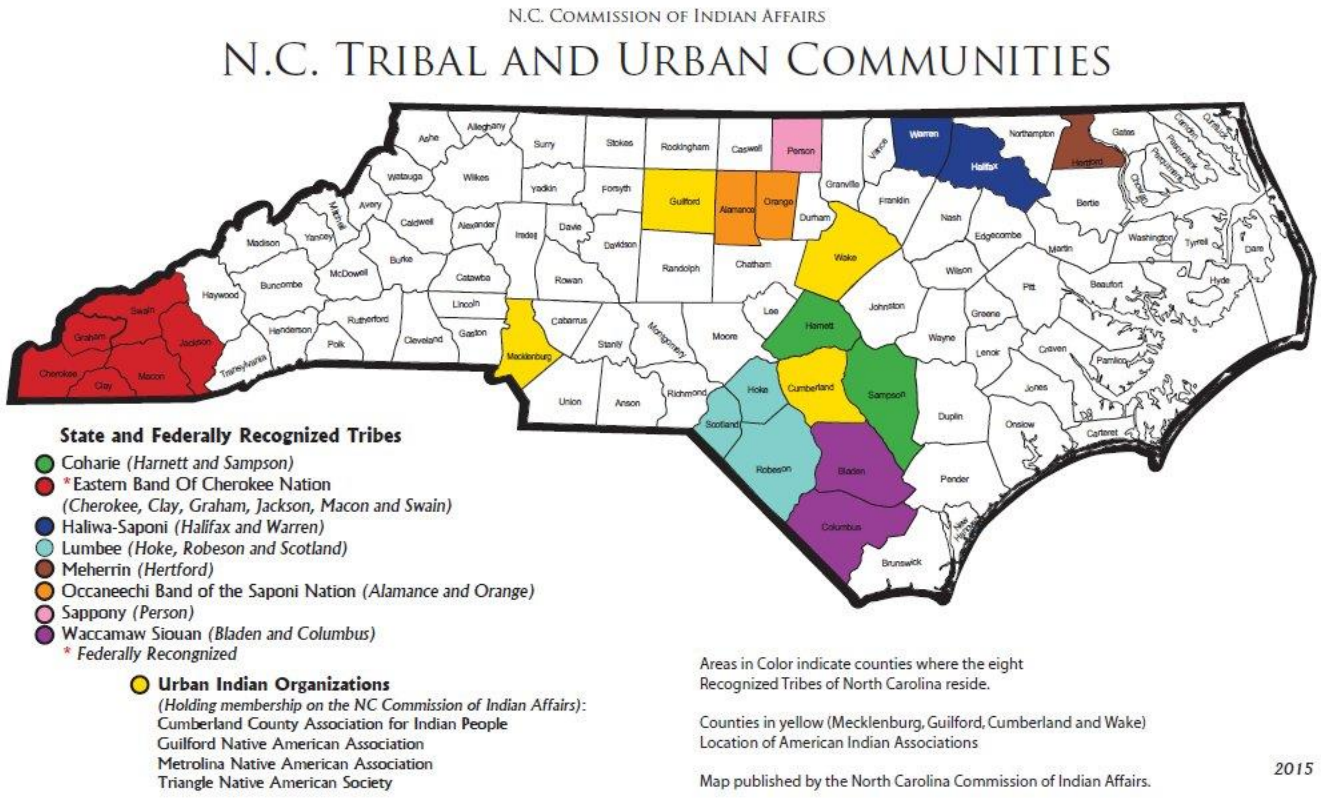
National Demographics (cont.)

- There currently are 573 federally recognized tribes in the United States.
  - There are over 100 non federally recognized tribes that are recognized by their states.
- Size of tribes varies widely.
- Approximately 30% of AI/AN people are under the age of 18.

