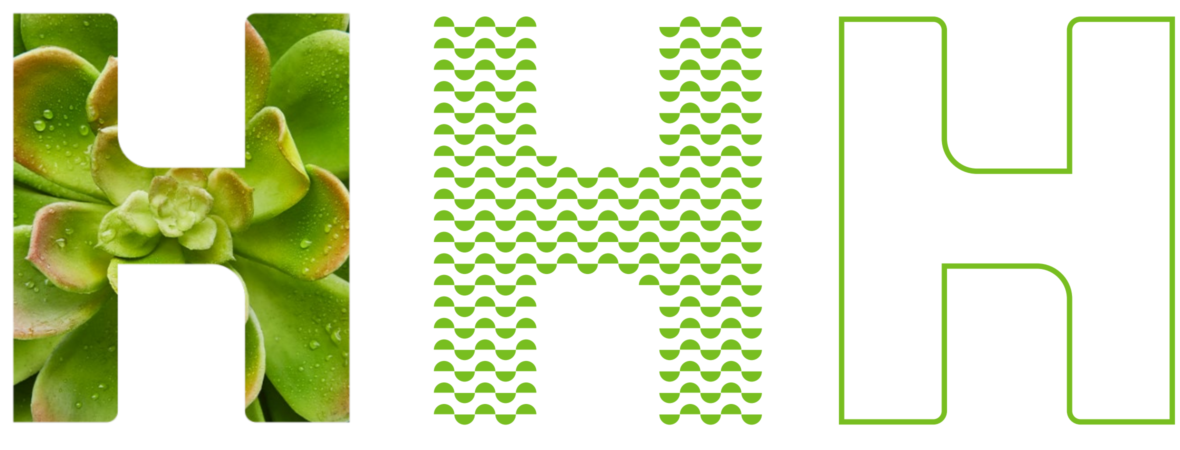
Humana

Cultural humility, health equity and implicit bias training for providers | 2025

Humana offers this training to all subcontractors supporting its contracts for Medicaid or Medicare-Medicaid programs, based on Humana's applicable contractual and regulatory obligations to the states. Please note that some state Medicaid plans may have state-specific cultural competency trainings.



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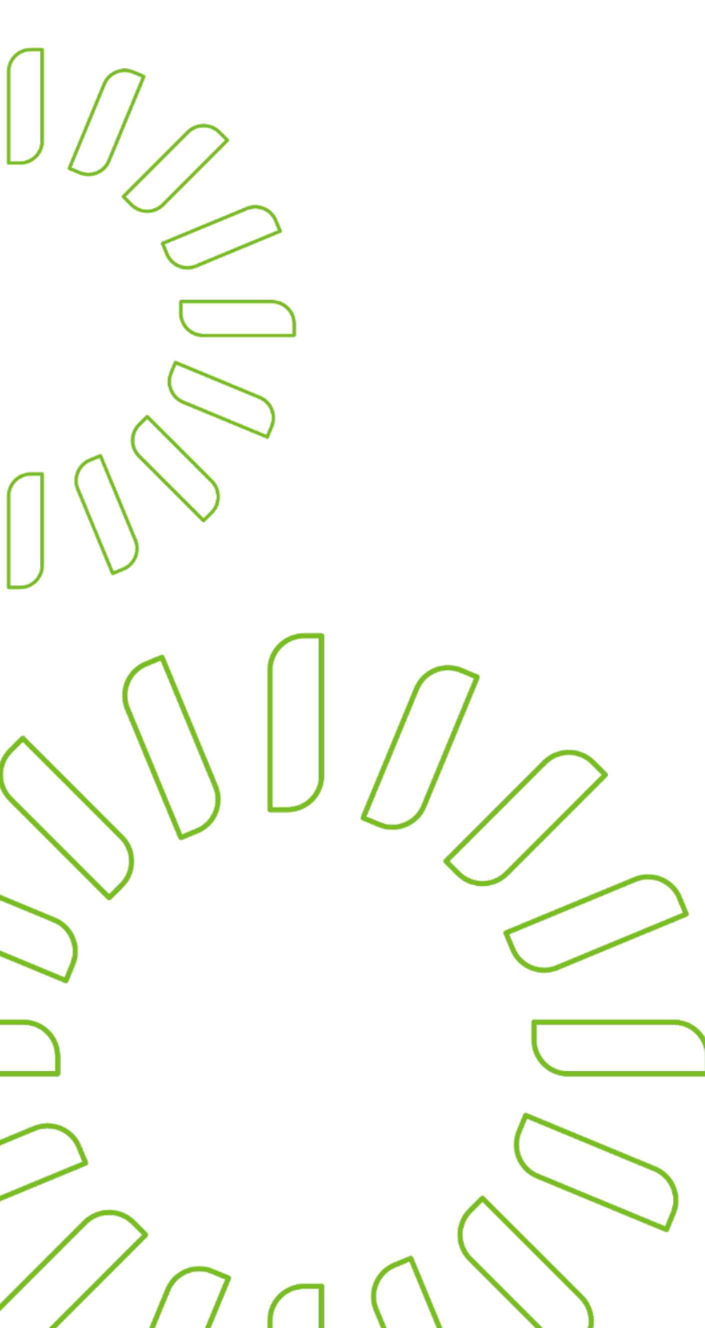


Notable changes since 2024

- Added slides regarding completing an attestation of training completion, how providers can address health inequities and their impacts, Humana's Community Navigator, and an example of discrimination
- Updated and added new terminology definitions
- Added new references for further reading

Training attestation

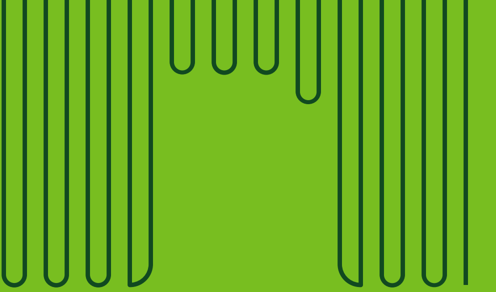
All contracted or subcontracted providers serving patients with Humana Gold Plus® Integrated Medicare-Medicaid in Illinois coverage can submit an attestation to certify adherence to Medicaid training requirements, as applicable based on each state's requirements.

