MONTANA EMERGENCY MEDICAL SERVICES FOR CHILDREN/CHILD READY

Instructor/Facilitator

Culture of Care Toolkit

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MONTANA EMERGENCY SERVICES for CHILDREN/CHILD READY CULTURE of CARE TOOLKIT CONTENTS

TRAINING TOOLS

1. MT EMS Children/Child Ready Culture of Care Guide
2. Comparing Norms and Values
3. Bias Exercise
4. Affecting Health Care Assessment

COMPETENCY CHECK TOOLS

5. Cultural and Linguistic Competency Survey
6. Cultural Diversity Test
7. Cultural Inventory for Individual Caregivers/Providers

INFORMATIONAL RESOURCES

8. Child Ready Family and Provider Guide
9. Cultural Diversity Document
10. SAMHSA's "A Guide to Build Cultural Awareness"
11. Understanding and Responding to Children in Crisis (Colorado)

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Training Tools

1. Montana Emergency Services for Children/Child Ready Culture of Care Guide
2. Comparing Norms & Values
3. Bias Exercise
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Table of Contents

Table of Contents (Continued)

1.0 Introduction

Instructor/Facilitator:

***Explain that* Cultural Competence is possessing knowledge-based understanding and skills with which to provide culturally acceptable and relevant care with diverse cultures.**

This *Culture of Care Toolkit* is organized into specific training modules that can be utilized in one-hour segments or in any training time frame that fits the organizations' specific needs.

Each participant will be given a Student Guide to follow along the Instructor and for future reference.

For Instructor/Faciltator, the following is for your information and does not need to be read aloud to class participants.

Each training component, along with a short activity, help to enhance knowledge of providing culturally appropriate care in a practice, service and or facility. A genuine understanding of cultural and patient centered care concepts is critical in treating unique patient populations.

The Instructor Guide includes specific instructions for each section of the Culture of Care Toolkit. Facilitators are encouraged to modify the length and order of presentations to meet the needs of their audience. Presentations may be combined to create a full-day training, or may be broken into parts to create a series of shorter trainings. Modules can be presented over time, such as during monthly faculty meetings or by dividing the modules into one-hour, two-hour, or half-day presentations.

Be careful to order presentations so that introductory information comes first and subsequent sections build on learned knowledge from the previous sections.

Increasing Participant Engagement

To provide additional opportunities for participant engagement, facilitators should determine which strategies will work best for their audience and personal presentation style. When planning for participant engagement activities, consider how the size of the group and the space in which the training occurs will affect the activities. Also, think about providing engagement activities that allow participants to process the information in a variety of formats (e.g., talking with a partner, larger group discussions, personal reflection through writing). It would be impossible to document all of the possible participant activities in this guide.

Helpful Strategies for Addressing Questions

It is important to give participants a chance to ask questions on the information presented, but it can feel intimidating to answer questions on the spot. Below are some suggestions to help you both encourage and respond to questions.

Parking Lot: Consider using a "parking lot" to store questions during the presentation. This strategy allows participants to ask questions without disrupting the flow of the presentation. It also gives the facilitator a chance to sift through potentially difficult questions and think about the best way to address them.

To use a Parking Lot:

1. Place a few large pieces of chart paper around the room. Label each "Parking Lot."
2. At the beginning of the presentation, tell participants that if they have a question at any time, they should write it on a sticky note and post it to one of the parking lots.
3. At the end of a section or during a break, collect questions from the parking lots and think about how to respond to each question.
4. After the break, read (or paraphrase) each question out loud to the group, followed by your answer.

Some general tips for addressing questions during the presentation include acknowledging all questions, being sure that everyone has heard the question by repeating it, and being honest and answering questions directly. Presenters should feel comfortable answering with "I don't know, but I can try to find out" if the answer is unknown.

Confrontational Questions

When dealing with a confrontational question, it is important for presenters to separate the attitude of the questioner and tone of the question from the content of the question. Presenters should try to rephrase and restate the question without the confrontational tone and answer the question as honestly as possible. If the question is impossible to address in the group setting, the presenters may consider meeting the participant during the next break.

Strategies for Gaining Attention

There are many strategies for gaining participants' attention. Presenters should consider using strategies with which they feel the most comfortable. A strategy will be most effective if it is used consistently throughout the presentation. At the beginning of the training, it is recommended that presenters communicate how they will bring the group back together. For example, a presenter might say, "When I raise my hand, it is time to pause conversations and come back together as a group."

Several other strategies are as follows:

- Use a bell, tone, or sound
- Use a clapping pattern
- Flick the lights
- Use a countdown (could be a timer on your computer)

Equipment needed:

Flipchart
Markers for flipchart
Computer
Hard copies of the handout for sections
Student Guides
Depending on the length of training, water, tea and coffee

Instructor/Facilitator:

Read the Ground Rules for Training aloud to the class. Ask them for any additional ground rules.

GROUND RULES FOR TRAININGS

1. MAINTAIN CONFIDENTIALITY
2. SPEAK OPENLY
3. RESPECT ONE ANOTHER'S OPINIONS
4. BE HONEST
5. BE OPEN TO LEARNING
6. TAKE BREAKS WHEN NEEDED- WE ARE ADULTS
7. HAVE FUN!

Introduction to the Training:

Cultural competence is the ability of health organizations and practitioners to recognize the cultural beliefs, values, attitudes, traditions, language preferences, and health practices of diverse populations and to apply the knowledge to produce a positive health outcome.

Cultural Competence is possessing knowledge-based understanding and skills with which to provide culturally acceptable and relevant care with diverse cultures. Cultural Humility is:

- A life-long process of self-reflection that includes being aware of one's personal beliefs and biases.
- Understanding and recognizing the inherent power imbalances in patient-provider communication, and
- Using patient focused care to demonstrate mutual respect and partnership with patients, families, and co-workers.

Cultural competence is grounded in a set of ethical principles that guide continual cultivation of self-awareness, respectful behaviors, and the pursuit of knowledge. The culturally competent health care professional should be a positive role model and provide training to others on cultural competency, as well as be open to listening and learning from all. This action creates a collaborative, respectful work environment and a responsive culture of care.

An understanding of cultural diversity, health disparities, health literacy, and cultural competence is vital in providing the best possible interactions with those of which you serve.

This ***Cultural of Care Toolkit*** was developed to provide resources and training to facilitate the development of cultural competence and humility in one's self, colleagues, the work environment and its' application to practice.

This ***Culture of Care Toolkit*** will provide information and activities that will help increase knowledge on:

- How population data presented by race and ethnicity has contributed to making health disparities a priority in our state and the nation.
- How cultural competence begins with the individual.
- How language and culture influence how we approach health and provide care.
- How Providers and patients/clients bring their unique cultural backgrounds and expectations to the medical encounter.
- How there must be effective communication between patients and providers for quality care to result.

Training Evaluation Form

For Culture of Care Training

Date of Training: _____

Title and Location of Training: _____

Instructor/Facilitator: _____

Instructions: Please indicate your agreement with the following statements:

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1. The objectives of the training were clearly defined.					
2. Participation and interaction were encouraged.					
3. The topics covered were relevant to me.					
4. The content was organized and easy to follow.					
5. The materials used were helpful.					
6. This training experience will be useful in my work.					
7. The trainer was knowledgeable about the topic.					
8. The Trainer was well prepared.					
9. The training objectives were met.					
10. The time allotted for the training was sufficient.					
11. The meeting room and facilities were adequate and comfortable.					

Instructor/Facilitator:

Explain there are different ways of adult learning and that people learn at different rates and different styles.

State: Please ask questions for more clarifications as we go along.

TO START: THERE ARE 8 FUNDAMENTAL PRINCIPLES OF ADULT LEARNING:

1. Self-Directing.
2. Learn by doing.
3. Relevance.
4. Experience.
5. All the Senses
6. Practice.
7. Personal Development.
8. Involvement.

As professionals, it is essential that we understand the unique learning requirements of adult learners to ensure that trainings are effective. For adults to learn effectively, training needs to be designed in a way that meets the following core principles of adult learning:

1. Self-Directing- adults are autonomous and self-directing, they need to know the benefits, values and purposes of a learning program.

2. Learn by doing- Adults learn through direct experience; therefore, their training and learning interventions must include active and practical participation and offer implementable techniques and methodologies.

3. Relevance- The content of a training program must be meaningful and relevant to the adult learners, their lives and their business.

4. Experience- Adult learners need to be able to draw upon their past experiences to aid their learning. Training needs to be contextualized to use language that they are familiar with and use case scenarios and examples that they can relate to, as well as refer to their direct past life, work and social experiences.

5. All of the Senses- Adult learners need multi-sensory learning and teaching methodologies including audio, visual, reading/writing, kineesthetic, dependent and independent learning preferences.

6. Practice- Adult learners are often engaged in learning because a problem needs to be solved. The more an adult learner can practice new skills, competencies or the application of knowledge, the more transformational impact the learning intervention will have.

7. Personal Development -The intrinsic, personal desires and ambitions of an adult learner need to be considered when planning and delivering adult learning programs.

8. Involvement - Adults need to feel as though they have a sense of responsibility, control and decision-making over their learning.

In terms of education, this requires the flexibility of the learning situation, the learning program and most importantly, the educator to actively involve the participant in a way that allows them to have a degree of control over what they do, or, in fact, how much they learn.

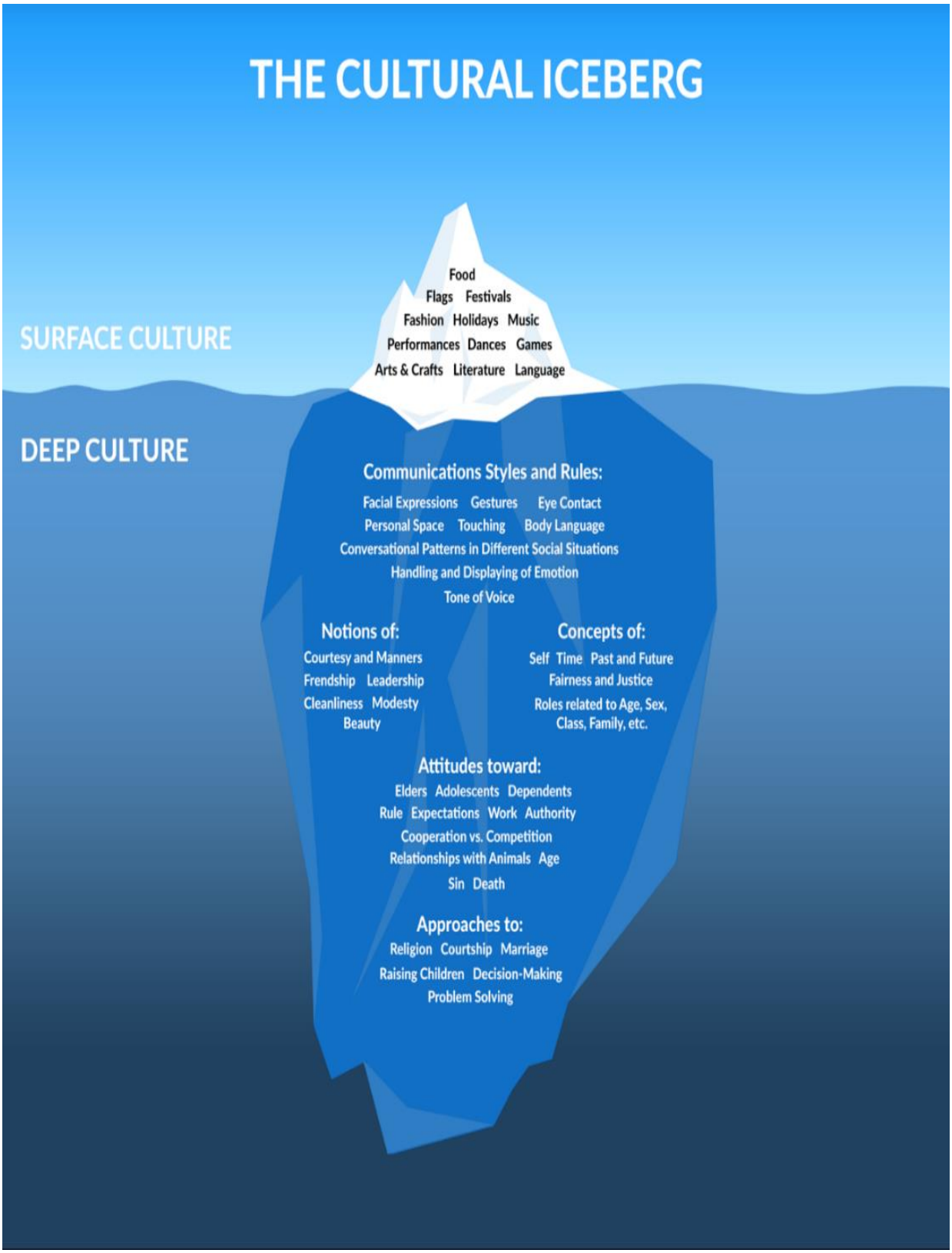
We have tried to include the fundamental principles of adult learning into this ***Culture of Care Toolkit.***

Instructor/Facilitator:

Explain that Culture is very similar to an iceberg. It has some aspects that are visible and many others that can only be suspected, guessed, or learned as understanding of the culture grows. Like an iceberg, the visible part of culture is only a small part of a much larger whole.

The iceberg depicts the culture of a country, with the visible part above water representing the behavior of a culture (and some beliefs), and the much larger part under water as the deep-seated beliefs, values, and the thought patterns.

This is the part of a culture that is hardest to understand. It is unconscious—our "common sense" assumptions of how our country should operate.
https://vintageamericanways.com/the-cultural-iceberg/


THE CULTURAL ICEBERG
SURFACE CULTURE
DEEP CULTURE
Food
Flags Festivals
Fashion Holidays Music
Performances Dances Games
Arts & Crafts Literature Language
Communications Styles and Rules:
Facial Expressions Gestures Eye Contact
Personal Space Touching Body Language
Conversational Patterns in Different Social Situations
Handling and Displaying of Emotion
Tone of Voice
Notions of:
Courtesy and Manners
Frendship Leadership
Cleanliness Modesty
Beauty
Concepts of:
Self Time Past and Future
Fairness and Justice
Roles related to Age, Sex, Class, Family, etc.
Attitudes toward:
Elders Adolescents Dependents
Rule Expectations Work Authority
Cooperation vs. Competition
Relationships with Animals Age
Sin Death
Approaches to:
Religion Courtship Marriage
Raising Children Decision-Making
Problem Solving

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1.1 Cultural Competence Pre-Test

Instructor/Facilitator:

Have enough hard copies of the Pre-Test for each participant. Hand out the Pre-test and give the participants about 20 minutes to complete.

Explain that this is not graded but a way to gauge their knowledge.

Give answers to the questions after the 20 minutes.

Ask if anyone wants to share any insight of the pre-test.

Explain that the toolkit will provide information on the content.

1. **Cross-cultural misunderstandings between providers and patients can lead to mistrust and frustration but are unlikely to have an impact on objectivity measured clinical outcomes.**
    a. True
    b. False

2. **When the patient and provider come from different cultural backgrounds, the medical history obtained may not be accurate.**
    a. True
    b. False

3. **When a provider expects that a patient will understand a condition and follow a regimen, the patient is more likely to do so than if the provider has doubts about the patient.**
    a. True
    b. False

4. **A conscientious health provider can eliminate his or her own prejudices or negative assumptions about patients.**
    a. True
    b. False

5. **When taking a medical history from a patient with a limited ability to speak English, which of the following is LEAST useful?**
    a. Asking questions that require the patient to give a simple “yes” or “no” answer, such as “Do you have trouble breathing?” or “Does your knee hurt?”
    b. Encouraging the patient to give a description of her/his medical situation, and beliefs about health and illness.
    c. Asking the patient whether he or she would like to have a qualified interpreter for the medical visit.
    d. Asking the patient questions such as “How has your condition worsened over the past days?’ or “What makes your condition get better or worse?”

6. **During a medical interview with a patient from a different cultural background, which is the LEAST useful technique?**
    a. Asking questions about what the patient believes about his/her illness – what caused the illness, how severe it is, and what type of treatment is needed.
    b. Gently explaining which beliefs about the illness are not correct.
    c. Explain the “Western” or “American” beliefs about the patient’s illness.
    d. Discussing differences in beliefs without being judgmental.

7. **When a patient is not adhering to a prescribed treatment after several visits, which of the following approaches is NOT likely to lead to adherence?**
    a. Involving family members.
    b. Repeating the instructions very loudly several times to emphasize the importance of the treatment.
    c. Agreeing to a compromise in the timing or amount of treatment.
    d. Spending time listening to discussions of folk or alternative remedies.

8. **When a patient who has not adhered to a treatment regimen states that he/she cannot afford the medications prescribed, it is appropriate to assume that financial factors are indeed the real reasons and not explore the situation further.**
    a. True
    b. False

9. **Which of the following are correct ways to communicate with a patient through an interpreter?**
    a. Making eye contact with the interpreter when you are speaking, then looking at the patient while the interpreter is telling them what you said.
    b. Speaking slowly, pausing between words.
    c. Asking the interpreter to further explain the patient’s statement to get a more complete picture of the patient’s condition.
    d. None of the above.

10. **If a family member speaks English as well as the patient's native language, and is willing to act as an interpreter, this is the best possible solution to the problem of interpreting.**
    a. True
    b. False

11. **Which of the following statements is TRUE?**
    a. People who speak the same language have the same culture.
    b. The people living in Asia share the main features of Asian culture.
    c. Cultural background, diet, religious, and health practices, as well as language, can differ widely within a given country or part of a country.
    d. An alert provider can usually predict a patient's health behaviors by knowing what country he/she comes from.

12. **Which of the following statements is NOT TRUE?**
    a. Friendly (non-sexual) physical contact is an important part of communication for many Latin American people.
    b. Many Asian people think that it is disrespectful to ask questions of a health provider.
    c. Most African people are either Christian or follow a traditional religion.
    d. Eastern Europeans' are highly diverse in terms of customs, language, and religion.

13. **Because Hispanics have a lower incidence of certain cancers than most of the US population, their mortality rate from these diseases is correspondingly lower.**
    a. True
    b. False

14. **Minority and immigrant patients in the US who go to traditional healers and use traditional medicines generally avoid conventional Western treatments.**
    a. True
    b. False

15. **Providers whose patients are mostly European-American, US-born, and middle-class still need to know about health practices from different world cultures.**
    a) True
    b) False

16. **Which of the following is good advice for a provider attempting to use and interpret non-verbal communication?**
    a) The provider should recognize that a smile may express unhappiness or dissatisfaction in some cultures.
    b) To express sympathy, a health care provider can lightly touch a patient's arm or pat the patient on the back.
    c) If a patient will not make eye contact with a health care provider, it is likely that the patient is hiding the truth.
    d) When there is a language barrier, the provider can use hand gestures to bridge the gap.

17. **Some symbols – a positive nod of the head, a pointing finger, a "thumbs up" sign – are universal and can help bridge the language gap.**
    a) True
    b) False

18. **Out of respect for a patient's privacy, the provider should begin a relationship by seeing an adult patient alone and drawing the family in as needed.**
    a) True
    b) False

19. **In some cultures, it may be appropriate for female relatives to ask the husband of a pregnant woman to sign consent forms or to explain to him the suggested treatment options if the patient agrees and this is legally permissible**.
    a) True
    b) False

20. **Which of the following is NOT TRUE of an organization that values cultural competence?**
    a) The organization employs or has access to professional interpreters that speak all or at least most of the languages of its clients.
    b) The organization posts signs in different languages and has patient education materials in different languages.
    c) The organization tries to hire staff that mirror the ethnic and cultural mix of its clients.
    d) The organization assumes that professional medical staff do not need to be reminded to treat all patients with respect.

2.0 Cultural Humility

Instructor/Facilitator: Read the objective aloud to the class.

OBJECTIVE:

The objective in this section is to show the multi-faceted aspects that make up "cultural humility" and provide insight to the participant. To do this, all three areas including Cultural Humility, Trauma Informed Care and Health Literacy will be addressed. The three components are illustrated below.

Cultural Humility Definition is a "Lifelong commitment to self-evaluation and self-critique, to redressing the power, imbalances in the patient-physician dynamic, and to developing mutually beneficial and values the welfare of another, clinical advocacy partnerships with communities on behalf of individuals and defined populations."

The term "Humility" however, has differing connotations or meaning for different segments of Montana's demographic makeup. For the purpose of this document, the term will be used as well as cultural competence.

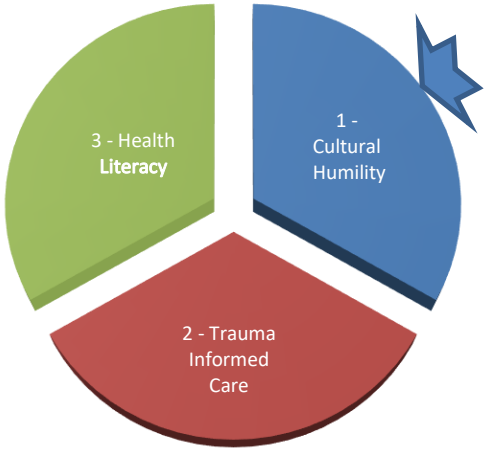
CULTURE

Culture is our way of life, the way we do things, the way we hear what others are saying and even the way we see what is around us.

Culture is how we identify our experiences and give them meaning.

Many things shape our personal culture including:

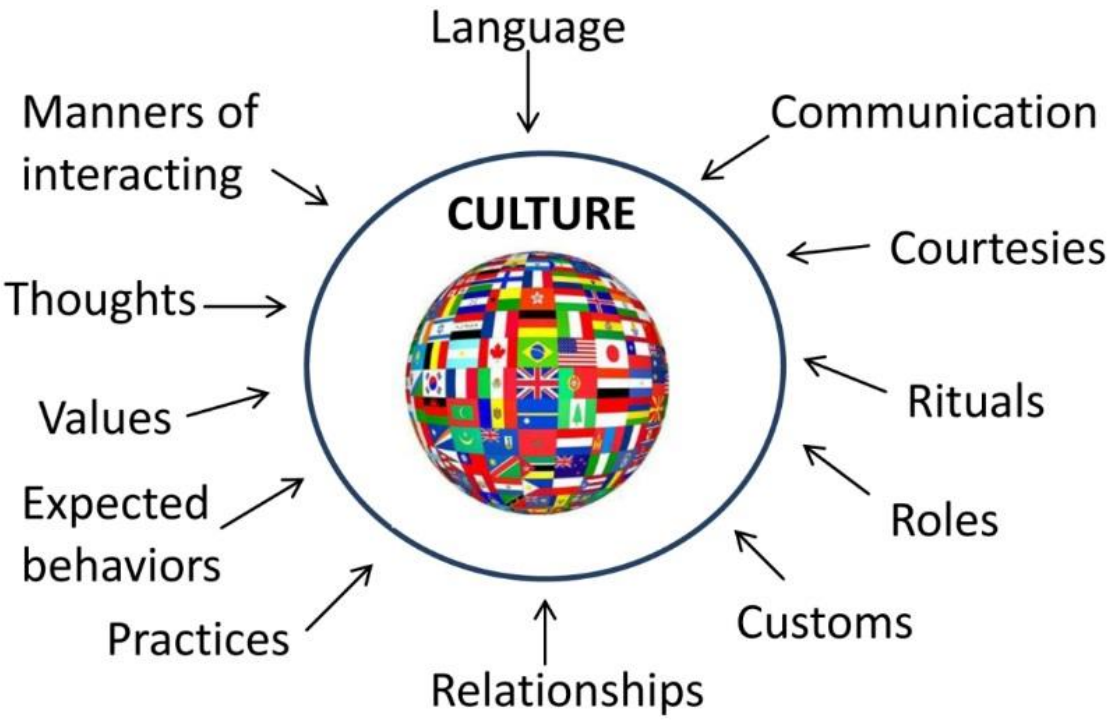
- Gender
- Race
- Age
- Sexual orientation
- Ethnicity
- Religious and political associations
- Physical ability
- Socioeconomic class
- Current realities and life experiences.



The scope of culture is so large, it would be impossible to learn about so many things for everyone that we meet. **Being culturally competent does not mean that you must be an expert on every culture.**

It means that we care and do not make assumptions about others. It means that we ask questions to get information that will help us in providing care to the patient.

Instructor/Facilitator: Discuss what the term "Humility" means to each member of your class. In some segments, it is viewed as a negative term rather than a positive one. As an example; some Native American Tribal members feel that the term Humility is a demeaning term. We will explain this further in this training.



2.1 Cultural Competence

Instructor/Facilitator: To facilitate discussion, ask "How do we get quality care that will address cultural differences"?

Cultural competence is:

- Sharing respect for each other
- Accepting that there are many ways of viewing the world.
- Knowing everyone is unique with different views and languages

How do we get quality care that will address differences?

- It is the ability to function effectively in the context of cultural differences.
- It is the understanding of who we are, so we can allow others the opportunity to share who they.

Steps to Cultural Competency –

Awareness

- Awareness of self includes information sharing about issues, positions, interests and needs.
- Answer the question: What are my values?
- Answer the question: What are my personal biases and assumptions about people who are different from me?

Acknowledgement

Acknowledgement means exploring differing values, not making assumptions and shaping uninformed expectations of others.

Honest validation

Honest Validation is a process of understanding that different perspectives are of value.

- Do I have one belief or value that everyone in the world shares?
- What other values can I think of that may be different from a value I have?
- Am I willing to learn more about a belief that is different from mine?
- Can I see the importance of a value that may be different from one I hold?
- Are my values/viewpoints threatened by learning about a different value/viewpoint?
- Do I want to share information about my values with someone who does not share my experiences?
- Can I challenge myself to see that different viewpoints/values contribute to my experiences and my self-awareness?

- Do I have enough information about my patient's experiences to understand my patient's health care needs?

Negotiation

Negotiation allows us to expand our outlook to see different options and different approaches.

Taking Action

Taking Action is the final step - adapting practice skills to fit the cultural context of the client.

Getting Started--Respect Activity

Instructor/Facilitator:

Ask everyone to find someone in the room who they do not know. Instruct them to introduce themselves to that person, and spend five to ten minutes talking about respect.

What does it mean for you to show respect, and what does it mean for you to be shown respect?

After the allotted time, ask the participants to return to their seats, and open the discussion.

What ideas did people come up with?

"Golden Rule,"

- looking somebody in the eyes,
- being honest, and
- appreciating somebody's ideas even when you do not agree with them.

It is important to mention that respect is a crucial ingredient in any discussion, but especially in a discussion of often controversial issues regarding multicultural issues.

The point is to learn from our differences--to understand each other's understanding. The point is NOT to agree.

Another important part of respect is knowing each other's names, and how to pronounce them. Also, respect includes keeping the conversation in the group. This type of community building--and the safety which people feel with it--can make or break an attempt to facilitate discussions on multicultural issues.

This activity touches many bases. First, it starts the crucial path toward building a community of respect.

This is the first step in maintaining a constructive exchange regarding issues such as racism, sexism, etc.

At the most basic level, participants meet someone they did not know, and exchange ideas with that person.

Second, the community is built through an understanding of how the group perceives respect, and how they negotiate its meaning.

Third, the similarities and differences in participants' ideas about respect begin to show the first signs of similarities and differences within the group on a larger level.

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2.2 Bias

What is "**BIAS**"? Bias is something that is inherent in each of us, some learned from experiences we have had. It can also be from our upbringing, our surroundings, and/or our perceptions. While it is easy to try and dismiss the idea that we are biased, it really isn't true.

Definition of BIAS = prejudice in favor of or against one thing, person, or group compared with another, usually in a way considered to be unfair.

Activity #1

Instructor/Facilitator:

Ask the participants "What are some other words that describe bias?" Let participants come up with as many words as possible (write them on the whiteboard or Flip Chart) Ask: How many can we define?

1. Prejudiced
2. Inclination
3. Angled or slanted
4. Direct
5. **Partiality**
6. **Partisanship**
7. **Favoritism**
8. **Unfairness**
9. **Color**
10. **Influence**

As you can see from this exercise, bias is disguised in various forms, words and actions. As providers, we must be continually on guard to sub-conscious or even conscious tendencies that lead us down the path of bias towards our patients or clients. This is essential to achieve positive outcomes.

Activity #2

Instructor/Facilitator: After reading the definition of BIAS ask participants to close their eyes. You will name off several topics, populations and items and the participants will remain quiet as you quickly name each item.

Northern Lights, poverty, Star Bucks, critical access, death, administration, pediatrics, privilege, Hispanic, Folgers, Walmart, doctor, middle age, Fed X, Native American, foreign, white, nurse, immigrant, geriatric, abuse, African- American, hospital, happy, sad, night shift, day shift, neglect, paramedic, Spanish speaking, bilingual, LGBTQ, parents, family, home, love.

State - Open your eyes

I quickly named a lot of words. Your brain responded to those names and provided images. Those are your bias's. If the images you saw were good, bad or otherwise, it's your responsibility to ask yourself:

Why do I have those biases?

Where did these biases come from?

How do I best overcome them to provide better patient care?

What biases are harmful?

ACTIVITY #3

Research shows that our brain makes decisions up to 10 seconds before you realize it. This indicates that most of your conscious decisions are unconscious decisions. Your brain reaches conclusions based on what is already familiar, safe, likable, valuable, logical or illogical. Clinical decision-making is the process of making an informed judgment about the treatment necessary for our patients. However, medical conclusions can be based on non-medical factors.

Instructor/Facilitator: Have the participants name examples of non-medical factors that may influence decisions.

Examples of non-clinical influences on clinical decision-making

Patient-related factors

Patient's socioeconomic status

Patient's race

Patient's age, gender and other personal characteristics

Patient's adherence to treatment or inappropriate behaviour that may influence adherence (e.g. chaotic life style, frequent non-attendance for follow-up appointments)

Patient's wishes and preferences

Patient's attitude and behavior

Patient's concerns and worries (medical and non-medical concerns)

Others: Influences of patient's family members and friends, faith, culture and quality of life

Physician-related factors

Physician's personal characteristics, age, gender, culture, faith and race

Physician's time constraints and work overload in the clinic

Physician's professional interaction; e.g. relationship with colleagues, hospital staff and with pharmaceutical industry

Practice-related factors

Type of practice (e.g. private vs public)

Size of practice, practice organization, geographical location, and availability of health resources

Management policies/implication of treatment cost

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2862069/

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2.2.1 Explicit & Implicit Bias

Instructor/Facilitator: In this section, try to have students bring up traits that they can associate with the different biases. Faciltate discussion on how those biases made them feel as they encountered them.

There are two (2) types of bias- **Explicit and Implicit.**

EXPLICIT BIAS

- Person is aware of their evaluation of a group
- Believes evaluation to be correct
- Deliberately generated
- Consciously experienced as one's own

CHARACTERISTICS OF EXPLICIT BIAS

- Racism
- Discrimination
- Hate speech/hate crimes

IMPLICIT BIAS

- Automatically triggered
- Does not require any endorsement or attention for expression
- Operates in an unintentional, often unconscious manner
- Can be activated quickly and unknowingly by situational cues (skin color, accent)
- Influence behavior without awareness
- Common and persistent

CHARACTERISTICS OF IMPLICIT BIAS ATTITUDES

- Predict Behavior (choices, judgments, and nonverbal behavior) toward members of social groups
- In some cases, are more informative than explicit attitudes
- Often outperform measures of explicit attitudes in socially sensitive domains (e.g., stereotyping, and prejudice)
- Triggered automatically, often without awareness, often dependent on social context
- Pervasive – found across different demographic groups and topics

PROVIDER FACTORS IMPLICATED IN HEALTH DISPARITIES (higher burden of illness, disability, or mortality experienced by one group relative to another)

- Health care professionals exhibit implicit bias as does the wider population
- Providers with stronger implicit bias demonstrate poorer patient-provider communication.
- Significant positive relationship between level of implicit bias and lower quality of care
- Higher implicit bias is associated with disparities in:
- Treatment recommendations
- Pain management
- Empathy

EXPLICIT & IMPLICIT BIAS EXERCISE

Instructor/Facilitator:

Break class into two (2) separate groups. One group takes "Explicit Bias" and the other takes "Implicit Bias" . Each group will then discuss possible characteristics of that bias and present to the class with examples.

As an example, for "Explicit Bias"; My whole family has said that you couldn't trust …..

Discuss why as professionals, we also have these biases.

What can trigger these biases?

(Examples; skin color, hair, clothing, language, your own personal experiences, physical location, etc.).

"Implicit bias isn't a choice but dealing with it is."

2.2.2 Bias Activity #3

Read each question and enter your response in the appropriate box.		YES ✓	NO ✓
1.	Do you ask about a client's or patient's background or cultural beliefs?		
2.	Have you judged an individual due to his or her dress code?		
3.	Are you being sensitive to another person's fear of racism or prejudice?		
4.	Have you examined your personal ethnic and class background and how others may perceive you?		
5.	Have you ever felt different and/or separate from a majority ethnic group?		
6.	Do you feel more at ease treating client's/patients of your ethnicity, skin color, culture, or socio- economic class?		
7.	Do you utilize casual conversation to establish rapport with your client's or patients?		
8.	Have you stereotyped a client or patient based on his/her looks, language, dress and other outward appearances?		
9.	Do you ask the client or patient how they would like to be addressed?		
10.	Have you felt uncomfortable when there is a long pause in the conversation?		

Being aware of biases will allow you the ability to work collaboratively toward Cultural Humility/Competence. This exercise was designed to illustrate how bias plays an important part of our personal lives. This exercise helped to demonstrate that we all have our biases, whether we believe it or not. It is learning how to work with those biases that allow us to effectively integrate into multicultural situations.

Instructor/Faciltator:

After this exercise, were there any surprises discussed by the class members? Ask if anyone cares to share their thoughts and feelings.

Did they have to consciously think about their reaction to the statements?

Was there any "uncomfortable moments" for individual class members during the exercise?

Did this exercise help to illustrate how bias can be present in our everyday lives?

2.3 Communication

Instructor/Facilitator: Ensure that class members are aware of how important that communication is in regards to every interaction.

The definition of **communication** is - "the process of passing information and understanding from one person to another." In simple words it is a process of transmitting and sharing ideas, opinions, facts, values etc. from one person to another or one organization to another."

We communicate for a variety of reasons! **We** use **communication** to share information, comment, ask questions, express wants and **needs**, develop social relationships, social etiquette, etc. **Communication** is much more than wants and **needs**. Our main reasons for **communication** may change over time.

Five (5) methods of communication include; verbal, non-verbal, written, oral and face-to-face.

Although all five methods of communication are important in communication, we will highlight two. The two we will discuss in this section are **Verbal and Non-Verbal.**

VS

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2.3.1 Verbal Versus Non-Verbal Communication

Instructor/Facilitator: Discuss the verbal Vs. Non-Verbal communication and highlight the differences.

When we think about communication, we most often focus on how we exchange information, ideas, feelings, and opinions using the spoken word.

Nonverbal communication is a process of generating meaning using behavior other than words. Rather than thinking of nonverbal communication as the opposite of or as separate from verbal communication, it's more accurate to view them as operating side by side—as part of the same system.

Nonverbal communication is a process of generating meaning using behavior other than words. Nonverbal communication includes:

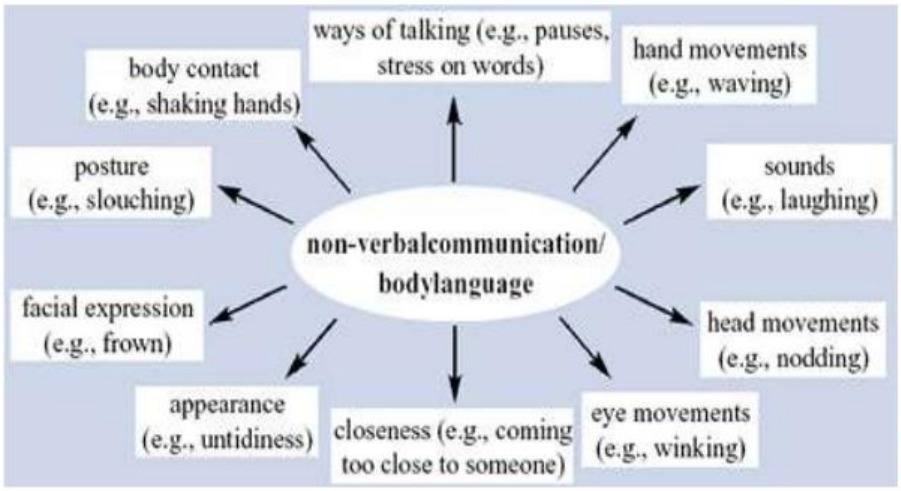
- Eye contact
- Facial expression
- Gesture
- Posture and body orientation
- Body language
- Space and distance
- Touch
- Silence
- Vocal elements include pitch, volume, and rate, and non-vocal elements

Non-verbal communication conveys critical information—but it may differ dramatically across cultures.

ACTIVITY #1: Discuss the verbal and non-verbal communication.