Footnotes:

- Office of Minority Health. (2018, March 28). Profile: American Indian/Alaska Native. Retrieved from https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=62

State and Federally Recognized Tribes in North Carolina



Footnote:
Source: NC Commission of Indian Affairs. (2015). Map of NC Tribal Communities. Retrieved from https://ncadmin.nc.gov/citizens/american-indians/map-nc-tribal-communities

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Federal and State Recognized Tribes in North Carolina (cont.)

North Carolina currently has eight state or federally recognized tribes

Tribe name	Location	Approx. size
Lumbee Tribe of North Carolina	Cumberland /Hoke /Robeson /Scotland counties	55,000
Eastern Band of Cherokee Indians (federally recognized)	Cherokee /Graham /Jackson /Haywood /Swain counties	15,000
Haliwa-Saponi Indian Tribe	Halifax /Warren counties	4,300
Coharie Tribe	Sampson /Harnett counties	3,000
Waccamaw Siouan Tribe	Bladen /Columbus counties	2,000
Occaneechi Band of the Saponi Nation	Alamance /Orange counties	1,100
Meherrin Indian Tribe	Hertford County	900
Sappony	Person County	850

Footnote:
Source: UNC American Indian Center. (2017, Nov). North Carolina's Tribal Nations & Urban Indian Organizations. Retrieved from https://americanindiancenter.unc.edu/resources/about-nc-native-communities.

North Carolina Urban Indian Organizations

North Carolina also recognizes four Urban Indian Organizations:

Organization	Area(s) supported
Cumberland County Association for Indian People (CCAIP)	Cumberland County
Guilford Native American Association (GNAA)	Guilford County
Metrolina Native American Association (MNAA)	Mecklenburg and surrounding counties
Triangle Native American Society (TNAS)	Wake/Johnston/Durham/Orange/Chatham counties

These organizations help support the cultural, educational and economic needs of Indian people (in addition to other support depending on the organizations' scope and purpose).

Footnote:
Source: UNC American Indian Center. (2017, Nov). North Carolina's Tribal Nations & Urban Indian Organizations. Retrieved from https://americanindiancenter.unc.edu/resources/about-nc-native-communities.

Lumbee Tribe of North Carolina

- The Lumbee tribal territory is Cumberland, Hoke, Robeson and Scotland counties.
- Approximate size of the tribe: 55,000
- The Lumbee Tribe is the:
  - Largest tribe east of the Mississippi River.
  - Ninth largest tribe in the United States.
  - Largest nonreservation tribe in the United States.

Footnote:
Source: UNC American Indian Center. About NC Native Communities. (2017, Nov). Retrieved from https://americanindiancenter.unc.edu/resources/about-nc-native-communities.

History of the Lumbee Tribe

- American Indians have continuously occupied Robeson County for at least 10,000 years.
- The first contact with Lumbee ancestors in the region occurred in the 1730sand 1740s.
- In 1835, the North Carolina state constitution was amended to disenfranchise Indians (along with African Americans) and rescind citizenship rights.
  - This is **only one example of a multitude of traumas** American Indian/Alaskan Native people experienced, and such events continue to have impact and reverberate in the community to this day.
- In 1885, the NC General Assembly recognized the Indians of Robeson County as ‘Croatan’ and established a separate school system for Indians in Robeson County.

Footnote:
Source: UNC American Indian Center. About NC Native Communities. (2017, Nov). Retrieved from https://americanindiancenter.unc.edu/resources/about-nc-native-communities.

History of the Lumbee Tribe (cont.)

- In 1887, the General Assembly established Croatan Normal School to train Lumbee teachers. The institution is known today as the University of North Carolina at Pembroke (UNCP). In 1911, the NC General Assembly changed the name of the tribe to Indians of Robeson County.
- In 1913, the General Assembly changed the tribe's name to 'Cherokee Indians of Robeson County.'
- In 1952, a tribal referendum was held to change the tribe's name to 'Lumbee,' and in 1953, the NC General Assembly affirmed the vote and changed the legal name to Lumbee. Lumbee is the ancestral American Indian name for the river that runs through Robeson and Scotland counties.