For information on how to complete and attest to completing this training via Availity Essentials™, please refer to Provider.Humana.com/working-with-us/provider-compliance.

Welcome

Welcome to the cultural humility, health equity and implicit bias training for Humana providers. In this training, we will:

- Define cultural humility, health equity and implicit bias
- Discuss the significance of these concepts
- Outline ways to practice cultural humility
- Describe methods for mitigating health inequities and implicit bias



Agenda

01 | Learning objectives and key definitions

02 | Health equity imperative

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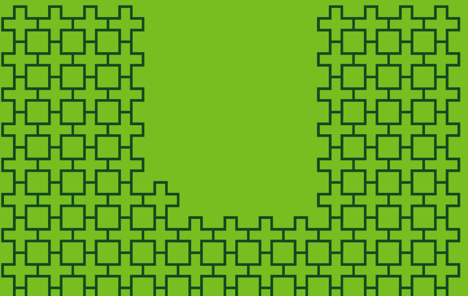
04 | Implicit bias

05 | Mitigating bias

06 | Clear communication

07 | Takeaways and resources



Learning objectives and key definitions

Learning objectives

1. **Define and apply** key terminology and concepts foundational to cultural humility and implicit bias.
2. **Recognize** personal and systemic hidden preferences, assumptions and biases and how they impact patient care delivery.
3. **Understand** the effects of power and privilege on internal staff interactions and patient care delivery.
4. **Identify and apply** skills to mitigate bias, address power dynamics and engage institutional accountability toward cultural humility in patient care delivery.
5. **Self-identify and evaluate** biases and commit to ongoing education and evaluation.

Key definitions

Bias: A particular tendency, trend, inclination, feeling or opinion, especially one that is preconceived or unreasoned.

Belonging: The intersection between diversity, equity and inclusion.

Cultural acuity: The sharpness or keenness of perception in understanding and navigating cultural differences. It involves a high level of cultural awareness and sensitivity, allowing individuals to effectively interpret and respond to cultural nuances.

Cultural competence: The integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices and attitudes used in appropriate cultural settings to improve the quality of services with the intention of producing better outcomes.

Cultural humility: The ability of organizations, systems and healthcare professionals to value, respect and respond to diverse cultural health beliefs and practices, behaviors and needs (e.g., social, cultural, linguistic) when providing equitable healthcare services.

Cultural identity: The definition of groups or individuals in terms of cultural or subcultural categories (can include race, ethnicity, nationality, language, religion, gender).

Key definitions (cont'd.)

Cultural sensitivity: Awareness and appreciation of the values, norms and beliefs characteristic of a cultural, ethnic, racial or other group that is not one's own, accompanied by a willingness to adapt one's behavior accordingly; cultural sensitivity is broadly recognized as the knowledge, skills, attitudes and beliefs that enable people to work well with, communicate effectively with, and be supportive of people in cross-cultural settings.

Diversity: Describes the myriad ways in which people differ, including the psychological, physical and social differences that occur among all individuals, such as race, ethnicity, nationality, socioeconomic status, religion, economic class, education, age, gender, gender identity or expression, sexual orientation, marital status, mental and physical ability, and learning style.

Equity: Ensures individuals are provided the resources and support they need to have access to the same opportunities as the general population. While equity represents impartiality, the distribution is made in such a way to even opportunities for all people, i.e., leveling the playing field.

Health equity: The attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.

Key definitions (cont'd.)

Health inequities: Differences in health and health outcomes that are systemic, avoidable, unnecessary, unfair and unjust.

Inclusion: A dynamic state of operating in which diversity is leveraged to create a fair, healthy and high-performing organization or community. An inclusive environment ensures equitable access to resources and opportunities for all.

Implicit bias: Bias that results from the tendency to process information based on unconscious associations and feelings, even when these are contrary to one’s conscious or declared beliefs.

Prejudice: An unfavorable opinion or feeling formed beforehand or without knowledge, thought or reason.

Racism: A conscious prejudice, discrimination or antagonism directed against a person or people based on their membership of a particular racial or ethnic group and societal power dynamics.

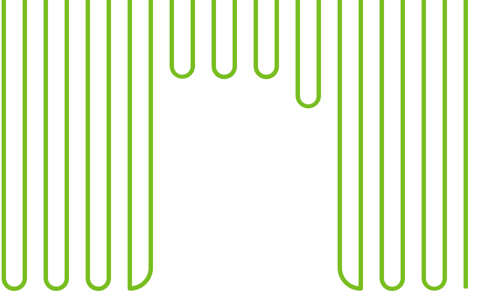
Self-reflexivity: Referring to or discussing itself or its own creation.

Training terminology

Please note that the terms cultural competence, cultural competency, cultural sensitivity and cultural humility all describe the same concept with slight nuances as outlined in the previous slides.

For this training and in alignment with Humana's best practices, we will use the term cultural humility throughout this presentation.

Health equity imperative

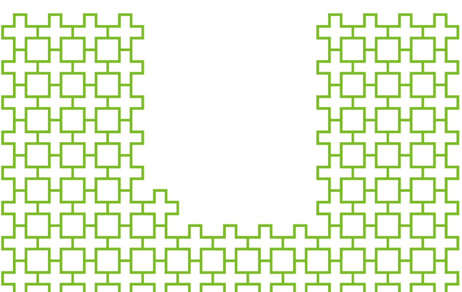


What is health equity?

Please watch this short video on health equity.

Health equity is the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language or other factors that affect access to care and health outcomes.

It includes the elimination of **health inequities**, which are differences in health and health outcomes that are systemic, avoidable, unnecessary, unfair and unjust.