- **You enter the patient's room, and say "How can I help you? What brings you in today?" As the patient starts to explain, you glance at your watch without making eye contact.**
- **You enter a patient's home, and your partner sighs and crosses his/her arms across chest and says, "What is going on with you today?"**
- **At the Emergency Department Admitting desk, the Clerk is shaking her head as the family enter the doors, she turns away and acts busy shuffling papers while looking at the clock. Her shift ends in 10 minutes. She has paperwork she needs to finish. She turns around as the Mom of the infant comes to the window. She quickly shoves a form and says fill this out with your insurance information. The Mom quickly explains they have lost their insurance. The Clerk jerks the paperwork away from the Mom. The Mom starts to cry.**

WHAT IS NON-VERBAL COMMUNICATION?



ACTIVITY #2.

Instructor/Facilitator: Ensure that you hard hard copies of this exercise for all class members.

Reading Nonverbal Cues

The column on the left contains examples of nonverbal communication. The center column is how a receiver might interpret the sender's data. In the column on the right, list other ways the sender's data could be interpreted.

Sender Data	Receiver Interprets	Other Possibilities
Folds arms	Feels superior	
Drums fingers	Is uninterested	
Shakes head sideways	Is disagreeing	
Nods head vertically	Is agreeing	
Hands on hips	Is defiant	
Avoids eye contact	Isn't truthful	
Stares at you	Is threatening	
Looks at watch	Is impatient	
Leans forward	Ready to disagree	
Leans back	Dislikes your message	
Removes eyeglasses	Has a headache	
Raises eyebrows	Does not believe	

1. What might your initial reactions affect your communication and impact on others?

2. Compare your list with someone else. What does that tell you?

Body language speaks louder than any words. Your body movements reveal your thoughts, moods, and attitudes. Both consciously and sub-consciously your body tells observers what's really going on with you.

93% of communication is non-verbal. We spend almost 70% of our waking time communicating with others. Failed communications can lead to conflict and frustration.

Non-Verbal Cues

- Non-verbal communication conveys more emotional meaning than verbal communication
- Non-verbal communication is often more credible than verbal communication.
- Non-verbal communication affects verbal communication in that it can complement, reinforce, substitute, or contradict verbal messages.
- Non-verbal communication influences others, as it is a key component of deception and can be used to assert dominance.

Non-verbal communication affects relationships, as it is a primary means through which we communicate emotions, establish social bonds, and engage in relational maintenance.

EYE CONTACT

When someone is avoiding eye contact, don't immediately assume he/she is not listening or is hiding something, especially if you are conveying complex or surprising information. Looking away may also signal cognitive activity, they may be processing information. You may need to pause and ask them to repeat what you just state. This will help you understand if they need further explanations.

A “sideways glance,” which entails keeping the head and face pointed straight ahead while focusing the eyes to the left or right, has multiple contradictory meanings ranging from interest, to uncertainty, to hostility. When the sideways glance is paired with a slightly raised eyebrow or smile, it is sign of interest. When combined with a furrowed brow it generally conveys uncertainty. But add a frown to that mix and it can signal hostility.

Allan Pease and Barbara Pease, The Definitive Book of Body Language (New York, NY: Bantam, 2004), 179.

Instructor/Facilitator: Ask the Question; IS NON-VERBAL COMMUNICATION UNIVERSAL?

Every culture interprets body language, gestures, posture and carriage, vocal noises (like shrieks and grunts), and degree of eye contact differently. We might think that nodding one’s head up and down would indicate yes, but in some countries, it means just the opposite.

In the Middle East, nodding the head down indicates agreement, while nodding it up is a sign of disagreement; in Japan, an up-and-down nod might just be a signal that someone is listening [source: Wang, Li]. The thumbs-up signal is vulgar in Iran.

The "OK" signal made by forming a circle with the thumb and forefinger refers to money in some countries, while in others it's an extremely offensive reference to a private body part.

Point with the wrong finger, or with anything less than your entire hand, and you risk offending somebody, and while some cultures value eye contact as a sign of respect, averting your eyes may be the sign of respect in others.

The list goes on and on: Some countries consider a handshake rude, and it's always rude to hand an object to another person with your left hand in the Middle East -- after all, that hand is reserved for matters of personal hygiene.

While burping after a meal is considered the height of uncouthness here in the U.S., a hearty belch is a sign of appreciation for the cook in India.

In some places, people value a certain degree of personal space in conversation, while those from the Middle East might get right up in your face when they want to converse.

In Latin America, it's expected that you'll get very touchy-feely with both strangers and friends -- perhaps exchanging a hearty embrace -- whereas in the U.S., such contact might be considered sexual.

And restrain the desire to pat a child on the head in Asia; there's a belief that such a touch would damage the child's soul.

FACIAL EXPRESSIONS:
Facial expressions might be the only form of nonverbal communication that could be considered universal. Researchers determined that there are six universal facial expressions:

- anger,
- disgust,
- fear,
- happiness,
- sadness and
- surprise [source: Matsumoto].

In more recent years, other researchers have argued that looks of contempt and embarrassment may also constitute universal expressions. No matter where you are, it seems, you must remember that your body is always saying something, even when you're not speaking.

2.3.2 Non-Verbal Communication

Instructor/Facilitator:

Read the following and ask for instances where the participants have seen these in work?

93% of communication is non-verbal. We spend almost 70% of our waking time communicating with others. Failed communications can lead to conflict and frustration. Most of us were not taught to communicate in a way that produces desired results.

Quick Tips on Effective Communication Skills (Non-Verbal)

Non-verbal factors such as posture, body movement, gestures and facial expressions often convey a clearer and more accurate message than the actual words we use. Consider the following:

1. Happiness
2. Surprise
3. Anger
4. Sadness
5. Fear
6. Disgust

A person's attitude may be easily recognized through specific posture, body movement, and gestures. Consider the following:

1. Defensiveness: crossed arms or legs, pointing fingers.
2. Evaluative: Scowl/glare or frown, shaking fingers, hands on hips.

It is important to understand that when giving and receiving the message, non-verbal language speaks just as loud as your verbal words. Know the signs when a person is receptive to listening to you.

Warm Behaviors	**Cold Behaviors**
Direct eye contact	Stare
Touching	Fake yawn
Smiling	Looking away
Nods	Nervous habits, fidgeting
Eyes wide open	Shakes heads negatively
Forward lean	Moves away from speaker
Positive facial expression	Negative facial expression

Eye contact is a key element in developing effective communication skills. There is usually more eye contact when:

- You are discussing impersonal subjects
- You are at a distance from your partner
- You like your partner
- You are talking with your supervisor
- You tend to be extroverted
- You are self-confident
- You are listening (not speaking)

There is usually less eye contact when:

- You are discussing intimate subjects
- You are speaking (not listening)
- You dislike your partner
- You are introverted
- You are trying to hide something (guilt, sorrow, etc.)
- You are talking with a subordinate
- You are interested in your partner's reactions

NON-VERBAL BODY LANGUAGE TRAITS

The following list of traits are ones that you will readily associate with. We see them all the time, however we need to understand the implications of them to others.

NEGATIVE FACIAL EXPRESSIONS (nervousness, dislike, stress, and contempt):

- Furrowed forehead.
- Nose crinkle.
- Eyelid flutter.
- Lips pursing.
- Jaw moving to the side.
- Repeated touching of the nose or eyelid.
- A smirk, corner of the lip raised.
- Looking in a different direction while verbally responding.

POSITIVE FACIAL EXPRESSIONS:

- Consistent eye contact.
- Raised eyebrows.
- A perked head position, nodding in agreement.
- A head tilt to the side is a submissive signal, exposing the throat and neck; it conveys inquisitiveness and interest.

NEGATIVE TORSO EXPRESSIONS:

- Shoulders slowly rising and turned inward shows a lack of confidence in what's presented, and a sense of discomfort.
- The “Lint-Picker,” looking down and performing an irrelevant action i.e. picking imaginary lint, is a sign of disapproval and dismissal.

POSITIVE TORSO EXPRESSIONS:

- A ventral exposure—leaning inward is a positive sign of interest.
- An upright, but not stiff open chest that parallels the other person is a sign of congruence and agreement.

NEGATIVE ARM EXPRESSIONS:

- Placed behind the back is a regal stance of authority and wanting distance.
- Arms across chest in any way is an expression of concern and threat.
- A noticeable freeze, stiffness, complete lack of arm movement, is an attempt to conceal, to deflect, and avoid attention.

POSITIVE ARM EXPRESSIONS:

- Arms at the waist, or slightly tucked into pockets with thumbs pointing forward is an inquisitive and interested stance.
- Arms rested across the belly-button is a relaxed and open position.

NEGATIVE HAND EXPRESSIONS:

- Fingers interlocked with palms pressed together conveys stress or concern.
- Nail biting is a sign of insecurity and nervousness.
- Rubbing palms together shows doubt, stress, or the need for more information.

POSITIVE HAND EXPRESSIONS:

- Hand stippling shows confidence and lack of threat.
- Palms showing conveys agreement and rapport.

NEGATIVE LEGS AND FEET EXPRESSIONS:

- Feet withdrawn from the front to beneath a chair is a distancing reaction that conveys discomfort.
- A shift from foot jiggling to foot kicking (front to back motion) is a disagreement response.
- Feet locked behind legs or rubbing hands on legs is a stress response and attempt to conceal feelings.
- If someone’s feet are pointed toward the door, that’s exactly where they want to head.

POSITIVE LEGS AND FEET EXPRESSIONS:

- The foot-forward position, body weight is shifted to one hip, and the lead foot is pointing toward the speaker, this is an expression of attraction and interest.
- In seated positions, legs uncrossed in a neutral position—not overly spread apart, nor are the knees touching together.
- With reading body language, one of the most important elements is to establish a baseline. It the first few minutes of meeting someone, pay careful attention of their natural mannerisms. Otherwise, it can be easy to misread their behaviors as exaggerated when they are in fact normal.

Activity #5

Body language speaks louder than any words you can ever utter. Whether you're telling people that you love them, you're angry with them, or don't care less about them, your body movements reveal your thoughts, moods, and attitudes. Both consciously and sub-consciously your body tells observers what's really going on with you.

Instructor/Facilitator:

Ask for volunteers to participate in this activity. Have volunteers perform some of these non-verbal body language traits. Ensure that they role play those traits to establish the actual feelings that they create.

2.4 Cultural Competence in The Health Care Encounter

Instructor/Facilitator: Read and discuss the objective with the class

Objective:

To integrate Cultural Competence into every encounter. Health care encounters happen in the field as a first responder, in a facility and in every aspect of care to the patient. How we deal with these encounters can make a dramatic difference in the health and well-being of our patients and families.

Patient Perspective - Understanding the issues facing racial and ethnic minority patients can help the provider improve effectiveness in providing quality health care to all patients.

A culturally competent health care system can help improve health outcomes and quality of care and can contribute to the elimination of racial and ethnic health disparities.

- Examples of strategies to move the health care system towards these goals include providing relevant training on cultural competence and cross-cultural issues.

WHAT IS CULTURAL COMPETENCE IN HEALTH CARE?

Cultural competence in health care is broadly defined as the ability of providers and organizations to understand and integrate these factors into the delivery and structure of the health care system.

The goal of culturally competent health care services is to provide the highest quality of care to every patient, regardless of race, ethnicity, cultural background, English proficiency or literacy.

Some common strategies for improving the patient-provider interaction in health care include:

- Recruit and retain minority staff
- Provide training to increase cultural awareness, knowledge, and skills
- Coordinate with traditional healers
- Incorporate culture-specific attitudes and values
- Include family and community members in health care decision making
- Provide linguistic competency that extends beyond the clinical encounter to the appointment desk, advice lines, medical billing, and other written materials.

Comparing Cultural Norms and Values

Aspects of Culture	U.S. Health Care Culture	Other Cultures
1. Sense of self and space	Informal Handshake	Formal Hugs, bows, and handshakes
2. Communication and language	Explicit, direct communication Emphasis on content -meaning found in words	Implicit, indirect communication Emphasis on context -meaning found around words
3. Dress and appearance	"Dress for success" ideal Wide range in accepted dress More casual	Dress seen as a sign of position, wealth, and prestige Religious rules More formal
4. Food and eating habits	Eating as a necessity – Fast food	Dining as a social experience Religious rules
5. Time and time consciousness	Linear and exact time consciousness Value on promptness Time = money	Elastic and relative time consciousness Time spent on enjoyment of relationships
6. Relationship, family, friends	Focus on nuclear family Responsibility for self Value on youth, age seen as handicap	Focus on extended family Loyalty and responsibility to family Age given status and respect
7. Values and norms	Individual orientation Independence Preference for direct confrontation of conflict Emphasis on task	Group orientation Conformity Preference for harmony Emphasis on relationships
8. Beliefs and attitudes	Egalitarian (Democratic, open) Challenging of authority Gender equity Behavior and action affect and determine the future	Hierarchical Respect for authority and social order Different roles for men and women Fate controls and predetermines the future
9. Mental processes and learning style	Linear, logical Problem-solving focus Internal locus of control Individuals control their destiny	Lateral, holistic, simultaneous Accepting of life's difficulties External locus of control Individuals accept their destiny
10. Work habits and practices	Reward based on individual achievement Work has intrinsic value	Rewards based on seniority, relationships Work is a necessity of life

Lee Gardenswartz and Anita Rowe, *Managing Diversity: A Complete Desk Reference and Planning Guide* (Burr Ridge, Ill.: Irwin, 1993), p. 57.

Cultural Competence in the Health Care Encounter Exercise

This following exercises are meant to present to you different scenarios that are common, and therefore, ones that you will likely encounter in your work area. Our being able to handle them effectively determines how the health care encounter succeeds.

Instructor/Facilitator:

This exercise is a good way to help participants develop more empathy, consider other perspectives, build their communication and negotiation skills.

First, make sure you have enough people for at least three teams of two, enough playing cards to give out between 4 and 6 cards to each person, and 15 minutes to spare.

Here's how the activity works:

1. Cut each playing card into half diagonally, then in half diagonally again, so you have four triangular pieces for each card.

2. Mix all the pieces together and put equal numbers of cards into as many envelopes as you have teams.

3. Divide people up into teams of three or four. You need at least three teams. If you're short of people, teams of two will work just as well.

4. Give each team an envelope of playing card pieces.

5. Each team has three minutes to sort its pieces, determine which ones it needs to make complete cards, and develop a bargaining strategy.

6. After three minutes, allow the teams to start bartering for pieces. People can barter on their own or collectively with their team. Give the teams eight minutes to barter.

7. When the time is up, count each team's completed cards. Whichever team has the most cards wins the round.

Afterward, you can use these questions to guide discussion on the exercise:

- Which negotiation strategies worked? Which didn't?
- What could they have done better?
- What other skills, such as active listening or empathy, did they need to use?

2.5 Group Scenario Exercises

Instructor/Facilitator: For the following exercises, have the class members discuss each scenario and discuss.

SCENARIO #1

A call comes in that an individual has been seen staggering on the sidewalk, apparently confused and has slurred speech and is sitting down on the sidewalk. As an EMS responder, you roll to the scene.

Instructor questions and points for discussion:

What do anticipate seeing upon your arrival on scene?

Is it possible that you had some preconceived idea about what you would find?

Can those preconceived ideas affect your response?

Instructor/Facilitator may need to provide examples to start discussion. (Examples may include stroke, drug or alcohol).

How does this change when it is determined that the patient is experiencing a diabetic reaction?

What would you consider during your assessment?

Diabetic reaction?

Cardiac situation?

Stroke?

SCENARIO #2

A patient in your ambulance states that their gender is male, however outward appearances make you feel that information was not correct. How do you approach the issue to ensure proper care for the patient and maintain a positive space in your ambulance?

Instructor/Facilitator questions and points for discussion:

According to an article from EMS World dated August of 2018, the following information is provided:

"When interviewing patients use phrases that do not assume heterosexuality. Small cues signal to LGBT people that you are open to their existence and/or lifestyle choice. Treat spouses and partners of LGBT patients the same as you would any other spouse, including them as appropriate in information-gathering and decision-making. They will have the same pertinent information about a patient as any spouse. Other steps include asking your employer to post a positive-space symbol on your ambulance window or inside the patient compartment or incorporate it into the uniform. The upside-down rainbow triangle and rainbow flag is recognizable symbols. Advocating for positive-space training from your employer or acknowledgement of days of observance like World AIDS Day or the National Transgender Day of Remembrance are actionable steps."

Additional information is available at the following website:

https://www.emsworld.com/220931/ce-article-abcs-lgbt-creating-positive-space-ambulance

SCENARIO #3

An unconscious patient is admitted to the emergency Room, lying on the bed and the curtain is open. The nurse is talking about the next steps with other staff. Staff, patients and visitors are walking by listening, glancing and staring.

Instructor/Facilitator questions and points for discussion:

If the patient was conscious, what would they say or feel about the lack of respect and privacy?

What role does the ER staff have in providing safe and respectful care to each patient?

How do ethics fit into this scenario?

If the patient was conscious, what would be the focus in providing care?

Does the patient's autonomy influence the care process?

Describe to me what you think is respectful behavior?

Provide some examples of things that you think would be respectful or disrespectful? They can be related to medicine or not.

Provide some examples of ways which you have been treated with respect?

Give some examples of ways in which you have been treated disrespectfully?

SCENARIO #4

There has been an automobile accident and one of the patients requiring medical attention is a young special needs teenager. The teen is agitated and upset and not being very cooperative. Discuss possible interventions to help rectify this situation so proper care may be provided.

Instructor/Facilitator questions and points for discussion:

1. **What do you do immediately to try and calm the patient down, so you are able to obtain valid vital signs?**
2. **How can you determine if the individual is accompanied by an adult?**
3. **What can you do at the scene to try and contact his/her adult parent or caregiver?**

Attached is the **SAMHSA "Tips for Talking with and Helping Children and Youth Cope After a Disaster or Traumatic Event."** This article may provide you some guidance to help dealing with patients who are Special Needs and to achieve a successful outcome.

Tips for Talking With and Helping Children and Youth Cope After a Disaster or Traumatic Event:

A GUIDE FOR PARENTS, CAREGIVERS, AND TEACHERS

Adult support and reassurance is the key to helping children through a traumatic time.

Children and youth can face emotional strains after a traumatic event such as a car crash or violence.[1] Disasters also may leave them with long-lasting harmful effects.[2] When children experience a trauma, watch it on TV, or overhear others discussing it, they can feel scared, confused, or anxious. Young people react to trauma differently than adults. Some may react right away; others may show signs that they are having a difficult time much later. As such, adults do not always know when a child needs help coping. This tip sheet will help parents, caregivers, and teachers learn some common reactions, respond in a helpful way, and know when to seek support.

Possible Reactions to a Disaster or Traumatic Event

Many of the reactions noted below are normal when children and youth are handling the stress right after an event. If any of these behaviors lasts for more than 2 to 4 weeks, or if they suddenly appear later on, these children may need more help coping. Information about where to find help is in the **Helpful Resources** section of this tip sheet.

PRESCHOOL CHILDREN, 0–5 YEARS OLD

Very young children may go back to thumb sucking or wetting the bed at night after a trauma. They may fear strangers, darkness, or monsters. It is fairly common for preschool children to become clingy with a parent, caregiver, or teacher or to want to stay in a place where they feel safe. They may express the trauma repeatedly in their play or tell exaggerated stories about what happened. Some children's eating and sleeping habits may change. They also may have aches and pains that cannot be explained. Other symptoms to watch for are aggressive or withdrawn behavior, hyperactivity, speech difficulties, and disobedience.

- **Infants and Toddlers, 0–2 years old,** cannot understand that a trauma is happening, but they know when their caregiver is upset. They may start to show the same emotions as their caregivers, or they may act differently, like crying for no reason, withdrawing from people, and not playing with their toys.
- **Children, 3–5 years old,** can understand the effects of trauma. They may have trouble adjusting to change and loss. They may depend on the adults around them to help them feel better.

EARLY CHILDHOOD TO ADOLESCENCE, 6–19 YEARS OLD

Children and youth in these age ranges may have some of the same reactions to trauma as younger children. Often, younger children want much more attention from parents or caregivers. They may stop doing their school work or chores at home. Some youth may feel helpless and guilty because they cannot take on adult roles as their family or the community responds to a trauma or disaster.

- **Children, 6–10 years old,** may fear going to school and stop spending time with friends. They may have trouble paying attention and do poorly in school overall. Some may become aggressive for no clear reason. Or they may act younger than their age by asking to be fed or dressed by their parent or caregiver.
- **Youth and Adolescents, 11–19 years old,** go through a lot of physical and emotional changes because of their developmental stage. So, it may be even harder for them to cope with trauma. Older teens may deny their reactions to themselves and their caregivers. They may respond with a routine "I'm okay" or even silence when they are upset. Or, they may complain about physical aches or pains because they cannot identify what is really bothering them emotionally. Some may start arguments at home and/or at school, resisting any structure or authority. They also may engage in risky behaviors such as using alcohol or drugs.

How Parents, Caregivers, and Teachers Can Support Children's Recovery

The good news is that children and youth are usually quite resilient. Most of the time they get back to feeling okay soon after a trauma. With the right support from the adults around them, they can thrive and recover. The most important ways to help are to make sure children feel connected, cared about, and loved.

- Parents, teachers, and other caregivers can help children express their emotions through conversation, writing, drawing, and singing. Most children want to talk about a trauma, so let them. Accept their feelings and tell them it is okay to feel sad, upset, or stressed. Crying is often a way to relieve stress and grief. ***Pay attention and be a good listener.***
- Adults can ask the teens and youth they are caring for what they know about the event. What are they hearing in school or seeing on TV? Try to watch news coverage on TV or the Internet with them. And, limit access so they have time away from reminders about the trauma. Don't let talking about the trauma take over the family or classroom discussion for long periods of time. ***Allow them to ask questions.***
- Adults can help children and youth see the good that can come out of a trauma. Heroic actions, families and friends who help, and support from people in the community are examples. Children may better cope with a trauma or disaster by helping others. They can write caring letters to those who have been hurt or have lost their homes; they can send thank you notes to people who helped. ***Encourage these kinds of activities.***
- If human violence or error caused an event, be careful not to blame a cultural, racial, or ethnic group, or persons with psychiatric disabilities. This may be a good opportunity to talk with children about discrimination and diversity. ***Let children know that they are not to blame when bad things happen.***
- It's okay for children and youth to see adults sad or crying, but try not to show intense emotions. Screaming and hitting or kicking furniture or walls can be scary for children. ***Violence can further frighten children or lead to more trauma.***[3]
- Adults can show children and youth how to take care of themselves. If you are in good physical and emotional health, you are more likely to be readily available to support the children you care about. ***Model self-care, set routines, eat healthy meals, get enough sleep, exercise, and take deep breaths to handle stress.***

Tips for Talking With Children and Youth of Different Age Groups After a Disaster or Traumatic Event

PRESCHOOL CHILDREN, 0–5 YEARS OLD

Give these very young children a lot of cuddling and verbal support:

- Take a deep breath before holding or picking them up, and focus on them, not the trauma.
- Get down to their eye level and speak in a calm, gentle voice using words they can understand.
- Tell them that you still care for them and will continue to take care of them so they feel safe.

EARLY CHILDHOOD TO ADOLESCENCE, 6–19 YEARS OLD

Nurture children and youth in this age group:

- Ask your child or the children in your care what worries them and what might help them cope.
- Offer comfort with gentle words, a hug when appropriate, or just your presence.
- Spend more time with the children than usual, even for a short while. Returning to school activities and getting back to routines at home is important too.
- Excuse traumatized children from chores for a day or two. After that, make sure they have age-appropriate tasks and can participate in a way that makes them feel useful.
- Support children spending time with friends or having quiet time to write or create art.
- Encourage children to participate in recreational activities so they can move around and play with others.
- Address your own trauma in a healthy way. Avoid hitting, isolating, abandoning, or making fun of children.
- Let children know that you care about them — spend time doing something special with them, and make sure to check on them in a nonintrusive way.

A NOTE OF CAUTION: *Be careful not to pressure children to talk about a trauma or join in expressive activities. While most children will easily talk about what happened, some may become frightened. Some may even get traumatized again by talking about it, listening to others talk about it, or looking at drawings of the event. Allow children to remove themselves from these activities, and monitor them for signs of distress.*

Helpful Resources

Substance Abuse and Mental Health Services Administration Disaster Technical Assistance Center (SAMHSA DTAC)
Toll-Free: 1-800-308-3515
Website: http://www.samhsa.gov/dtac

Treatment Locators

Mental Health Treatment Facility Locator
Toll-Free: 1-800-789-2647 (English and español)
TDD: 1-866-889-2647
Website: http://findtreatment.samhsa.gov/MHTreatmentLocator

MentalHealth.gov
Website: http://www.mentalhealth.gov
MentalHealth.gov provides U.S. government information and resources on mental health.

Substance Abuse Treatment Facility Locator
Toll-Free: 1-800-662-HELP (1-800-662-4357)
(24/7 English and español); TDD: 1-800-487-4889
Website: http://www.findtreatment.samhsa.gov

Hotlines

National Suicide Prevention Lifeline
Toll-Free: 1-800-273-TALK (1-800-273-8255)
TTY: 1-800-799-4TTY (1-800-799-4889)
Website: http://www.samhsa.gov
This resource can be found by accessing the Suicide Prevention Lifeline box once on the SAMHSA website.

Disaster Distress Helpline
Toll-Free: 1-800-985-5990 Text "TalkWithUs" to 66746
Website: http://disasterdistress.samhsa.gov

Child Welfare Information Gateway
Toll-Free: 1-800-4-A-CHILD (1-800-422-4453)
Website: http://www.childwelfare.gov/responding/how.cfm

Additional Behavioral Health Resources

National Child Traumatic Stress Network
Website: http://www.samhsa.gov/traumaJustice
This behavioral health resource can be accessed by visiting the SAMHSA website and then selecting the related link.

Administration for Children and Families
Website: http://www.acf.hhs.gov/

When Children, Youth, Parents, Caregivers, or Teachers Need More Help

In some instances, a child and his or her family may have trouble getting past a trauma. Parents or caregivers may be afraid to leave a child alone. Teachers may see that a student is upset or seems different. It may be helpful for everyone to work together. Consider talking with a mental health professional to help identify the areas of difficulty. Together, everyone can decide how to help and learn from each other. If a child has lost a loved one, consider working with someone who knows how to support children who are grieving.[4] Find a caring professional in the **Helpful Resources** section of this tip sheet.

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[1] National Center for Statistics and Analysis. (n.d.). Traffic safety facts, 2003 data: Children. (DOT HS 809 762). Washington, DC: National Highway Traffic Safety Administration. Retrieved from http://www-nrd.nhtsa.dot.gov/Pubs/809762.pdf.

[2,4] National Commission on Children and Disasters. (2010). National Commission on Children and Disasters: 2010 report to the President and Congress. (AHRQ Publication No. 10-M037). Rockville, MD: Agency for Healthcare Research and Quality. Retrieved from http://archive.ahrq.gov/prep/nccdreport/nccdreport.pdf.

[3] Children's Bureau. (2010). Child maltreatment 2009. Washington, DC: Administration on Children, Youth and Families; Administration for Children and Families; U.S. Department of Health and Human Services. Retrieved from http://www.acf.hhs.gov/programs/cb/resource/child-maltreatment-2009.

Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

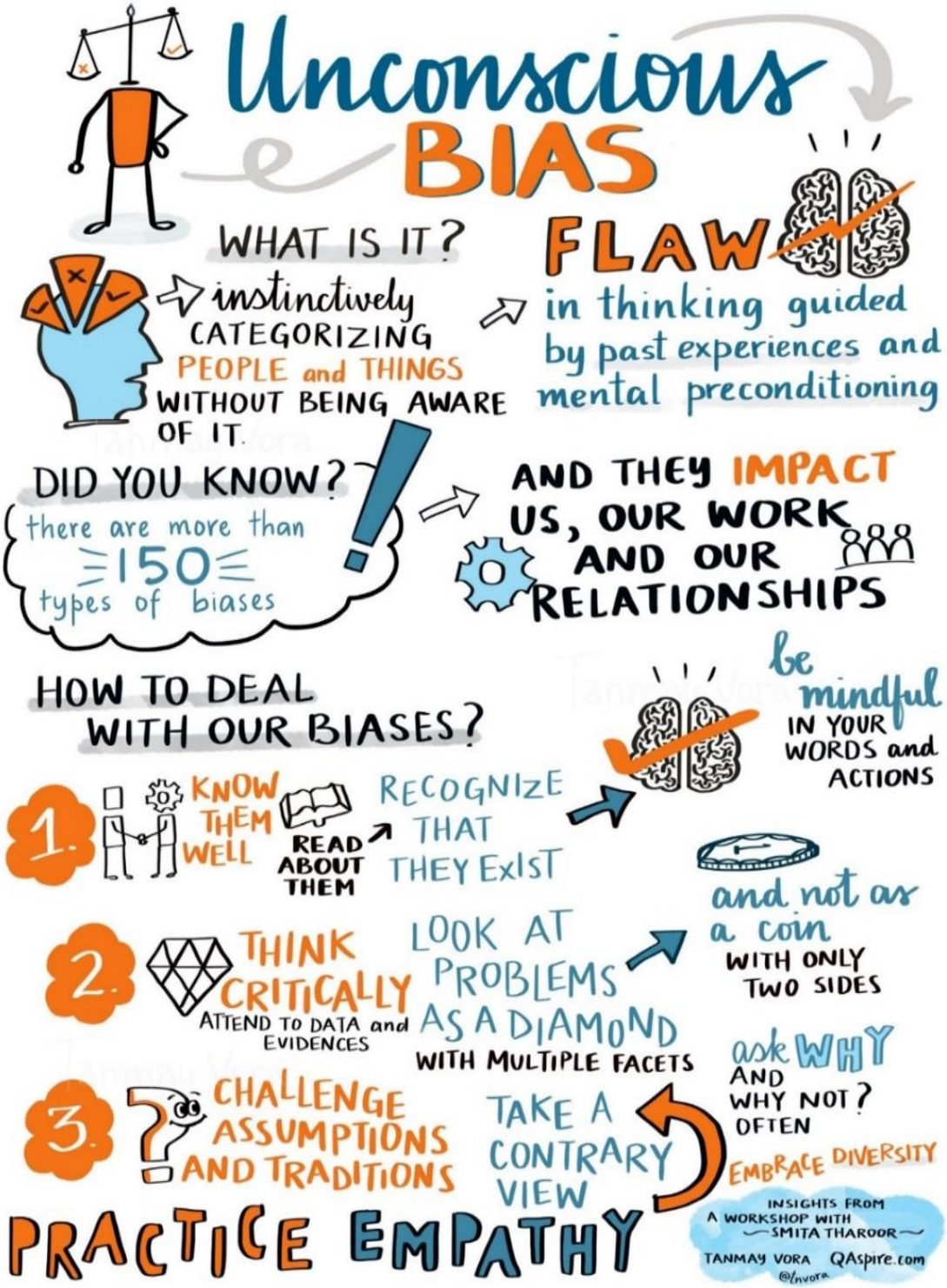
HHS Publication No. SMA-12-4732
(Revised 2013)

Instructor/Facilitator: Ask the the participants -

In all the scenarios depicted, you can ask yourself this question; ***"Do you see yourself reacting differently to the patient based on who or what you perceive the patient to be?"***

Depending on that answer, it may dictate that you indeed need to look at your potential biases to ensure that as a healthcare provider, that you meet the needs of all children by providing "the right care at the right time with the proper resources".

The picture on the following page depicts the visualization of Unconscious Bias. This would be a good handout for this section.


Unconscious
BIAS
WHAT IS IT?
instinctively CATEGORIZING PEOPLE and THINGS WITHOUT BEING AWARE OF IT.
FLAW
in thinking guided by past experiences and mental preconditioning
DID YOU KNOW?
there are more than 150 types of biases
AND THEY IMPACT US, OUR WORK AND OUR RELATIONSHIPS
HOW TO DEAL WITH OUR BIASES?
be mindful IN YOUR WORDS and ACTIONS
1.
KNOW THEM WELL
READ ABOUT THEM
RECOGNIZE THAT THEY EXIST
2.
THINK CRITICALLY
ATTEND TO DATA and EVIDENCES
LOOK AT PROBLEMS AS A DIAMOND WITH MULTIPLE FACETS
and not as a coin WITH ONLY TWO SIDES
3.
CHALLENGE ASSUMPTIONS AND TRADITIONS
TAKE A CONTRARY VIEW
ask WHY AND WHY NOT? OFTEN
EMBRACE DIVERSITY
PRACTICE EMPATHY
INSIGHTS FROM A WORKSHOP WITH SMITA THAROOR
TANMAY VORA QAspire.com
@tvora

2.5.1 Understanding Issues and Barriers

The issues below detail several areas that are common barriers that health care professionals deal with daily. In understanding these issues, we can provide better care. By understanding that we all have biases, we can better control them to effect positive outcomes for our patients.

Instructor/Facilitator:

Discuss each word/concept with group. Ask for other barriers the group may want to include.

There may be common barriers that health care professionals deal with daily. In understanding these issues, we can provide better care.

ACCULTURATION

For first- and second-generation Americans, acculturation—the degree to which they learn the values, beliefs, and behaviors of the host culture is a major factor in health care decisions and use of preventive services. Common fears include language barriers and the cultural insensitivity. *(See Appendix 2 — Comparing Cultural Norms and Values).*

COMMUNICATION PATTERNS

Communication about health often differs by ethnicity, age, socioeconomic status, geographic location, and sexual orientation. A communication approach that takes for granted a shared cultural background, gender orientation, and level of literacy may create instant barriers to care for many underserved communities.

ASSUMPTIONS OR GENERALIZATIONS

Just as one size doesn't fit all, one program or service won't work for all groups of a population. For example, within the Native Americans population there are differing:

- languages,
- customs and histories, and
- attitudes toward health, illness, sexuality, and spirituality.

DIFFERING HISTORY AND COMMUNITY MEMORY

Because groups within an ethnic community have different histories and differing community memories, a single program will not meet the needs of everyone in the larger community.

LACK OF CULTURALLY APPROPRIATE MATERIALS AND INADEQUATE LANGUAGE RESOURCES

Materials appropriate for one group of clients may not convey important concepts to another group of clients/patients.

- Prevention materials that are appropriate for use with some groups of Native Americans/American Indians and/or tribal affiliations could be inappropriate for use with other tribal affiliations.

- Materials provided in English and those translated into a single other language may simply be inadequate in conveying health care information.

SYSTEMS AND ORGANIZATION IMPROVEMENT

Institutions are designed to give a consistent level of service for the greatest number of people in the most cost-efficient manner. However, many organizations are finding that providing culturally and linguistically appropriate services for their ethnic minority patients not only improves patient care but may also improve business efficiency.

According to the Federal Health Resources and Services Administration (HRSA), systems that successfully provide culturally and linguistically competent services tend to:

- define culture broadly;
- value clients' cultural beliefs;
- recognize complexity in language interpretation;
- facilitate learning between providers and communities;
- involve the community in defining and addressing service needs;
- collaborate with other agencies;
- recognize training in cultural competence and medical interpretation as equally important as training in other essential clinical skills; and
- Institutionalize cultural and linguistic competence.

Engaging the community in their health care will help create solutions to meet the challenges we face in providing culturally and linguistically appropriate care.

PROVIDER ACTIONS - Reducing disparities in health care and outcomes is a national and state priority. Various efforts are underway to improve:

- Cultural competency awareness through training in medical education programs
- Data collection and research methodologies among underserved communities
- The number and availability of culturally diverse health care providers and administrators.

Individuals involved at all levels of health care can take steps to improve the quality of care provided to culturally diverse patients with:

- Patient-centered, individualized care is crucial to effective treatment;
- Asking the right questions in an open-ended manner.

Patients who see positive characteristics in their providers (such as being thorough, understanding, responsive and respectful) are more likely to seek treatment and follow medical advice. Patients with higher levels of trust are more satisfied with the patient-provider relationship.

This higher level of trust fosters:

- **Increased patient participation in their care.**
- **Reduced appointment cancellations and no-shows.**
- **Improved health outcomes.**
- **Improved patient safety.**

ENHANCING YOUR CULTURAL COMMUNICATION SKILLS AS A PROVIDER

IMPROVING YOUR INTERPERSONAL COMMUNICATION:

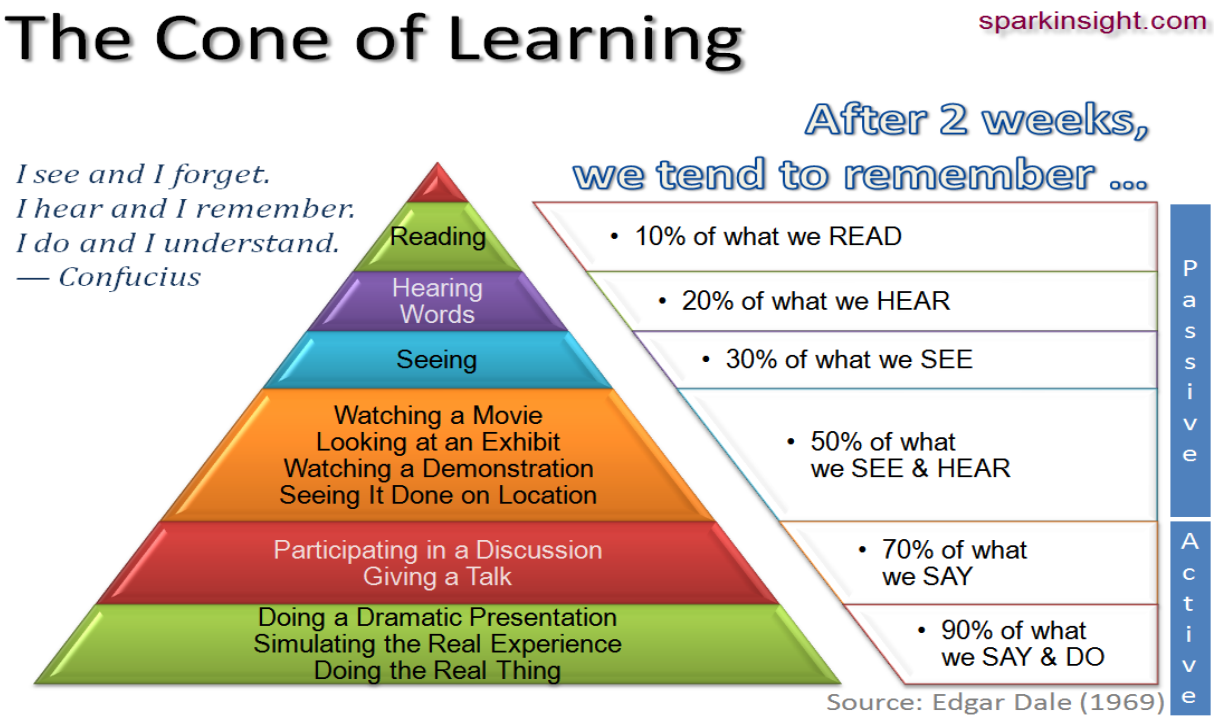
- Slow down.
- Use plain, non-medical language.
- Show or draw pictures or use Medical Visual Language Translator cards.
- Limit the amount of information provided and repeat it.
- Use the **teach-back** or show-me technique.
- Create a shame-free environment.