Footnote:
Source: UNC American Indian Center. About NC Native Communities. (2017, Nov). Retrieved from https://americanindiancenter.unc.edu/resources/about-nc-native-communities.

History of the Lumbee Tribe (cont.)

- The Lumbee hold no treaty with the federal government, but in 1956, Congress passed the *Lumbee Act* which recognized the American Indians of Robeson and adjoining counties as the Lumbee Indians of North Carolina. The bill, however, contained language that made Lumbee ineligible for financial support and program services administered by the federal Bureau of Indian Affairs (BIA).

Footnote:
Source: UNC American Indian Center. About NC Native Communities. (2017, Nov). Retrieved from https://americanindiancenter.unc.edu/resources/about-nc-native-communities.

Prevalent Health Issues and Considerations for Overall AI/AN Population

Factors Impacting Health and Well-Being of AI/ANs

- **Poverty** – average income about 30% less than the average of other American communities
- **Lack of access** to quality health care

Footnote:
Source: Substance Abuse and Mental Health Services Administration. (2019, Feb). Treatment Improvement Protocol (TIP) 61: Behavioral Health Services for American Indians and Alaska Natives. Retrieved from https://store.samhsa.gov/product/tip-61-behavioral-health-services-for-american-indians-and-alaska-natives/sma18-5070.

Factors Impacting Health and Well-Being of AI/ANs (cont.)

- **Historical traumas** – loss of culture, history, land and family structure

  Early treaties with pledges of protection, health care and services were repeatedly broken, resulting in written word and verbal promises from non-members holding little value.

  Examples:

  - Practicing cultural traditions was illegal for AI/ANs from 1878 until 1978, often resulting in imprisonment and fines for those who broke the law. Today, many tribes are working to restore important and protective cultural practices in their communities. These cultural practices are a pathway to prevention and healing.
  - The Boarding School Movement removed AI/AN children from their families in order to force attendance at distant schools where the goal was to erase traditional culture and assimilate the students.

Footnote:
Source: Substance Abuse and Mental Health Services Administration. (2019, Feb). Treatment Improvement Protocol (TIP) 61: Behavioral Health Services for American Indians and Alaska Natives. Retrieved from https://store.samhsa.gov/product/tip-61-behavioral-health-services-for-american-indians-and-alaska-natives/sma18-5070.

Factors Impacting Health and Well-Being of AI/ANs (cont.)

- **Myths and misinformation** complicate provider relationships

  Examples:

  - Gambling casinos make many AI/ANs wealthy.
  - AI/ANs have an innate, unquenchable appetite for alcohol and become extremely violent when they consume too much.
  - AI/ANs receive a lot of services at no cost, such as education and health care.

Footnote:
Source: Substance Abuse and Mental Health Services Administration. (2019, Feb). Treatment Improvement Protocol (TIP) 61: Behavioral Health Services for American Indians and Alaska Natives. Retrieved from https://store.samhsa.gov/product/tip-61-behavioral-health-services-for-american-indians-and-alaska-natives/sma18-5070.

Prevalent Health Issues for AI/AN Population

Compared to non-Hispanic Whites, AI/ANs have **higher prevalence and mortality rates** of:

- Asthma (both children and adults).
- Certain cancers.
  - Stomach, colorectal, kidney and renal pelvis, liver and IBD (intrahepatic bile duct).
    - AI/ANs have lower rates of colorectal cancer screenings
    - AI/ANs women have higher prevalence and mortality rates for cervical cancer, despite slightly higher rates of screening
- Diabetes.

Footnote:
Source: Office of Minority Health. Minority Population Profiles: American Indian/Alaska Native. Retrieved from https://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=62.

Prevalent Health Issues for AI/AN Population (cont.)