Disparities in the U.S. healthcare system are well documented

Ethnic minority-based healthcare disparities

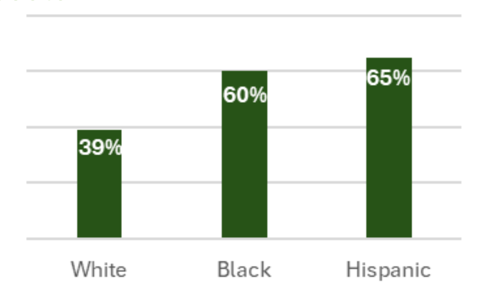
Receipt of evidence-based care	Timeliness of care	Access to care

Pain management
Black patients are **22%** less likely to receive pain medication than white patients when reporting pain[1].

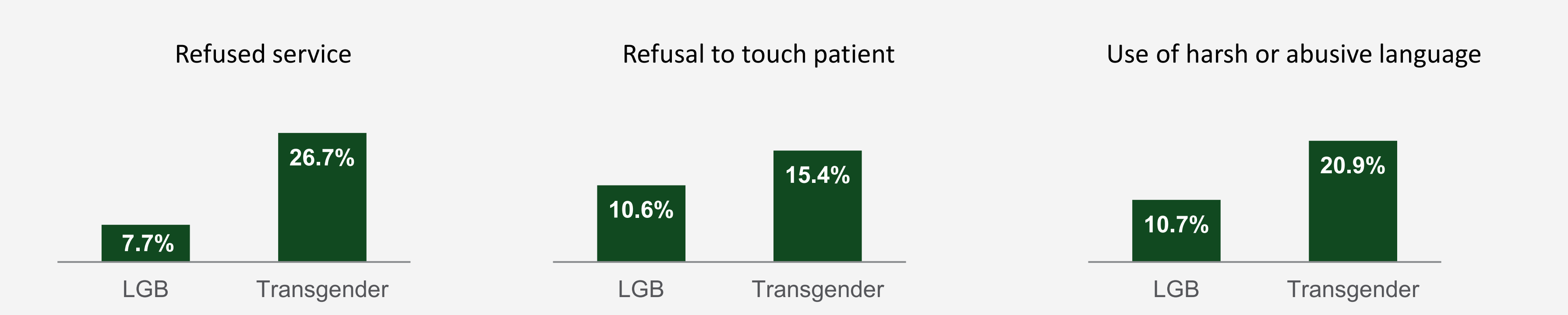
Quality measures
Hispanic patients received worse care than non-Hispanic patients for about **35%** of quality measures[1].

Emergency room (ER) wait times
9% increase in ER wait times experienced by Black patients[1]

Adults who find it very/somewhat difficult to afford health care costs[2]



LBGTQ+-based healthcare disparities[3]



1. "Health Disparities at the Point of Care," Advisory Board, last accessed August 26, 2024, https://www.advisory.com/topics/patient-experience-and-satisfaction/2021/04/health-disparities-at-the-point-of-care.
2. Luna Lopez et al., "Americans' Challenges with Health Care Costs," Kaiser Family Foundation, last accessed August 26, 2024, https://www.kff.org/health-costs/issue-brief/americans-challenges-with-health-care-costs/#:~:text=About%20a%20quarter%20%2823%25%29%20of%20adults%20say%20they,Black%20and%20Hispanic%20adults%2C%20and%20women%20reporting%20this.
3. "When health care isn't caring," Lambda Legal, last accessed September 27, 2024, whcic-report_when-health-care-isnt-caring.pdf (lambdalegal.org).

Defining and recognizing underserved communities

Underserved communities – As defined by the federal government, underserved communities are populations that share a particular characteristic, including geographic communities that have been systematically denied a full opportunity to participate in aspects of economic, social and civic life. These communities typically face higher levels of health inequity. Underserved communities include:

- Members of some racial and ethnic communities[1,2]
- Persons with disabilities[1,2]
- Members of the lesbian, gay, bisexual, transgender and queer (LGBTQ+) community[1,2]
- Individuals with limited English proficiency[2]
- Members of rural communities[1,2]
- Persons with low income and/or in persistent poverty[1,2]
- People who are immigrants[2]
- People of advanced age[2]
- People with limited digital literacy[2]
- Members of religious minorities[1]

As we think about underserved communities, it is important to remember that your patients have complex identities that may intersect multiple communities. To account for each patient's unique intersectional identity, you should tailor your interactions and care to each individual patient. For more information about specific considerations for working with individuals in each of these communities, please review the references at the bottom of this slide and at the end of this training.

1. "Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government," The White House, last accessed Aug. 26, 2024, https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/.
2. "Health Equity in Telehealth," U.S. Department of Health and Human Services, last accessed Aug. 15, 2023, https://telehealth.hhs.gov/providers/health-equity-in-telehealth.

Social determinants of health and health-related social needs

Social determinants of health (SDOH) and health-related social needs are important drivers of health equity.

- **SDOH:** The conditions in the places where people are born, live, learn, work, play, age and worship (e.g., living conditions, food availability, social cohesion) that can negatively affect health outcomes.
- **Health-related social needs (HRSN):** Individual needs that arise due to social and economic barriers that affect one's ability to maintain health and well-being (e.g., food security, housing quality and stability, and transportation security). HRSN can be seen as the result of SDOH that negatively impact an individual's circumstances and that fall in the purview of healthcare providers to identify and help address.

For additional information about SDOH, you can also consult this Humana toolkit.

Domains of SDOH

Long-standing inequities in 6 key areas influence a wide range of health and quality-of-life risks and outcomes. Examining these health and social inequities can help us better understand how to promote health equity and improve health outcomes[1].

Key areas include:

Social and community context: Includes a patient's interactions with the places they live, work, learn, play and worship and their relationships with family, friends, coworkers, community members and institutions. This includes discrimination and racism.

Healthcare access and use: Underserved communities are more likely to face multiple barriers to accessing healthcare.