Obtaining information to help with patients and families from culturally diverse backgrounds**.**

- The more accurate information we have about others, the more likely we will be able to assist them.
- How do we get information we need? How do we know if it is proper to ask questions of our patients? We can start by asking permission.

TEACH BACK METHOD (also called Show Me Method)

This is a communication confirmation technique used to confirm whether a patient/family understands what is being explained. This is a way to check understanding by asking patients to state in their own words what they have just heard, what they need to do, and follow-up needs. Studies show that **40-80% of medical information told to patients is forgotten immediately and nearly ½ of the information retained is incorrect**.



Consider using it with all patients, regardless of education level. When talking to your patients about prediabetes, you might say:

- *"We covered a lot today about prediabetes, and I want to make sure that I explained things well. Can you tell me how you would describe it to a friend?"*
- *"I want to be sure that I clearly described some of the steps you can take to prevent type 2 diabetes. Is there one thing you can do this week to get started?"*

Sometimes all it takes is the question "what are you going to do when you get home?"

https://www.bing.com/videos/search?q=teach+back+techniques+in+the+healthcare+professional+vide&qpvt=tea

What the Heck is Teach Back?

27K views · Dec 14, 2016
YouTube › DTA Associates

Instructor/Facilitator: State these QUESTIONS TO HELP IN THE PROCESS OF CULTURAL HUMILITY. It is okay to ask question in a respectful manner.

So that I might be aware of and respect your cultural beliefs...

- Can you tell me what languages are spoken in your home and the languages that you understand and speak?
- Please describe your usual diet. Also, are there times during the year when you change your diet in celebration of religious and other ethnic holidays?
- Can you tell me about your beliefs and practices including special events such as birth, marriage and death that you feel I should know?
- Do you use any traditional health remedies to improve your health?
- Is there someone, in addition to yourself, with whom you want us to discuss your medical condition?
- Are there certain health care procedures and tests that your culture prohibits?
- Are there any other cultural considerations I should know about to serve your health needs?
- Is there anything else you would like me to know?
- Can you tell me what we discussed today? Encourage two-way communication.)
- Can you tell me when you need to come back for follow-up medical care?
- Do you want me to explain what we discussed with a family member?

SILENCE

When interacting with ethnic minority patients, it is wise to not be offended if there are periods of silence. In some cultures, this is a sign that they are contemplating what has been said. Improving interpersonal communication skills is a must.

The first statement is letting the patient know that you need them to help you. It is a thoughtful way of asking permission.

The purpose of each question is to make communication respectful while establishing trust.

Instructor/Facilitator Actions for Class Participation

Running the Activity:

1. Introduce yourself and say you are about to start your session. Give it a big build.

2.Then stop talking and remain silent for at least 30 seconds, walking around the room or looking at your notes.

3. At the end of 30 seconds, thank participants for their patience and, with a big smile, ask them what they learned in the last 30 seconds.

Instructor/Facilitator:

During the silence, you will notice that people become restless and uncomfortable as they begin to suspect that you have forgotten what to say/do. Notice this, but keep the silence going for as long as you can.

Conclusion

Stress to the class that "Western Culture" is not comfortable with silence while other cultures are very comfortable. For other cultures, it can be a time of reflection.


SILENCE
IS NOT ALWAYS A
SIGN OF WEAKNESS;
IT'S ALSO A SIGN
OF STRONG
SELF CONTROL.
©QUOTESEMPIRE.COM

2.6 Addressing Language Barriers in Health Care

Instructor/Facilitator: Read and discuss the objective with the class. Ask the group if they have any other challenges to add to the list. List those challenges and discuss each.

Ask what they have done personally to help mitigate any of these challenges.

Objective:

Language barriers are a common barrier in healthcare settings. To achieve positive outcomes, such as a dedicated medication regimen; scheduled appointments; and transportation all play a part in achieving positive/culturally appropriate outcomes. Ensuring that patients and families leave with a complete understanding of follow-up, medication dosing, and future care can be challenging due to multiple issues as discussed below.

SYSTEM CHALLENGES

Health care has its own terminology. Even if the provider and the patient speak the same language, there are still challenges to effective communication. However, the quality of medical care is closely linked to how well providers meet the language needs of the patient.

Treating non-English speaking (NEP) patients, those with low English proficiency (LEP) or low literacy takes more time and additional resources to ensure patients receive the appropriate level of care. Language barriers are often complicated by cultural differences.

Effective communication can overcome most challenges.

PATIENT CHALLENGES

Patients often encounter the following basic types of problems:

- Lack of awareness of existing services and how to access them.
- Inability to communicate adequately with providers and staff at all points within the health care delivery system.
- Low patient satisfaction with the health care system
- Fear-that can lead to reluctance to return to the health care setting for further treatment and follow-up care.

Research shows that even when LEP patients can access health care, health care quality may be diminished, and health outcomes may be poorer for them than for other patients.

PROVIDER CHALLENGES

Language barriers often cause health care providers challenges in the following tasks:

- In making an accurate diagnosis.
- In meeting informed consent responsibilities.
- In explaining care options
- In convincing NEP/LEP patients to allow patient care they may not understand.

LINGUISTIC COMPETENCY

A non-English speaking or LEP patient experiences language barriers during every health care encounter. Gaining access to care, reading forms, and understanding questions and directions present barriers from the outset.

Resources to support this capacity may include, but are not limited to, the use of:

- Trained medical interpreters;
- Bilingual/bicultural or multilingual/multicultural staff;
- Print materials in easy to read, low literacy (6^{th} to 8^{th} grade reading level), picture and symbol formats; i.e. signage such as a Medical Visual Translator.

Instructor/Facilitator:

Say the followings words.

***Enfermedad; pronounced* En·fer·medad *(can* refer to an illness, sickness or disease.)**

***Dolor pronounced doe lure* means "pain." "It can refer to either physical or mental pain.**

Stoy enfermo/enferma* means "I am sick." Following standard grammar rules, a man would use *enfermo* while a woman would use *enferma.

Síntoma pronounced sin tow ma = Symptom

In a medical setting, *consultorio (pronounced conult ore eo)* can mean "doctor's office" or "surgery." In other contexts, it can refer to another office or a consultancy.

https://www.fluentu.com/blog/spanish/spanish-medical-terms/

Ask the group what you just said. Language can be a huge barrier to health care.

USING INTERPRETERS

Good care means having good communication. Trained medical interpreters are the best resource to have available. Providers need to know the proper way to work with interpreters in the medical encounter**.**

When a patient has limited ability to speak English, it is nearly impossible for even the most skilled clinician to provide high-quality healthcare services without accurate interpreting performed by a trained, qualified and credentialed interpreter who has a working knowledge of medical terminology and medical systems. **If family members, friends or staff who are not trained as health care interpreters try to interpret in health care settings, errors in understanding and/or communication are more likely to occur, posing grave risks to the patient and immense liability to the healthcare provider or institution.**

Interpreters may also be asked to work with other individuals, such as family members or a patient representative, and they serve to help provide cultural information to facilitate support for a treatment plan.

Health care interpreters often render sight translation of basic health care documents by orally translating a written document into the patient's language. Health care interpreters may also interpret over the phone (OPI-over the phone or telephonic interpreting) or through video (VRI-video remote interpreting).

Many health care interpreters perform their work over the telephone or using video technology. Due to limited resources, particularly in rural areas and/or when specific language needs arise for Languages of Lesser Diffusion (LLDs) such as indigenous languages, telephonic interpreting is an industry that has seen considerable growth in the past few years. Throughout the United States, interpreters are key and highly valued members of the health care team.

OTHER LANGUAGE CHALLENGES

Patients and families often encounter the following basic types of problems:

- Inappropriate follow-up care and
- medication dosing.

Instructor/Facilitator:

Ask the following questions to facilitate discussion.

Do you know the Translator System your service or facility uses?

Do you know how to access this service?

Do you know if your service/facility has multi-lingual staff?

Have you looked at your health information (brochures, instructions, etc.)? If possible have some rxamples to share.

Are they understandable?

Does your service/facility collaborate with the community to offer Cultural Trainings?

Effective Communication Is Essential in The Health Care Encounter

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2.7 Understanding Montana's Population

Instructor/Facilitator: Read the Objective. Have the class members discuss issues that arise in their demographic areas.

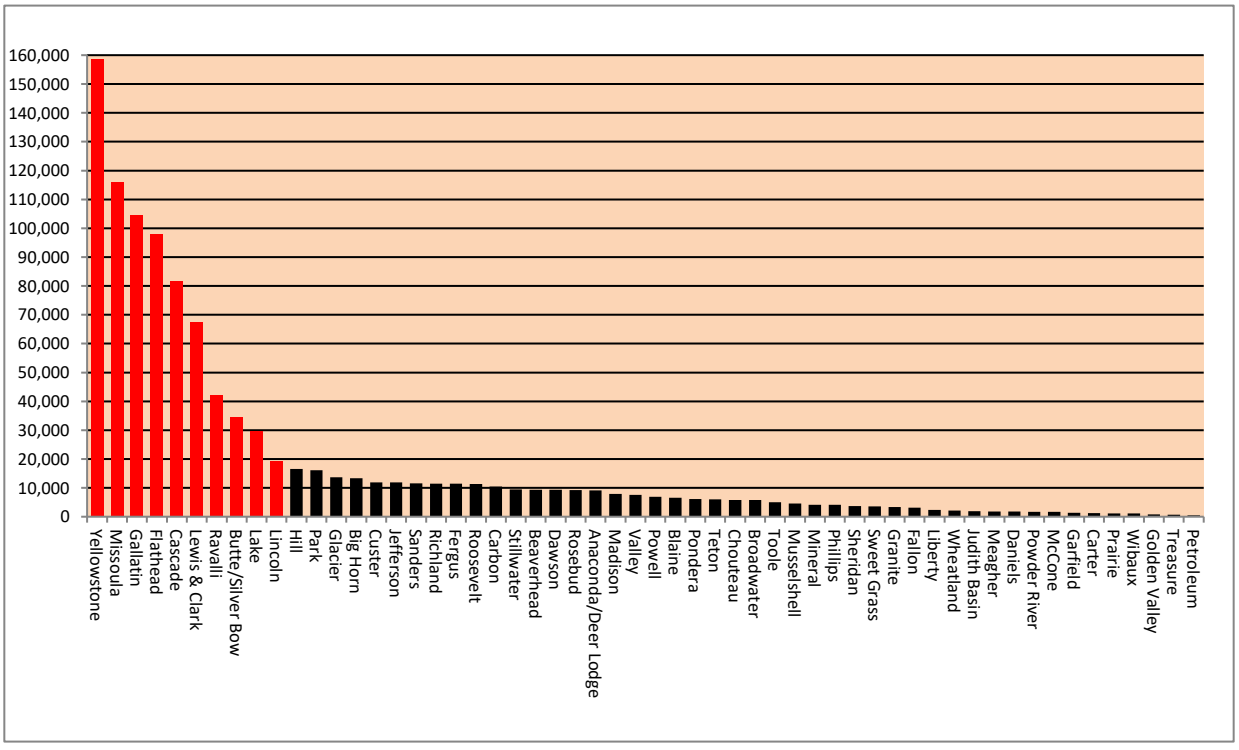
Objective:

To offer the best healthcare to our children and families, we must understand the diversity, geography, and populations of our State.

Montana has a diverse and dynamic population. Based on data from 2017, Montana has **10 counties out of a total of 56, that account for 72% of the total population**. What that means is that the remaining 46 counties have the sparest density of population, making the provision of high-quality healthcare services difficult at best. This distribution is shown on the graph below.

As can be seen by this graph, most of Montana's 56 counties have relatively sparse population, but have significant square miles in each, making the delivery of emergency services a much more acute situation. The 10 counties depicted in **RED** constitute 72% of the total population of the state.

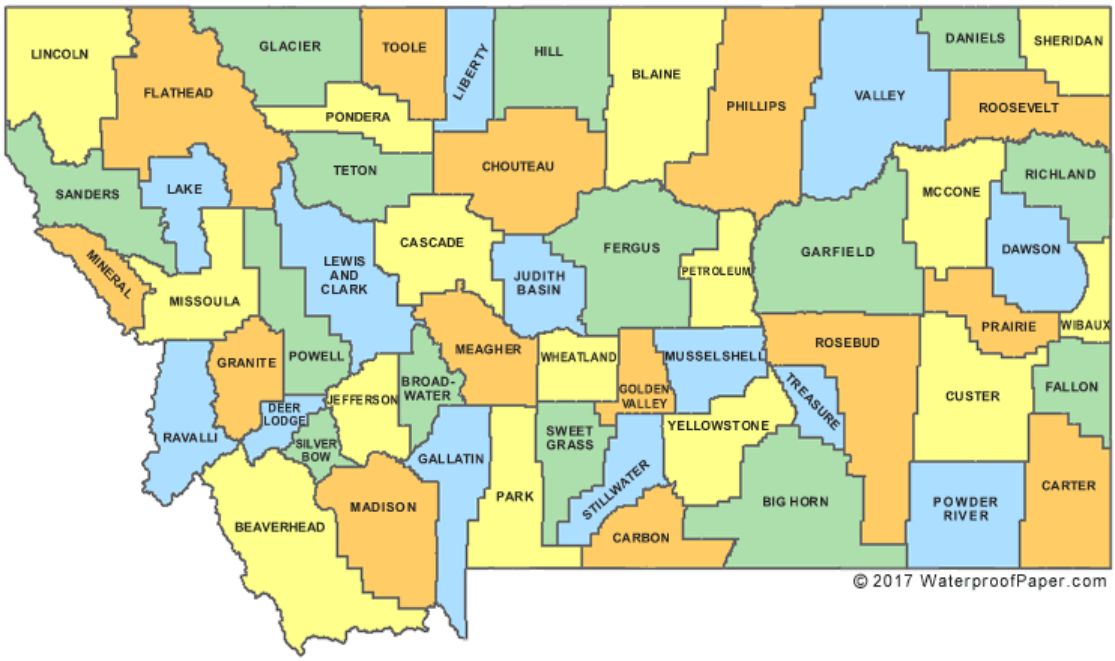
MONTANA POPULATION DISTRIBUTION BY COUNTY



Montana Population Density -- portions of Montana are classified as “Frontier”.

Montana Population/Area Overview						
County	County Seat	Population	% of Population	Total Area, Sq. Miles	Overall % of State Sq. Miles	Population Density
Yellowstone	Billings	158,437	15.20%	2,648.8	23	60
Missoula	Missoula	116,130	11.14%	2,618.1	25	44.4
Gallatin	Bozeman	104,502	10.02%	2,634.0	24	39.7
Flathead	Kalispell	98,082	9.41%	5,255.5	2	18.7
Cascade	Great Falls	81,755	7.84%	2,711.4	21	30.2
Lewis & Clark	Helena	67,282	6.45%	3,497.9	14	19.2
Ravalli	Hamilton	42,088	4.04%	2,400.5	26	17.5
Butte/Silver Bow	Butte	34,553	3.31%	718.6	56	48.1
Lake	Polson	29,758	2.85%	1,653.8	44	18.0
Lincoln	Libby	19,259	1.85%	3,675.1	12	5.2
Hill	Havre	16,542	1.59%	2,916.5	18	5.7
Park	Livingston	16,114	1.55%	2,813.3	19	5.7
Glacier	Cut Bank	13,694	1.31%	3,035.8	17	4.5
Big Horn	Hardin	13,343	1.28%	5,016.3	6	2.7
Custer	Miles City	11,924	1.14%	3,793.0	11	3.1
Jefferson	Boulder	11,853	1.14%	1,659.3	43	7.1
Sanders	Thompson Falls	11,534	1.11%	2,790.0	20	4.1
Richland	Sidney	11,482	1.10%	2,104.1	32	5.5
Fergus	Lewistown	11,413	1.09%	4,350.4	8	2.6
Roosevelt	Wolf Point	11,305	1.08%	2,368.3	29	4.8
Carbon	Red Lodge	10,460	1.00%	2,061.6	33	5.1
Stillwater	Columbus	9,406	0.90%	1,806.7	38	5.2
Beaverhead	Dillon	9,401	0.90%	5,573.2	1	1.7
Dawson	Glendive	9,327	0.89%	2,383.5	28	3.9
Rosebud	Forsyth	9,287	0.89%	5,025.4	5	1.8
Anaconda/Deer Lodge	Anaconda	9,085	0.87%	741.2	55	12.3
Madison	Virginia City	7,924	0.76%	3,603.4	13	2.2
Valley	Glasgow	7,539	0.72%	5,061.7	4	1.5
Powell	Deer Lodge	6,858	0.66%	2,332.7	30	2.9
Blaine	Chinook	6,601	0.63%	4,238.6	9	1.6
Pondera	Conrad	6,084	0.58%	1,641.6	45	3.7
Teton	Choteau	6,056	0.58%	2,292.0	31	2.6
Chouteau	Fort Benton	5,759	0.55%	3,996.7	10	1.4
Broadwater	Townsend	5,747	0.55%	1,237.9	50	4.6
Toole	Shelby	4,977	0.48%	1,944.6	34	2.6
Musselshell	Roundup	4,589	0.44%	1,871.5	35	2.5
Mineral	Superior	4,184	0.40%	1,223.4	51	3.4
Phillips	Malta	4,133	0.40%	5,211.7	3	0.8
Sheridan	Plentywood	3,648	0.35%	1,704.2	41	2.1
Sweet Grass	Big Timber	3,623	0.35%	1,862.2	37	1.9
Granite	Phillipsburg	3,368	0.32%	1,732.8	40	1.9
Fallon	Baker	3,120	0.30%	1,622.5	46	1.9
Liberty	Chester	2,409	0.23%	1,447.1	47	1.7
Wheatland	Harlowton	2,117	0.20%	1,427.5	48	1.5
Judith Basin	Stanford	1,940	0.19%	1,870.5	36	1.0
Meagher	White Sulphur Springs	1,827	0.18%	2,394.7	27	0.8
Daniels	Scobey	1,755	0.17%	1,426.5	49	1.2
Powder River	Broadus	1,746	0.17%	3,298.8	16	0.5
McCone	Circle	1,700	0.16%	2,682.1	22	0.6
Garfield	Jordan	1,310	0.13%	4,849.2	7	0.3
Carter	Ekalaka	1,203	0.12%	3,348.1	15	0.4
Prairie	Terry	1,182	0.11%	1,742.3	39	0.7
Wibaux	Wibaux	1,093	0.10%	889.1	54	1.2
Golden Valley	Ryegate	831	0.08%	1,175.3	52	0.7
Treasure	Hysham	692	0.07%	984.5	53	0.7
Petroleum	Winnett	489	0.05%	1,674.5	42	0.3
		1,042,520	**100%**	**147,040.0**		

MONTANA MAP BY COUNTY



MONTANA TRAUMA REGIONS

Instructor/Facilitator Questions to Ask:

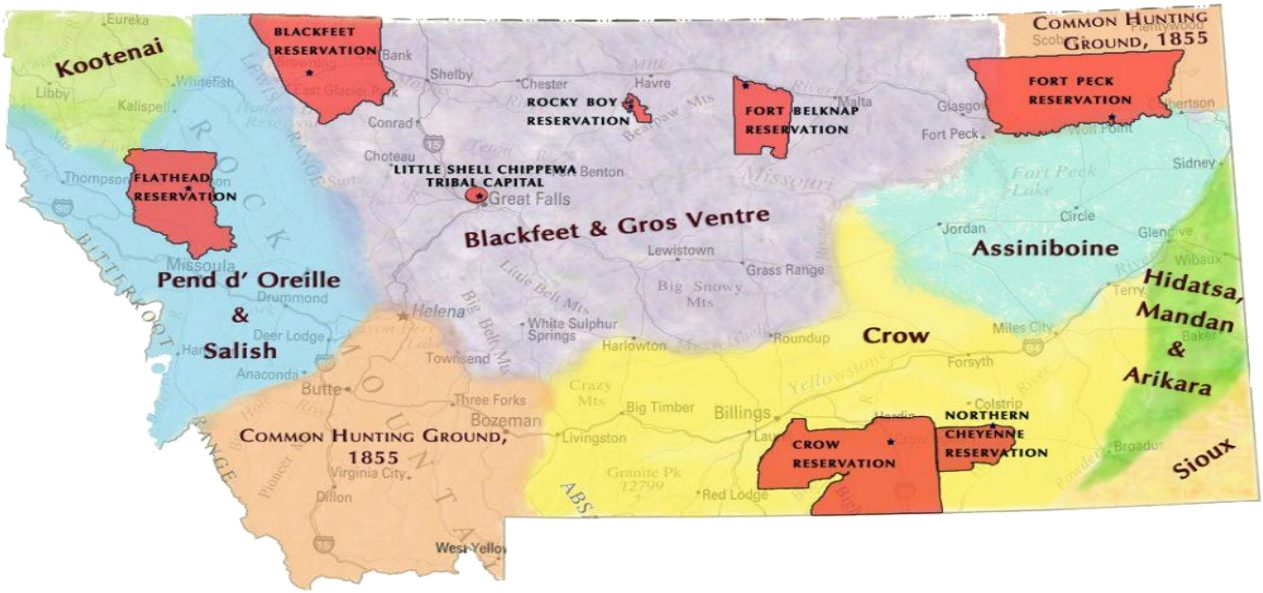
- **What is your counties' population?**
- **What difficulties does your service or facility have due to the rural nature of your county?**
- **What is your average transport time?**
- **What are the possible impacts for a "low density" population area regarding transfer of patients to a larger facility.**
- **How can Trauma Region groups assist in meeting the demands of rural Montana challenges?**
- **How do we meet challenges is providing the right care at the right time with the right resources in less dense counties?**

2.8 Native American Population

Instructor/Facilitator: Montana's constitutional requirement and duly enacted policy require recognition of the distinct and unique cultural heritage of American Indians and a commitment in our educational goals to preserve their cultural heritage. The Office of Public Instruction ensures this provision.

Every Montanan, whether Indian or non-Indian, should be encouraged to learn about the distinct and unique heritage of American Indians in a culturally responsive manner to ensure we all have the knowledge, tools and resources necessary.

ASK THE GROUP IF THEY CAN NAME ALL 7 NATIVE AMERICAN RESERVATIONS IN MONTANA.



THERE ARE SEVEN NATIVE AMERICAN RESERVATIONS LOCATED IN MONTANA.

BLACKFEET

- US Bands: Blackfoot/Blackfeet/Amskapi Piikani
- Canadian Bands: Peigan: Northern Peigan and Southern Peigan, Blood, Blackfoot/ Siksika

CROW, APSAALOOKE

FORT BELKNAP

- Gros Ventre-White Clay People-Aaniiih
- Assiniboine (Nakoda)

FORT PECK

- Assiniboine
- Nakota

ROCKY BOY

- Chippewa
- Cree

NORTHERN CHEYENNE

SALISH-KOOTENAI

- Salish
- Kootenai
- Pend d'Orielle

LITTLE SHELL TRIBE/BAND OF CHIPPEWA (Received Federal recognition in 2019.)

TRIBAL HEADQUARTERS

Blackfeet Nation --	(406) 338-7521
Chippewa Cree Tribe--	(406) 395-5705
Crow Nation --	(406) 638-3708
Confederated Salish & Kootenai Tribes --	(406) 675-2700
Fort Belknap Assiniboine & Gros Ventre Tribes-	(406) 353-2205
Fort Peck Assiniboine & Sioux Tribes -	(406) 768-2300
Little Shell Chippewa Tribe -	(406) 315-2400
Northern Cheyenne Tribe	(406) 477-6284

FOR MORE INFORMATION, YOU CAN CONTACT:

Governor's Office of Indian Affairs
State Capitol Building
2nd Floor, Room 202
PO Box 200801
Helena, Montana 59620
P (406) 444-3702
F (406) 444-1350
website: tribalnations.mt.gov
email:oia@mt.gov

For fast facts on the tribes, reservations and their economy, and tribal councils, please see the links below:

- https://tribalnations.mt.gov/tribalnations
- Blackfeet Tribe of the Blackfeet Reservation
- Chippewa Cree Tribe of the Rocky Boy's Reservation
- Confederated Salish & Kootenai Tribes of the Flathead Reservation
- Crow Tribe of the Crow Reservation
- Fort Belknap Tribes of the Fort Belknap Reservation
- Fort Peck Tribes of the Fort Peck Reservation
- Little Shell Chippewa Tribe (state recognized)
- Northern Cheyenne Tribe of the Northern Cheyenne Reservation

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2.8.1 TRIBAL BACKGROUND INFORMATION

Instructor/Facilitator: This section discusses in detail the Tribal Nations in Montana.

Native Americans and Alaska Natives in the United States today. That's about 1.5 percent of the population. According to an American Community Survey, the Native American population in Montana is 64,643 – at 6.2% of the total population of Montana.

A brief description for each of the tribes is depicted below.

BLACKFEET: (*Niitsitapi)*
Approximately 15,560 enrolled tribal members, with 7,000 living on or near the reservation. Nearly 27% of enrolled members are of three-fourths or greater Indian blood. The Blackfeet Indians are commonly thought to have acquired their name because of the characteristic black color of their moccasins, painted or darkened with ashes. The Blackfeet are the largest and most dominant Indian tribe in Montana. The Blackfeet are members of the Algonquin linguistic group.

The Blackfeet Nation has been described as a confederacy of three semi-independent tribes: Piegan, Bloods and North Blackfeet.

The South Piegan (Blackfeet or Piikani), the Blood (or Kainai), the North Piegan, and the North Blackfoot (or Siksika). They traditionally called each other Niitsitapii, or "Real People."

LOCATION: This confederation traditionally occupied the northwest portion of the Great Plains from the northern reaches of the Saskatchewan River of western Saskatchewan and southern Alberta, Canada, to the Yellowstone River in central Montana including the headwaters of the Missouri River. The Northern Blackfoot live farthest north, the Blood and North Piegan in the middle just north of the Canadian border, and the South Piegan (Blackfeet) furthest south along the eastern edge of the Rocky Mountains in northern Montana.

The Blackfeet Reservation is in northwestern Montana along the eastern slopes of the Rocky Mountains. Its one-and-a-half million acres are bordered on the north by Canada and on the west by Glacier National Park. The reservation encompasses 1,462,640 acres with 555,00 owned by non-Indians. The remainder is either allotted to tribal members or is owned by the Blackfeet Tribe.

LEADERSHIP: The confederation had more than one tribal leader. Each tribe consisted of several hunting bands, which were the primary political units of the tribe. Each of these bands was headed by a war leader and a civil leader, the former chosen because of his reputation as a warrior, and the later chosen because of his eloquent oratory.

Each band could range from 10 to 30 lodges or 80 to 240 people. The band was the basic unit of organization for hunting and defense. Once the Blackfeet obtained horses, they vigorously broadened their territory by pushing other tribes such as the Kootenai, Flathead and Shoshone west of the Continental Divide. Their hunting lands soon covered an enormous landscape. By the early 1800s, they were doing battle with most tribes who ventured into the Northern Great Plains. It is estimated their numbers exceeded 15,000, and this size, coupled with their warrior skills, struck fear in the hearts of all who encountered them.

SOCIETIES: Members of the religious society protected sacred Blackfoot items and conducted religious ceremonies. They blessed the warriors before battle. Their major ceremony was the Sun Dance, or Medicine Lodge Ceremony. By engaging in the Sun Dance, their prayers would be carried up to the Creator, who would bless them with well-being and abundance of buffalo.

Women's societies also had important responsibilities for the communal tribe. They designed refined quillwork on clothing and ceremonial shields, helped prepare for battle, prepared skins and cloth to make clothing, cared for the children and taught them tribal ways, skinned and tanned the leathers used for clothing and other purposes, prepared fresh and dried foods, and performed ceremonies to help hunters in their journeys.

In the Blackfoot culture, men were responsible for choosing their marriage partners, but women had the choice to accept them or not. The male had to show the woman's father his skills as a hunter or warrior. If the father was impressed and approved of the marriage, the man and woman would exchange gifts of horses and clothing and were considered married. The married couple would reside in their own tipi or with the husband's family. Although the man was permitted more than one wife, typically he only chose one. In cases of more than one wife, quite often the male would choose a sister of the wife, believing that sisters would not argue as much as total strangers.

Within the Blackfoot nation, there were different societies to which people belonged, each of which had functions for the tribe. Young people were invited into societies after proving themselves by recognized passages and rituals. For instance, young men had to perform a vision quest, begun by a spiritual cleansing in a sweat lodge. They went out from the camp alone for four days of fasting and praying. Their main goal was to see a vision that would explain their future. After having the vision, a youth returned to the village ready to join society. In a warrior society, the men had to be prepared for battle.

CEREMONIES: Sage and sweet grass are both used by Blackfoot and other Plains tribes for ceremonial purposes and are considered sacred plants. Sage and sweet grass are burned with the user inhaling and covering themselves in the smoke in a process known widely as smudging. Sage is said to rid the body of negative emotions such as anger. Sweet grass is said to draw in positive energy. Both are used for purification purposes. The pleasant and natural odor of the burning grass is said to attract spirits. Sweet grass is also often present

and burned in pipe-smoking mixtures alongside bearberry and red willow plants. The smoke from the pipe is said to carry the user's prayers up to the creator with the rising smoke.

MEDICAL: Large medicine bags often decorated with ornate beaded designs were used by medicine men to carry sage, sweet grass, and other important plants. Blackfoot also used sweet grass smoke, or sachets of sweet grass in their clothing, as an effective insect repellent. They apply a poultice of chewed roots Asclepias viridiflora to swellings, to rashes, to the sore gums of nursing infants, sore throats and to irritated eyes. Plants were used for food and as a flavoring. They make use of Viola adunca, applying an infusion of the roots and leaves to sore and swollen joints, giving an infusion of the leaves and roots to asthmatic children, and using the plant to dye their arrows blue.

The creation myth is part of the oral history of the Blackfoot nation. Many myths or legends provide oral history to the tribal members.

ECONOMY: A manufacturing plant on the reservation produces pencils, pens and markers. Major uses of the land are ranching and farming. The principle crops are wheat, barley and hay.

The Tribe has wildlife resources; with a diversity of deer antelope, mountain goat black and grizzly bear, mountain lion, bighorn sheep, trout, salmon, grayling and northern pike.
The Tribe has diverse resources, ranging from gas, coal, oil, water and wind energy.

The Tribe operates campgrounds, capitalizing on the annual tourist visitation to Glacier National Park and the Tribes beautiful mountains and landscape. More than 2.3 million people drive through the reservation each year while visiting Glacier National Park.

The Tribe highlights their culture through the celebration of the North American Indian Days in July and other celebrations throughout the summer months; including rodeos.

CONFEDERATED SALISH AND KOOTENAI TRIBES

Salish: *(Se'lic)*

Pend D'Oreille: *(Ql'ispe')*

Kootenai: *(ḱupawi¢Q̓nuk or Ksanka)*

The Flathead Indian Reservation is home to three tribes, the Bitterroot Salish, Upper Pend D'Oreille, and the Kootenai.

The subsistence patterns of our Tribal people developed over generations of observation, experimentation and spiritual interaction with the natural world, creating a body of knowledge about the environment closely tied to seasons, locations and biology. This way of life was suffused with rich oral history and a spiritual tradition in which people respected the animals, plants and other elements of the natural environment. By learning from Elders and teaching the children, Tribal ways of life continue today.

LOCATION: The territories of these three tribes covered all western Montana and extended into parts of Idaho, British Columbia and Wyoming. Today, location consists of North of Interstate 90 between Missoula and Kalispell, fertile valleys, Flathead Lake and towering mountain peaks of northwestern Montana surround the Flathead Reservation. The reservation comprises over 1.2 million acres.

LAND OWNERSHIP: The wording of the treaty was such that the tribes "conditionally" lived on the reservation, but would retain their rights to hunt, gather, and fish on their aboriginal land. Land ownership was a foreign concept to the tribes, and since the treaty wording did not give the tribes total ownership of the reservation, the reservation was opened for settlement to non-tribal members under the Allotment (Dawes Act of 1887). After relinquishing most of the land to the U.S. Government that was granted to them through treaty, it was further subdivided and auctioned off to non-Indian people. The Hellgate Treaty of 1855 established the Flathead Reservation, but over half a million acres passed out of Tribal ownership during land allotment that began in 1904. Today, land ownership and people on the Flathead Reservation consist of mostly non-Indians.

THE PEOPLE:
Today the Flathead Indian Reservation is home to the Confederated Salish and Kootenai tribes. The tribes are a combination of the Salish, the Pend D'Oreille and the Kootenai. Of the approximately 7,753 enrolled tribal members, about 5,000 live on or near the reservation.

The Salish and Pend D'Oreille practice similar culture, traditions and the same Salish language.

ECONOMY:
The principle sources of income for the tribes are derived from its timber industry sales and from revenues paid to the tribes through the co-license for the Kerr Dam facility with Montana PPL. The tribes also operate a full-service resort and casino in Polson, which is overseen by S&K Gaming, a tribal corporation. The Tribes also operate S&K Electronics, which manufactures various computer components and circuits, S&K Technologies, and S&K

Holding, which operates several revenue producing enterprises as well as offering business loans to tribal members.

TRIBAL GOVERNMENT:
The Confederated Salish & Kootenai Tribal Council consists of ten councilmen and women elected from the following eight districts: Jocko Valley, Mission Districts, Ronan, Pablo, Polson, Elmo-Dayton, Hot Springs-Camas Prairie, and Dixon. Council members serve four-year staggered terms. Elections are held in October and December of every other year. The Chair serves at the Chief Executive Officer of the tribe. The council upholds the Tribal constitution and By-Laws for the Confederated Salish & Kootenai Tribes.

POINTS OF INTEREST:
Cultural Center "The People's Center." For thousands of years the Salish, Pend D'Oreille and the Kootenai have inhabited lands that eventually became western Montana and the surrounding region. The People's Center tells the story of these tribes through a museum, an exhibit gallery, educational programs and a quality gift shop.

The National Bison Range/Pablo National Wildlife Refuge. Approximately 500 readily visible bison roam nearly 20,000 acres of natural grassland. The wildlife refuge also is home to elk, bighorn sheep, antelope and deer.

St. Ignatius Mission. Established in 1854, the mission was built by Native Americans under the direction of Catholic missionaries. There are 58 original murals by Brother Joseph Carignano on its walls and ceiling. The Mission Range of mountains provides a striking backdrop for the mission.

Salish Kootenai College. The college offers two- and four-year degrees, college attendees are both tribal and non-tribal members of the communities. The college is home to a nine-hole executive golf course, Silver Fox.

CROW TRIBE: *(Apsaaalooke)*

HISTORY:
The origin of the name Crow, came from the Hidatsa, a neighboring tribe donning them "children of the large-beaked bird". Upon contact with the French Canadians, they were termed "handsome men. Prior to European colonization, the ancestral homeland of the Crow was in and around the Ohio and Great Lakes regions of the United States. The Crows ultimately settling Wyoming, North Dakota and Montana, historically they have lived in the Yellowstone River valley.

The Crow have come to be known for their agricultural skills and artistic creations. The Crow are skilled horse trainers. Crow Fair was started to share the abundance of the crops and provide social gathering of the Tribes, clans and surrounding neighbors.

LOCATION: Pre-reservation, the Crow's territory stretched from Yellowstone National Park and the headwaters of the Yellowstone River or "Elk River" in the west, north to the Musselshell River, then northeast to the Yellowstone's mouth at the Missouri River, then southeast to the confluence of the Yellowstone River and Powder River, south along the South Fork of the Powder River and westward in the southwest by the Wind River Range. The Crow migrated and searched for game for fur trade, bison for substance and horses for transportation. The migration placed tribes overlapping hunting areas and could cause enemies.