- Higher prevalence of heart disease
  - Includes higher prevalence of obesity, hypertension and cigarette smoking
- Higher likelihood to have a stroke
- Higher rate of HIV infection
- Higher infant mortality rate, including higher mortality rate from sudden infant death syndrome (SIDS)
  - Higher rate of late or no prenatal care
  - Higher rate of smoking during pregnancy

Footnote:
Source: Office of Minority Health. Minority Population Profiles: American Indian/Alaska Native. Retrieved from https://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=62.

Mental Health Information for Overall AI/AN Population

- Suicide was the second leading cause of death for AI/AN people between the ages of 10 to 34 in 2014.
- The same year, suicide was the leading cause of death for AI/AN girls between the ages of 10 to 14.
- AI/AN young men ages 15 to 24 account for nearly 40% of all suicide deaths among natives.
- Suicide rates for Alaska Natives are more than double those for the U.S. population as a whole.

Footnotes:

- Office of Minority Health. Minority Population Profiles: American Indian/Alaska Native. Retrieved from https://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=62
- Substance Abuse and Mental Health Services Administration. (2019, Feb). Treatment Improvement Protocol (TIP) 61: Behavioral Health Services for American Indians and Alaska Natives. Retrieved from https://store.samhsa.gov/product/tip-61-behavioral-health-services-for-american-indians-and-alaska-natives/sma18-5070.

Substance Use Disorder Information for Overall AI/AN Population

- AI/ANs are less likely to use alcohol than Whites:
  - However, those who do are more likely to binge drink and have a higher rate of past-year alcohol use disorder than other racial and ethnic groups.
- AI/ANs are more likely than Whites or Latinos to abstain from alcohol and drugs:
  - Among people who have been alcohol users, AI/ANs are about three times more likely to have become abstainers than in the general population.

Footnote:
Source: Substance Abuse and Mental Health Services Administration. (2019, Feb). Treatment Improvement Protocol (TIP) 61: Behavioral Health Services for American Indians and Alaska Natives. Retrieved from https://store.samhsa.gov/product/tip-61-behavioral-health-services-for-american-indians-and-alaska-natives/sma18-5070.

Prevalent Health Issues and Considerations for AI/AN Population in North Carolina

Racial and Ethnic Disparities for AI/ANs in North Carolina

- According to the North Carolina Office of Minority Health and Health Disparities 2018 Health Equity Report, disparities are present for American Indians as well as other diverse populations in a number of health-related categories as compared to non-Hispanic Whites.
- Disparities of particular concern for AI/ANs in North Carolina are:
  - Maternal and child health, specifically:
    - Infant mortality rates, late or no prenatal care, and smoking during pregnancy
  - Health risk factors, specifically:
    - The highest percentage of adult smokers among all races and ethnicities
- Higher rates of unintentional commonly prescribed opioid overdose than any other race.

Footnote:
Source: N.C. Office of Minority Health and Health Disparities. (2018). Racial and Ethnic Health Disparities in North Carolina: Health Equity Report 2018. **Retrieved from** https://ncminorityhealth.org

North Carolina Health Equity Summary Report

HEALTH EQUITY REPORT SUMMARY

Subject	Subcategory	African American	American Indian	Hispanic/Latinx	Other
Social and Economic Well-Being	Income				
	Education				
	Employment				
Maternal/Child Health	Infant Death Rate				
	Late or No Prenatal Care				
Child and Adolescent Health	Death of Children				
	Teen Pregnancy				
	Children without Health Insurance		◆		
Risk Factors	Current Smokers				
	Overweight		◆		
Mortality Rates	Cancer				
	Heart Disease				
Communicable Diseases	HIV Infection				
	Chlamydia				
Violence and Injury	Homicide				
	Suicide				
Access to Health Care	No Health Insurance				
	Could Not See a Doctor		◆		