Neighborhood and physical environment: Includes crime, lack of access to healthy food, lack of safe and affordable housing, lack of public transportation, and limited infrastructure and resources.

Poor quality or dangerous workplace conditions: Some people in underserved communities may face exposure to elements that can have negative impacts on their health in their workplace, such as secondhand smoke or loud noises.

Education level: Underserved communities are disproportionately affected by inequities in access to high-quality education.

Income and wealth gaps: Underserved communities typically 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.

1. "Social Determinants of Health," Healthy People 2030, U.S. Department of Health and Human Services, last accessed Jan. 12, 2024, https://health.gov/healthypeople/priority-areas/social-determinants-health.

Multiple choice question: financial costs of health inequity

How much is the annual direct cost of health inequities?	
A	$155 million
B	$193 million
C	$320 billion
D	$130 billon

Financial costs of health inequity (cont'd.)

$320 billion is correct

Expected to reach $1 trillion by 2040 if left unchecked[1]

1. "US health care can't afford health inequities," Deloitte, last accessed September 25, 2024, https://www2.deloitte.com/us/en/insights/industry/health-care/economic-cost-of-health-disparities.html

Impact of disparities in care on health outcomes

1.5 times

For babies born by Black people, the rate of preterm birth was **1.5 times higher** than the preterm birth rate among babies born by all other people from 2020 to 2022[1].

9.6 cases

Hispanic women had an incidence rate of **9.6 cases per 100,000 people** for cervical cancer while non-Hispanic white women had an incidence rate of **6.8 cases per 100,000 people** in 2021[2].

2 to 2.5 times

Non-heterosexual people are **2 times** more likely to have moderately severe to severe depression and **2.5 times** more likely to see a mental health professional than heterosexual people according to a 2022 study[3].

1.9 times

The infant mortality rate among babies born by Black people was **1.9 times** the national rate from 2019 through 2021[1].

1. "2023 March of Dimes Report Card United States," March of Dimes, last accessed Aug. 27, 2024, https://www.marchofdimes.org/sites/default/files/2023-11/MarchofDimesReportCard-UnitedStates.pdf.
2. "Cancers by Age, Sex, Race, and Ethnicity," Centers for Disease Control and Prevention, last accessed Aug. 28, 2024, https://gis.cdc.gov/Cancer/USCS/#/Demographics/.
3. Prashant Sakharkar & Kafi Friday, "Examining Health Disparities and Severity of Depression among Sexual Minorities in a National Population Sample," Diseases (October 2022), accessed Aug. 28, 2024, https://doi.org/10.3390/diseases10040086.

Health disparities in underserved communities

Underserved communities often lack equal access to healthcare, leading to consequences that include:

- Higher mortality rates
- Higher rates of disease
- Greater severity of illness
- Higher medical costs
- Lack of access to treatment
- Less understanding of the need for adhering to preventive care

How providers can address health inequities and their impacts

Raise awareness: Obtain and share education about the existence of health disparities and their consequences.

Enhance knowledge base: Collect and analyze data to better understand the prevalence and causes of health disparities and seek evidence-based interventions to reduce them.

Integrate equity into quality and safety: Incorporate equity considerations into harm-event reporting and patient safety quality improvement practices.

Address social determinants: Partner with local organizations to address SDOH, including housing, food, and transportation initiatives, and provide information about community resources to patients who need them.

How providers can address health inequities and their impacts (cont'd.)

Use data to inform care: Collect and use demographic data to tailor healthcare services to the needs of diverse patient populations. Encourage patients to come in for preventive visits and address any barriers they have with this.

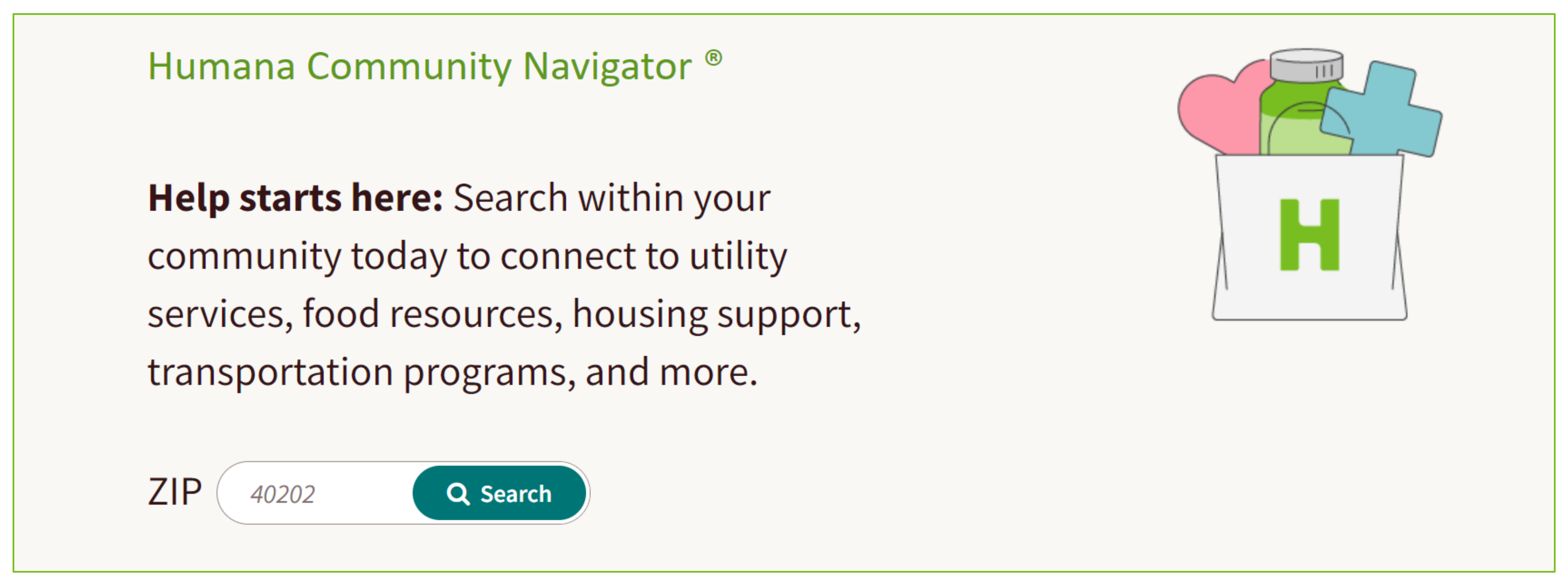
Community engagement: Engage with communities to support their efforts to address inequities and build patient trust in healthcare systems.