Currently the reservation stretches across south-central Montana is a large reservation covering approximately 2,300,000 acres (9,300 km2) of land area, the fifth-largest Indian reservation in the United States. The reservation is primarily in Big Horn and Yellowstone counties with ceded lands in Rosebud, Carbon, and Treasure Counties.

The 2000 census reported a total population of 6,894 on reservation lands. Its largest community is Crow Agency. The tribal headquarters in located at Crow Agency Montana. The Crow tribe has an elected Tribal Chairman and Tribal council, representing districts of the reservation.

CLAN SYSTEM:
The clan system is one of the religions, providing for social control (building character, install morale, self-esteem, respect and motivates self-control. The Crow are matrilineal (descent through the maternal line) typically the husband will move with the wife's family. Women hold significant roles within the tribe. The Crow Tribe has thirteen original clans; coinciding with lunar months of the year: Cropped Eared Pets, Furious Pets, Hairy Hide Lodges, Ties the Bundle, Brings Game Without Shooting, Dung Eaters, Big Lodge, Newly Made Lodges, Prairie Dog Do Gooders, Disputed Coups, Treacherous Lodge and Greasy Mouth.

SPIRITUALITY, MYTHOLOGY AND RELIGION:
The Crow mythology includes small beings known as the Little People. They are respected and thought of as tricksters. Crow mythology shares stories of the old coyote trickster spirit, teaching generations stories of creation and life lessons.

The sweat lodge provides purification and healing powers. Prayers are offered during the sweat four or more times and may continue before the seat lodge door is opened. The pipe

may be included in the ceremony utilizing tobacco or bear root. In the Crow tradition, one must earn the right to carry the pipe; it is not inherited. While the pipe is being smoked, the pipe must not touch the ground or be rotated. Traditionally, women do not take part in the pipe ceremonies.

Thousands of years ago, the Crow were farmers, hunters and fisherman. Upon the introduction of the horse, the Crow followed the buffalo and other game. During this time, the Crow adopted the tepee. The Crow are among the few that use four poles in the base structure, with the opening facing east.

LEADERSHIP:
Leadership, trust and respect are earned. The Crow War Bonnet may have one or two tails depending on the achievement of the owner. There are certain restrictions in respect of sacred items and the eagle feather war bonnet.

Honor was given through leading a successful war party, touching the live enemy with the bare hand or with a coup stick, capturing the enemies weapon while under fire, to sneaking into an enemy camp and taking horses.

War societies and the Sacred Tobacco Society are important in Crow tradition; historically and today.

FORT BELKNAP: GROS VENTRE *(ANIIIH)* & ASSINIBOINE *(NAKODA)*

LOCATION:
The Fort Belknap Reservation and additional tribal lands encompass 650,000 acres of the plains and grasslands of northcentral Montana. Its headquarters is located just south of the small town of Harlem, Montana. Stat., L., XXV, 113), the Blackfeet, Gros Ventre and Assiniboine tribes ceded 17,500,000 acres of their joint reservation and agreed to live upon three smaller reservations. These are now known as the Blackfeet, Fort Peck and Fort Belknap Reservations. Fort Belknap was named for William W. Belknap, who was Secretary of War.

HISTORY:
The reservation is the homeland of the Assiniboine and Gros Ventre people. Established in 1888, the reservation is what remains of the vast ancestral territory of the Blackfeet and Assiniboine Nations.

The Gros Ventre, as members of the Blackfeet confederacy, and the Assiniboine Nation signed the Fort Laramie treaties of 1851 and 1855 with the United States Government establishing their respective territories within the continental United States. The Fort Belknap Reservation is part of what remains of these two nations ancestral territory that included all central and eastern Montana and portions of western North Dakota. The Blackfeet, and Fort Peck Indian Reservations are also part of this territorial boundaries.

Gros Ventre
Today the Gros Ventre are a federally recognized Tribe with 4,000 enrolled members, which also includes the Assiniboine, who were once the historical enemies of the Gros Ventre tribe.

The Gros Ventre people call themselves the Haaninin or “white clay people”, also spelled A’aninin. The French called them Gros Ventres or a translated as “fat bellies”, misinterpreting a physical sign for waterfall; and the English called them the Fall Indians, related to waterfalls in the mountains. The Blackfoot referred to them as the Piik-siik-sii-naa (“snakes”) or Atsina (“like a Cree”), because of years of enmity. They were allied with the Blackfeet Confederacy from circa 1793 to 1861 but came to disagreement and were enemies of it thereafter.

GROS VENTRE HISTORY:
The Gros Ventre Tribe of Montana is a tribe of the Northern Plains Indigenous group, located in North central Montana. They live on the Fort Belknap Reservation, which is shared with the Assiniboine tribe. The Gros Ventre live primarily in the south end of the reservation, near the Little Rocky Mountains.

The Gros Ventre, as far as anyone can tell, were once closely affiliated with the Algonquin speaking Arapaho and Cheyenne. It is said that all three tribes together were among the last to migrate into Montana. After they migrated to Montana, the Arapaho moved southwards to the Wyoming and Colorado area. The Cheyenne who migrated with the Gros Ventre and Arapaho also migrated on. Some went to the Oklahoma area, and some stayed in the Tongue River valley. Each tribe was separate by the time of the signing of the Treaty of Fort Laramie.

The earliest known contact of Gros Ventre with whites was around 1754. This contact placed them between the north and south forks of the Saskatchewan River. Exposure to smallpox

reduced their numbers during this time. Around 1793, in response to attacks by well-armed Cree and Assiniboine, Gros Ventre burned two Hudson Bay Company trading posts. These trading posts were providing guns to the Cree and Assiniboine tribes in what is now present-day Canada. In 1826, the Gros Ventre made contact with the German explorer and naturalist, Prince Maximilian. Along with the naturalist painter, Karl Bodmer, they painted portraits and recorded their meeting with the Gros Ventre, near the Missouri River in Montana.

The Gros Ventre, after their migratory break from the Arapaho, were next closely associated with the Blackfeet. It is from this point that most of what is known about the Gros Ventre is found. After joining up with the Blackfeet, the Gros Ventre roamed north central Montana and southern Canada.

In 1855, Isaac Stevens, Governor of the Washington Territory, concluded a treaty (Stat., L., XI, 657) to provide peace between the United States and the Blackfeet, Flathead and Nez Perce Tribes. The Gros Ventre signed the treaty as part of the Blackfeet Nation, whose territory became common hunting grounds for all signatories, including the Assiniboine. In 1868, the United States government established a trading post called Fort Browning near the mouth of Peoples Creek on the Milk River. This trading post was originally built for the Gros Ventre and Assiniboine, but because it was built on a favorite hunting ground of the Sioux, it was abandoned in 1871.

In 1876, the fort was discontinued and the Gros Ventre and Assiniboine receiving annuities at the post were instructed to go to the agency at Fort Peck and Wolf Point. The Assiniboine did not object to going to Wolf Point and readily went about moving; but the Gros Ventre refused to go. If they did, they would come into contact with the Sioux, with whom they could not ride together in peace. They forfeited their annuities rather than move to Fort Peck.

In 1878, the Fort Belknap Agency was re-established, and the Gros Ventre, and remaining Assiniboine were again allowed to receive supplies at Fort Belknap. It was at this site that the Fort Belknap reservation was established, in 1888. By an act of Congress on May 1, 1888, (In 1884, Gold was discovered in the Little Rocky Mountains. Pressure from miners and mining companies forced the tribes to cede sections of the mountains in 1885. Jesuits came to Fort Belknap in 1862 to convert the Gros Ventre people to Catholicism. In 1887, St. Paul's Mission was established at the foot of the Little Rocky Mountains, near Hays. Much of the traditional ceremonies were lost through the course of time following the establishment of the mission. However, the two sacred pipes, The Feathered Pipe and The Flat Pipe remain central to the traditional spiritual beliefs of the Gros Ventre people.

They are Algonquian speaking. They are related to the Arapahoe and closely associated with the Cheyenne. Aboriginally, the Gros Ventre were divided into 12 bands, each of which was led by a chief who usually made decisions in consultation with other male members of the band. Chiefs were awarded their status because of their prowess in war. In winter, the bands usually camped separately but came together in the spring and fall for large buffalo hunts and various ceremonies. They subsided primarily on buffalo but also hunted deer, elk, and antelope, and the women collected berries, fruits, and roots.

SOCIETY:
Historically, young girls were given in marriage before puberty to older men, but the marriage was usually delayed until the girls were about 20 years old. Polygyny was common, as was

divorce, which was usually initiated by the husband. Most women married three or four times during their lifetime. Children belonged to the band of his or her father.

At adolescence, boys entered one of the age-graded societies and became a member of either the Star Society or the Wolf Society, each of which had peacekeeping and social functions. At death, the individual had a scaffold burial, in a tree or in a cave, with some personal possessions. The Flat Pipe and Feathered Pipe Rites were important Ceremonies, with personal supernatural powers and visions also significant.

The Assiniboine refer to themselves as “Nakoda” meaning the generous ones. This tribe split with the Yanktonai Sioux in the seventeenth century and migrated westward onto the northern plains with their allies, the Plains Cree. “Assiniboine” is a Chippewa word meaning, “One who cooks with stones.” The Assiniboine are located on both the Fort Belknap and Fort Peck Indian Reservations in Montanan and on several reserves in Saskatchewan and Alberta.

Today, the two Tribes are united as one government called the Fort Belknap Indian Community. Together, the tribes have formed and maintained a community that has deep respect for its land, its culture, and its heritage.

ASSINIBOINE

ASSINIBOINE HISTORY:

The Assiniboine are people of the northern Great Plains of North America who call themselves Nakoda or Nakota. To the Chippewa, they are known as AS’see’nee pai-tue (those who cook with stones). In Canada they are called the Stoney, in the United States they are known as the Assiniboine. Through years of separation, differences in dialect and custom have developed between the two branches. But they still remember their common origins and consider themselves a single people.

Origins, location, and language. Pierre Jean Desmet, a French Jesuit missionary of the early 19th centuries stated that the Assiniboine were once members of the Yanktonai band of Dakota (Sioux). The oral tradition of the Assiniboine, however, refutes that claim. According to oral history in all Assiniboine tribal bands, their origins are Algonquian. Scholars of Assiniboine descent have been involved in research in the area since the mid-1970s.

Tribal oral history states that the Assiniboine originated in the Lake of the Woods and the Lake Winnipeg area of Canada and became allied with the Cree. In 1744, a division was noted, and “the people” divided again. Some bands moved west into the valleys of the Assiniboine and Saskatchewan Rivers in Canada, while others moved south into the Missouri Valley. The bands inhabited an area from the White Earth, Minnesota, region west to the Sweet Grass Hills of Montana. They also lived and roamed north of the U.S.-Canadian border to a line running east and west from Hudson Bay to the Rocky Mountains.

Thirty-three bands of Assiniboine have been identified. According to Edwin T. Denig, the Assiniboine returned to the Missouri region between 1800 and 1837, numbering about 1,200.

The Assiniboine language is a dialect of Dakota, a subdivision of the Siouan family. In many respects, it could be considered a simple language. A mini analysis was conducted by Ken Ryan, an Assiniboine from the Fort Peck Reservation, utilizing the International Phonetic

Alphabet. he developed a phonetic Assiniboine alphabet, and found that there are 26 phonemes, 20 consonants, and 6 vowels in the language.

ASSINIBOINE CULTURE:
The Assiniboine were typically large game hunters, dependent on the buffalo for a considerable part of their diet. They used buffalo hides for clothing and receptacles and lived in hide tipis. By about 1750 the Assiniboine hunting grounds embraces all the Canadian prairies. Both the Canadian and U.S. branches occasionally slaughtered entire herds by driving them into compounds. The meat was roasted on spits or boiled in hide bags by means of hot stones. The Assiniboine also made pemmican, which they traded or ate themselves. The dog was the only aboriginal domestic animal and was generally used to carry packs and pull travois, although the pups were sometimes eaten for religious purposes.

Most Assiniboine attached great importance to visions, and these took precedence in religious life. The elements of ceremonies and rites were performed individually or in groups. They included offerings, prayers, and the solemn unfolding of a pack containing sacred objects, and the singing of sacred songs. Tremendous importance was attached to the songs, which were repeated according to their mystic number. The Assiniboine considered sweating necessary purification before participation in any major ceremony. Their favorite incense for major ceremonies was made from sweet grass. Tobacco was, as a rule, reserved for ceremonies and other solemn occasions. The pipes were handed and passed according to definite tribal traditions.

The Assiniboine believed in great power- The Creator. They lived their religion every day. Therefore, they made sacrifices, fasts, and prayers to this unknown power, which they knew form actual phenomena had existence. mythological stories were told mainly for amusement. Most of them, however, contained a moral or ambiguous meaning and were interesting and imaginative.

FORT PECK: ASSINIBOINE *(NAKODA)* & **SIOUX** *(NAKATA)*

About 6,800 Assiniboine and Sioux live on the Fort Peck Reservation, with another approximately 3,900 tribal members living off the reservation. Fort Peck Reservation is home to two separate Indian nations, each composed of numerous bands and divisions. The Sioux divisions of Sisseton/Wahpeton, the Yanktonai, and the Teton Hunkpapa are all represented. The Assiniboine bands of Canoe Paddler and Red Bottom are represented.

HISTORY:
The Assiniboine are also known as the Stoney Indians, as they used heated stones to boil most of their food. In their own language, the Assiniboine call themselves the Nakota or Nakoda, which means “the allies.”

In the United States, the Assiniboine Indians live on two reservations, Fort Belknap and Fort Peck. A reservation is land that belongs to an Indian tribe and is under their control. The Assiniboine at Fork Belknap share a reservation with the Gros Ventre, and the Assiniboine at Fort Peck share a reservation with the with the Sioux.

Assiniboine women were in charge of the home. Besides cooking and cleaning, an Assiniboine woman built her family’s house and dragged the heavy posts with her whenever the tribe moved. The home belonged to the women in the Assiniboine tribe. Men were hunters and warriors, responsible for feeding and defending their families. Only men became Assiniboine chiefs, but both genders took part in storytelling, artwork and music, and traditional medicine.

The Fort Peck Reservation is home to two separate American Indian nations, each composed of numerous bands and divisions. The Sioux divisions of Sisseton, Wahpeton, the Yanktonai, and the Teton Hunkpapa are all represented. The Assiniboine bands of Canoe Paddler and Red Bottom are represented. The Reservation is located in the extreme northeast corner of Montana, on the north side of the Missouri River.

ASSINIBOINE HISTORY TIMELINE:
The Assiniboine lived in northwest Ontario, Saskatchewan and eastern Alberta. Living near Lake Superior the British and French made contact with the tribe and began trading with them. The Assiniboine became affiliated with the Cree. Southern Assiniboine acquire horses and began to move south. Assiniboine territory extended along the Missouri River in the area of northwestern North Dakota and northeastern Montana

LOCATION:
The Reservation is 110 miles long and 40 miles wide, encompassing 2,093,318 acres (approximately 3,200 square miles). Of this, approximately 378,000 acres are tribally owned, and 548,000 acres are individually allotted Indian lands. The total of Indian owned lands is about 926,000 acres. There are an estimated 10,000 enrolled tribal members, of whom approximately 6,000 reside on or near the Reservation. The population density is greatest along the southern border of the Reservation near the Missouri River and the major transportation routes, U.S. Highway 2 and the Amtrak routing on the tracks of the Burlington Northern Railroad. The Fort Peck Reservation is in northeastern Montana, 40 miles west of the North Dakota border and 50 miles south of the Canadian border, with the Missouri River defining its southern perimeter. It includes more than two million acres of land.

The new Fort Peck Indian Agency was established in 1871 to serve the Assiniboine and Sioux Indians. The Agency was located within the old stockade of Fort Peck, purchased from traders Durfee and Peck. In 1878, the Fort Peck Agency was relocated to its present-day location in Poplar because the original agency was located on a flood plain, suffering floods each spring.

Attempts by the U.S. government to take the Black Hills and bind the Sioux to agencies along the Missouri in the 1860s resulted in warfare, reopening the issues that had been central to the Great Sioux War (1866-68). As part of the Sioux agreed to come into agencies, part chose to resist. Army efforts to bring in the other Sioux (characterized as “hostiles”) led to battles in the Rosebud country and culminated in the Battle of the Little Bighorn in 1876.

As the victors dispersed, Sitting Bull led followers north into the Red Water country, where contact with the Sioux of Fort Peck Agency kept the Hunkpapa and assorted Tetons supplied. When military pressure increased, Sitting Bull led most of his followers into Canada in 1877. The military presence increased in an effort for Sitting Bull to surrender.

Camp Poplar (located at Fort Peck Agency) was established in 1880. Finally, without supplies and barely tolerated by Indians around present-day southern Saskatchewan, Sitting Bull came in to surrender at Fort Buford on July 19, 1881. Some of his Hunkpapa intermarried with others at Fort Peck and resided in the Chelsea community.

The early 1880s brought many changes and much suffering. By 1881, all the buffalo were gone from the region. By 1883/84, over 300 Assiniboine died of starvation at the Wolf Point sub-agency when medical attention and food were in short supply. Rations were not sufficient for needs, and suffering reservation-wide was exacerbated by particularly severe winters. The early reservation traumas were complicated by frequent changes in agents, few improvements in services, and a difficult existence for the agency’s tribes. Negotiations the winter of 1886-87 and ratified in the Act of May 1, 1888, established modern boundaries.

In 1887, Congress passed the Dawes Act, which provided the general legislation for dividing the tribally owned Indian reservations into parcels of land to be given to individuals. During the turn of the century, as the non-Indian proceeded to inhabit the boundary areas of the Reservation, the prime grazing and farmland areas situated within the Reservation drew their attention. As more and more homesteaders moved into the surrounding area, pressure was placed on Congress to open up the Fort Peck Reservation to homesteading.

Finally, the Congressional Act of May 30, 1908, commonly known as the Fort Peck Allotment Act, was passed. The Act called for the survey and allotment of lands now embraced by the Fort Peck Indian Reservation and the sale and dispersal of all the surplus lands after allotment. Each eligible Indian was to receive 320 acres of grazing land in addition to some timber and irrigable land. Parcels of land were also withheld for Agency, school and church use. Also, land was reserved for use by the Great Northern (Burlington Northern) Railroad. All lands not allotted or reserved were declared surplus and were ready to be disposed of under the general provisions of the homestead, desert land, mineral and townsite laws.

In 1913, approximately 1,348,408 acres of unallotted or tribal unreserved lands were available for settlement by the non-Indian homesteaders. Although provisions were made to sell the remaining land not disposed of in the first five years, it was never completed. Several additional allotments were made before the 1930s.

EDUCATION
The Reservation included a government boarding school program which was begun in 1877 and finally discontinued in the 1920s. Missionary schools were run periodically by the Mormons and Presbyterians in the first decades of the 20th century, but with minimal success.

The Fort Peck Reservation is served by five public school districts, which are responsible for elementary and secondary education. In addition, an independent post-secondary institution is located on the Reservation: Fort Peck Community College, which offers nine associate of arts, six associate of science, and ten associate of applied science degrees.

LEADERSHIP:
The Fort Peck Tribes adopted their first written constitution in 1927. The Tribes voted to reject a new constitution under the Indian Reorganization Act in 1934. The original constitution was amended in 1952, and completely rewritten and adopted in 1960. The present constitution remains one of the few modern tribal constitutions that still includes provisions for general councils, the traditional tribal type of government. The official governing body of the Fort Peck Tribes is the Tribal Executive Board, composed of twelve voting members, plus a chairman, vice-chairman, secretary-accountant, and sergeant-at-arms. All members of the governing body, except the secretary-accountant are elected at large every two years.

Tribal government consists of a Constitution & By-laws of the Fort Peck Assiniboine & Sioux Tribes of the Fort Peck Reservation. The Fort Peck Tribal Executive Board consists of a Chairman, a Vice-Chairman, a Secretary/Accountant, a Sergeant-at-Arms, and twelve (12) Board Members. All members of the governing body, except the secretary-accountant are elected at-large every two years.

ECONOMY:
A prosperous industrial park in Poplar is one of the largest employers in Montana. A variety of enterprises, including metal fabrication and production sewing, are housed here. Other industries, including an electronics manufacturer, flourish on the reservation. Farming, ranching and oil extraction also play a part in the reservation economy.

FORT PECK NAKOTA

The Nakota, also known as the Yanktonai or Yankton Sioux, split from the Dakota and moved to the prairies in the region that is now southeast South Dakota.

They were divided into three bands: Yankton who are now on the Yankton Reservation in South Dakota; the Upper Yanktonai who are split between the Standing Rock Reservation in South Dakota and the Devil's Lake Reservation in North Dakota; and the Lower Yanktonai who are split between the Crow Creek Reservation in South Dakota and the Fort Peck Reservation in Montana.

The name Sioux derives from the Chippewa word "Nadowessioux" which means "Snake" or "Enemy." The Sioux generally call themselves Lakota or Dakota, meaning "friends, allies, or to be friendly."

Though the Sioux were known as great warriors, the family was considered the center of Sioux life. Children were called “Wakanisha” which meant sacred and were the center of attention. While monogamy was most often practiced, Indian men were allowed to take on more than one wife. However, infidelity was punished by disfigurement.

The Sioux were a deeply spiritual people, believing in one all-pervasive god, Wakan Tanka, or the Great Mystery. Religious visions, music and dance were means to connect with the spirit world. Rituals of self-sacrifice, by inflicting slashes upon themselves or other self-inflicted wounds, asserted their identity as Indian warriors. This was also practiced by mourners during burial ceremonies.

War and battles were another underlying principle of the Sioux people because, through it, men gained prestige, and their prestige was reflected in the family honor.

POINTS OF INTEREST:

Fort Peck Assiniboine And Sioux Culture Center and Museum. Features The Culture Center and Museum features permanent exhibits of Assiniboine and Sioux heritage, arts and crafts.

FORT PECK COMMUNITY COLLEGE:

The college offers associate degrees in the Arts and Sciences, along with one-year certificates. There is a tribal law library on campus, and a cultural center is planne

LITTLE SHELL CHIPPEWA: *(Anishinaabe)*

HISTORY:
The Little shell Band of the Chippewa Indians are the newest federally recognized tribe; The President signed the order December 2019 giving federal recognition and the opportunity to have educational and health benefits.

The Little Shell Band is descended from the Pembina, one of dozens of bands of Chippewa, (Ojibwe) who followed the buffalo from the western Great Lakes across the Plains states. The Little Shell Band of Chippewa are a mixed-culture recombinant group — some having pure Chippewa ancestry, but the majority having mixed Ojibwe, Cree, Assiniboine, European and Metis heritage. Despite their varied ancestry, they were a cohesive group with its own cultural identity.

The mid-19th Century brought great change to the Chippewa. The fur trade, which had previously sustained them, now declined. Buffalo were quickly disappearing from the Plains while white settlers and the railroad were encroaching tribal lands. The U.S. government was working furiously to push Native Americans onto reservations or across the border into Canada.

The turning point for the Little Shell Pembina came in 1892, when Chief Little Shell, refused to sign the so-called “Ten Cent” treaty ceding nearly 10 million acres (4 million hectares) of prime farm land in the Red River Valley for 10 cents an acre and omitting many Little Shell families from the rolls. Some of the Little Shell Band members did eventually settle on the Turtle Mountain Indian Reservation. Others migrated north and west into Saskatchewan and Alberta, and then later made their way back south into Montana.

LEADERSHIP:

The Little Shell Tribe is governed by a constitutionally defined elected Tribal Council. The Tribal Chairman is also elected. Four council seats are up for election every 4 years and 3 council seats every 2 years, in a largely mail-in balloting process. The tribal council meets regularly in Great Falls at least monthly. The Tribe has maintained its integrity throughout the 20th century. The constitution has been revised, most recently in 2016. The government, social structure and culture have been maintained.

In 2000, Montana recognized the Little Shell Tribe of Chippewa Indians of Montana.

Before 2020, the Council are unpaid and was not federally-recognized, the Little Shell did not qualify for federally funded educational or government support services such as housing and medical facilities, typically provided tribes recognized by the United States government. During this time, the Little Shell Tribal members could obtain some services available in urban centers as well as public benefits available to all Montana residents.

NORTHERN CHEYENNE *(Tsetsehesestahase/So'taahe)*

LOCATION:
They formerly resided in the great lakes area of Minnesota and along the Missouri River. The Cheyenne had conflict and competition with the Ojibwe, Arikara, and Mandan Indians, they initiated a westward migration in the late 1600s. It is believed that around 1700, they lived in the Black Hills of South Dakota. Finally, in 1832, the Cheyenne tribe divided into two groups namely the Northern Cheyenne that settled along the Platte River, and the Southern Cheyenne that dwelled along the Arkansas River further south in Colorado and Kansas. Originally the Cheyenne were relocated to Oklahoma and later the Northern Cheyenne were relocated to Montana. Located in southeastern Montana, the reservation is approximately 690 square miles in size and home to approximately 11,266 enrolled tribal members, with 5,012 residing on the reservation.

HISTORY:
The Cheyenne are one of the indigenous people of the Great Plains and their language is of the Algonquian language family. The Cheyenne comprise two Native American tribes, the Suhtai or Sutaio and the Tsitsistas, translates to "the beautiful people". These tribes merged in the early 19th century. Today, the Cheyenne people are split into two federally recognized Nations: the Southern Cheyenne, or **Suhtai** or **Sutaio** , who are enrolled in the Cheyenne and Arapaho Tribes in Oklahoma, and the Northern Cheyenne, or **Tsitsistas,** enrolled Northern Cheyenne Tribe of the Northern Cheyenne Indian Reservation in Montana.

After the acquisition of horses, the Cheyenne gave up farming and became buffalo hunters, trading the hides for tobacco, fish and fruit. Teepees permitted a nomadic existence. The Cheyenne had a military society to supervise law and order, the Dog soldiers were the most prominent among the society.

The Cheyenne was divided into ten bands:

- Heviksnipahis (*Iviststsinihpah*)
- Hévhaitanio (*Heévâhetaneo'o*)
- Masikota
- Omísis (*Ôhmésêheseo'o*, the Notameohmésêhese proper)
- Só'taeo'o (*Suhtai* or *Sutaio*, Northern and Southern)
- Wotápio
- Oivimána (*Oévemana*, Northern and Southern)
- Hisíometanio (*Hesé'omeétaneo'o* or *Issiometaniu*)
- Oakton (*Oqtóguna*)
- Hónowa (*Háovôhnóva*)

LEADERSHIP:
The tribal and government headquarters are in Lame Deer Montana. The current constitution and By-Laws of the Northern Cheyenne Tribe have elected members from the following districts: Ashland, Birney, Busby, Muddy and Lame Deer. The president and members of the Tribal Council serve four-year staggered terms.

Cheyenne have a matrilineal band system. The Cheyenne's status may be defined by extended family and distinguished ancestors. The Cheyenne woman is expected to be

hardworking, chaste, modest and skilled in traditional crafts, knowledgeable about Cheyenne culture and history and speak Cheyenne fluently. It is expected that her family be reputable to add to her status as a role model.

SPIRITUALITY AND BELIEFS:
Northern Cheyenne look to the entire person and provide care before unhealthily lifestyles become a problem. The healing is considered to start from within the person, considering the spiritual, physical, mental and emotional environment to find the balance for health.

The Northern Cheyenne focus on the body and the symptoms of balance or imbalance. For example:

- The lungs provide freedom, originating from tuberculosis and the freedom that was taken away from the person.
- The heart is love; most heart problems happen to people that perceive they are not loved.
- The shoulders carry the burdens of life, resting is one way to have time for oneself and heal.
- The neck is where guilt is carried. Northern Cheyenne believe that guilt is an emotion that can be discarded.
- With pain, some believe that anger interferes with the healing process and laughter starts the healing process. The Northern Cheyenne believe and observe people, helping the quiet ones laugh and taking away the unhealthy emotions before it becomes a disease.
- The head provides Northern Cheyenne with the concept of paying attention to our bodies. Hence a headache is a reminder to take time and pay attention to our bodies and healing process and experience the fits of smell, tough, hearing, taste and sight.

The Northern Cheyenne practice the respect for taboos. Examples of common taboos to be considered while providing care for Northern Cheyenne are:

- You never run in a house
- Never point at people with your finger
- Never leave a handprint in the dirt or snow
- When you get water always dip the bucket up stream
- Northern Cheyenne woman should never touch a speckled eagle feather

The taboos may be hard to explain but Northern Cheyenne follow and respect taboos and never ask why.

ECONOMY:
Major employers on the Northern Cheyenne Reservation are the local schools, the federal government, tribal government, power companies and construction companies. The education system, farming, ranching and small business contribute to the economy.

ROCKY BOY: CREE AND CHIPPEWA CREE *(Anishinaabe Ne-I-Yah-Wahk)*

HISTORY:
The name "Rocky Boy" was derived from the name of a leader of a band of Chippewa Indians. It meant "Stone Child," but it was not translated correctly from Chippewa into English, and "Rocky Boy" evolved.

The Cree lived from Lake Superior westward. The Cree migrated westward and were traders and hunters. The Cree were identified through their band and clans, a group claiming descendancy from a common ancestor. At one time the Cree lived in northern Minnesota, North Dakota and Montana. Today American Cree are enrolled in the federally recognized Chippewa Cree Tribe, located on the Rocky Boy Indian Reservation.

Chippewa and Cree were Plains Indians, with a primarily hunting and gathering culture. The hunting of buffalo was central to the lifestyle of Cree people for thousands of years and to western Chippewa since the early 1800s. The Tribes could use the surplus meat for trade items among other tribes and non-Indians. It wasn't much longer when the state governments stopped hunting of other animals such as deer and elk. The Chippewa and Cree had no reservation to return to. They wandered Montana for some 30 years before they were finally given a home to plant gardens and practice their ceremonial ways. This 30-year period was a sad time; full of sickness, starvation, despair, rejection, and sometimes humiliation.

The Rocky Boy Indian Reservation is different from other reservations in Montana in several ways. It was the last reservation to be established in the state. It was established not by treaty, but by congressional act; and it is the smallest reservation in the state, home to the smallest tribe, the Chippewa Cree. Congress acted and approved a home for the Chippewa Cree on September 7, 1916. The current total Chippewa Cree tribal enrollment as of July 2017 is 6,868 with 4,041 members living on or near the reservation.

Traditionally the Chippewa people are divided into clans. Inter-clan marriage was not allowed. The Chippewa Cree Tribe of the Rocky Boy's Reservation is a very wealthy tribe in terms of language, culture, traditions, and in history.

LOCATION:
The Rocky Boy Reservation is near the Canadian border, in northcentral Montana, and encompasses approximately 122,000 acres, including the Bears Paw Mountains.

ECONOMY:
Rocky Boy Chippewa Cree residents who work on the reservation are employed by the schools, Bureau of Indian Affairs, Indian Health Service and tribal government. There is wheat farming and post and pole production. The tribe is actively working toward development of its natural resources to be able to provide more jobs and income for its people.

LEADERSHIP:
The Chippewa Cree Business Committee is the governing body of the Tribe. The eight Council members and Chairman are elected at large; serving four years on staggered terms. Elections are held in the fall of even numbered year.

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2.8.2 CEREMONIAL SMUDGING

Instructor/Facilitator:

Go through each section and discuss the different customs. Ask the participants if they want to add any information or other customs. In order to perform a smudging, the Instructor will need to ensure the it is permissible in their location (i.e., smoke alarms, etc.). To demonstrate your cultural competence, it is adviseable to invite a local Tribal Member to perform the ceremony. As a note, Sweetgrass may be difficult to obtain otherwise.

While individual tribes will have different customs, language and cultures, all Native American tribes have customs such as smudging that have been used for centuries.

SMUDGING is a practice used by many Native American tribes, as well as other cultures all over the world. Smudging is the scared practice of creating a cleansing smoke bath, calling on the spirits of the plants and the Creator for healing prayer, to restore balance, and for purification of the mind, body, and space. Smudging drives away negative energy and attract positivity. The smudging ceremony may be performed by an immediate family member or selected spiritual leader.

Many people use sage, cedar, sweetgrass, and tobacco in their smudging ceremonies, whether individually or in bundles. A common bundle is sage and sweetgrass.

SAGE is believed to cleanse negative spirits and feelings and push that energy away.

CEDAR is believed to carry prayers to the Creator and ward off illness, while cleansing negative energy.

SWEETGRASS is believed to attract beauty, sweetness and positive energy while cleansing negative energy.

TOBACCO is considered by many tribes to be the most sacred of plants, working to cleanse negative energy and welcoming positivity. It is also considered a poison when disrespected and abused.

Some tribes prefer clay or stone bowls while others prefer the use of a shell. The plant of choice is either lit and burned from one end or placed in the bowl/shell and burned. Bird feathers are also a common element to the smudging ceremony, using the feather's ability to comb the energy and aid in the cleansing process.

Figure 1 White Sage Smudge

Figure 2 Components of Smudge Materials (Cedar, Sage & Sweetgrass)

Affecting Health Care Assessment

Instructor/Facilitator: State Not all AI/AN elders use these patterns; and not all AI/AN will use them all the time, depending on the situation. Euro American patterns tend to be institutionalized within the health care system culture. The table below differentiates patterns that would be helpful in each interaction with providers.

American Indian	Euro-American
Avoidance of direct eye contact as a sign of respect	Direct contact considered sign of honesty and sincerity
Handshake lightly; some women touch only the fingertips	Firm handshake denotes power
Information passed by "word of mouth" rather than media, some Internet used	Lectures, newspapers, TV, radio and Internet use
Personal information not forthcoming	Self-disclosure valued, "open and honest" communication style
Ideas and feelings conveyed through behavior rather than speech	Verbal expression of ideas and feelings
Words are chosen carefully and deliberately, the power of words is understood	Verbosity and small talk are appropriate behavior
Listening is valued over talking	Schools teach speaking over listening. Importance of expressing one's opinion
Use of observational skills and non-verbal communication	Verbal and written communication valued
Criticism communicated indirectly through another family member. Direct criticism considered disrespectful and rude	Direct criticism used to alter behavior
Withdrawal used as a form of disapproval ("voting with your feet")	Direct expression of approval
Request given through indirect suggestion	Directness of requests

The above table was created by Levanne R. Hendrix, MSN, RN, GNP, PhD
Sources: Hendrix l, 1999; American Indian Education Handbook Committee, 1991

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2.9 MONTANA'S URBAN INDIAN CENTERS

Instructor/Faciltator: To help understand the different venues within the Native American Healthcare Systems, it is necessary to know more about each system.

The Urban Indian Health Program (UIHP) consists of 41 non-profit 501 (c)(3) programs nationwide. The programs are funded through grants and contracts from the I.H.S., under Title V of the Indian Health Care Improvement Act, PL 94-437, as amended.

Approximately 45% of the UIHPs receive Medicaid reimbursement as Federally Qualified Health Centers (FQHC) and others receive fees for service under Medicaid for allowable services, i.e. behavioral services, transportation, etc. Over 28.8 million dollars are generated in other revenue sources. In the Omnibus Reconciliation Act (OBRA) of 1993, Title V, and tribal 638 programs were added to the list of specific programs automatically eligible for FQHC designation.

The North American Indian Alliance (NAIA) is committed to the establishment and maintenance of a form of management that protects and perpetuates the health and welfare of all eligible Native Americans residing in an urban setting.

To further understand the range of health care providers for Native American patients in Montana this section describes the range of I.H.S./Urban grant and contract programs. Services include:

- information,
- outreach and referral,
- dental services,
- comprehensive primary care services,
- limited primary care services,
- community health,
- substance abuse (outpatient and inpatient services),
- behavioral health services,
- immunizations,
- HIV activities,
- health promotion and disease prevention, and
- other health programs funded through other state, federal, and local resources, i.e. WIC, Social Services, Medicaid, Maternal Child Health, etc.

To learn more about the I.H.S. and Urban Indian Centers, use the link below: Indian Health Service Office of Urban Indian Health Programs Strategic Plan 2017-2021

MONTANA URBAN INDIAN CENTERS LOCATIONS AND CONTACT INFORMATION:

BILLINGS URBAN INDIAN HEALTH & WELLNESS CENTER - 1230 N. 30th Street, Billings MT 59102 **-** (406) 534-4558 - The mission of the Indian Health Board of Billings is to empower the urban Indian/Alaska Native community, by improving health care services through education and outreach. Mindful that healing involves every aspect of the human being; emotional, mental, physical and spiritual. To create an American Indian/Alaskan Native Health Center that fosters the dreams and hopes of the people we serve with integrity and respect.

NORTH AMERICAN INDIAN ALLIANCE (Butte) – 55 East Galena, Butte, MT 59701 - (406) 782-0461 - The North American Indian Alliance (NAIA) is committed to the establishment and maintenance of a form of management that protects and perpetuates the health and welfare of all eligible Native Americans residing in an urban setting. To do so, a system of personnel management has been established setting forth the standards and clarifying the rights and responsibilities of the employer and employees.

GREAT FALLS INDIAN FAMILY HEALTH CLINIC - 1220 Central Avenue, Suite 1B, Great Falls, MT 59401 - (406) 268-1587 - The mission of the Indian Family Health Clinic is to support and strengthen individual, family, and community health by providing high-quality and comprehensive health care services to Urban Indians in the Great Falls area. Our long- term vision is to become a model organization for promotion and delivery of health care services to Native Americans.