Green indicates a group is faring better than the referent group
Red indicates a group is faring worse than the referent group
White indicates there is no significant difference between the referent and comparison group
◆ Symbol indicates reliable rates could not be calculated

Footnote:
Source: N.C. Office of Minority Health and Health Disparities. (2018). Racial and Ethnic Health Disparities in North Carolina: Health Equity Report 2018. Retrieved from https://ncminorityhealth.org

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Important Considerations in Provider/Patient Interactions

Important Considerations in Provider/Patient Interactions

- Build a supporting relationship with AI/AN patients.
- Recognize that biomedical and traditional therapies, interventions and supports may be used concurrently by some AI/AN people.
- Ask appropriate questions as this can convey respect. Examples include:
  - Why do you think this illness started?
  - What kind of treatment do you think you need?
- Pay attention to nonverbal communication and cues such as:
  - A gentle handshake can communicate respect.
  - Stories may be used to communicate indirectly.
  - Ignoring someone can indirectly communicate disagreement with them.
  - Humor may cover up discomfort.

Important Considerations in Provider/Patient Interactions (cont.)

- Spirituality:
  - Views can vary. Find out what is important to your individual patient.
  - Many American Indians in North Carolina now practice Christianity.
  - Do not make assumptions or broad generalizations about their beliefs and practices.
- Role of elders:
  - Tribal elders can play an active role in AI/AN members' health care, either directly or indirectly.
  - The advice of elders is highly valued and sought out, and often influences decision-making.
  - Your AI/AN patient may wish to discuss treatment and care options with an elder before making a decision.

Summary

- It is important to build relationships with your individual patients.
- Respect cultural beliefs and practices.
- Ask appropriate questions to gain a better understanding.
- Do **not** make assumptions.
- Be aware of the significant health issues AI/ANs are at risk for.
- Recognize the impact historical trauma, poverty and lack of access to quality health care have on overall well-being.

Additional Resources to Support the Delivery of Culturally and Linguistically Appropriate Services

Supporting the Additional Tribes in Region 5

Please note that Region 5 is home to **three** American Indian tribes. This presentation provides specifics for the Lumbee since they are the largest in the state. You can find more information about the additional tribes in your county by visiting the tribes' website (links below).

- If you are a provider in **Sampson & Harnett** counties, the primary AI population is the **Coharie Tribe**
- If you are a provider in **Columbus & Bladen** counties, the primary AI population is the **Waccamaw Siouan**

Coharie Tribe (Harnett and Sampson counties)

Waccamaw Siouan Tribe (Bladen and Columbus counties)

Lumbee Tribe (Hoke, Robeson, and Scotland counties)

Source: NC Commission of Indian Affairs. (2015). Map of NC Tribal Communities. Retrieved from https://ncadmin.nc.gov/citizens/american-indians/map-nc-tribal-communities

Culturally and Linguistically Appropriate Services (CLAS) Standards

- Healthy Blue is committed to cultural competency. We have adopted all 15 CLAS standards in health care to ensure all Healthy Blue members who enter the health care system receive equal, quality and effective treatment.
  - You can review the CLAS standards at https://www.thinkculturalhealth.hhs.gov/clas.

- We actively recognize and understand the roles age, culture, ability, socioeconomic status and ethnicity play in the lives of our members to ensure equal and effective access to health care, support systems and community services.

Additional Resources

- Please visit the Healthy Blue provider website at https://provider.healthybluenc.com for additional cultural competency resources.

Opportunity to Share Feedback

Feedback is important to us. Please complete a brief evaluation so Blue Cross NC may:

- Identify who has completed the training. Be sure to include your name and NPI number in the evaluation. Your completion of the training will be noted in our Provider Directory.
- Learn more about your experience with the training.
- Identify ways to improve our offering.

The survey will take 2 to 5 minutes to complete. Thank you in advance for your time!

Cultural competency training course evaluation

Thank you!

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BNCPEC-0693-21 December 2021