Offer and promote communication in multiple languages: Provide communications, including emails, text messages and education materials, in the 2 or 3 languages that are most used by your patients. Encourage use of translation services to help patients engage in meaningful conversation.

Data analysis: Collect and disaggregate member health data by race, ethnicity, language, geography, sexual orientation and gender identity.

Humana Community Navigator

Another way that you can help reduce health inequities is by connecting patients and caregivers in need with local community programs and services through the Humana Community Navigator® tool, powered by FindHelp. Humana Community Navigator makes it easy for people with social needs to find community resources. These programs offer patients help finding food resources, utility services, housing support, education resources, jobs sourcing and training, and more.



Digital health literacy

Digital health literacy, as defined by the World Health Organization, is the ability to seek, find, understand and appraise health information from electronic sources and apply the knowledge gained to address or solve a health problem. As online health tools, including MyHumana, and virtual visits with doctors become more widespread, patients with limited digital health literacy face barriers when accessing and using these services.

Humana implemented processes to help address these inequities and continues to pioneer new ways to reduce low digital health literacy among our membership.

Cultural humility

Defining and understanding cultural humility

Cultural humility means admitting what we do not know about patients and being willing to learn from their experiences, while also being aware of our own embedded cultural beliefs.

Cultural humility in healthcare can take many forms, including self-reflexivity and assessment, appreciation of the patient's expertise in the social and cultural context of their lives, openness to establishing power-balanced relationships with patients, and a lifelong dedication to learning.

3 key components of cultural humility are outlined below and on the following slides:

Balancing power and privilege → Institutional accountability → Lifelong learning and self-reflection

Balancing power and privilege

Balancing power and privilege → Institutional accountability → Lifelong learning and self-reflection

Balancing power and privilege means:

- Advocating to address power and privilege within healthcare institutions and doing the individual work needed to rebalance for a more equitable healthcare system
- Recognizing patients bring valuable insight and knowledge to the equation of their medical care
  - Multiple studies show there is increased mistrust and unequal treatment in vulnerable communities.
- Realizing medical systems hold scientific knowledge and power, while patients hold power in personal history, preferences and the cultural context in which they express their desires related to care.

Learn it and live it! Ask questions of your patients that validate their power in their care plan: "What considerations should I keep in mind for you and your family when we discuss your care?"

Institutional accountability

Balancing power and privilege → Institutional accountability → Lifelong learning and self-reflection

Institutional accountability means:

- Examining the relationships organizations have with the communities they serve
- Making space for evolving knowledge about a cultural community and developing trusting relationships within the context of their beliefs and values
- Ensuring efforts are a top priority amongst leaders at the organization and understanding cultural humility is an active journey

Learn it, live it! Think about how your specific care site/clinic (and colleagues) can develop a practice of organizational introspection that, in return, helps the care site/clinic environment become more flexible, adaptable, coherent, energized and stable.

Lifelong learning and self-reflection

Balancing power and privilege → Institutional accountability → Lifelong learning and self-reflection

Lifelong learning and self-reflection means:

- Being curious and open to learning from patients, families and communities, which is necessary for growth
- Learning from patients who are the experts and authorities in their own lives
- Examining one's own biases, beliefs and assumptions, which is critical as we continue our lifelong learning

Learn it, live it! Ask your patients questions that reflect genuine curiosity and show you value their input: "What cultural courtesies can we practice during your visit to ensure you feel respected and heard?"

Benefits of becoming a culturally appropriate healthcare organization

Social Benefits	Health Benefits	Business Benefits
• 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 organization

Source: American Hospital Association, 2013.

Implicit bias

What is implicit bias?

Everyone has bias, even highly skilled medical professionals, and it can unwittingly lead to unequal care. But what is implicit bias and why do we have it?

We tend to think of biases as bad, but that's not always the case. Implicit bias refers to the unconscious mental shortcuts our mind uses to filter the massive amount of information we are bombarded with each day, and healthcare professionals can certainly relate to that.

Thanks to implicit bias, we can make some decisions more effectively. But the danger of implicit bias is that most of us don't recognize we have it, hindering our ability to see details that matter, skewing our perspectives and clouding our judgment.

"Of course, no provider is saying 'we care less about our patients of color,'" says Rae Chaloult, associate director at the March of Dimes. "But when we're looking at implicit bias, we're investigating long-standing false beliefs, the kind of thing you absorb without even realizing it."

Rae Chaloult, Associate Director at March of Dimes – January 2023

For an optional Implicit Association Test, go to Project Implicit (harvard.edu).

Examples of implicit bias in healthcare

Race and ethnicity

White patients are more likely to receive better quality care than patients from racial and ethnic minority groups (BIPOC)[1].

Sex and gender

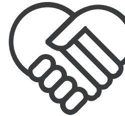
A woman with chronic pain is often perceived as emotional, hysterical or sensitive, and their pain is dismissed more often than a man's pain[1].

Sexual identity

Heterosexual healthcare providers may implicitly prefer heterosexual people over non-heterosexual people, which could lead to mistreatment of non-heterosexual people[1].

Weight

Healthcare providers may view overweight patients as lacking self-control and incorrectly recommend weight loss to treat their conditions[1].