HELENA INDIAN ALLIANCE - 501 Euclid Avenue, Helena, MT 59601 - (406) 442-9244 - The Helena Indian Alliance develops, implements, and maintains cultural, social, and economic programs for families, seniors, and youth. The HIA contracts with the Indian Health Service to operate our Leo Pocha Memorial Clinic. Distinct service is given to the physical, diabetic, and behavioral health of the Helena-area Indian population. The Helena Indian Alliance is committed to the general welfare and betterment of the Native American community, the broader non-Indian community, and other native peoples residing in the community of Helena, Lewis & Clark County, Montana.

MISSOULA URBAN INDIAN HEALTH CENTER - 830 West Central, Missoula, MT 59808 - (406) 829-9515 - **SERVES** as a respectful gathering place, welcoming Native families from all Nations. **DEVELOP** a strong, supportive Native community by building collaborations and promoting healthy family activities. **SUPPORT** Native families to identify opportunities & resources to thrive & be healthy. **SUPPORT** Tribal traditions to maintain comfort and belonging at home and in the city. **PROMOTE** Wellness by offering opportunities for emotional, mental, physical and spiritual healing.

2.10 BUREAU OF INDIAN AFFAIRS

Instructor/Faciltator:: To help understand the different venues within the Native American Healthcare Systems, it is necessary to know more about each system.

Established in 1824, Indian Affairs (IA) is the **oldest bureau** of the United States Department of the Interior. IA or Bureaus of Indian Affairs (BIA) as it is known today, **currently provides services (directly or through contracts, grants, or compacts) to approximately 1.9 million American Indians and Alaska Natives.**

There are **573 federally recognized American Indian tribes and Alaska Natives in the United States**. Bureau of Indian Affairs is responsible for the administration and management of 55 million surface acres and 57 million acres of subsurface minerals estates held in trust by the United States for American Indian, Indian tribes, and Alaska Natives. Bureau of Indian Education (BIE) provides education services to approximately 42,000 Indian students.

BIA and BIE's missions are to *enhance the quality of life, to promote economic opportunity, and to carry out the responsibility to protect and improve the trust assets of American Indians, Indian tribes, and Alaska Natives."*

Delivery of program services to the federally recognized tribes and individual Indians and Alaska Natives, whether directly or through contracts, grants or compacts, is administered by the twelve regional offices and 83 agencies that report to the BIA Deputy Director-Field Operations, located in Washington, D.C.

The twelve regional offices are in the heart of Indian Country with the agencies located at the reservation level. Each regional office is headed by a Regional Director who is responsible for all Bureau activities within a defined geographical area except education, law enforcement and functions of an administrative nature. The typical Regional Office includes a Deputy Regional Director for Trust Services and Deputy Regional Director for Indian Services.

The Deputy Regional Director for Trust Services oversees a staff of specialists responsible for natural resources (water resources, forestry and fire, irrigation and safety of dams), agriculture, (farm, pasture, and range), fish, wildlife and parks and real estate services (land acquisition and disposal land title records office, probate, rights-of-way, and lease/permit). The Deputy Regional Director for Indian Services oversees a staff of specialists responsible for transportation (planning, design, construction, and maintenance) and Indian services (tribal governments, human services, housing improvement).

Inception of IA or as known today, for almost 200 years, dating back to the role it played in negotiating treaty agreements between the United States and tribes in the late 18th and 19th

centuries, the BIA has embodied the trust and government-to-government relationships between the U.S. and the Federally recognized tribes.

Over the years, the BIA has been involved in the implementation of Federal laws that have directly affected all Americans:

- The General Allotment Act of 1887 opened tribal lands west of the Mississippi to non-Indian settlers,
- The Indian Citizenship Act of 1924 granted American Indians and Alaska Natives U.S. citizenship and the right to vote, and
- The New Deal and the Indian Reorganization Act of 1934 established modern tribal governments.
- The WW II period of relocation and the post-War termination era of the 1950s led to the creation of the Indian Self-Determination and Education Assistance Act of 1975.
- The Tribal Self-Governance Act of 1994 along with the Self-Determination and Education Assistance Act has fundamentally changed how the Federal Government and the tribes conduct business with each other.

2.11 INDIAN HEALTH SERVICE

Instructor/Faciltator:: To help understand the different venues within the Native American Healthcare Systems, it is necessary to know more about each system.

Indian Health Service is NOT an Insurance Agency. Note that this is a common error within healthcare situations.

The Indian Health Service ("I.H.S.") is an agency within the United States Department of Health and Human Services**. I.H.S. is responsible for providing federal health services to American Indians and Alaska Natives.**

The provision of health services to members of federally recognized tribes grew out of the special government-to-government relationship between the federal government and Indian tribes. This relationship, established in 1787, is based on Article I, Section 8 of the Constitution, and has been given form and substance by numerous treaties, laws, Supreme Court decisions, and Executive Orders.

The I.H.S. is the principal federal health care provider and health advocate for Indian people and its goal is to raise their health status to the highest possible level. IHS provides a comprehensive health service delivery system for approximately 2.2 million American Indians and Alaska Natives who belong to 573 federally recognized tribes in 37 states.

The Indian Health Service has set policies and procedures in place. For example, after a Native American patient visits the emergency department or urgent care clinic, he/she must notify the Indian Health Services (IHS) Purchase Referred Care office within 72 hours (three calendar days).

IHS Purchase Referred Care determines eligibility for coverage based on:

- Where the patient resides (on or near a federally recognized reservation)
- Tribal affiliation
- Health coverage (Medicaid, Medicare or private health insurance)
- Whether the patient notified IHS within **three days** of onset of care

Montana has combinations of Tribal and Indian Health Service providing care to tribal members and their families. It is important to note that the Indian Health Service is not an insurance agency.

INSTRUCTOR: Explain to the participants: To receive IHS health care benefits, Native Americans should go to the patient registration office of the local IHS facility in person and present proof of enrollment as a member of a federally

recognized tribe. (See the Indian Health Manual, Part 2—Services to Indians and Others, Chapter 6—Patient Registration System for specific information).

There are Two types of services are provided by the IHS:

(1) **Direct health care services**, which are provided by an IHS facility, or

(2) **PRC**, which are provided by a non-IHS facility or provider through contracts with the IHS. PRC are provided principally for members of federally recognized tribes who **reside on or near the reservation** established for the local tribe(s) in geographic areas called contract health service delivery areas (CHSDAs). The eligibility requirements are stricter for PRCthan they are for direct care.

A member of a Federally recognized tribe may obtain care at any IHS hospital or clinic if the facility has the staff and capability to provide the medical care. One of the additional requirements for PRC is that the patient must reside in certain areas. One way to meet the residency requirement is to live on the reservation of any Federally recognized tribe. Another way to meet the residency requirement is to reside within the Purchased/Referred Care Delivery Area (PRCDA) for the patient's tribe.

Many, or even most, people who move away from their home reservations are not eligible for PRC since they would be moving away from the PRCDA in which they have eligibility. Native Americans must check with their home or local Service Unit about eligibility, since they will be the ones making all determinations and paying bills for approved care. **Most PRC provided is for urgent or emergency needs, as defined by the local service unit, and requires prior approval for non-emergency care and notification within 72 hours for emergency care.**

Some programs or portions of programs are tribally operated instead of being operated by the Federal Government through the IHS. Some tribally operated hospitals or clinics restrict services to members of their own tribe. Consequently, just because a patient is a member of a Federally recognized tribe does not mean that they will be provided medical care at a tribally operated hospital or clinic.

Direct health care services are services provided at an IHS/Tribal/Urban facilities/Purchased/Referred Care (PRC) are services that the IHS is unable to provide in its own facilities. PRC are provided by non-IHS health care providers and facilities. PRC payments are authorized based on clearly defined guidelines and are subject to availability of funds. The Indian Health Service cannot always guarantee that funds are always available. **Funds appropriated by the U.S. Congress currently cover an estimated 60% of health care needs of the eligible American Indian and Alaska Native people.**

Unfortunately, that means that services obtained under PRC must be prioritized, with life-threatening illnesses or injuries being given highest priority. The patient medical referral is reviewed by PRC to determine if the medical need is within the available

funding at that time. It also means that the IHS formulary (the list of drugs and medicines available from IHS pharmacies) may not include all drugs and medicines, but will include most of the ones that have proven to be beneficial and cost-effective.

Locating the nearest IHS/Tribal/Urban health care facility to your location can be found using the IHS Find Health Care on the IHS website. The Find Health Care locator will identify the facility name, address, contact number, and directions. Note: Before traveling to any facility listed on the website, call to ensure that the services needed can be provided. https://www.ihs.gov/forpatients/faq/

The Indian Health Service is not an entitlement program, such as Medicare or Medicaid. The Indian Health Service is not an insurance program. The Indian Health Service is not an established benefits package.

TRIBAL SELF-GOVERNANCE PROGRAM ("TSGP", ALSO KNOWN AS "638")

The Indian Self-Determination and Education Assistance Act (ISDEAA), also known as Public Law 93-638, authorizes Indian Tribes and Tribal Organizations to **contract for the administration and operation of certain Federal programs which provide services to Indian Tribes and their members**.

Under the ISDEAA, Tribes and Tribal Organizations have the option to either (1) administer programs and services the IHS would otherwise provide (referred to as Title I Self-Determination Contracting) or (2) **assume control over health care programs and services that the IHS would otherwise provide** (referred to as Title V Self-Governance Compacting or the TSGP).

These options are not exclusive:

Tribes may choose to combine them based on their individual needs and circumstances. Since the first Demonstration Project agreements were signed in 1993, the IHS TSGP has seen tremendous growth.

As of December 2011, 337 Tribes are participating in the TSGP. That's nearly 60 percent of the 566 federally recognized Tribes in the United States. In fiscal year (FY) 2011, approximately one-third of the total IHS budget appropriation was transferred to Tribes to support 82 TSGP Compacts and 107 TSGP Funding Agreements. The TSGP is still growing. In FY 2011, nine new Tribes and Tribal Organizations joined the TSGP

With the addition of two new IHS Areas since 2009, the TSGP is now operating in 10 of the 12 IHS Areas. **The TSGP has proven to have a significant positive impact on the health and well-being of participating Tribal communities**. The TSGP produces results because Tribal communities are in the best position to understand and address their own health care needs and priorities. Through the TSGP, Tribes continue to develop innovative solutions that address the health care delivery challenges facing their communities.

Tribes and Tribal Organizations have ability to select and:

(1) administer programs and services the IHS would otherwise provide (referred to as Title I Self-Determination Contracting) or

(2) assume control over health care programs and services that the IHS would otherwise provide (referred to as Title V Self-Governance Compacting or the TSGP).

These options are not exclusive; Tribes may choose to combine them based on their individual needs and circumstances. See the links provided under the Resources section for comprehensive information about Title I and Title V regulations.

Indian Health Services Locations & Services Provided

Blackfeet Community Hospital
P.O. Box 760
Browning, Montana 59417
Main: (406) 338-6100
Fax: (406) 338-2959

Behavioral Health & Social Services	Community Health Nursing	Diabetes Program
Ear, Nose & Throat (ENT) Clinic	Emergency Care	Medical Records
Nursing Department	Office of Environmental Health	Physical Therapy
Purchase/Referred Care & Dental Services	Risk Management	Utilization Review & Compliance

Heart Butte Health Station
P.O. Box 80
Heart Butte, Montana 59448
Main: (406) 338-2151
Fax: (406) 338-5613

Crow/Northern Cheyenne Hospital
P.O. Box 9
Crow Agency, Montana 59022
Main: (406) 638-3500
Fax: (406) 638-3569

Behavioral Health	Dental	Diabetes Clinic
Emergency Department	ENT/Audiologic Services	Family Medicine
Internal Medicine	Laboratory Services	Medical Records
Nutritional/Dietary	Obstetrics/Gynecology	Optometry
Pediatrics	Pharmacy	Primary Care Clinic
Podiatry & Surgery	Public Health Nursing	Radiology Services

Lodge Grass Health Clinic
P.O. Box AD
Lodge Grass, Montana 59050
Main: (406) 639-2317
Fax: (406) 639-2976

Pryor Health Station
P.O. Box 9
Pryor, Montana 59066
Main: (406) 259-8238
Fax: (406) 259-8290

Lame Deer Health Center
P.O. Box 70
Lame Deer, Montana 59043
Main: (406) 477-4400
Fax: (406) 477-4427

Behavioral Health	Community Health Nursing	Dental
Ear Nose & Throat (ENT)	Laboratory	Nephrology
Oral Dental Surgeon	Optometry	Orthopedic
Outpatient Ambulatory Care	Physical Therapy	Podiatry
Purchased/Referred Care	Radiology	Risk Management
Specialty Clinics	Urgent Care	

Fort Belknap Hospital
669 Agency Main Street
Harlem, Montana 59526
Main: (406) 353-3100
Fax: (406) 353-3227

Eagle Child Health Station
P.O. Box 610
Hays, Montana 59527
Main: (406) 673-3777
Fax: (406) 673-3835

Behavioral Health	Dental	Emergency Medical Services
Laboratory	Mammography	Men's Health
Optometry	Outreach/Referrals	Pharmacy
Nutrition	Public Health	Purchased/Referral Care
Radiology	Specialty Clinics	Transportation Services
Women's Health		

SERVICES OFFERED BY TRIBAL HEALTH:

Chemical Dependency Treatment	Community Health	Diabetes Program
Family Planning	FAS/FAE Program	Health Education
Nutrition	Personal Care Attendants	Public Health Nursing
Sanitation/Environmental Program	WIC	

Ft. Peck Service Unit
Chief Redstone Clinic
550 6th Avenue North
P.O. Box 729
Wolf Point, MT 59201

Verne E. Gibbs Clinic
107 H. Street
P.O. Box 67
Poplar, MT 59255

Administration	Appointments/Registration	Audiology
Business Office	Dental	Laboratory
Nursing	Nutrition	Optometry
Pharmacy	Public Health Nursing	Purchased/Referred Care
Radiology	Specialty Clinics	Telehealth

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2.12 TRIBAL HEALTH SELF-GOVERNANCE PROGRAMS

Instructor/Faciltator:: To help understand the different venues within the Native American Healthcare Systems, it is necessary to know more about each system.

The Office of Tribal Self-Governance (OTSG) is in Rockville, MD, in the Office of the Director of the Indian Health Service (IHS), US Department of Health and Human Services (HHS**).**

OTSG is responsible for a wide range of Agency functions that are critical to IHS' relationship with Tribal leaders, Tribal Organizations, and other American Indian and Alaska Native groups. OTSG develops and oversees the implementation of Tribal Self-Governance legislation and authorities within the IHS under Title V of the Indian Self-Determination and Education Assistance Act (ISDEAA), Public Law 93-638, as amended.

OTSG is a national program providing information, technical assistance, and policy coordination in support of I.H.S. Self-Governance activities, with maximum input from IHS staff and workgroups, Tribes and Tribal Organizations, and the Tribal Self-Governance Advisory Committee (TSGAC).

Flathead: Confederated Salish & Kootenai Tribal Health P.O. Box 880
St. Ignatius, Montana 59865
Main: (406) 745-3525

Polson Health Center
#5 Fourth Avenue East
Polson, MT 59860
(406) 883-5541

St. Ignatius Health Center
35401 Mission Drive
St. Ignatius, MT 59865
(406) 745-3525

Hot Springs Health Center
214 North Spring Street
Hot Springs, MT 59845
(406) 741-3266

SKC Student Health Center
35928 Joe McDonald Drive
Pablo, MT 59855
(406) 675-2700 ext. 1630

Arlee Health Center
71972 Bitterroot Jim Road
Arlee, MT 59821
(406) 726-3224

Elmo Health Center
33116 US Highway 93 North
Elmo, MT 59915
(406) 849-5798

Ronan Health Center
35860 Round Butte Road
Ronan, MT 59864
(406) 676-0137

SERVICES OFFERED:

Access and Transportation
Communications
Elective Procedures
Home Health & Medical Supplies
Outpatient Services
Alternative Medicine
Dental Services
Environmental Health & Engineering
Inpatient Services
Patient Support Services
Client Services
Direct Care
Family Services
Mental Health & Addiction
Pharmacy

Public Health Nursing	Purchased/Referred Care	Relations with Providers

Rocky Boy Tribal Health
P.O. Box 664
Box Elder, Montana 59521
Main: (406) 395-4486
SERVICES OFFERED:

Community Health	Diabetes Program	Emergency Medical Services
Emergency Preparedness Planning	Environmental Health & Engineering	Outpatient Chemical Dependency Services
Outpatient Clinic	Purchased/Referred Care	Wellness Program

RESOURCES:

http://www.chippewacree-nsn.gov/index.php/about
http://www.nei-yahw.com/historical.html
http://tribalnations.mt.gov/blackfeet
https://blackfeetcountry.com/
http://www.umt.edu/this-is-montana/columns/stories/blackfeet.php
https://manataka.org/page255.html
http://www.csktribes.org/history-and-culture
http://www.flatheadwatershed.org/cultural_history/pend_salish.shtml
https://www.sktcorp.com/our-story-an-introduction-to-the-confederated-salish-and-kootenai-tribes/
https://ftbelknap.org/history
https://en.wikipedia.org/wiki/Blackfoot_Confederacy
https://www.legendsofamerica.com/gros-ventre-tribe/
Excerpts from: “The Gros Ventre of Montana, Part I Social Life” by the Catholic University of America Press.
http://tribalnations.mt.gov/fortpeck
http://fortpecktribes.org/tribal_history.html
https://www.warpaths2peacepipes.com/indian-tribes/assiniboine-tribe.htm
https://www.legendsofamerica.com/na-sioux/
https://www.voanews.com/usa/little-shell-chippewa-tribe-montana-homeless-no-more
https://www.greatfallstribune.com/story/news/2019/12/20/montana-little-shell-tribe-chippewa-indians-federal-recognition/2439763001/
https://hill57.blogspot.com/2009/11/sweat-lodge.html
http://everything.explained.today/Little_Shell_Tribe_of_Chippewa_Indians_of_Montana/

2.13 Hutterite Populations in Montana

Instructor/Facilitator: To offer the best care possible, we must understand the culture and history of the Hutterite populations across Montana.

The term Hutterite comes from the name of the founder of the group, Jakob Hutter, a hat maker by trade. Hutterite people live in colonies located primarily throughout rural Montana, South Dakota and the Canadian Provinces of Alberta, Saskatchewan and Manitoba.

A colony is a group of families governed by an elected minister. Each colony has an elected Secretary, who writes checks and keeps the records and an assistant minister. Each adult has assigned responsibilities to sustain the colony. They are democratic, and all major decisions are made by the people who are affected. About 100 people live on each colony.

There are approximately 50+ colonies in Montana.

The Hutterite colonies in Montana contribute to the state's economy as hog, beef, dairy, egg, poultry and grain producers. The colonies are primarily self-sufficient. They:

- Contribute to the local economy by contracting for specialized services
- Make their own clothing
- Build their own buildings
- Repair and maintain farm equipment
- Diversify and provide some services on a neighborly basis, and
- May be among the school district's biggest property taxpayers, contributing to Montana public schools

HISTORY

Hutterites are a communal branch of Anabaptists, who, like the Amish and Mennonites trace their roots to the Reformation of the sixteenth century. Their beliefs, especially the concept of Christian Community, have resulted in hundreds of years of odyssey through many countries. Nearly extinct by the eighteenth and nineteenth centuries, the Hutterites found a new home in North America. They migrated to the United States after the Civil War, and from a population of about 400, grew to upwards of 50,000.

There are some small differences between the groups:

Dariusleut

- There are approximately 15 Dariusleut colonies in Montana
- Use hooks and eyes as fasteners
- Women wear head scarves with smaller polka dots

Lehrerleut

- There are approximately 47 new or established Lehrerleut colonies in Montana
- Use buttons on clothing
- Women wear head scarves with large polka dots
- Usually more conservative of the two branches

RELIGION

Religion is central to everything the Hutterites do. They are Christians, but they have some important distinctions from other protestant churches. They are Anabaptists, which means that they believe their members should wait until they are adults and can choose to be baptized. Some wait into their twenties or thirties to commit to their religion and life on the colony.

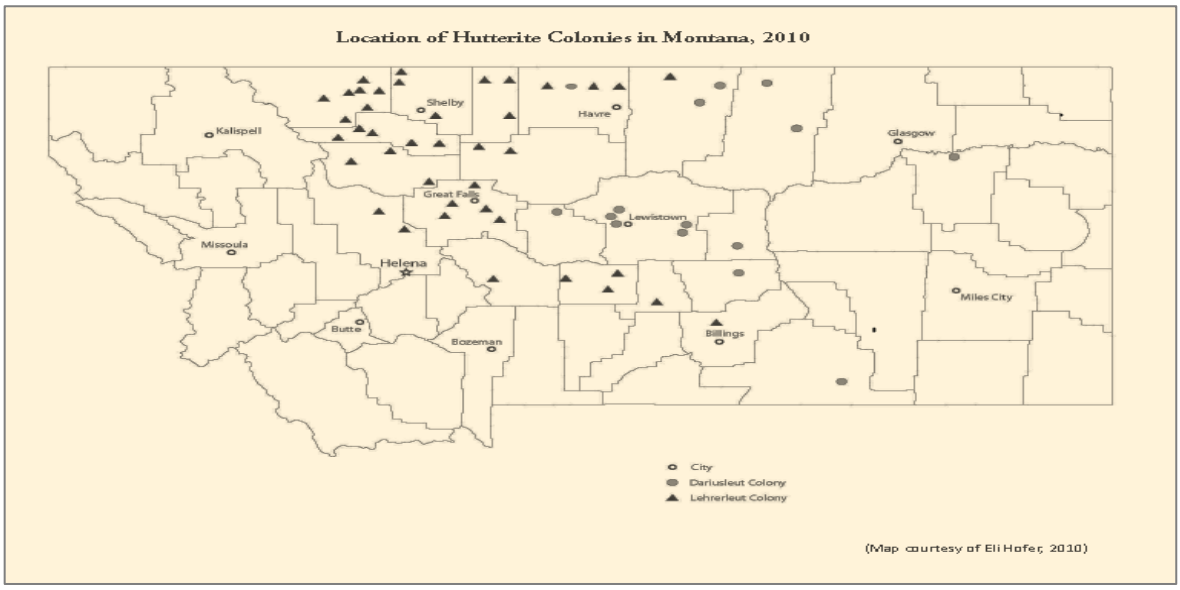
There are distinctions that most English (the name given to all non-Hutterites) see:

- The handmade, dark clothes, hats for the men, head scarves for the women.
- The German language when they speak to each other.
- They shun superfluous material possessions.
- Work together as a community for the common good.
- Their modest clothes show obedience and humility.

MONTANA'S HUTTERITE COLONIES

Big Sky	**Big Stone**	**Birch Creek**	**Camrose**	**Cascade**	**Duncan Ranch**
Eagle Creek	East End	Fair Haven	Glacier	Glendale	Golden Valley
Hartland	Hidden Lake	Hilldale	Hillside	Kingsbury	Martinsdale
Milford	Miller	Mountain View	New Miami	New Rockport	Pleasant Valley
Pondera	Rimrock	Riverview	Rockport	Sage Creek	Seville
Springdale	Springwater	Twin Hills	Ayers Ranch	Deerfield	East Malta
Flat Willow Creek	Fords Creek	Forty Mile	Gildford	Kilby Butte	King Ranch
Loring	North Harlem	Prairie Elk	Spring Creek	Surprise Creek	Turner
Sunny Brook	Elk Creek	Horizon	Midway	Big Rose	Cool Spring
Hidden Valley	Hillcrest	Zenith	Hilltop	Hilltop	

HUTTERITE COLONY LOCATIONS



HUTTERITE CULTURAL NORMS

- The health of the members of the colony is the concern of the whole community.
- Most do not oppose vaccination.
- Nor are they averse to medically advanced treatment.
- Hutterites seek medical care in emergencies and for serious chronic illness.
- Time and distance required to travel to a clinic is considered a big impediment to obtaining preventive care.
- Recognizing the prevalence of urgency in these visits is essential.
- Interest in health in individualistic society is largely in terms of monetary value, the cost of medical services, and the loss in earnings, this concern with the economic implications of poor health **is secondary** in a Hutterian colony as it is covered by the colony.
- The sick and invalided and their families have no worries about the cost of medical care, the loss of wages through unemployment, or the economic future of the family in the case of the death of a parent.
- Colony members are free to select their doctors and hospital.
- Hutterians carry no life insurance but the family provider's illness or death in no way affects the financial security of the family.

Figure 1. A Broad Spectrum of Typical Hutterite Children

Instructor/Facilitator: NOTE: As with any culture, the Hutterite Population has Core Themes in care. FIGURE 1. CORE THEMES OF HUTTERITE'S EXPERIENCE WITH HEALTHCARE PROVIDERS

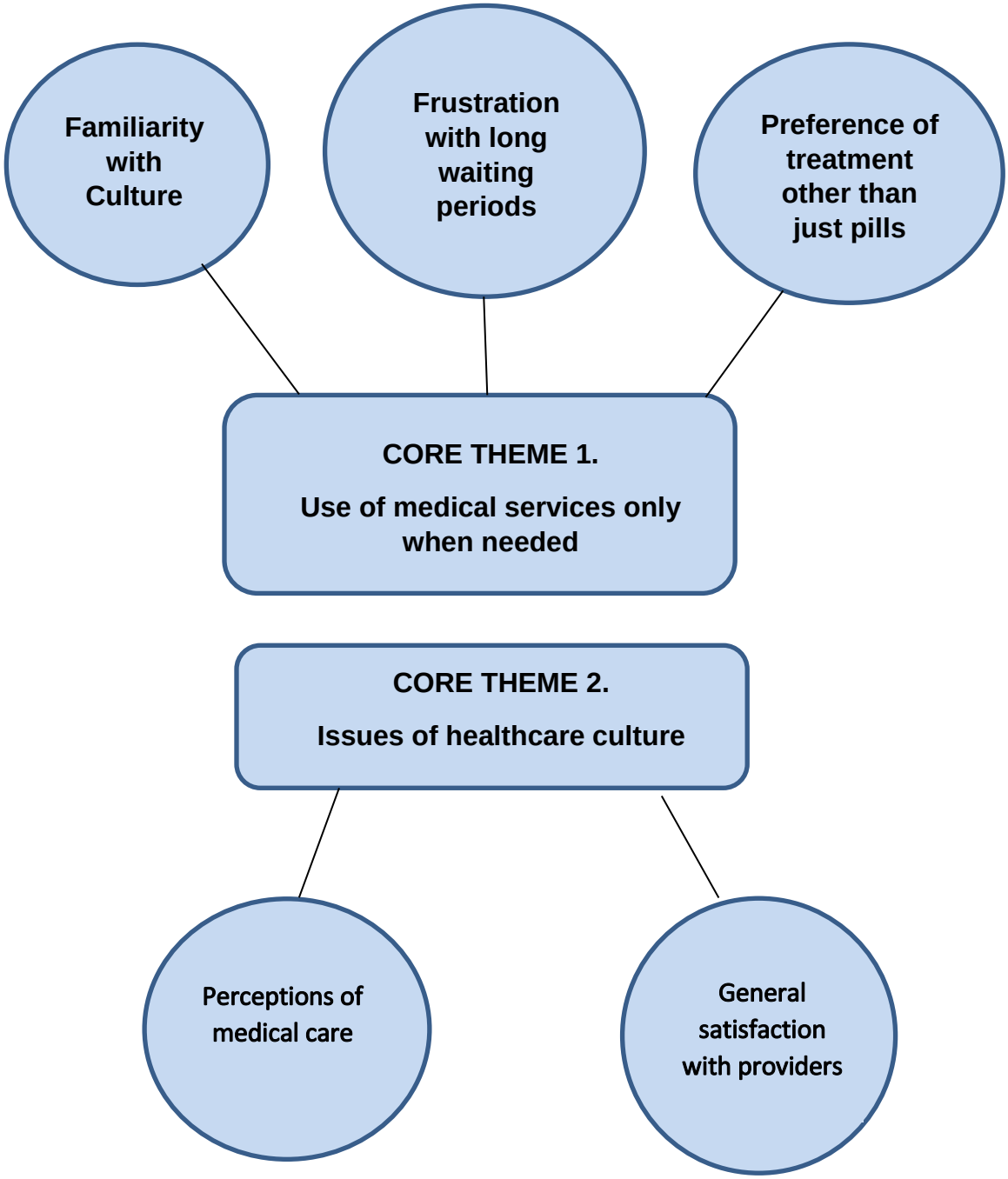


Table 1: Themes and significant statements of Hutterite's experience with healthcare providers	
Theme	Significant Statements
Use of medical services only when needed	"I want them to respect that I go when I feel I need to." "I didn't take all my appointments when I was pregnant, the doctor was twenty miles away and wanted me to come once per week, but I thought that was too much. I went to the doctor when I felt like it." "I seldom go to the doctor just for a checkup, only if I have a reason."
Familiarity with culture	"My local clinic is especially familiar because not just us, but other colonies go there. They don't necessarily know what we do daily. Some ask about daily life, but they wouldn't know our cycle of life."
Frustration with long waiting periods	"The patients don't get to care fast enough, especially in emergencies… we have waited hours for service at our local clinic." "It took them three days until they did an x-ray. He had to stay at the local clinic until Sunday. They didn't treat him for all those three days. After three days, my aunt demanded the x-ray. After the x-ray, they took him to Sioux Falls. They didn't say why they didn't treat him."
Preference of treatment other than just pills	"I don't expect much from my local clinic, It's not Rochester. In Rochester, they talk it over. At the local clinic, they just write scripts for a bunch of pills. When I take too many pills, I feel like a robot." "I prefer herbs to drugs. The homeopathic doctor is working and helping."
Issues of healthcare culture	"I went to the doctor more often during pregnancies. In some cases, I wouldn't h Know what was going on. I didn't understand when the doctor was explaining procedures." "There is a problem with the education level. Many people have problems understanding the doctor or explain what's wrong. Other people have asked me to describe their symptoms to the doctor."
Perceptions of medical care	"At a local clinic, they didn't take very good care of a lady from the colony. The doctors treated her too quickly. Her husband asked them about this, and they banned him from the hospital. The doctors gave them the wrong pills." "My Grandpa broke his hip and laid in the hospital in pain for three and a half days. Thursday night through Sunday morning. It was three weeks ago. His daughter insisted on doing something, so they did an x-ray and took him in to Sioux Falls. They found out that he had a disease on his bone. There were doctors present those three days, but they just gave him pain pills and did not explain anything."
General satisfaction with providers	"A doctor should not laugh something off. I had a deep cut in my finger and the doctor laughed it off. I was humiliated and would not go back. I could feel there was something wrong with my finger because there was a lot of pain." "The doctors should listen to the patient because every patient needs their own help. They should treat every patient individually."

Miscommunication of symptoms to the healthcare provider could result in many things, including a misdiagnosis. Cultural competence is of utmost importance in healthcare, and the Hutterites are no exception.

Instructor/Facilitator: Either verbally test your participants knowledge or hand the participants a hard copy of the below "Test." This can be done in discussion with the whole group or in small group settings.

TEST YOUR KNOWLEDGE: TRUE OR FALSE

		True	False
1	Hutterite colonies contribute to the local economies?		
2	English is the first language of the Hutterite population?		
3	Religion is central to everything the Hutterite people do?		
4	There are 100 Hutterite Colonies in Montana?		
5	Hutterites value their superfluous worldly possessions?		
6	Hutterites are opposed to vaccinations?		
7	The health of the members of the colony is not the concern of the whole community?		
8	Health care costs are not a major issue for the Hutterites?		
9	Colony members are free to select their doctors and hospitals?		
10	Colony members work for their individual good?		

NOTES:

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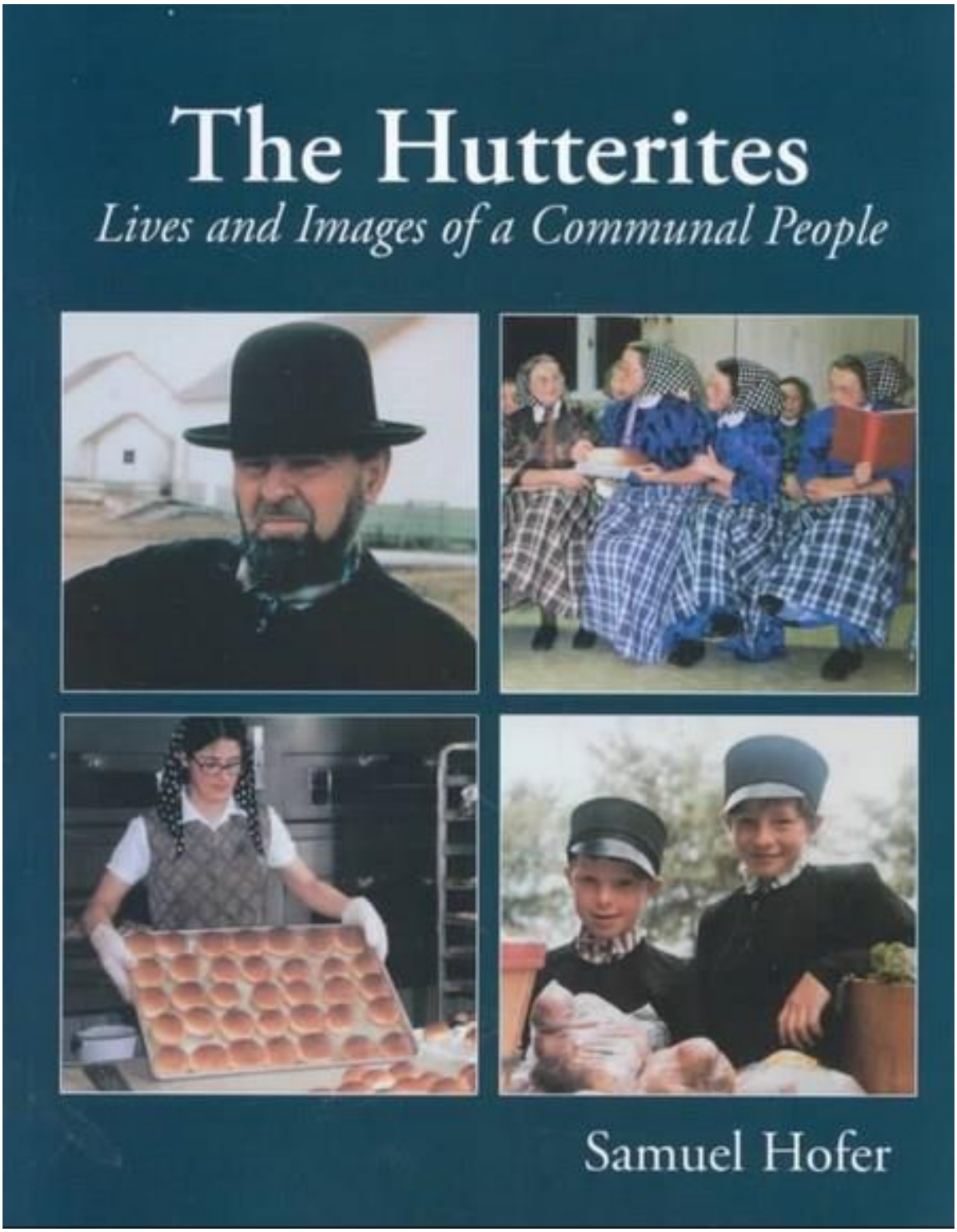


Figure 2. Book written by Samuel Hofer describing Hutterite Culture.

2.14 IMMIGRANTS AND MIGRANT WORKERS

Instructor/Facilitator: More than 2 percent of Montana residents are immigrants, while 4 percent are native-born U.S. citizens with at least one immigrant parent. To further understand the Montana populations, we must discuss the Immigrant and Migrant Worker population.

In 2015, 21,356 immigrants (foreign-born individuals) comprised 2.1 percent of the state's population. Montana was home to 11,065 women, 9,033 men, and 1,258 children who were immigrants. The top countries of origin for immigrants were Canada (26.7 percent of immigrants), Mexico (12.5 percent), Germany (7.2 percent), England (5.7 percent), and Korea (4.4 percent).

In 2016, 44,815 people in Montana (4.4 percent of the state's population) were native-born Americans who had at least one immigrant parent. **Over half of all immigrants in Montana are naturalized U.S. citizens.** More than 9 in 10 immigrants (93.3 percent) reported speaking English well or very well.

Montana has a small but growing immigrant community, much of which emigrated from Canada and Mexico. Many of Montana's immigrants lend their expertise as architects and engineers, accounting for 10 percent of residents working in the field, and roughly 14 percent of all Montanans working in the extraction industry are immigrants. As workers, business owners, taxpayers, and neighbors, immigrants are an integral part of Montana's diverse and thriving communities and make extensive contributions that benefit all.

Currently, nearly all the cherry harvest workers are Hispanic.

MIGRANT CULTURAL NORMS:

EDUCATION

- Children are subject to migration of parents seeking seasonal work.
- Children may receive fragmented education; some education may be within the USA and some in their home country, such as Mexico.
- Children may miss school because they were engaged with agricultural work with their families.

LANGUAGE

- Person speaking Spanish may or may not be proficient in the English language.

HOUSING

- The number of people cohabitating together while performing agricultural related duties due to the lack of affordable housing.
- The families may consist of multi-generational members.
- Migrant workers may reside in apartments, trailers, motels, campground/camping or automobiles.
- Migrant workers may lack toilet and bathing facilities, laundry, cooking, water, (hot or drinking), heat or air conditioning, bedding and hygiene products.
- Safety concerns: include residences near pesticides and little protection from rain and snow

HEALTH

Migrant workers and their families may seek medical care as well as utilize the ancient folk medicine practices of ancient Mexico. Some examples are:

Sobador is a manual therapist who offers chiropractic or physical therapies.

Yerbero is a person who practices herbalism. Examples of herbal remedies:

- Chamomile (manzanilla) which is taken as a tea for its calming properties,
- Aloe Vera (zabila) which is used topically on the skin to cure bites and rashes,
- Eucalyptus (eucalipto) is used as a tea to alleviate symptoms associated with the common cold.

Curandero, a person that integrates the relationship between illness, healing and religion, and an underlying belief and trust among the Hispanic community about symptoms, healing practices and the source of illness.

COMMON DISORDERS:

Mal de ojo (evil eye); associated with envy. Symptoms are high fever, fretfulness, headaches and crying. Treatment uses an egg rubbed among the child's body, while prayer is conducted.

Susto (fright sickness) resulting from a startling or frightful occurrence or scare which has caused the soul to temporarily leave the body. The symptoms associated with it include loss of appetite and weight, lack of motivation and listlessness. The treatment of susto involves sweeping the body with herbs three times while prayer is conducted.

Mollera caida (fallen fontanelle) It is believed to be caused by bouncing a baby too roughly or removing a nipple or bottle from the baby's mouth too suddenly. It is also marked by the

baby having a bulging palate, fever, vomiting and crying. The treatment involves applying salve to the baby's head and pressing on the baby's palate. Both a curandero and a Western practitioner would see mollera caida as a severe condition that requires immediate attention.

HEALTH CARE PERSPECTIVE TO CONSIDER IN THE EXAM AND TREATMENT OF MIGRANT WORKERS AND THEIR FAMILY MEMBERS:

- Differences in medical and cultural perspectives that must be overcome by health center staff.
- Many patients claim that they do not inform their doctors of alternative medicine or alternative treatments simply because their healthcare providers do not ask about them.
- Alternative or traditional medicine within the Latino culture is deeply rooted in spirituality and religion. In the United States, discussing the basis of illness from a spiritual perspective with a doctor or clinician may not be a welcome gesture.
- Awareness and working with the cultural component of the patient's symptoms associated with certain illnesses and curanderismo practices will facilitate the diagnosis and treatment of a sick patient

"Those who used home remedies were not clear about which home remedy they used for which problem, as many answered that one home remedy was used for many problems.

The majority of those used manzanilla (chamomile) and hierba buena (mint) stated they used home remedies for stomachache, though they were just as likely to say they used home remedies for things like pain, kidney problems and coughs. (2005)

A medical professional at the mobile health unit stated that she has difficulty explaining to adults what basic over-the-counter remedies can be used. Many people are unaware of the uses and benefits of such thigs as cough syrups, and Ibuprofen. Adults do not often understand that pain relievers relieve different types of symptoms and that all "headache medicines" are not created equally."

Resources: http://www.ncfh.org/uploads/3/8/6/8/38685499/fs-folk_medicine.pdf & Angela Branz-Spall, the Montana Migrant Education Director.

Instructor/Facilitator:

Ask group if they have any other information to add from their experience.

Discuss in a group setting how migrant workers could have an adverse healthcare encounter in Montana.

(Examples: Housing, language, moving from community to community, education, lack of medical home.)

Where would we most likely see migrant workers in Montana?

(Most likely in the Flathead Valley during the annual cherry picking season)

Would their presence be year-round or seasonal and why?

(Usually seasonal as they migrate from agricultural jobs locations to the next job opportunity)

Discuss how communication could be difficult with migrant workers.

(In Montana, most migrant workers are Hispanic and are not necessarily English proficient, thereby making healthcare discussions challenging.)

2.15 HMONG POPULATION IN MONTANA

Instructor/Facilitator: Another Minority population in Montana is the HMONG (Mong) Hmong pronunciation: [m̥ɔ̃ŋ]) are an ethnic group in East and Southeast Asia.

HISTORY

In the late 1970s and early 1980s, refugees from Laos began immigrating to the United States. A small group settled in Missoula where they began to assimilate into the American lifestyle. There are approximately 250 Hmong refugees living in Montana, most all in and around Missoula. They are very involved in the Farmers Market held each weekend and contribute culturally to Missoula's demographics.

The transition from life in Laos to America was difficult, exacerbated by language and culture barriers. One of the major problems refugees may face upon their arrival to this country is conflict with the U.S. medical system.

This conflict arises from misunderstanding and mistrust from both health professionals and refugee patients. With refugee children, misunderstandings can escalate.

A more comprehensive understanding of Southeast Asian peoples and their cultures, especially their views regarding illness, can help make this transition much easier both for refugees and health care providers.

Instructor/Facilitator: Ask the participants: How might these traditional beliefs of the HMONG affect health care?

How could these be mitigated?

(This may be an opportunity to utilize Interpter services to ensure that healthcare decisions can be made appropriately while also maintaining cultural respect.)

Due to their unique cultural beliefs and indigenous practices, Hmong refugees settled in the United States often present a unique set of challenges to healthcare professionals. As a people, their adaptation to our western model of healthcare delivery is often slow, hindered by particularly strong traditional beliefs, culturally-based patterns of communication, limited English proficiency, and a deep distrust of governments. Their history as a marginalized people fleeing persecution as war refugees has made them an insular people. Indeed, history has taught them to mistrust outsiders and large impersonal institutions, i.e. hospitals.

FAMILY DYNAMICS AND HEALTHCARE

Role of Mother: It is often women who will converse with healthcare providers, but men usually will make decisions related to healthcare.

Role of Elderly Hmong: The elderly get the most respect of all members of the family and are consulted when important decisions need to be made. They help discipline the younger children. The elderly remain with the family throughout their life. Grandmothers may or may not actually be present during healthcare visits, but they typically make key decisions about managing illness in the family.

Clan Leader: Each clan has a leader. All adult members of a Hmong clan help in selecting their leaders; a leader must be deemed honest, respectful, and capable of making wise decisions. The leader helps make important decisions whenever there is a problem, such as a divorce, illness, or death in the family. The leader is often the person in the clan who decides whether to go forward with a surgery or whether to resuscitate a patient. He calls people together to discuss issues and then he informs the clan members of his decision. Many clan leaders are very powerful indeed.

Religious Leader: A clan leader is often assisted in decision-making by a religious leader called a shaman. Some Hmong shamans are very powerful. They may make the decisions related to spiritual healing. (The book The Spirit Catches You and You Fall Down is an excellent resource for understanding the clan dynamics in healthcare situations involving a sick child.)

VERBAL/NON-VERBAL COMMUNICATIONS

High Context Communicators: Hmong may not communicate dissatisfaction with regards to the quality of their healthcare directly. They may not feel comfortable speaking up, asking questions, etc. Instead, they may politely refuse care and go somewhere else for treatment. Older Hmong are often accustomed to speaking in metaphor, telling a story in answer to a question. The story is important. Concentrated listening on the part of the provider is extremely important, as is asking for clarification of a story's intended meaning.

Avoid Addressing Hmong Women by their first name. Use Ms./Mrs. and a last name.

Eye Contact: Hmong people tend to listen attentively to healthcare professionals, but will often avoid direct eye contact because it is considered rude in their culture.

Be Aware of Your Body Language:
Use a normal tone of voice. Be aware of body language. Hmong who don't speak English fluently will listen intently and interpret what is being said by tone of voice and body language.

• Information about healthcare appointments needs to be written and carefully explained.

• Allow extra time to get consent forms signed as it may involve discussion with Hmong elders and family members.

• Remind Hmong parents about scheduled immunizations for kids. It is helpful to reiterate that immunizations are part of preventive care, a concept unfamiliar in the traditional Hmong medicine tradition.

BELIEFS ABOUT ILLNESS CAUSATION

Traditional Hmong view illness from a holistic perspective. Perfect health is a balance between the spirit and the body. Illness is seen as having either spiritual or physical causes. Typical physical causes are exposure to environmental factors and unsuitable dietary practices including hot/cold food imbalances. Physical illness is treated with various traditional curatives and/or western medical care. Spiritual causes of illness include:

• Evil spirits that are unhappy with the ill person

• Loss of one's own spirit (an ill person has lost their soul)

• Unhappy ancestors (Perhaps someone has done something to offend the family's spirits or ancestors. An example might be forgetting to provide food to needy ancestors or forgetting to make offerings of paper money. Those in the real world offer paper money by burning it; it is converted to silver and gold in the spirit world.

• A curse upon the family by someone

• (Note: Some Hmong accept western concepts of illness causation along with their culture's traditional view)

SPIRITUAL HEALING AND SOUL LOSS

Hmong believe good health depends on souls living in each person. These souls govern the body. Illness or an invasive procedure of any kind can cause soul loss. Spiritual healing rituals are common, often conducted in the home or even in the hospital. Spiritual healing involves retrieving the lost soul from another plane of existence. The practice of soul calling during ritualistic ceremonies is performed by a shaman.

PREVENTIVE CARE

Many Hmong, especially older ones, focus on treating illness when it occurs, but do not have an understanding of preventive medicine or of chronic disease requiring daily treatment even when symptoms are not experienced. Similarly, these are often people who have no concept

of germs causing disease. Younger Hmong who are raised in the US will naturally be much more familiar with these concepts and will be more likely to value preventive medicine. They will understand that immunizations are required when children enter schools. As cross-generational conflicts are common in refugee communities, it is important that healthcare professionals in the US understand the importance of respect – younger Hmong must demonstrate respect for the opinions of Hmong elders to maintain familial harmony.

TRADITIONAL TREATMENTS

Many Hmong continue to use traditional herbal treatments. Others will use herbal treatments as complements to western treatments. Traditionally, someone who is sick is required to eat hot food and certain vegetables. Hmong prefer hot chicken and rice. They drink hot or warm water. Within 30 days of childbirth, Hmong mothers will usually only eat warm foods.

CARING FOR A SICK CHILD IN A HMONG FAMILY

Sick children are often put on a strict dietary regimen, such as eliminating vegetables and only feeding a diet of rice and chicken. Chicken must be boiled, not fried. Herbal medicines are added to the meal in small amounts. Other treatments for physical illness include cupping, coining, and moxibustion. Treatment for illness of a spiritual nature involves religious ceremonies, wearing amulets, or food/animal sacrifices.

IMMUNIZATIONS

Traditionally not acceptable. Hmong believe it is not a good idea to put something into their bodies. If a person is immunized or has surgery, he/she will be reincarnated with less than a complete body or a body with something foreign in it. However, most Hmong parents will have their children immunized once they know it is required for school or other activities.

SURGERY

Usually not acceptable. Opening the body allows the soul to escape; soul loss is one of the Hmong's greatest health concerns. However, in some cases, with the support of the clan shaman and leader, the Hmong are willing to consider surgery.

ORGAN DONATION/ BLOOD TRANSFUSIONS

Traditionally, both are unacceptable. Younger Hmong, however, are more accepting of these medical procedures.
Blood Tests: Hmong accept blood tests. But they may question why they have to have blood taken more than once in one visit or why a large volume of blood is needed.

PRACTICAL TIPS TO ACHIEVE POSITIVE HEALTH OUTCOMES FOR HMONG PATIENTS

Build trust: Building trust from the very outset is essential with the Hmong. Providers need to be open to the family's suggestions. Show respect for the family by listening.

Privacy Concerns: Hmong share information among certain clan members. All staff and all interpreters in healthcare settings must honor the privacy of patients and their families. This policy needs to be communicated to the Hmong.

Alternative Medicines/Herbs/Healing: Ask what care, if any, is already under way? What herbal treatments are being used? What is the source of the herbs?

Should You Inform the Patient Directly: Before sharing information regarding a serious diagnosis with a Hmong patient consult the family. If may be a necessary to hold a conference if there is a major problem or surgery is needed. A conference may need to involve all important family decision-makers including clan leader and shaman. Consider the location. Hold the session in a conference room, not in the patient's room.

Use Hmong Interpreters: Be aware that even if the patient/parents speak English, other important other decision-makers may not. Provide a Hmong interpreter.

Explain Explain! The Hmong may be fearful and distrustful at the outset. Be very clear about details of the patient's condition and intended care (but be sure to talk to important family decision-makers before informing a patient of bad news).

• Explain why many immunizations are needed.
• Explain what a chronic disease is; asymptomatic does not mean cured
• Repeat information about medicines.
• Explain purpose of blood withdrawals. Explain what the test is and why so much blood is needed.

http://www.dimensionsofculture.com/2012/01/providing-healthcare-to-hmong-patients-and-families/

ENTERING THE US HEALTH SYSTEM

The Hmong refugee is understandably confused by the difference between traditional Hmong health Practices and those of the US medical system. On observer described the Hmong plight as follows: "The have jumped 2,000 years in a matter of a few days. It's like cryogenics and they've awakened from a deep sleep for centuries."

The Hmong who enters the US medical system often does so only when all traditional curing methods fail. At this point, the patient is usually extremely ill, sometimes critically.

This emergency health care entry reflects the pattern practiced in their homeland. Their extreme geographical isolation during pre-refugee times prevented them from regularly seeking more sophisticated medical care, which was available only - if at all - in the more urban communities. A family member usually had to be close to death before the arduous trip could even be considered or justified by the clan.

Apart from the spiritual dimension, other cultural differences make Southeast Asians more reluctant to enter the US medical system. The intense cultural shock of relocation, for one, may serve to further confuse the Hmong. They may lose their sense of socioeconomic identity. The significant language barrier sometimes seems nearly impossible to overcome.

The typical Hmong is very shy, conditioned by Hmong culture to remain closed, not revealing fears and anxieties.

CULTURAL

To be respectful, one must ask to speak with the head of the household, usually the father, when conversing with a Hmong family.

Hmong people tend to be humble and may not want to express their emotions in front of others. They may not say “no” directly even if that is what they mean and may say “okay” or “yes” when they mean “no” but feel pressured. Instead of giving a firm positive or negative response, a person may say “maybe” or “I will try”.

For traditional Hmong, making direct eye contact is considered inappropriate and rude. A person may look down or away rather than looking directly at the other person or into their eyes while talking or listening.

To smile when meeting a Hmong person is considered warm, welcoming and friendly, though laughing or speaking roughly may be considered a sign of insincerity and rudeness.

When entering a Hmong home, a seat or chair will be offered. If the visitor does not sit on the family’s furniture, family members might assume that the visitor thinks that something is wrong with their furniture, or that the visitor assumes a higher status than the family.

Before entering a Hmong home, ask if visitors are allowed to enter. Traditional families may have just had a shaman perform a ritual when a woman has given birth, or a ritual to get rid of bad spirits. For a period following this ritual, visitors are not allowed to come into the house, wear shoes and carry handbags into the house.

Watch for a taboo sign outside the front of the house indicating the family should not be disturbed because the house is being protected from evil spirits. The sign may look like a cross, made of sticks with some green leaves, or may consist of a simple cluster of green leaves. A white or black woven octagon shaped basket made of bamboo or plastic may be placed next to the leaves. Upon observing this sign, do not knock or enter the house.

Most traditional Hmong elders, especially men, do not want strangers to touch their heads, or those of their children, due to their religious beliefs and personal values. It is considered dangerous to remark out loud about the cuteness or positive qualities of a child, as spirits may hear and steal the child’s soul.

PREGNANCY

Pregnancy is considered sacred and especially fragile in the first trimester. Traditionally, young pregnant women are encouraged not to inform others about the pregnancy due to a fear of evil spirits that would endanger the pregnancy leading to spontaneous abortion.

The pregnancy is kept unknown until it becomes self-evident in the later trimester cycles. Today, some Hmong women may not seek early prenatal care for this reason. In addition, due to lack of medical knowledge, the gender of the infant is said to be due to the faith (luck)

of the women. For instance, if the first child is a boy, it is said that the daughter in-law/wife has brought good fortune.

CHILDBIRTH AND POST-PARTUM PRACTICES

In Hmong culture, mothers and mothers-in-law help at the birth, which often occurs in the squatting position, with the husband helping to cut the cord and wash the newborn infant. Women prefer natural tearing and healing to clinical episiotomies. Today, a woman requiring a Caesarean section under general anesthetic may have concerns that when her body is cut, her soul will be lost. Traditionally, Hmong believe the placenta is required for reincarnation and bury it at the place of birth, under the house.

Traditionally, the woman is kept warm for three days post-partum, and touching cold water is prohibited. In Laos, women lay by fires. In the US, women may wear warm clothes and use heating. Women should drink hot or warm water after birth. There is a belief that drinking cold water or failing to eat properly can lead to having wrinkles or skin rashes, or walking bent over in old age.

In the hospital, women might not eat the hospital diet. Traditionally they should eat hot rice and chicken soup with special herbs for 30 days post-partum. Eggs, pork and some fish may be added after the first 10 days. No fruit, vegetables or cold drinks are allowed. Physical activity post-partum is also restricted, as this may cause internal organs to collapse. Furthermore, during the first 30 days, a new mom is not permitted to visit other homes.

DEATH

When an old person dies, the body is usually kept inside the house for five to ten days. The body must be kept in the house until the deceased's family and relatives arrive. Members of a shared ceremonial family – those who can trace common ancestors between them, rather than people belonging to a clan or sub-clan by virtue of a shared name – can die and have funerals in one another's house.

A funeral consists of 5 days of ceremony including speeches, drumming, hours-long chants to guide spirits home to Heaven, and ritualized crying – a way of declaring love for the person.

Traditionally, Hmong graves can be a mound of earth on which tree branches are piled to protect disruption by animals, a mound of earth surrounded by a wooden fence, or a mound protected by boulders, the type depending on sub-clan funeral tradition.

In the United States, it still may be important for terminally ill patients to return home to die, as the soul of a person who does not die at home may wander and not be reincarnated.

Family members of the deceased may refuse autopsies, and reasons for this include belief that intact body parts and organs are needed for smooth reincarnation and response to rumors that organs are taken out for eating and for sale. *(Cha, 2003)*

https://ethnomed.org/culture/hmong/

TOP TEN HMONG TRADITIONAL CULTURAL BELIEFS

1. ANIMISM

Hmong traditionally believe animism, and this is used widely in the Hmong religion. This belief is that everything has a soul or spirit, every living being to natural objects. The traditional Hmong believe there is a Superior Being that created all these living beings. The Supreme Being is responsible for all the living beings and the spirits inherited in each being. The spiritual world coexists with the physical world which can influence human life due to the multiple spirits that exist in this world.

2. SHAMANISM

Shamanism is the traditional belief of the Hmong. Shamanism consist of a Shaman, which are human beings, that travel between the visible and the spirit worlds through ritual practices. The practices are conducted for purposes of healing, divination, and control over natural events. The Hmong Shaman also known in Hmong as, Txiv Neeb, is the traditional healer that cannot be studied or passed on to one another but is chosen from healing spirits called "Dab Neeb." These spirits chose their host by causing illnesses and examples are intolerable foods, fatigue, weakness and more. Shamans are all different and hold a different level of healing power. Some specialize in certain fields of illness. Hmong Shamans are roughly capable of mending to most kinds of sickness. Shamans also diagnose and refer patients to other sources if they are unable to cure the patient. For Shamans to be able to go from the physical world to the spirit world, they need the following: The gong "nruas," the rattle "txiab neeb," the buffalo horn "kuam," the rattle rings "tswb neeb," the sword "riam neeb," a red hat or black clothes, a bowl of holy (shaman) water, a bowl of uncooked rice for incense base, a few dozen incense sticks, and a bowl of uncooked rice with eggs.

3. HUMAN SOULS

Hmong souls are differentiated from spirits and are the spiritual energy inside a person's body. The belief is that people have 12 souls. The three major ones are the reincarnation soul, the residing soul and the wandering soul. The reincarnation soul leaves the body at death and is reborn in another being's body. The residing soul stays with the body as it breaks down and becomes the ancestral spirit that descendants revere and pay homage to. The wandering soul leaves the body during dreams to play with other souls or spirits. If frightened, the wandering soul may be lost in the spirit world. At death, *the* wandering soul returns to the spirit world and continues to live life there much as it did in the physical world.

4. ANCESTRAL SPIRITS

Each Hmong family has a group of ancestor spirits, which belong to the fathers/ husband's side of the family. From time to time the ancestor spirits need certain things from the descendants' family to be used or spent in the spiritual world by causing illness in a member of the family. To make appropriate diagnosis a shaman or diagnostician must be called in and may begin a ritual of animal sacrifice as an offer to the ancestor spirits. If a request is fulfilled, they will protect the descendants from illness and natural disasters. Variations in rituals are found in the practices among different clans and lineages and are passed down from generation to generation through oral tradition. Traditionally, about once a year, the Hmong call in their ancestors to come eat with the family as a way to pay respect and give thanks.

5. HOUSE SPIRITS

Traditionally, there are six house spirits who plays important roles in the house by guarding the individual person's souls and spirits and fending off any outside spirits. The spirits of the of fire or stove and the spirit of the kitchen, which is the middle floor, helps protect every member of the entire family ancestor spirits from harm or misfortune. The spirits live in the central pillar and defends any evil against the households. The spirit of wealth and prosperity live in the middle back wall of the house and protects the entire household. The spirit of the marital bedroom lives in a gourd in the bedroom and the gourd needs to be kept clean.

6. WILD SPIRITS AND LOST SOULS

Hmong traditionally believe that there are spirits everywhere and in everything. Wild spirits dwell in trees, rocks, streams, and other places of nature. Calls and offerings are made to these spirits to provide protection in any major undertaking, agricultural work and/or trade. Hmong traditions believe that crops, domestic animals, silver, gold, and money also have souls; and if they can attract these souls to come live with them, they will prosper. Hmong people may offer paper money to nature spirits, so they will prosper with their crop or business. There are nature spirits that controls their properties like hills, mountains, rivers, caves, trees, animals, and its kingdom. Nature spirits do not harm humans unless offended. Then they can cause illness to the offender or family members. Evil spirits are believed to live everywhere, especially in uninhabited areas such as forests and jungles. When these evil spirits get offended, they will attack the perpetrator and cause pain, sickness and/or death.

Hmong traditions believe that each person has twelve souls - three major souls and nine shadow souls-united in the body. The more souls lost and the longer they are lost, the sicker the person will be. The souls can be lost in any way from fear, depression, trauma, kidnapped by evil spirits, a long trip, and simply getting lost. Calling the soul back ranges from

different ceremonies in complexity to simple soul callers. Hu plig is where a shaman, with his spirit healers, uses a gong and a buffalo horn, to call back the lost soul.

7. TAMED SPIRIT MASTERS

In Hmong tradition, the Tamed Spirit is called Txiv Khawv Koob, also known as Black Magic.

There are two kinds of spirit masters, the good and the bad. The good spirit masters are the healers to the people. These spirit healers have similar powers in removing foreign objects from the body that cause illness, stopping blood flow from a fresh cut, wound or nosebleed, healing broken bones, burns, speeding up labor and delivery, and removing various aches and pains. One downfall is these good spirit healers are not able to fend off attacks from tamed evil spirits, nor possess the power to cause illness in others with spirits. They are only able to cure one another.

The Tamed Evil-Spirit Master can cause illness or cure the illness and undo attacks by other Tamed Evil-Spirit Masters. This spirit master can remove and insert objects from and into a person's body. The foreign objects cause various types of acute pains, illnesses and death. The tamed evil-spirit masters are feared by the Hmong society, so they keep their skills a secret.

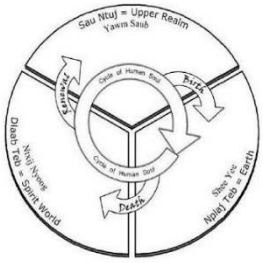
8. GENDER ROLE

Traditionally, men have a higher status in public because they are the head of the family. They take care of household events, important decisions with the clan, performing rituals and calling the names of ancestors during occasions like New Years, weddings, christenings, new harvests, family feasts, invoking the dead and more.

The women tend to stay home but they are the leader at home, performing all tasks that need to be done cooking, cleaning, and raising children. Traditionally, women do not go to school but work at home.

9. LIFE AND DEATH CYCLE

When a person dies, the body is traditionally kept inside the house for five to ten days until relatives and the deceased's family arrive. The funeral of a person traditionally last five days including speeches, drumming, hours-long chants to guide spirits home to heaven and ritualized crying a way of declaring love for the person. The traditional Hmong believe that it is important to return to the deceased's hometown, from where he/she belongs so they can reincarnate. Hmong traditionally believe that each person carries a visa from God, and this determines the length of a person's stay on Earth. Deaths are usually meant that their visa has expired. To restore a person's visa, a shaman must perform a ritual of trance or incarnation, make negotiations to extend or renew the visa.



10. KARMA

Karma is a strong belief in the traditional Hmong culture. Which is why they believe a person should do good deeds to receive good deeds in life. Karma is strongly believed across Asia, but Hmong believes that souls return to earth time after time, and life on earth is designated by luck, and by karma. Traditional Hmong culture describes people born with birth defects, mental retardation, handicaps, and chronic illnesses are often regarded as paying for sins committed in past lives.

CONCLUSION:

Traditionally, Hmong believe that an illness has either a spiritual or physical cause. In addition to using Western medicine, some Hmong will call on a shaman, religious leader, to perform healing ceremonies for illness that may have a spiritual cause. Illness may be caused by evil spirits, a curse from an unhappy ancestor, or because the spirit has left the body.

Demystifying Hmong Shamanism: Practice and Use. This book discusses shamanism as practiced and experienced by Hmong Americans, 2015.

Hmong Shaman Work with Traditional Doctors to Heal Patients at California Hospital. A small hospital allows spiritual shamans to perform healing ceremonies on patients in conjunction with the hospital staff's more traditional medical care. Mother Nature Network, March 12, 2017.

Providing Healthcare to Hmong Patients and Families. Overview of diversity within the Hmong community, spiritual healing, beliefs of causation of illness, vaccinations, traditional treatment.

INCLUSION

2.16 Lesbian, gay, bisexual, transgender, queer or questioning (LGBTQ)

Instructor/Facilitator: Ask if the partipants what the Acronym LGBTQ stands for. Emphasize: *The acronym **LGBTQ** is meant to include all sexual orientations, gender identities and expressions. We understand that identities are not limited to the terms represented by the letters in this acronym and aim to be representative of the entirety of identities across the queer spectrum."*

WHAT DOES "LGBTQ" STAND FOR?

According to an article written by Kristin O'Conner on August 20, 2017, this is the general accepted definition. Many of us have heard of the term's "LGBTQ" or "LGBT". Please note that these are not official definitions, nor are they agreed upon between communities.

L stands for lesbian, which can be defined as a person who identifies as a woman being attracted to another person identifying as a woman.

B stands for bisexual, which is usually defined as a person being attracted to both women/females and men/males. Being bisexual does not mean that a person cannot decide what they like, or that they are actively trying to date both genders. Bisexuality is usually seen as a spectrum, where a person can sometimes favor one gender over the other. Bisexuals can remain bisexual regardless of who they are in a relationship with.

T usually stands for transgendered. Transgendered is when a person's identity and gender does not correspond with their birth sex. Transitioning from one gender to another is a very personal journey and should not be probed or revealed without the person' consent (for example, asking about a person's genitals or birth name is not appropriate). Generally, whatever gender a person identifies with is the gender they should be addressed with (for example, a woman born in a male's body is referred to as a woman, unless they state otherwise). It is important to note that this definition does not deal with sexual orientation, as the first three do.

Q can either stand for "queer" or "questioning". Queer is a broad term that covers many marginalized groups. Some, not feeling comfortable with falling under other labels (such as gay or bisexual or transgendered) prefer to call themselves queer. Queer also has a

background of once being a slur, so not everyone feels comfortable using it. Questioning means that the person is still unsure what type of label, if any, they fall under.

LGBTQ youth may face discrimination in their communities, whether urban, suburban or rural. LGBTQ young people living in rural communities potentially also face multiple barriers accessing services and supports.

The acronym **LGBTQ is meant to include all sexual orientations, gender identities and expressions. We understand that identities are not limited to the terms represented by the letters in this acronym and aim to be representative of the entirety of identities across the queer spectrum."*

Acknowledging someone's experiences, what brought them to this place, and their personal history is an integral step in establishing a relationship of trust with a patient. Care often begins with meeting someone where they are, physically, emotionally, and psychologically, and medical practitioners have the unique opportunity to provide these very supports. Despite these efforts, LGBTQ communities experience significant degrees of discrimination and violence that can be fostered, condoned and maintained throughout many systems of care[1]. The fear of ongoing harassment and violence can force many LGBTQ youth to spend energy questioning their worth, censoring themselves and their movements, and potentially limiting their opportunities for selfcare, whether personally or professionally.

Given these realities, it is essential that medical settings and the people who provide care are both respectful and responsive to the diverse needs of LGBTQ youth.

WHAT WOULD THAT LOOK LIKE IN PRACTICE?

KNOW THE RISK FACTORS

65% of LGBT young people living in rural communities reported hearing homophobic remarks from their teachers, while 81% of the same young people felt unsafe in their schools.

28% of Trans and gender nonconforming people have experienced verbal harassment in a medical setting[2]

Accessing care can be a challenge. Nearly 1 in 5 Trans and gender nonconforming people have been refused treatment at one point in their lifetime.[2]

28% of sick or injured Trans and gender nonconforming people reported that they postponed medical care due to discrimination and 48% postponed due to an inability to afford care[2]

Lesbian, gay and bisexual (LGB) youth are more likely to experience physical and psychological dating abuse, sexual coercion and cyber dating abuse than their heterosexual peers[3]

Lesbian, gay and bisexual (LGB) youth are more likely than their heterosexual peers to seek help after experiencing dating abuse.[3]

Fifty percent of Trans and gender nonconforming people have had to teach their medical providers about transgender care.[2]

CREATE A CULTURE OF RESPECT

Create a culture of respect where everyone is valued, and their identity and self-determination are respected.[4]

Not sure what someone's **gender pronouns** are? **Ask**. Use a person's self-identified pronouns (She/Her, He/Him, They/Them, Ze/Zir/Zem/Zeir, Xe/Xir/Xem/Xeir, etc.). This helps to establish rapport from the very beginning including at the welcome desk or reception/admitting.

Assess the overall environment, approach to marginalized patients, and staff's perceptions. Consider staff's willingness to support all patients regardless of identity, their openness to learning best practices for interaction and care, and commitment to addressing any problems that may occur in the workplace.

Examine accessibility barriers. One way to reduce barriers is to establish a welcoming and respectful space; this is an important step in making patients feel comfortable. Consider subscribing to national LGBTQ magazines or newsletters, and display posters and brochures in waiting, reception, and treatment areas depicting images that people can relate to, as one step.

Organizations in rural communities that work with LGBTQ youth can enhance their effectiveness by creating safer, more welcoming, and accessible programming. This can be done in multiple ways, from collaborating with LGBTQ organizations to speaking with members of these communities, or even something more basic like doing online research if in-person support is not an option.

VALUE IDENTITIES

Develop and operationalize inclusive intake forms and paperwork as a measure to show that you value all patients equally. Many intake forms are exclusionary without realizing it Break the binary of male and female. Offer additional options for patients to report their gender identity (transgender, gender queer, etc**.).**

Make sure to leave a blank space for those who wish to self-identify but avoid labeling that option as "other." Include options beyond heterosexual and bisexual as the only sexual orientation choices.

Consider bisexual, asexual or pansexual (not limited in sexual choice with biological sex, gender, or gender identity.), etc., and leave space for self-identification. **Unless medically necessary for the care a patient is requesting, avoid questions about a patient's preferred sexual partners.**

Enhance knowledge of terminology, for example, FTM (female-to-male), MTF (male-to-female), passing, and binding, are just some of the many terms that patients may use.

BE MINDFUL

It is important to avoid making a patient feel as if they need to teach you something[6], especially something you may be able to find through online research or a community partner organization.

Curiosity is natural, but it is essential to follow proper protocol and etiquette when working with LGBTQ youth. **Do not ask questions abou:**

- **A community**
- **Sexuality**
- **Gender identity**
- **or transitioning that is not related to a patient's medical care.**

While inquiring about physical conditions, traits, marks, sexual history, surgical history and other common intake questions, be intentional that you are only asking the questions that are relevant to why that patient is seeking services. If you must chart injuries, particularly on a form with a gendered figure, do so outside of the patient's room.[7]

If a situation presents itself when there is a medical reason to ask about information that may seem sensitive, assure your patient that this is a normal question that you ask everyone seeking similar medical attention. This can help to relieve anxiety about being used as a curiosity or study case and can even help increase rapport.

BE RESPONSIVE

Confidentiality is important for supporting young LGBTQ patients. LGBTQ youth may be hiding their identities due to abusive partners, community, or family members. Communicate with patients if records of their sexual orientation and/or gender identity may be available to parents through their medical records. If parental notification is subjective or flexible, keep this in mind as outing a young person can have serious ramifications.

Know what you don't know. Fifty percent of Trans and gender nonconforming people have had to teach their medical providers about transgender care. Remember that being culturally informed is not a box to check; it requires lifelong learning.

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Additional Resources

https://www.breakthecycle.org/sites/default/files/TipSheet_MedicalSetting_2016FINAL.pdf
http://www.lgbtqi2stoolkit.net/pdf/GLMA_Quality_Healthcare.pdf
https://www.apa.org/pi/about/newsletter/2015/12/affirming-supporting
https://www.apadivisions.org/division-44/resources/advocacy/transgender-children.pdf
https://www.healthychildren.org/English/ages-stages/gradeschool/Pages/Gender-Diverse-Transgender-Children.aspx
https://www.aap.org/en-us/Documents/solgbt_webinar_transition_garofalo.pdf

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2.17 MENNONITES AND AMISH POPULATIONS IN MONTANA

Instructor/Facilitator: The Amish are very cautious health care consumers. They pay for most of their medical procedures out-of-pocket and in cash. All forms of insurance are generally discouraged, including medical health care coverage. Purchasing insurance shows a lack of faith in God who provides.

If there does not seem to be improvement as a result of their own remedies, then they will usually turn to health care providers for service. Thus, when an Amish person does show up in the emergency room, the provider often assumes that the person has already experienced much pain and may be advanced in their medical condition.

With the emphasis on communal care rather than individual care, the decision is often made to forgo a procedure that is deemed too costly – and may burden the community too much. It is common for Amish to reject extraordinary measures to save a life, as such measures may attempt to interfere with God's will.

Knowing that the Amish prefer to stay at the bedside of a loved one during a hospital stay, nontraditional visitation hours are commonly accepted. Knowing that the Amish prefer to pay cash – fee reductions for cash, payment are the norm.

ASK: How can these beliefs affect medical care?

Mennonites and Hutterites are communities based on Anabaptist; with roots that trace to the 16th Century's Radical Reformation. Mennonite followers were named after Frisian Menno Simons; Dutch Catholic Priest. Teachings of the community are based on their belief in ministry and mission of the Jesus Christ. Mennonites are documented in America as early as 1633, with the first permanent settlement was in Germantown PA area in 1863.

The **Mennonites** historically have been **known for their nonviolence**, their emphasis on issues such as peace, justice, simplicity, community, service, and mutual aid. They are opposed to military services; however, they respond to disasters as an alternative means of serving their country. Mennonite Christians believe in living in the world but not being of the world in terms of embracing worldly spiritual and moral values. The Mennonites embrace technology but warn against falling for its temptation.

Mennonites have their own churches, although the majority live amongst the general population. They practice a plain and simple lifestyle and have a moderate use of modern technology. **Mennonites allow electricity and telephones in their homes. Some Mennonites depend on horses for transportation, however, most drive cars**.

Girls and women dress in calf-length dresses and aprons, their long hair is tucked into bonnets or scarves. Women may dress for work in boots, leather gloves, jacket or sweatshirts and jeans. Men can be seen wearing blue jeans and flannel shirts. Some Mennonites are not visually distinct regarding clothing/ dress.

Some Mennonites end their formal education with eighth grade, but others continue their studies. Mennonites have private schools with a church focus. Many communities have Mennonite teachers, using their own Mennonite syllabuses for teaching and class activities.

Older order Mennonites may speak Pennsylvania Dutch, a German dialect. Members of conservative Mennonite communities may use English.

MONTANA MENNONITE CHURCHES AND SETTLEMENT INCLUDE:

- **Ashland Christian Fellowship: Ashland**
- **Lame Deer Mennonite Church: Lame Deer**
- **White River Cheyenne Mennonite Church: Busby**
- **White Chapel Mennonite Church: Glendive**
- **Reedpoint Montana**

Resources: https://www.differencebetween.com/difference-between-mennonites-and-vs-hutterites/

C:\Users\perklanc\Desktop\Who Are Mennonites_ — Mountain View Mennonite Church.html

https://billingsgazette.com/news/state-and-regional/mntana/mennonite-volunteers-help-montana-ranchers-fix-fence-damaged-by-hobble/article

AMISH

The Amish are descendants of the 16th Century European Anabaptists. The Amish separated from the Mennonites in the late 1600′s, are widely known for their plain dress and rejection of modern technology and conveniences. The Amish are a division from the Mennonites named for Jacob Amman. The Amish sought religious tolerance and emigrated to the United States in 1730, many settling in Lancaster Pennsylvania region.

The Amish have strong commitment to lead a simple lifestyle and live-in close-knit communities. The Amish are very resistant to technology. The Amish are strict followers of nonresistance.