Age

Healthcare providers are less likely to recommend to older adults invasive or aggressive procedures, resulting in lower quality of life[1].

Disability

Healthcare providers may assume people with disabilities have a lower quality of life or are unwell because of their disability[1].

What other examples of bias may be prevalent in each of these categories?

1. "Biases in Healthcare: An Overview," Medical News Today, last accessed Aug. 27, 2024, https://www.medicalnewstoday.com/articles/biases-in-healthcare#racial-groups.

Examples of the effects of implicit bias

- Hispanic patients in 1 study were **7** times less likely to receive opioids in the emergency room than non-Hispanic patients with similar injuries, even when adjusting for confounders. These findings were duplicated with Black patients[1].

- A study found that **34%** of LGBT providers reported observing discriminatory care of an LGBT patient. In another study, **26%** of HIV-infected patients reported perceptions of provider discrimination. These patients reported discrimination from providers (**54%**), nurses and other staff (**39%**), dentists (**32%**), and case workers or social workers (**8%**)[2].

- A study found that **83.6%** of healthcare professionals included in the study implicitly preferred people without disabilities. These professionals may view people with disabilities as having lower quality of life or being unwell due to their disability[3].

- Research found that **52%** of women with obesity saw weight as a barrier to their healthcare[3].

- Research found gender-specific differences in myocardial infarction presentation and survival. Large cohort studies (n=23,809; n=82,196) found in-hospital mortality increased by **15–20%** (adjusted odds ratios) for female patients compared with male patients. Interviews with patients younger than 55 (n=2,985) who suffered myocardial infarctions revealed that women were **7.4%** (absolute risk) more likely to seek medical attention and were **16.7%** less likely to be told their symptoms were cardiac in origin[4].

- In 1 study, **48.7%** of U.S. medical students surveyed reported having been exposed to negative comments about Black patients by attending or resident physicians, and those students demonstrated significantly greater implicit racial bias in year 4 than they had in year 1[5].

1. Elizabeth N. Chapman et al., “Physicians and Implicit Bias: How Doctors May Unwittingly Perpetuate Health Care Disparities,” Journal of General Internal Medicine (April 2013), accessed Aug. 28, 2024, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3797360/.
2. Janice Sabin et al., “Health Care Providers’ Implicit and Explicit Attitudes Toward Lesbian Women and Gay Men,” American Journal of Public Health (September 2015), accessed Aug. 28, 2024, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4539817/.
3. “Biases in Healthcare: An Overview,” Medical News Today, last accessed Aug. 27, 2024, https://www.medicalnewstoday.com/articles/biases-in-healthcare#racial-groups.
4. Dipesh Gopal et al., “Implicit bias in healthcare: clinical practice, research and decision making,” Future Healthcare Journal (March 2021), accessed Aug. 28, 2024, https://www.sciencedirect.com/science/article/pii/S2514664524005678?via%3Dihub.
5. Janice Sabin, “Tackling Implicit Bias in Health Care,” The New England Journal of Medicine (July 2022), accessed Aug. 27, 2024, doi:10.1056/NEJMp2201180.

Displays of bias

Next, let’s define some displays of bias:

- Prejudice (feelings): an evaluation or emotion
  - How do you feel about a person? What are your attitudes toward that person?
- Stereotypes (thoughts): a belief that characterizes
  - How do you categorize or label someone?
- Discrimination (actions): a behavior that advantages or disadvantages
  - How do you act toward a person?

Case study: prejudice

Brian is in a meeting with his boss Jamie about an upcoming assignment. The project is a huge undertaking, and Jamie wants Brian to work on it with a member from an adjacent team, José.

“Great,” Brian thinks to himself. “He’s not even from here. I’m going to have to translate and explain everything.”

Case study: stereotyping

Alicia, Bethany and Lin are working on the analytics report together. They decided to divide and conquer the report to get through it faster and cross-reference later. The group allotted 3 hours to go through the entire report and list their findings.

After about an hour and a half, Lin completed her findings and let the other 2 know she was going to take an early lunch.

“Wow, I can’t believe Lin finished that report so fast,” Alicia said. Bethany replied, “Well, you know her family is Asian, so…”

Case study: discrimination

John is a 70-year-old gay man who is looking to find residential home care due to his growing need for support in his day-to-day life.

He is having a hard time finding a home he likes to accept him because of his sexual orientation.

Mitigating bias

Debiasing

Stereotype replacement: Identify the response within yourself, evaluate why you felt that way and replace those feelings with neutral/calmer ones.

Stereotype replacement: Recognizing a negative assumption you have made and replacing it with a positive example.

Individuation: Think of a person individually; don’t apply beliefs that may come from biased generalizations of a group.

Debiasing (cont'd.)

Perspective taking: Think about how it would feel if (or how it felt when) someone assumed something about you based on your looks.

Emotional regulation: Respond appropriately with flexibility in emotions; includes behaviors such as rethinking a challenging situation to reduce anger or anxiety, hiding visible signs of sadness or fear, or focusing on reasons to feel happy or calm.

Meaningful intergroup contact: Make sure everyone in the conversation feels valued and heard.

Debiasing (cont'd.)

Build partnerships: Reframe a patient interaction as one between collaborating equals.

Learn about your patients' cultures: Engage in self-reflexivity and assessment; reflect on patients' expertise on the social and cultural context of their lives.

Understand and check your biases: Cultivate expertise on the social and cultural context of patients' lives, embrace openness to establishing power-balanced relationships with patients, and commit to a lifelong dedication to learning.

Debiasing (cont'd.)

Perform a teach back: Check understanding by asking patients to state what they need to know and do before they leave an appointment.

Practice evidence-based medicine: Connect clinical decision making to evidence-based research during patient interactions.

Follow national Culturally and Linguistically Appropriate Services (CLAS) standards: CLAS is the blueprint for individuals in healthcare to implement services that are respectful of and responsive to health beliefs, practices and needs of diverse patients.