The Amish believe in keeping themselves spiritually focused by limiting their interaction with modern society, Mennonites believe in practicing Jesus' teaching of service to others in a broader context. The Amish practice a strict religious code of manner and dress. Amish communities embrace tourism, selling Amish-made crafts, opening restaurants and inns and taking visitors on buggy tours of their communities.

In Montana there are a few Amish communities; the oldest at Rexford in Lincoln County, across Montana to Rosebud County. There are seven settlements with estimated population of 760 in 2018.

- Rexford: settled in 1974. The area is known as West Kootenai Amish community
- St. Ignatius: settled in 1997, Mission Valley Amish Community. (Stores and auctions)
- Jefferson County: near Three Forks on the Jefferson River
- Fergus County
- Rosebud County
- Libby Community: previous members from the West Kootenai group.
- Dawson County: settled in early to mid-1900's. Ceased to exist in 1935

The Amish believe in the nuclear family structure, with one woman and one man who are married and raise children together. The Amish practice traditional gender roles. They believe that women should be subordinate to their husbands. Husbands are generally responsible for providing the family with financial stability, while wives oversee maintaining the home and raising the children. In some cases, wives run home-based businesses, such as small shops and gardens, but they seldom work outside the home. Although husbands are regarded as the spiritual head of the household, wives play an important role in fostering spirituality in their children.

Pennsylvania Dutch, a German dialect, as their first language. Distinctive old-fashioned clothing. The men grow beards. Most Amish use horse drawn buggies. Some may drive cars, speak English (known as Beachy Amish). Typically, the Amish end their formal education with the eighth grade.

HEALTHCARE:

The Amish pose challenges for providers of healthcare. Building trust and respecting cultural differences is important in working with Amish communities.

Similarly, many Amish and Mennonite children aren't fully vaccinated against communicable diseases and must now get immunized to attend schools.

Although they do not object to surgery or other forms of high-tech treatment, they are less inclined to use heroic life-saving interventions and are less likely to intervene when their elderly face terminal illness.

Considerations when working with Amish and meeting the healthcare needs:

Usually do not seek medical attention for minor aches and illnesses. Modern medicine is seen as a last resort rather than a first response.

Amish are likely to use folk remedies and drink herbal teas

Lack of health insurance. Reliance and support from the community are influenced by cultural factors and rural values such as natural antidotes, a lack of information, a sense of awkwardness in high-tech settings, difficulty accessing health care, as well as a willingness to suffer and lean on the providence of god.

RESOURCES:

http://mennoworld.org/2019/05/13/news/amish-pose-challenges-for-providers-of-health-care/ May 2019

https://groups.etown.edu/amishstudies/cultural-practices/health/

https://classroom.synonym.com/core-beliefs-philosophies-amish-5411.html

https://themennonite.org/mennonites-amish-pennsylvania-dutch-language/

sonline.com/story/news/special-reports/2019/10/10/amish-and-mennonites-differ-language-worship-and-education/3865079002/

https://groups.etown.edu/amishstudies/statistics/population-2018/

3.0 TRAUMA INFORMED CARE

Instructor/Facilitator:

Over the past two decades, professionals in education, health, and human services have become more aware of the wide-ranging effects of trauma on health and well-being.

Starting with the landmark Adverse Childhood Experiences study in the late 1990s, which linked the experience of potentially traumatic experiences in childhood to a wide range of long-term health effects, researchers have gone on to explore how adverse events experienced as trauma correlate with everything from graduation and incarceration rates to preterm birth.

In response to this research, practitioners have developed clinical and systems-based trauma-informed approaches to better support traumatized individuals and create environments that are sensitive to their needs while preventing re-traumatization.

Because of the emerging evidence that these approaches may improve health and academic outcomes, there has been a groundswell of interest in trauma-informed approaches in Montana.

Trauma-informed care is not a therapy, intervention, or specific action. **It is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives.**

Trauma is:

- extreme stress that overwhelms a person's ability to cope.
- An event, a series of events, or set of circumstances that harms a person's physical or emotional well-being.
- A medical office or hospital can be a terrifying experience for someone who has experienced trauma, particularly for childhood sexual abuse survivors. The perceived power differential, being asked to remove clothing, and having invasive testing can remind someone of prior episodes of abuse.

This can lead to anxiety about medical visits, flashbacks during the visit, or avoidance of medical care.

IMPACT OF TRAUMA

- Increases the risk of neurological, biological, psychological and/or social difficulties such as:
- Changes in brain neurobiology;
- Social, emotional & cognitive impairment;
- Adoption of health risk behaviors as coping mechanisms (eating disorders, smoking, substance abuse, self-harm, sexual promiscuity, violence); and
- Severe and persistent behavioral health, physical health and social problems, early death. (Felitti et al, 1998)

HOW VIOLENCE & TRAUMA AFFECT YOUR PATIENTS

Current violence can result in direct injuries such as bruises, knife wounds, broken bones, dental problems (e.g., loss of teeth), traumatic brain injury, back or pelvic pain, or headaches.

Ongoing violence can lead to cardiovascular, gastrointestinal, endocrine and immune system problems, exhaustion, sleep disorders, and psychological symptoms such as depression or substance abuse.

Childhood adversity and early life trauma can impact brain structures and energy metabolism, leading to a “cascade of risk factors” and ultimately to a wide range of chronic health and mental health conditions.

TRAUMA-INFORMED CARE SHIFTS THE FOCUS FROM *"WHAT'S WRONG WITH YOU?"* TO *"WHAT HAPPENED TO YOU?"*

A trauma-informed approach to care acknowledges that health care organizations and care teams need to have a complete picture of a patient's life situation — past and present — in order to provide effective health care services with a healing orientation. Adopting trauma-informed practices can potentially improve patient engagement, treatment adherence, and health outcomes, as well as provider and staff wellness. **It can also help reduce avoidable care and excess costs for both the health care and social service sectors.**

Video: What is Trauma-Informed Care? Explore additional videos addressing the benefits of trauma-informed care. LEARN MORE » https://www.traumainformedcare.chcs.org/trauma-informed-champions-from-treaters-to-healers/

TRAUMA-INFORMED CARE SEEKS TO:

- Realize the widespread impact of trauma and understand paths for recovery;
- Recognize the signs and symptoms of trauma in patients, families, and staff;
- Integrate knowledge about trauma into policies, procedures, and practices; and
- Actively avoid re-traumatization. (Adapted from the "The 4 R's'" from Substance Abuse and Mental Health Services Administration's "Concept of Trauma.")

What are the principles of trauma-informed care?

Following are recognized **core principles** of a trauma-informed approach to care that are necessary to transform a health care setting:

Safety

Throughout the organization, patients and staff feel physically and psychologically safe

Trustworthiness + Transparency

Decisions are made with transparency, and with the goal of building and maintaining trust

Peer Support

Individuals with shared experiences are integrated into the organization and viewed as integral to service delivery

Collaboration

Power differences — between staff and clients and among organizational staff — are leveled to support shared decision-making

Empowerment

Patient and staff strengths are recognized, built on, and validated — this includes a belief in resilience and the ability to heal from trauma

Humility + Responsiveness

Biases and stereotypes (e.g., based on race, ethnicity, sexual orientation, age, geography) and historical trauma are recognized and addressed

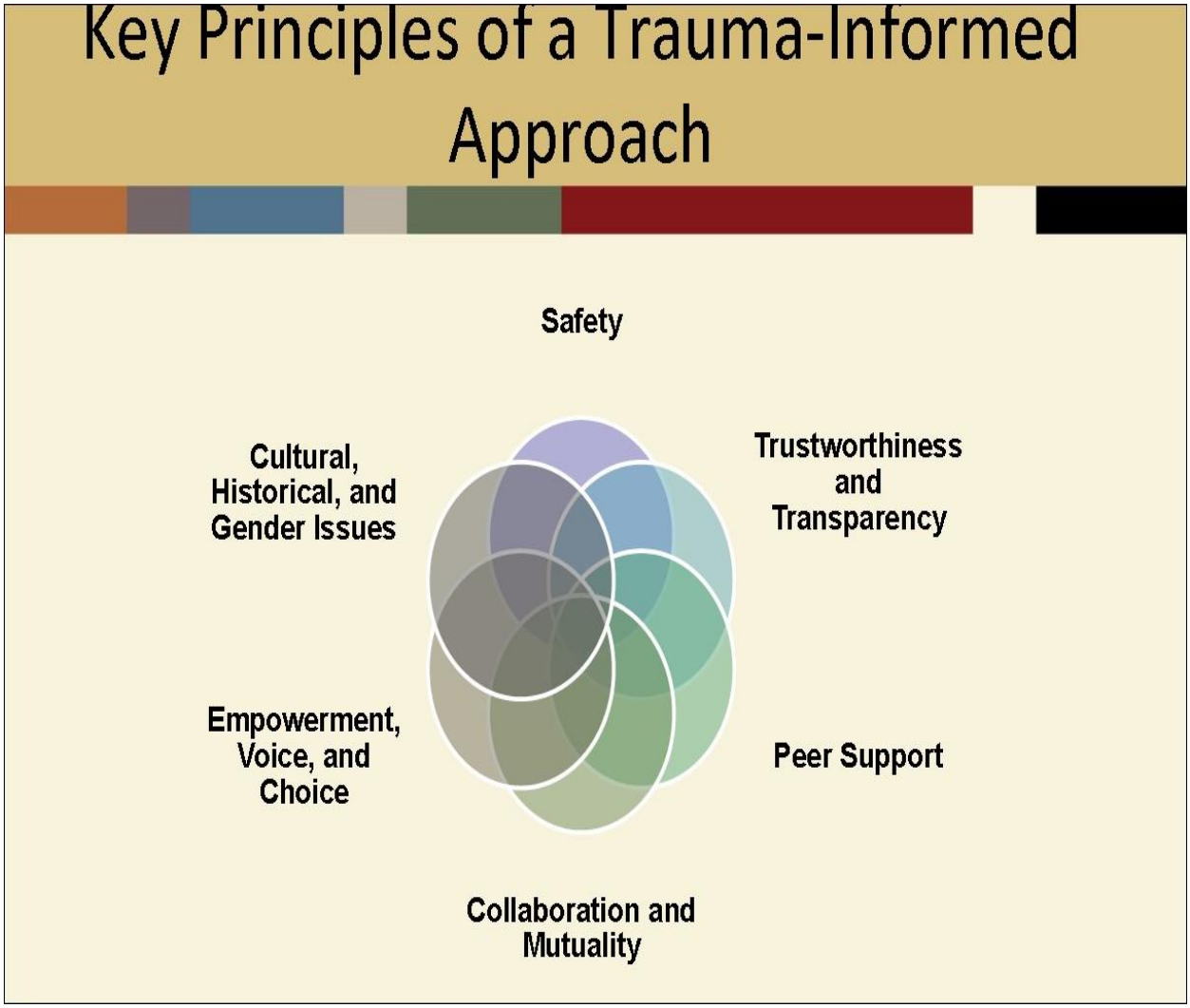
*(Adapted from the Substance Abuse and Mental Health Services Administration's **"Guiding Principles of Trauma-Informed Care."**)*

Any experience of violence and trauma can affect patients' engagement in health care *(examples)*

- ☐ Repeatedly missed or cancelled appointments
- ☐ Avoiding preventive care
- ☐ Poor adherence to medical recommendations
- ☐ Chronic unexplained pain
- ☐ Anxiety about certain medical procedures

Ways Medical Care Can Trigger Re-Traumatization:

- ☐ Invasive procedures
- ☐ Removal of clothing
- ☐ Physical touch
- ☐ Personal questions that may be embarrassing/distressing
- ☐ Power dynamics of relationship
- ☐ Gender of healthcare provider
- ☐ Vulnerable physical position Loss of and lack of privacy



WHAT DOES TRAUMA-INFORMED CARE LOOK LIKE?

The first step is to recognize how common trauma is, and to understand that every patient may have experienced serious trauma. We don't necessarily need to question people about their experiences; rather, we **should just assume that they may have this history and act accordingly**.

For someone who has experienced trauma, the hospital or doctor's office can be a scary place. Patients often do not volunteer such information about prior experiences, because of guilt or shame. Medical professionals often ask about safety in a patient's present relationships, but few ask about past experiences.

SIMPLE QUESTIONS TO ASK SUCH AS:

Is there something that makes seeing a practitioner or having a physical examination difficult for you?

"Is there anything I can do to make your visit and exam easier?" can lead to more sensitive practices geared to developing a trusting relationship.

Is there anything causing you anxiety with this medical visit?

Would you prefer a family member present?

Instructor/facilitator:

Ask participants if they have any other questions, they might ask the patient/family member, etc.

How easy is it to ask questions like these?

What might help the situation become easier?

TRAUMA-INFORMED CARE IS NOT ABOUT GETTING A DISCLOSURE BUT MORE ABOUT EMPATHY, COMPASSION, CARE AND UNDERSTANDING.

Adopting trauma-informed approaches to care can potentially improve patient engagement, enhance outcomes, and reduce avoidable care and excess costs for both the health care sector and social service systems.

Another key aspect of trauma-informed care is raising awareness among staff about the impact that trauma has on both patients and staff.

The cultural considerations component of the D-E-F protocol helps providers implement culturally competent pediatric trauma care in a manner that considers a child and family's unique cultural beliefs, values, and practices.

How to Assess: Culturally Sensitive Trauma-Informed Care

...QUESTIONS PROVIDERS SHOULD ASK

LISTEN

...for variations in understanding. Ask:

- What is your understanding of what's happened?
- What is worrying you the most?
- What does your family think about it?

BE OPEN

...to involving other professionals. Ask:

- Who do you normally turn to for support?
- Who else should be involved in helping your child?
- Are you open to outside referrals and resources?

RESPECT

...different communication practices. Ask:

- Who typically makes the decisions about your child?
- What information should be shared with your child?
- Is there anyone else you would like me to talk to?

How to Help: Culturally-Sensitive Trauma-Informed Care

...TIPS FOR PROVIDERS...

Families may attribute distress to culturally specific beliefs.

- Consider somatic/behavioral presentations of distress.
- Listen for and use the family's own terms.
- Attend to distress in the way the family defines it.

Families may have distinct traditions for decision-making and communication.

- Ask about decision-making practices in advance.
- Respect parents' wishes regarding what their child should know.
- Be open to involving other healing professionals and customs.

Families may be reluctant to seek help outside their cultural community.

- Connect families with community resources they trust.
- Be sensitive to the family's fear about immigration and legal status.
- Show respect by working within and through the family structure.

Instructor/facilitator:

Have printed copies of the ACE Questionnaire for each participant. Explain that the results are confidewntial and there is no need to share.

Give the group about 10 minutes to complete the questions.

State: that their answers are confidential and there is no need to share if they are uncomfortable. If you experienced adversity in your childhood, we highly recommend you take this survey only when you have appropriate support nearby such as someone you can trust or a mental health professional.

Reiterate that taking the following survey may activate emotions in you, which may be disturbing.

ADVERSE CHILDHOOD EXPERIENCES (ACES) - DO YOU KNOW YOUR ACE SCORE?

The Adverse Childhood Experience (ACE) Questionnaire is a 10-item self-report measure developed for the ACE study to identify childhood experiences of abuse and neglect. The study posits that childhood trauma and stress early in life, apart from potentially impairing social, emotional, and cognitive development, indicates a higher risk of developing health problems in adulthood.

HOW THE ACE QUESTIONNAIRE RELATES TO PHYSICAL AND MENTAL HEALTH

The questionnaire identifies major risk factors that may lead to the development of health and social issues among people. Besides suggesting that an individual may be more likely to experience health issues later in life, this questionnaire also shows how childhood trauma affects the mortality rate: The life expectancy of an individual with an ACE score of six or more may be reduced by up to 20 years.

The ACE Study suggests that there is a significant link between adverse childhood experiences and chronic disease in adulthood, including heart disease, lung cancer, diabetes, and autoimmune diseases.

The questionnaire may be able to help those who have a high ACE score become more informed about their increased risk factor for health issues. It could also encourage them to seek treatment or therapy if they have not already done so. Additionally, the study highlights how these childhood experiences influence the possible development of mental health issues in adulthood and may serve to assist mental health professionals in better understanding certain mental health concerns.

The connection between adverse childhood experiences, social issues, and adult mental and physical health might also be used to help inform programs and health policies that support prevention of these issues and recovery from them.

In 2011, 60% of Montana adults reported having one or more ACEs. A higher percent of American Indian than white non-Hispanic adults reported experiencing four or more ACEs, as did adults who had not completed high school compared to those who had more education, adults with lower annual incomes compared to those with higher incomes, and adults with disabilities compared to those without disabilities.

On the ACE Questionnaire, please answer the questions and find your ACE Scores. This is confidential, and no one needs to share their score. The Questionnaire can be used to start the discussion around resources in the area or other ways to help those with high ACE scores find solutions.

Please know that taking the survey may activate emotions in you, which may be disturbing. If you experienced adversity in your childhood, we highly recommend you take this survey only when you have appropriate support nearby such as someone you can trust or a mental health professional.

CHILD READY montana

CHILDWISE INSTITUTE

Finding Your ACE Score

WHILE YOU WERE GROWING UP, DURING YOUR FIRST 18 YEARS OF LIFE:

1. Did a parent or other adult in the household **often or very often**...
Swear at you, insult you, put you down, or humiliate you? **OR** act in a way that made you afraid that you might be physically hurt?

Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often or very often**...
Push, grab, slap, or throw something at you? **OR** ever hit you so hard that you had marks or were injured?

Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**...
Touch or fondle you or have you touch their body in a sexual way? **OR** attempt or actually have oral, anal, or vaginal intercourse with you?

Yes No If yes enter 1 _____

4. Did you **often or very often** feel that...
No one in your family loved you or thought you were important or special? **OR** your family didn't look out for each other, feel close to each other, or support each other?

Yes No If yes enter 1 _____

5. Did you **often or very often** feel that...
You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? **OR** your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

Yes No If yes enter 1 _____

6. Did you ever experience loss of a biological parent (separated/divorced/abandonment/death)?

Yes No If yes enter 1 _____

7. Was your mother, stepmother, father or stepfather:
Often or very often pushed, grabbed, slapped, or had something thrown at her? **OR** sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? **OR** ever repeatedly hit at least a few minutes or threatened with a gun or knife?

Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?

Yes No If yes enter 1 _____

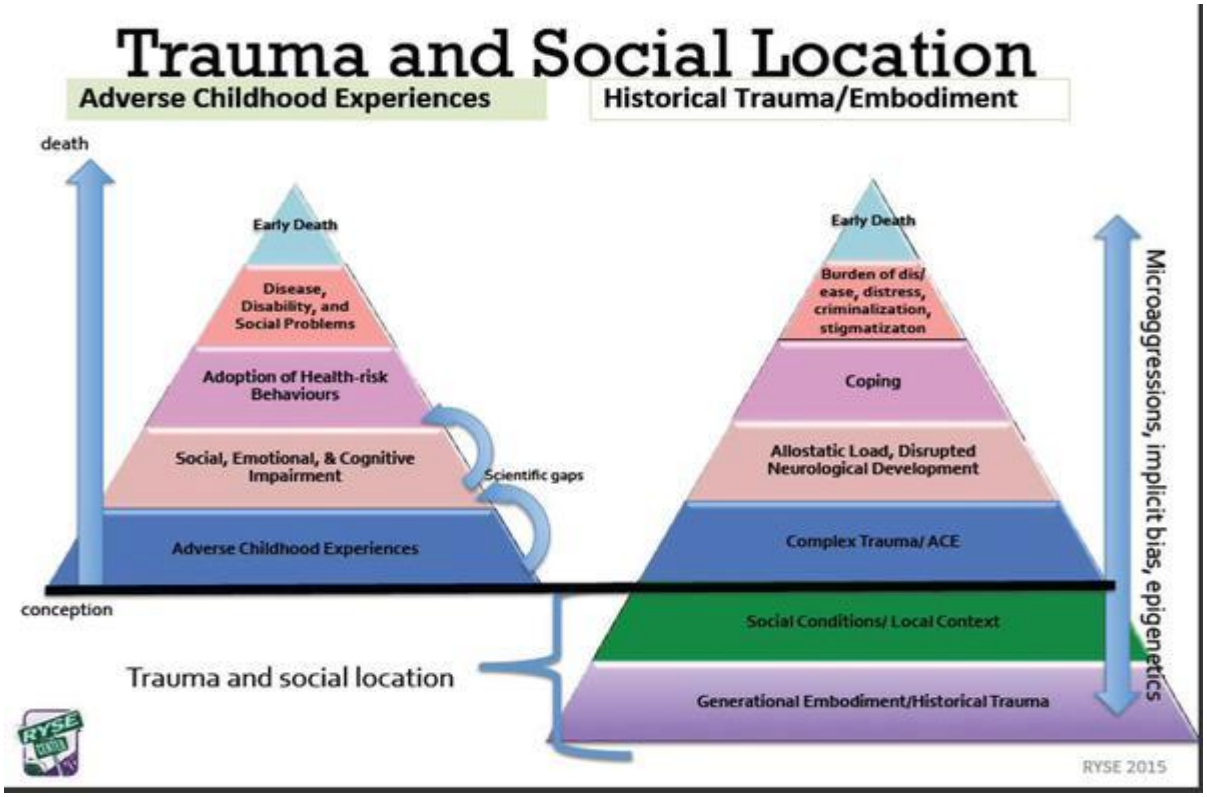
9. Was a household member depressed or mentally ill, or did a household member attempt suicide?

Yes No If yes enter 1 _____

10. Did a household member go to prison?

Yes No If yes enter 1 _____

NOW ADD UP YOUR "YES" ANSWERS: _____ THIS IS YOUR ACE SCORE.



<u>WHY ARE ACES SIGNIFICANT</u>? THE ACE STUDY REVEALED SIX MAIN DISCOVERIES:

- ACEs are common…nearly two-thirds (64%) of adults have at least one.
- They cause adult onset of chronic disease, such as cancer and heart disease, as well as mental illness, violence and being a victim of violence
- ACEs don't occur alone…. if you have one, there's an 87% chance that you have two or more.
- The more ACEs you have, the greater the risk for chronic disease, mental illness, violence and being a victim of violence. People have an ACE score of 0 to 10. Each type of trauma counts as one, no matter how many times it occurs.

- For example, people with an ACE score of 4 are twice as likely to be smokers and seven times more likely to be alcoholic. Having an ACE score of 4 increases the risk of emphysema or chronic bronchitis by nearly 400 percent, and attempted suicide by 1200 percent.

- People with high ACE scores are more likely to be violent, to have more marriages, more broken bones, more drug prescriptions, more depression, and more autoimmune diseases.

- People with an ACE score of 6 or higher are at risk of their lifespan being shortened by 20 years.

- ACEs are responsible for a big chunk of workplace absenteeism, **and for costs in health care, emergency response, mental health and criminal justice.**

- **So, the fifth finding from the ACE Study is that childhood adversity contributes to most of our major chronic health, mental health, economic health and social health issues.**

- On a population level, it doesn't matter which four ACEs a person has; the harmful consequences are the same. The brain cannot distinguish one type of toxic stress from another; it's all toxic stress, with the same impact.

Instructor/Facilitator:

Have copies of the Resiliency Questionnaire for each participant.

Reiterate that these are confidential, and they are not required to share the results.

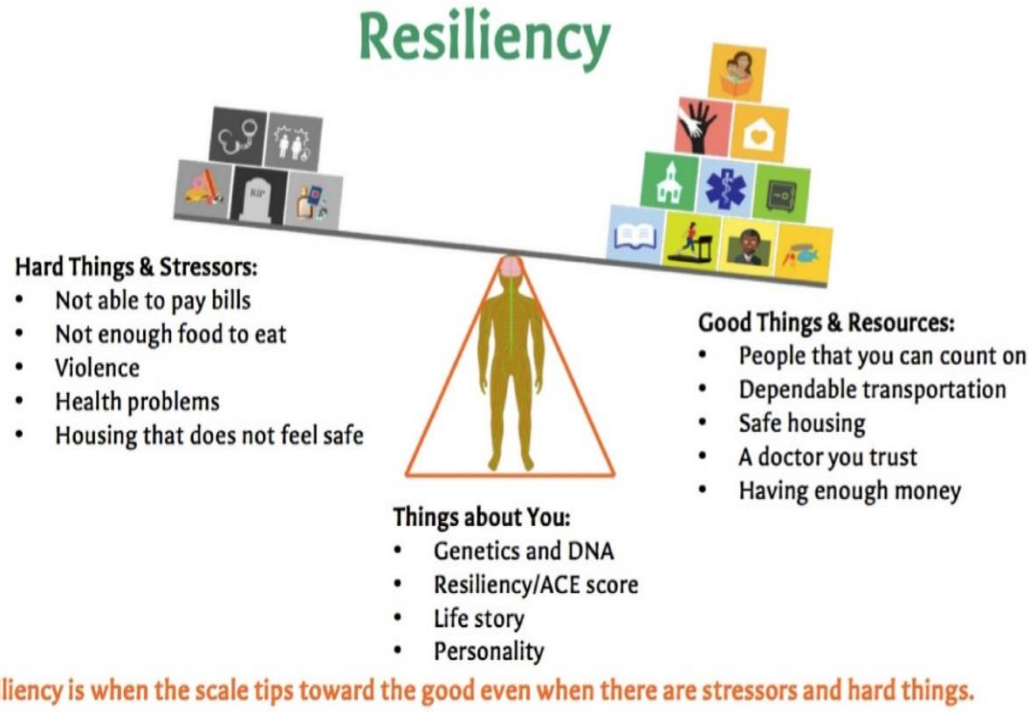
Give the participants about 10 minutes to finish the questionnaire.

If possible, know the resources in your area and have them in a handout for easier reference.

RESILIENCY

Whether an ACE score is 1 or 10, there are personal strategies and community resources that offer support. Having strong, stable relationships and using support are ways to build resiliency. These can assist in breaking the cycle of ACEs in a family. Reaching out to a trusted member of the community, such as a trusted neighbor or friend, a teacher, a leader in the community, or a church or spiritual leader is another way to get the needed support.

Supporting and strengthening communities can build everyone's resilence and can lessen the impact of adverse childhood experiences on families.



Social Connections: Having friends or family who can be there for you during a tough time or to support you can be a huge factor for resilience. Communities can support each other whenever there is something going on. The single most important factor in developing resilience in children is to have a stable and committed relationship with a supportive parent, caregiver, or other adult. People who have strong connections with family and friends and close social supports are better able to get help during difficult times.

Resilience: Learn to handle stress and take care of yourself, so you can take care of others. Resilience can be built by having relationships with others to support you or through learning skills on how to keep the nervous system regulated and within a resilient zone.

Providing a safe and nurturing environment for a child physically, mentally, and emotionally can allow them to grow up stronger and more resilient to trauma.

Concrete Support in Times of Need: Having basic needs such as food, clothing, and shelter met through whatever resources or support you can access provides a strong environment for resilience to grow. (2-1-1 is a local resource that can help you with access to the basics).

Social and Emotional Competence: Identify and understand your feelings, sensations, and emotions in order to express and process them in a healthy way without turning to harmful coping mechanisms.
Using these suggestions, both early in a child's life and as an adult, can lessen the impact of ACEs on you and your family.

WHAT'S YOUR RESILIENCE SCORE?

PLEASE CIRCLE THE MOST ACCURATE ANSWER UNDER EACH STATEMENT.

1. **I believe that my Mother loved me when I was little.**
   Definitely true Probably true Not sure Probably Not True Definitely Not True

2. **I believe that my Father loved me when I was little.**
   Definitely true Probably true Not sure Probably Not True Definitely Not True

3. ***When I little, other people helped my Mother and Father take care of me and they seemed to love me.***
   Definitely true Probably true Not sure Probably Not True Definitely Not True

4. **I've heard that when I was an infant someone in my family enjoyed playing with me, and I enjoyed it too.**
   Definitely true Probably true Not sure Probably Not True Definitely Not True

5. **When I was a child, there were relatives in my family who made me feel better if I was sad or worried.**
   Definitely true Probably true Not sure Probably Not True Definitely Not True

6. **When I was a child, neighbors or my friends' parents seemed to like me.**
   Definitely true Probably true Not sure Probably Not True Definitely Not True

7. **When I was a child, teachers, coaches, youth leaders, or ministers were there to help me**.
   Definitely true Probably true Not sure Probably Not True Definitely Not True

8. **Someone in my family cared about how I was doing in school.**
   Definitely true Probably true Not sure Probably Not True Definitely Not True

9. **My Family, neighbors and friends talked often about making our lives better**.
   Definitely true Probably true Not sure Probably Not True Definitely Not True

10. **We had rules in our house and were expected to keep them**.
    Definitely true Probably true Not sure Probably Not True Definitely Not True

11. **When I felt really bad, I could almost usually find someone I trusted to talk to.**
    Definitely true Probably true Not sure Probably Not True Definitely Not True

12. A**s a youth, people noticed that I was capable and could get things done.**
    Definitely true Probably true Not sure Probably Not True Definitely Not True

13. **I was independent and a go-getter.**
    Definitely true Probably true Not sure Probably Not True Definitely Not True

14. **I believed that life is what you make it.**
    Definitely true Probably true Not sure Probably Not True Definitely Not True

HOW MANY OF THE 14 CIRCLES WERE "DEFINITELY TRUE" OR "PROBABLY TRUE"?

_____

This is how many of these 14 protective factors I had as a child and youth.

3.1 HISTORICAL TRAUMA

Instructor/facilitator:

Historical trauma is an event, or a set of events, that happen to a group of people who share a specific identity. That identity could be based in nationality, tribal affiliation, ethnicity, race and/or religious affiliation.

The events are often a disruption of traditional ways of life, culture and/or identity.

It is important that every member of the clinic team participate in training to learn about the impact of trauma on the health and wellbeing of providers, staff and participants.

Training will help clinic staff develop skills to communicate more effectively with participants and with each other.

A factor that may have a huge influence with Native American patients is "**Historical Trauma**". Historical Trauma has multiple definitions, all which try to summarize the Native American beliefs, feelings and explanations of the past.

Historical trauma is "a deep embedded depression." This deep embedded depression is everything that was inflicted upon Native Americans i.e., oppression, boarding school, acculturation, English language learning, clothing, and cultures foreign to our ancestors' natural ways of knowing."

Historical trauma is the cumulative, multigenerational, collective experience of emotional and psychological injury in communities and in descendants. ... The effects of **historical trauma** among **Native Americans** include changes in the traditional ways of child rearing, family structure, and relationships.

Historical trauma, as used by social workers, historians, and psychologists, refers to the cumulative emotional harm of an individual or generation caused by a traumatic experience or event.

While many in such a group will experience no effects of the historical trauma, others may experience:

- poor overall physical and behavioral health, including low self-esteem, depression"
- self-destructive behavior,
- marked propensity for violent or aggressive behavior,
- substance misuse and addiction, and
- high rates of suicide and

- cardiovascular disease.

Acute problems of domestic violence or alcohol misuse that are not directly linked to historical trauma may be exacerbated by living in a community with unaddressed grief and behavioral health needs. Parents' experience of trauma may disrupt typical parenting skills and contribute to behavior problems in children. **Compounding this familial or intergenerational trauma, historical trauma often involves the additional challenge of a damaged cultural identity**. (Sotero, 2006).

HISTORICAL TRAUMA RESPONSE refers to the manifestation of emotions and actions that stem from this perceived trauma.

Effects of Historical Trauma on Native Americans can be manifested in many ways. Among Native Americans, it has included the following:

- A breakdown of traditional Native family values
- Alcohol and other substance abuse
- Depression, anxiety, and suicidality
- Child abuse and neglect and domestic violence
- Posttraumatic stress disorder
- General loss of meaning and sense of hope, and
- Internalized oppression, self-hatred

Key principles of this approach include organizational safety, trustworthiness, transparency, **cultural sensitivity**, collaboration, and empowerment among and between staff and patients.

This approach recognizes the role trauma plays in the lives of patients/consumers and seeks to shift the clinical perspective from "what's wrong with you" to "what happened to you" by recognizing and accepting *symptoms and difficult behaviors* as strategies developed to cope with childhood trauma.

When we are able to respond in trauma-sensitive, person-centered ways patients feel safer disclosing, are more likely to access services, and are more likely to find treatment helpful.

TRAUMA-INFORMED MEDICAL EXAMINATIONS

- **Always ask** for consent. Ensure continued consent at each step.
- **Explain** what will be done, how it will be done, and why it is necessary.
- **Ask whether the person would like someone with her/him**
- **Do not assume** that any procedure or examination is routine.
- **Observe body language**. Ask ''Are you comfortable with this?'' or ''Is it OK if I continue with the exam?''

- **Avoid** false **reassurance.** Give specific advice on how to relax if needed. Discuss in advance. Write things down.

- **If she/he is triggered**, let her/him know where she/he is, she's/he's in a safe place, encourage to look at you, and focus, calm voice.

- **Use similar precautions if examining children.**

Aaron et. al. 2013, Cole et. al. 2009

DISASTER RESPONSE IN INDIAN COUNTRY

The Substance Abuse and Mental Health Services Administration (SAMHSA) prepared the *Tip Sheet*. It is appropriate to use as a disaster could easily be a car wreck, major accident or other disaster requiring EMS response and subsequent admittance to a medical facility for treatment.

TIPS FOR DISASTER RESPONDERS: CULTURAL AWARENESS WHEN WORKING IN INDIAN COUNTRY POST DISASTER

> In this tip sheet, we respectfully use the term "Native Americans" to describe the hundreds of tribes, reservations, pueblos, and villages throughout the United States. Know that all tribes are unique, with highly individual cultures, governance, and belief systems. Find out the best way to offer response assistance for the tribe with which you are working.

When responding to a traumatic event, such as a natural or human-caused disaster in Indian Country, it is important not only to tailor the response efforts to address the event but also to understand the impact of the historical trauma experienced by Native Americans.

Some tribes do not have a word for "disaster," and refer to disasters differently than non-native cultures do. Some may feel that saying the word "disaster" may bring harm to their community.

It is important to pay attention to how members of the local tribal community refer to disasters and other traumatic events and use the same words and phrases they use. **It is also important to remember that each Native American tribe is a sovereign nation with a unique history and political status.**

CULTURAL VALUES

- While every tribe, reservation, pueblo, rancheria, and village is unique, several general cultural values are shared by most Native American communities:
- Importance is placed on harmony with the environment.
- Each person is seen as part of a larger system.
- Elders and other community leaders are respected for their knowledge and wisdom.
- Children are the future and are to be protected and supported.
- Helping others is more important than helping oneself. A community approach to healing is emphasized in most cases.
- Prayer and traditions are important facets of life and are sacred and must be protected.

AFTER A TRAUMATIC EVENT

After surviving a disaster or traumatic event, people may feel dazed or even numb. They may also feel sad, helpless, or anxious. It is important to normalize the type of emotional reactions to trauma that many people experience.

It is not unusual for tribal members, or any people who have gone through trauma, to experience:

- bad memories or dreams
- trouble sleeping,
- eating,
- paying attention,
- It is not unusual for people to withdraw socially or
- relapse into alcohol or drug misuse if that was an issue prior to the traumatic event.

These are all common and expected reactions to stress among adults and adolescents alike.

RESPONSE EFFORTS IN INDIAN COUNTRY

When working in Indian Country after a traumatic event, it is important to remember that Native American entities have a long history of being told what they "should" do and that they need to change their ways.

Such direction is unwelcomed because of past history with some non-native people who may have been well- meaning but imposed their ways upon the tribe, or even betrayed them in significant ways.

In the spirit of preparedness, you can offer your best in disaster response and recovery by building partnerships and getting to know trusted tribal liaisons such as a Tribal Emergency Manager.

Remember, you are a guest in a sovereign nation; so, by showing respect and working with a tribal liaison, you will increase your professional credibility. Community members place more value on who you are and how you develop relationships than on your degrees or professional qualifications.

Connecting as a person is critical to success. Get to know their history—both traumatic and otherwise—so that when a disaster occurs, you are more likely to be a resource and can work effectively with disaster survivors. While you may not agree with the beliefs and customs of the tribe you are working with, it is critical to be respectful of their choices, culture, and values.

Before an event occurs, you may consider seeking the wisdom of community leaders. The words and phrases used to describe mental and emotional health differ in tribal communities. It is important to know how your local community refers to these concepts before you meet with the leaders.

Keeping in mind that every tribe is different and knowing your community's disaster risks, you may choose to ask leaders some of these questions to help you build a relationship and connection:

- What is the leaders' sense of their community's physical and emotional wellbeing?
- What strengths do community members have that can help them cope with and overcome their problems?
- How have leaders helped community members overcome past trauma?
- How are children in the community taught coping and problem-solving skills?

Just after an event occurs, you may wish to ask community leaders if they can talk to residents about the event in a way that shows how it relates to their tribe's creation stories or other traditional teaching stories. This technique can be used to explain why things happen and lessons that can be learned from the experience. It is important to have a respected leader tell the story with the approval of tribal leadership.

USE OF TALKING CIRCLES

Many tribes have found talking circles to be one effective way of bringing people together in a quiet, respectful, and safe place where they can share their experiences and learn positive coping skills from each other.

Consider asking if talking circles are used in the community and whether there are community members who typically lead a talking circle. If this is a practice that is familiar and acceptable to the local tribal community, request that a disaster behavioral health responder be allowed to participate in the talking circle. The local leader and disaster behavioral health responder can discuss the issues to bring to the group and how these will be presented (e.g., talking stick, feather).