Actions you can take

Increase your self-awareness of cultural humility and implicit bias	Recognize your own privilege as a provider	Prioritize relationship building with each patient	Empower colleagues who may report to you
• Understand your education is your responsibility • Identify racial inequities and disparities • Champion anti-racist ideas and policies	• Reflect on your personal identity • Be thoughtful of the group of individuals you associate with regularly, and how those associations shape your beliefs and actions	• Listen from a place of cultural humility • Try to understand the *why* behind a patient's behavior • Understand the many determinants of health • During a patient visit, identify ways to establish rapport and connection	• Create a psychologically safe space for questioning and new thoughts • Have intentional conversations regarding belonging • Contribute to your clinic's culture of inclusion • Respond constructively to differences of opinion

Actions organizations can take

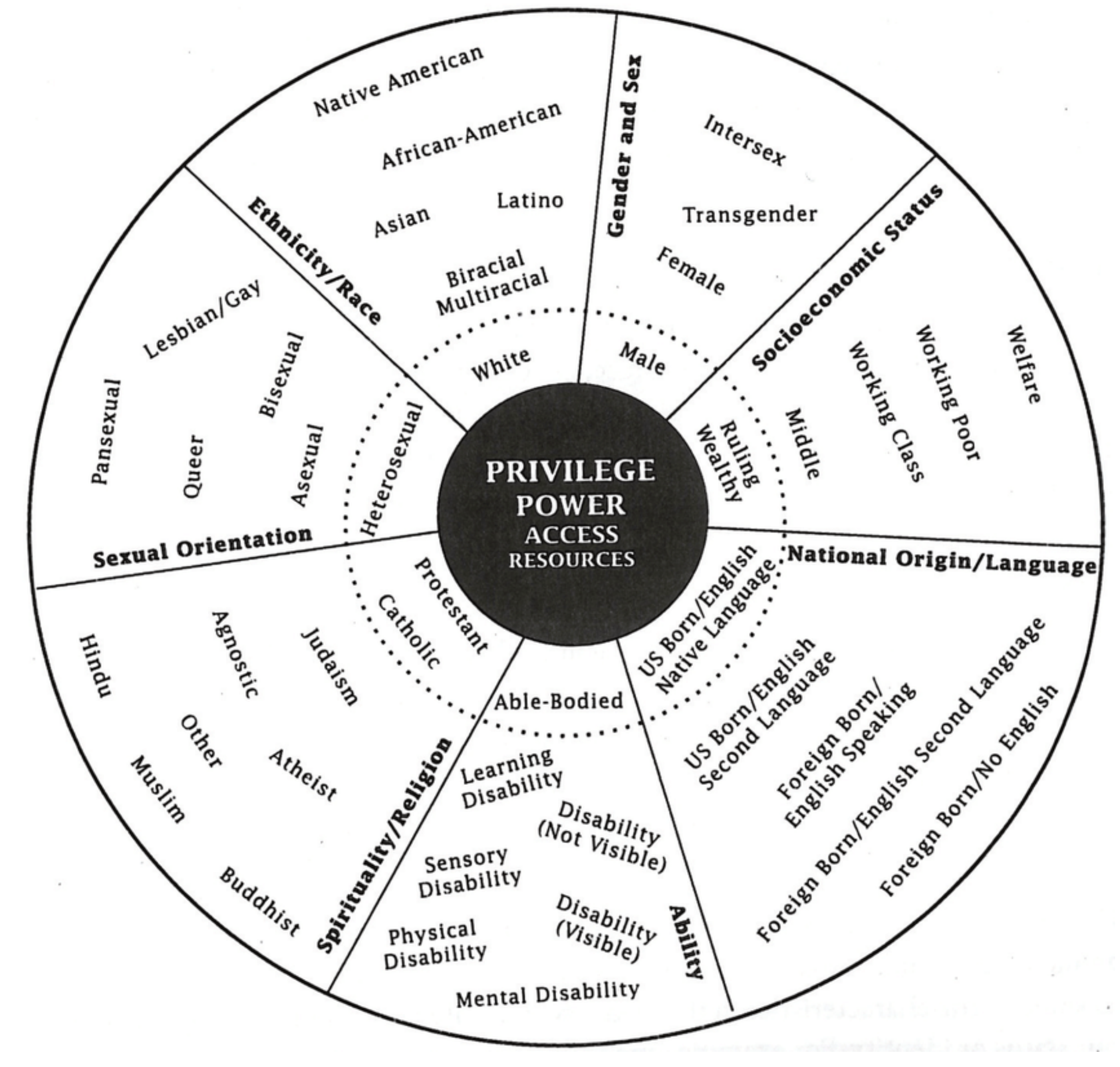
Identify health inequities	Provide education on cultural humility and implicit bias	Solicit feedback from employees and patients	Build an inclusive team
• Analyze organizational polices for disparate impact • Review clinical decision-making criteria and ensure collection of race, ethnicity and language and sexual orientation and gender identity data • Evaluate processes to determine failure modes for marginalized patients	• Promote and encourage trainings and facilitated discussions that promote a deeper understanding of bias • Incorporate discussions on diversity, equity and inclusion into the workplace	• Implement regular and anonymous surveys to gain more awareness about opportunities; openly share survey results • Promote a culture where leadership seeks feedback and input from others, without fear of retaliation	• Expand current talent acquisition, hiring and interviewing practices that proactively mitigate against bias • Include colleagues with a variety of roles, experience and tenure with the organization to participate in the hiring and onboarding processes

Adapted from Humana CenterWell™/Conviva Cultural Humility and Implicit Bias Training

Privilege, power and resources example

This figure illustrates how sexual orientation, ethnicity, race, gender, sex, socioeconomic status, national origin, language, ability, spirituality and religion influence an individual's relative privilege, power and access to resources.

This figure also highlights how individuals can be privileged in 1 aspect of their identity while being simultaneously disadvantaged in another aspect of their identity[1].



1. Sisneros, J. et al, "Critical Multicultural Social Work," 2008, https://www.amazon.com/Critical-Multicultural-Social-Work-Sisneros/dp/0190615974

Clear communication

Limited English proficiency

The Department of Health and Human Services identifies individuals with limited English proficiency (LEP) as those who do not speak English as their primary language and who have a limited ability to read, write, speak or understand English. Over 8% of the U.S. population, or more than 25 million Americans, have limited English proficiency[1].

Patients with LEP may have a difficult time interacting with you effectively in English. Even if your patient speaks English well, they may still struggle to find or understand English words when faced with a traumatic situation.

1. "Introduction to Language Access Plans," Centers for Medicare & Medicaid Services, https://www.cms.gov/Outreach-and-Education/MLN/WBT/MLN2059239-Language-Access-Plans/lap/lesson01/04-Limited-English-Proficiency-LEP/index.html.

Limited English proficiency (cont'd.)

The quality of communication between you and your patients can impact the quality of care you provide:

- More than **65%** of patients who did not speak the local language experienced barriers to healthcare, including **20%** who did not seek healthcare services because of fear of misunderstanding healthcare providers.
- Home health patients who preferred a language other than English had a higher hospital readmission rate **(20.4%)** than English-speaking patients **(18.5%).** Risk of readmission also varied by language, with higher risk among Spanish and Russian speakers and lower risk among Chinese and Korean speakers.
- A study found that **43%** of hospitalized patients with LEP had communicated without an interpreter present during admission, and **40%** had communicated without an interpreter present after admission.
- Spanish speakers receive approximately a third less care than other Americans, even when considering differences in baseline health, age, income and health insurance. Ultimately, researchers found that total use of care—as measured by healthcare expenses—was up to **42%** lower for primary Spanish speakers. In addition, Spanish-speaking adults registered **36%** fewer outpatient visits and **48%** fewer prescription medications than non-Hispanic adults, as well as fewer emergency room visits and hospitalizations.
- Studies found that among patients who did not speak the local language, nearly **35%** experienced confusion about how to use their medication and almost **16%** suffered a bad reaction to the medication due to not understanding the proper usage.

Allison Squires et al., "Assessing the influence of patient language preference on 30-day hospital readmission risk from home health care: A retrospective analysis," International Journal of Nursing Studies (January 2022): accessed Aug. 28, 2024, doi:10.1016/j.ijnurstu.2021.104093.

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Maura Deering, "Addressing Language Barriers in Healthcare," Nurse Journal, last accessed Aug. 28, 2024, https://nursejournal.org/articles/language-barriers-in-healthcare/.

Mitigating language barriers through Humana’s Language Assistance Program

Federal and state nondiscrimination laws, including Title VI of the Civil Rights Act and Section 504 of the Rehabilitation Act of 1973, require healthcare providers to make interpretation services available to disabled and members with LEP.

Humana can help you schedule interpretation services for Humana-covered patients who need to schedule a visit, need assistance during a visit and/or after the visit through our Language Assistance Program. Our language assistance services include:

- Over-the-phone interpretation services in more than 150 languages
- Sign language interpreters in-person or via video remote interpretation
- Spanish versions of Humana's public website and member materials
- Text telephone services and videophone capabilities
- Alternative formats of member materials, including Braille, audio, accessible PDFs, large print, digital accessible information system or read-over-the-phone

Humana members may request interpretation services or alternative formats of written materials by calling the Humana member service phone number on the back of their Humana ID card. If they need to schedule a sign language interpreter (in-person or through video remote interpretation), they should call 877-320-2233.

Using the teach-back method to provide culturally competent care

According to the Agency for Healthcare Research and Quality (AHRQ), 40-80% of the medical information patients are told during office visits is forgotten immediately, and nearly half of the information retained is incorrect. The teach-back method can be used to confirm that your patients and their caregivers clearly understood and retained the information you provided[1].

To use the teach-back method:

- Ask your patients to teach you what you just told them. Think about specifically how you ask your patients to teach back the information without quizzing the patient.
- Re-explain the information if your patient cannot accurately teach back the information you gave them, making sure to use different approaches and clear, plain language.
- Use the teach-back method throughout the patient encounter to review portions of information, rather than waiting until the end of the encounter to review all the information presented.

1. "Use the Teach Back Method," AHRQ, last accessed September 26, 2024, https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/healthlittoolkit2_tool5.pdf.

Tips for providing culturally competent care

When providing care and interacting with patients, consider:	To improve patient comprehension and comfort:
They may misunderstand how to use prescribed medicine (e.g., putting medicine into their ears instead of their mouths to treat an ear infection).	Use specific, plain language when describing how to use prescribed medicine.
They may get confused about information presented as percentages or ratios when discussing risk and benefit.	Use qualitative, plain language to describe risks and benefits; avoid using only numbers.
They may not expect required follow-up care.	Inform patients they may need follow-up care and why.
They may be surprised by referrals to visit multiple doctors.	Explain to patients why they may need to be seen by another doctor.
They may be surprised that they require diagnostic testing before a prescription is written.	Emphasize the importance of medication adherence.
They may not expect to wait when they arrive for an appointment.	Inform the patient about their anticipated wait time when they arrive.
They may prefer to be seen and treated by someone of the same gender.	Accommodate patient preferences by offering a doctor or interpreter of the same gender.
They may bring friends or family to help make decisions.	Confirm decision-makers at each visit.

Takeaways and resources

When practicing cultural humility

- Ask your patients questions that validate their power in their health plan.

  "What considerations should I keep in mind for you and your family when we discuss your care?"

- Think about how your specific care site/clinic (and colleagues) can develop a practice of organizational introspection that helps everyone become more flexible, adaptable, coherent, energized and stable.
- Ask questions of your patients that reflect genuine curiosity and value their input.

  "What cultural courtesies can we practice during your visit to ensure you feel respected and heard?"

- Be aware of your implicit bias and be ready to challenge your beliefs.

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