These tips, in combination with getting to know the Native American emergency management and tribal liaisons you plan to work with before a disaster occurs, will help ensure that you help provide a coordinated and effective response to any disaster or traumatic event.

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Indian tribe.” Journal of Transcultural Nursing, 17(1), 5-12.

Other Helpful Resources

Substance Abuse and Mental Health Services Administration Disaster Technical Assistance Center (SAMHSA DTAC)

Toll-Free: 1-800-308-3515

Website: http://www.samhsa.gov/dtac

SAMHSA Behavioral Health Disaster Response Mobile App Website: http://store.samhsa.gov/product/PEP13- DKAPP-1

American Indian and Alaska Native Culture Card

Website: http://store.samhsa.gov/product/American- Indian-and-Alaska-Native-Culture-Card/SMA08-4354

SAMHSA Disaster Distress Helpline

Toll-Free: 1-800-985-5990 Text “TalkWithUs” to 66746 Website: http://disasterdistress.samhsa.gov

National Suicide Prevention Lifeline

Toll-Free: 1-800-273-TALK (1-800-273-8255) TTY: 1-800-799-4TTY (1-800-799-4889)

Website: http://www.samhsa.gov

This resource can be found by accessing the Suicide Prevention Lifeline box once on the SAMHSA website.

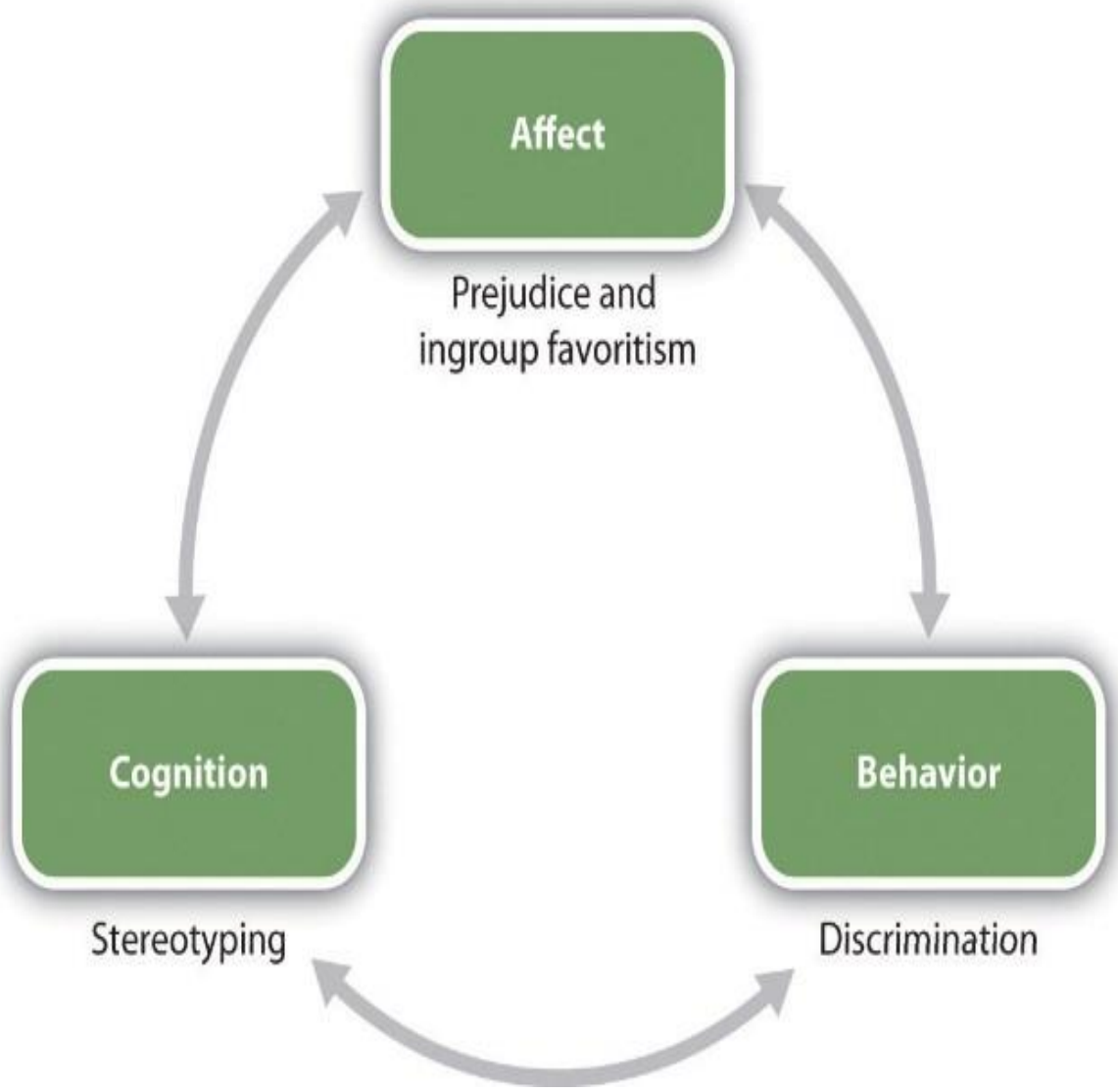
Indian Health Service* Responsible for providing health services to members of federally recognized tribes. Website: http://www.ihs.gov

U.S. Department of the Interior*

Bureau of Indian Affairs Tribal Leaders Directory

Website: http://www.bia.gov/cs/groups/public/ documents/text/idc002652.pdf

U.S. Office of Personnel Management* Online course: Working Effectively with Tribal Governments (available only to federal employees) Website: http://www.tribal.golearnportal.org/ * Note: Inclusion of a resource in this fact sheet does not imply endorsement by the Center for Mental Health Services, the Substance Abuse and Mental Health Services Administration, or the U.S. Department of Health and Human Services.


Affect
Prejudice and
ingroup favoritism
Cognition
Stereotyping
Behavior
Discrimination

3.2 An Overview of Social Determinants of Health

Instructor/Facilitator:

Though health care is essential to health, it is a relatively weak health determinant.

Research shows that health outcomes are driven by an array of factors, including underlying genetics, health behaviors, social and environmental factors, and health care.

While there is currently no consensus in the research on the magnitude of the relative contributions of each of these factors to health, studies suggest that health behaviors, such as smoking, diet, and exercise, and social and economic factors are the primary drivers of health outcomes, and social and economic factors can shape individuals' health behaviors.

For example, children born to parents who have not completed high school are more likely to live in an environment that poses barriers to health such as lack of safety, exposed garbage, and substandard housing. They also are less likely to have access to sidewalks, parks or playgrounds, recreation centers, or a library.

Further, evidence shows that stress negatively affects health across the lifespan and that environmental factors may have multi-generational impacts.

Addressing social determinants of health is not only important for improving overall health, but also for reducing health disparities that are often rooted in social and economic disadvantages.

In order to offer a complete picture of health, we need to understand the social determinants of health.

Healthy People 2020 External defines **social determinants of health** as conditions in the environments in which people live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Health disparities describe the disproportionate burden of disease, disability, and death among a population or group when compared to the general population.

This means there are differences in health outcomes for some groups when compared to outcomes for the greater population.

Minority Americans frequently report higher rates of specific health problems, such as diabetes or obesity. The poorer health status of racial and ethnic minority Americans reflects higher death rates for chronic diseases. Infant mortality rates, as well as overall mortality ratios at different age groups, are higher among African Americans and American Indian/Alaska Natives than among other groups in Montana. Infant mortality is a widely used indicator for health disparities.

A "health care disparity" typically refers to differences between groups in health insurance coverage, access to and use of care, and quality of care.

KEY FINDINGS IN HEALTH INSURANCE COVERAGE DISPARITIES

- Insurance coverage is strongly related to better health outcomes. Substantial disparities in uninsured rates were observed among all the demographic and socioeconomic groups.
- Disparities by sex existed during both 2004 and 2008, with a higher percentage of males being uninsured.
- The uninsured rate for young adults aged 18–34 years was approximately double the uninsured rate for adults aged 45–64 years.
- Hispanics and non-Hispanic blacks had substantially higher uninsured rates, compared with Asian/Pacific Islanders and non-Hispanic whites.

WHAT CAN BE DONE

Increased access to health care with or without insurance will reduce the importance of disparities in uninsured rates.

We can raise awareness and understanding of groups that experience the greatest health disparities. We can help motivate increased efforts to intervene at the state, tribal, and local levels to address health disparities and inequalities.

Instructor/Facilitator:

Ask the group: How important is having health insurance?

What are some potential consequences for not having health insurance?
(Examples; Lack of medical care when needed, not seeing a medical provider on a regular basis, dental needs, hearing needs, etc.).

What might some barriers be to having health insurance in Montana?
(Examples; Cost, remote distances from medical providers, transportation, etc.).

HEALTH DISPARITIES

Health insurance - According to data contained in the 2017 Montana State Health Assessment Report, the number of Montanans with health insurance has increased greatly in recent years. In 2016, 93% of Montanans aged 65 years and younger had health insurance. **A larger number are underinsured.**

This number has recently decreased due to state Medicaid expansion enacted in 2016. However, a small percentage, it remains that this equates to approximately 81,000 uninsured Montanans.

According to the American Community Survey, in the past decade the proportion of Montanans (less than 65 years of age) without health insurance has decreased by 50%, from 19% in 2007 to 7% in 2016. This large decrease in the proportion of Montanans without health insurance may be attributable to the enactment of two policies.

First, starting in 2014, Montanans who met certain criteria were eligible to purchase health insurance through the health exchange.

Then in 2016, Montana Medicaid expanded through the Montana Health and Economic Livelihood Partnership (HELP) Plan. The 2016 American Community Survey estimated that 93% Montanans had health insurance, leaving 7% of Montanans without health insurance.

Among American Indian adults aged 18 to 64 years, 9% reported not having health insurance in 2016.

CHILDREN AND HEALTH INSURANCE

Healthy Montana Kids (H.M.K.) Program, MT Department of Public Health and Human Services. (*http://hmk.mt.gov/)*

Notes: HMK is the combination of the state's two health insurance programs for low-income children, Children's Health Insurance Program (CHIP) and children's Medicaid. The numbers for each are combined into one enrollment figure for the entire program. CHIP is a federal/state partnership that expands health insurance to children whose families earn an income that is too high to qualify for Medicaid, but not high enough to purchase private insurance. In Montana, a child qualifies for CHIP if family income is too high to qualify for Medicaid, but less than 250% of the FPL.

Children's Medicaid provides medical benefits to low-income people with inadequate or no medical insurance. The Federal government establishes general guidelines for the program, while program requirements are set by each state. Eligibility for children is based on the child's status, not its parents', and is set at 100% of the FPL.

Health Disparity example: health insurance coverage for white Montana children under the age of 5 is 96%, compared to 77% for American Indian children of the same age.

Disparity resulting from inequity in health care access is evident in health outcomes, as more American Indian babies than white babies are born pre-term, are born at low birth weight and are born to mothers who did not receive adequate prenatal care.

State Indicators

Health Insurance

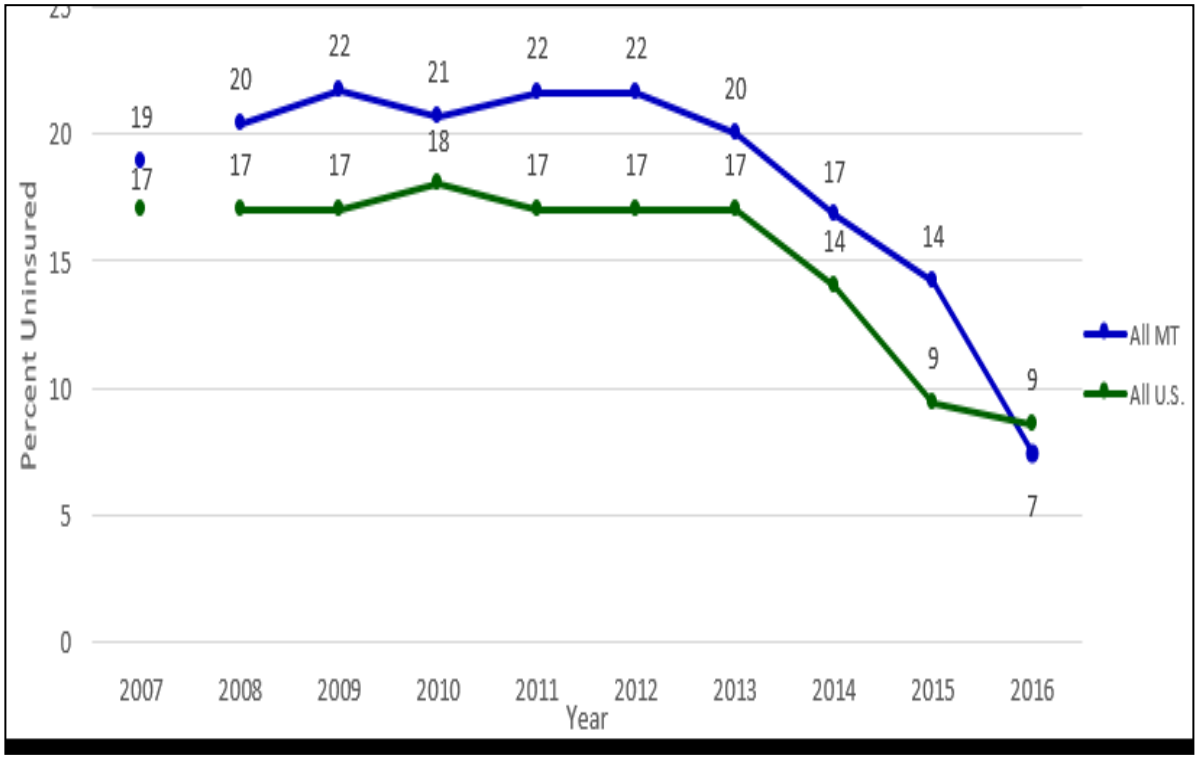
	FY 2001 Base Year	FY 2011	FY 2013	FY 2015
Children enrolled in Healthy Montana Kids (HMK; under age 19, monthly average)	N/A	84,439	N/A[1]	110,007
As percent of all children under age 19	N/A	36%	N/A[1]	49%
	2000 Base Year	**2010**	**2012**	**2014**
Percent of children under age 18 without health insurance	15%	12%	12%	8%
Percent of children ages 5 and under without health insurance	16%	14%	11%	6%
Percent of children ages 6-17 without health insurance	15%	12%	12%	9%
Percent of White children ages 5 and under without health insurance	N/A	11%	12%	4%
Percent of American Indian children ages 5 and under without health insurance	N/A	23%	26%	23%
Percent of children under age 18 without health insurance and in poverty (below 100% FPL)*	24%	13%	15%	2%

SOURCES: Montana Department of Public Health & Human Services; the Annie E. Casey Foundation; U.S. Census Bureau, American Community Survey

[1] Due to a DPHHS system conversion, this data is not available for FY2013.

Percent of Montanans under age 65 years with no health insurance, 2007-2016

Reproduced from Montana State Health Assessment for 2017.



INDICATOR	- STATE - Base Year 2000	- STATE - Current Year
DEMOGRAPHICS		
Total population (all ages), 2014	903,500	1,023,579
Percent population change, 2010-2014		3%
Total child population (ages 0-17), 2014	230,062	225,024
Children under age 5	54,869	61,194
Children ages 5-13	116,747	113,704
Children ages 14-17	58,446	50,126
Percent change in child population, 2010-2014		1%
Population under age 20 by race/ethnicity, 2014	257,440	251,199
White alone	223,467	208,678
American Indian/Alaska Native alone	24,372	25,573
Hispanic/Latino	8,117	14,269
Median age in years, 2014	38	40

https://dphhs.mt.gov/Portals/85/ahealthiermontana/2017SHAFinal.pdf)

NOTES:

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4.0 Health Literacy

Objective:

First and foremost, in Montana, we want to improve Health Literacy through effective one-on-one communication on healthcare issues, treatment options and follow-up care options. If we want health equity, we need to make health literacy a priority. Learning about issues surrounding Health Literacy is vital to ensuring that we are successful in this endeavor.

Instructor/Facilitator:

Ask what is Health Literacy?

Health care providers are a community's gateway to many health services. Providers are also trusted sources of information for many people. Improving health outcomes relies on patients' full engagement in prevention, decision-making, and self-management activities.

Health systems that incorporate health literacy strategies make it easier for people to understand and act on available health information.

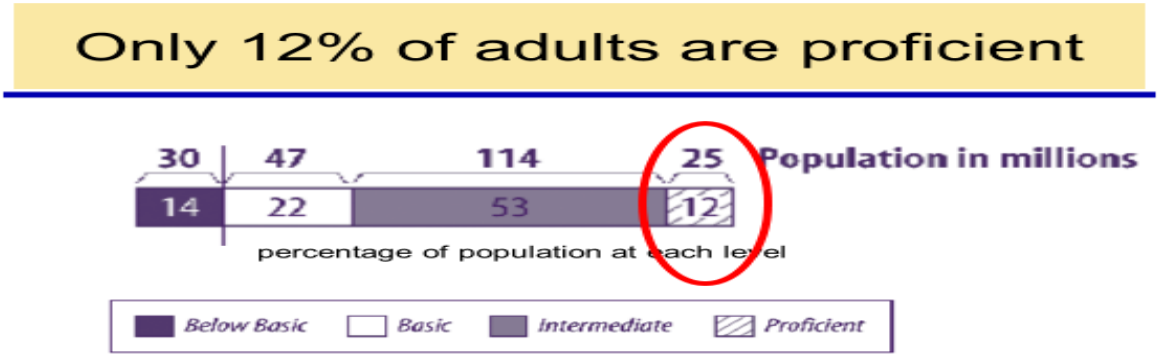
Health care has become so complicated that nearly everyone has some difficulty understanding health information and navigating the health care system.

Furthermore, more than 1 in 3 adults have limited health literacy, which means that they have difficulty with basic health-related tasks.

What is Health Literacy?

Health Literacy is the patient's ability to read, understand, and apply health-related information. Health Literacy plays a huge role in the effectiveness of both oral and written patient care and education.

A two-year-old is diagnosed with an inner ear infection and prescribed an antibiotic. Her mother understands that her daughter should take the prescribed medication twice a day. After carefully studying the label on the bottle and deciding that it doesn't tell how to take the medicine, she fills a teaspoon and pours the antibiotic into her daughter's painful ear. (Institute of Medicine, "Health Literacy: A Prescription to End Confusion", 2004, pg.3)



Health Literacy results from the National Assessment of Adult Literacy, US Dept of Education, 2003

Simply Put: Only 1/3 of patients with limited health literacy skills were able to answer correctly what it means to "take 2 tablets twice daily" – Wolf, annals of internal med 2006. 42% couldn't understand "take on an empty stomach" and 60% did not understand informed consent – Williams et al, JAMA 12/95

EXAMPLES OF TASKS AT EACH LEVEL: (*National Assessment of Adult Literacy, US Dept of Education, 2003*)
Below Basic: circle date on doctor's appointment slip
Basic: give 2 reasons a person with no symptoms should get tested for cancer based on a clearly written pamphlet
Intermediate: determine what time to take prescription medicine based on label
Proficient: calculate employee share of health insurance costs using table (**only a 67% probability individual can perform task at that level)*

WHO IS MOST AT RISK?

- Elderly
- Ethnic and racial minorities
- Limited education
- Low socioeconomic status
- People with chronic illnesses/disease

HOW TO IDENTIFY A PATIENT WITH LOW HEALTH LITERACY

***RECOGNIZE RED FLAGS**:*

MAKING EXCUSES
Less than half of the information provided during a typical medical encounter is retained by the patient, even if the patient is proficient in health literacy.

PERCEIVED RESISTANCE
Limiting the information by focusing on one to three key messages is crucial. Patients who struggle with health literacy will respond more to information that is designed to promote action than to detailed explanations and facts. Focusing the key messages on behavior instead will help to motivate and empower the patient.)

HAS NO QUESTIONS
(Do you UNDERSTAND? Patient nods head and looks away……..) Developing short explanations for common diagnosis and treatments will help the provider avoid giving the patient a lecture on pathophysiology and pharmacology.

Reviewing and repeating each point at the end of each visit will help to reinforce the key messages. The "**Teach Back" method is a powerful tool**. It is a test of how well the provider has explained the concept in a way that the patient understands. It provides an opportunity to check for understanding and if needed, to re-teach the information. It is important to use open-ended questions and avoid yes/no questions like, "Do you understand?" or "Do you have any questions?"

FREQUENTLY MISSED APPOINTMENTS
Cost: simply may be in response to financial strain.

Fear: Most people dread seeing a healthcare provider. In addition to concerns that they might receive bad news, patients worry that the health care provider may lecture them about unhealthy behaviors or for not following medical advice.

Time: Work and family commitments often take precedence over personal health. It is easy to forget or decide to skip appointments if it ends up following on a busy day.

Demographics: Disadvantage populations – due to income, language, or age barriers- often have more difficulty keeping appointments. Patients who are elderly, for example, may no longer drive but may be reluctant to ask for help, particularly during inclement weather. This challenge is even more pronounced in rural areas weather public transportation is unavailable.

NON-ADHERENT WITH MEDICATION OR TREATMENT
A great way to check the health literacy skills of a patient is by doing a medication review. Ask the patient to explain the purpose of the medications and show you how they are using them. Using plain, non-medical language can enhance understanding dramatically. Using the patient's own terms for their illness and treatments is a good starting point.

Health care has its own terminology and even if the provider and the patient speak the same language, there are still challenges to effective communication. However, the quality of medical care is closely linked to how well providers meet the language needs of the patient. The bottom line is to have effective communication and supports in place that can overcome these challenges.

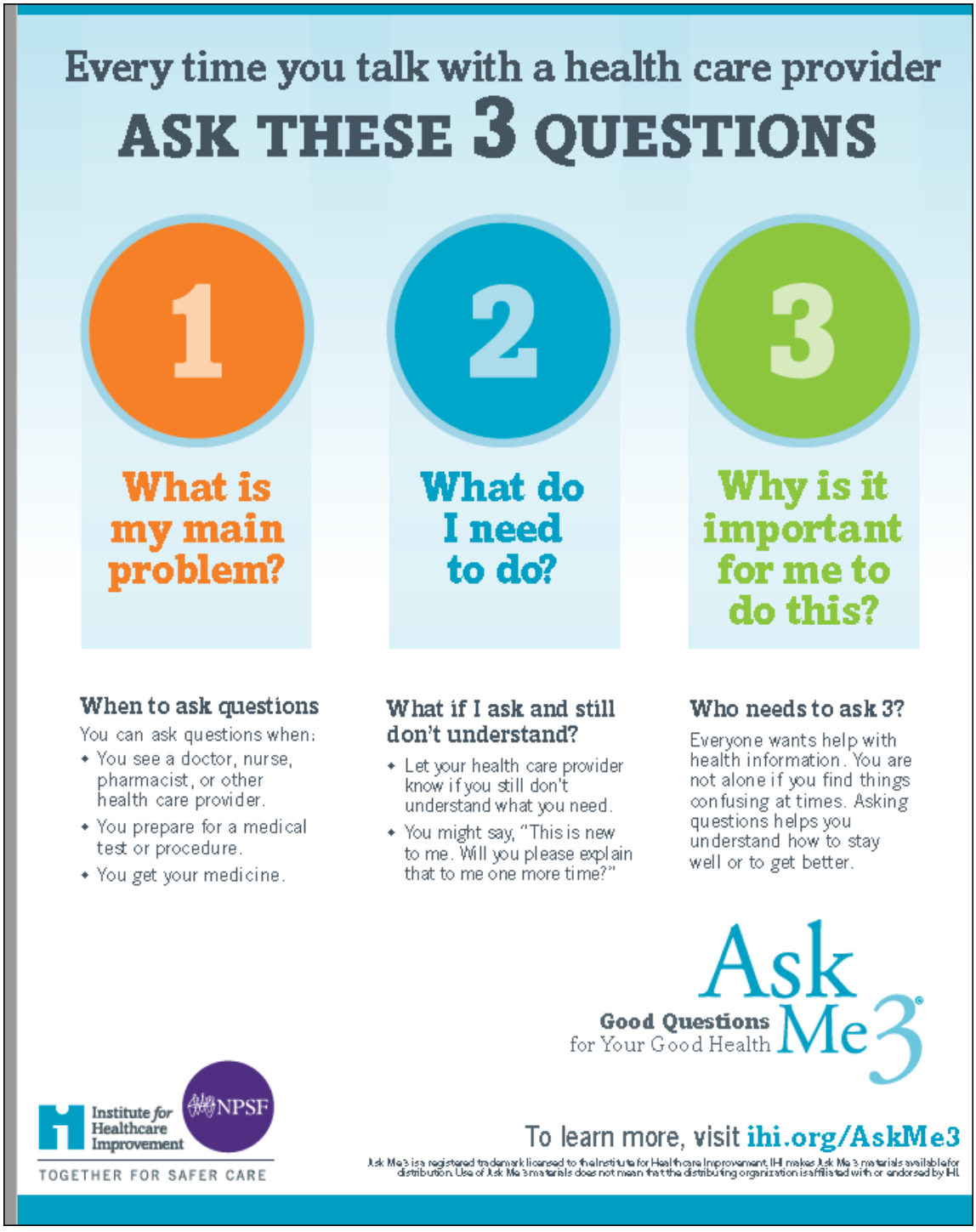
The following are suggestions for use when communicating with patients:

- Plan what you are going to say. Logical order and one step at a time.
- Define health care terms. Explain any and all acronyms
- Verify understanding. Restate and rephrase in a way that the patient understands, but it isn't condescending.
- Establish an environment conducive to discussion. Speak clearly allowing time to process the information.
- Organize your message. Omit extraneous information and repeat the most important information.
- Adjust to the needs of the patient. Be respectful of the need for silence while watching, listening, and reading the patient. Choose your words carefully!
- Encourage active participation in appointments. Ask the patient to write down concerns or make lists. Be sensitive that many older adults will be reluctant to ask questions of people in authority. Encourage family participation.
- Pay attention to non-verbal communication. Try to make sure the patient encounter is welcoming and respectful.

FIVE TALKING POINTS ON HEALTH LITERACY: These brief talking points may be helpful if you need to tell someone quickly what health literacy is and why it is important. Add in talking points relevant to your organization.

1. Nine out of 10 adults struggle to understand and use health information when it is unfamiliar, complex or jargon filled.
2. Limited health literacy costs the healthcare system money and results in higher than necessary morbidity and mortality.
3. Health literacy can be improved if we practice clear communication strategies and techniques.

4. Clear communication means using familiar concepts, words, numbers and images presented in ways that make sense to the people who need the information.
5. Testing information with the audience before it is released and asking for feedback are the best ways to know if we are communicating clearly. We need to test and ask for feedback every time information is released to the general public.



SCENARIO ACTIVITES:

Instructor/Facilitator:

Here are several scenarios or situations to help you practice. Use these situations to practice "living room" language, focusing on 1-3 key points (AskMe3) and the teach back method.

Have people break out into groups of 2-3 to practice together and then discuss experience with large group. You will need 10 minutes or more to do this activity.

SCENARIO #1

The patient has just found out that her baby has jaundice and will need to be in a special blanket called a billi-blanket and under a special lamp called a billilamp. This will help lower the baby's billirubin level and reduce the yellowing of the skin.

DR: Mr(s). Jones, your baby has elevated bilirubin levels in the liver. This is treatable through intensive therapy with a Billi-blanket and a Billi-lamp and pushing fluids. If bilirubin levels become extremely high, complications such as brain damage (kernicterus), cerebral palsy, and deafness can occur.

SCENARIO #2

The patient's child has been diagnosed with asthma and will need to start nebulizer treatments and using an inhaler and medications.

Dr.: Mr(s). Smith, your child has with an inflammation of the bronchial tubes and will require nebulizer treatments, medications such as $Beta_2$-agonists and inhalers to manage this problem. Here are some brochures to explain the disease.

ANALYSIS

- How do you feel both situations were handled?
- What could have been done that perhaps would make the parent feel better about their child's illness?
- Give some examples of how the information from the doctor could have been delivered.
- In your opinion, how would the parent(s) feel about the healthcare system?

PLAIN LANGUAGE: We often use an **esoteric language** in health care. Does anyone know what this means?

Esoteric means mysterious - confined to and understandable by only an enlightened inner circle, intended for understanding by only a group, not publicly disclosed. This is not the kind of message that health care is trying to get across.

Use this word instead of " ". For example, use the words "pain killer" instead of "analgesic."

B*reak up into small groups and convert a list of medical terms into "living room language" and then discuss activity.* ***What did you learn?***

Instructor/facilitator:

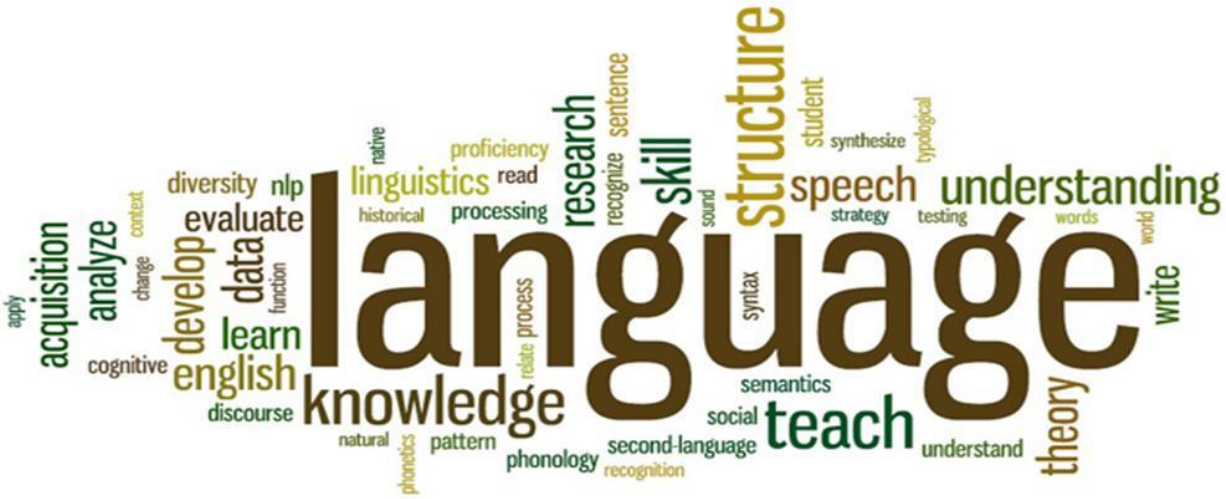
For the following exercise, have printed copies available for class members of the following handout.

Then a*sk participants to break up into small groups and convert the following list of medical terms into "living room language" and then discuss activity.*

What did you learn?

How can we change how we talk with our patients?

Medical terms that patients may not understand	
Medical Term	**Plain language explanation**
Adverse	Bad Reaction
Analgesic	Painkiller, Anesthetic
Anticoagulant	A substance that prevents blood from forming clots
Anti-inflammatory	Used to control or reduce inflammation
Arrthymia	Irregular heartbeat
Diet	the food that a person or animal usually eats
Generic	Common, General, Basic
Intermittent	Sporadic, Alternating, Occasional
Oral	By Mouth
Cellulitis	Inflammation of tissues
Enlarged	Distended, Engorged, Inflated, Bloated
Hypertension	High blood pressure
Last Oral Intake	Last time you ate or drank liquids
Lesion	Abrasion, Scratch, Wound, Injury
Lipids	Fats
Osteoporosis	Condition in which the bones become weak and break easily
Referral	Transfer, Recommendation, Appointment
Rhinoviruses	Common cold
Edema	Swelling
Nonsteroidal anti-inflammatory drugs (NSAIDs)	Drugs such as Advil, Tylenol
Thrombosis	Clotting, Blockage, Coagulation


language
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5.0 Summation

Cultural Humility, Trauma Informed Care, ACEs and Health Literacy: These were designed to provide you tools to accomplish the following two (2) items which are crucial to achieve positive outcomes. They are:

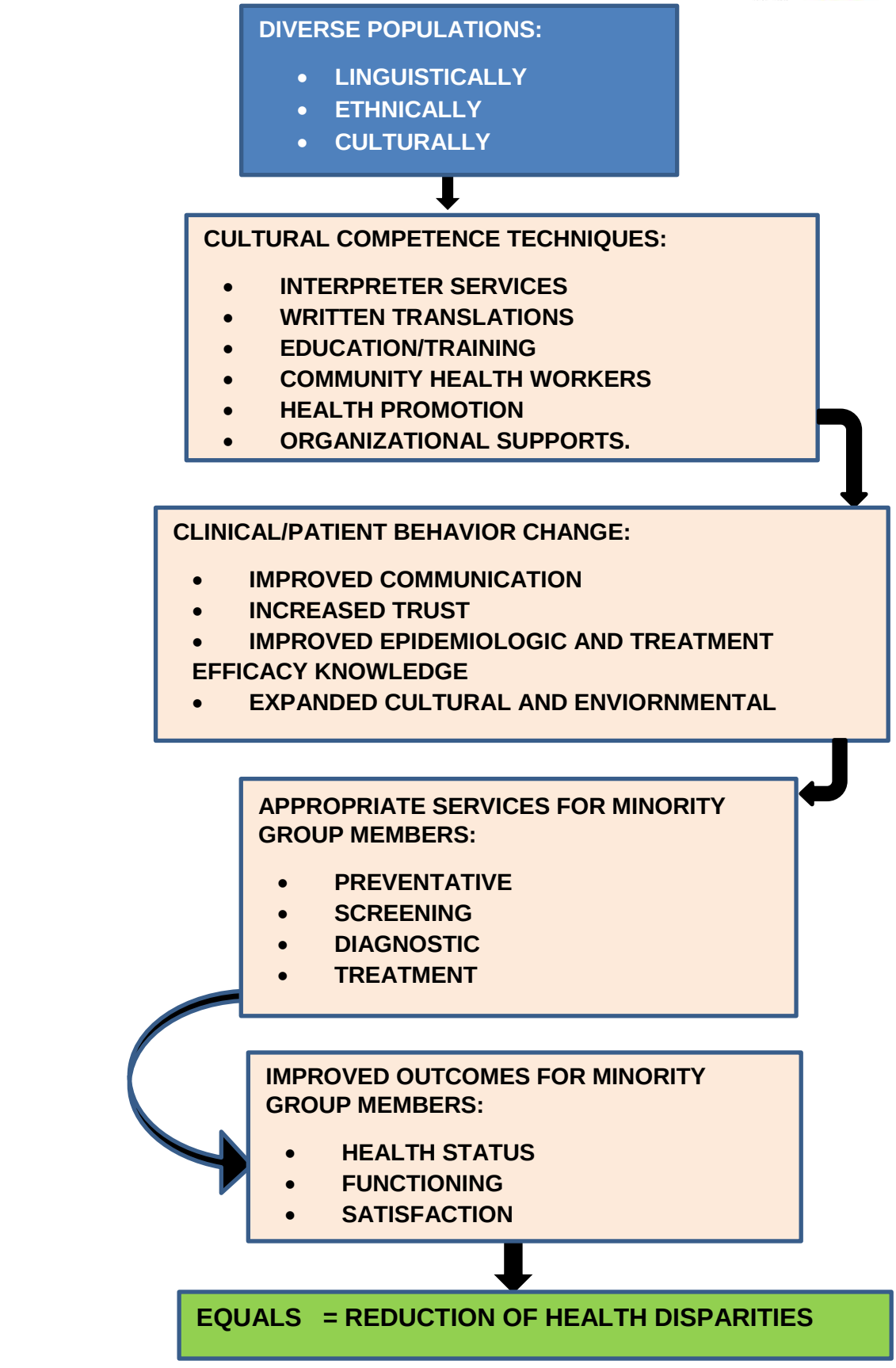
RESPECT, AND TRUST

To achieve positive outcomes in health and well-being, respect for the ethnicity of the patient is crucial in order to establish the trust bond. Once that is achieved, and then health and well-being are more likely to occur.

Respect as defined by the Merriam Webster English Language Learners Definition is; ***a feeling or understanding that someone or something is important, serious, etc., and should be treated in an appropriate way.***

According to Merriam Webster definition, trust is; ***assured reliance on the character, ability, strength, or truth of someone or something.***

If we truly learn cultural competence, that is a win-win situation.


DIVERSE POPULATIONS:
LINGUISTICALLY
ETHNICALLY
CULTURALLY
CULTURAL COMPETENCE TECHNIQUES:
INTERPRETER SERVICES
WRITTEN TRANSLATIONS
EDUCATION/TRAINING
COMMUNITY HEALTH WORKERS
HEALTH PROMOTION
ORGANIZATIONAL SUPPORTS.
CLINICAL/PATIENT BEHAVIOR CHANGE:
IMPROVED COMMUNICATION
INCREASED TRUST
IMPROVED EPIDEMIOLOGIC AND TREATMENT EFFICACY KNOWLEDGE
EXPANDED CULTURAL AND ENVIORNMENTAL
APPROPRIATE SERVICES FOR MINORITY GROUP MEMBERS:
PREVENTATIVE
SCREENING
DIAGNOSTIC
TREATMENT
IMPROVED OUTCOMES FOR MINORITY GROUP MEMBERS:
HEALTH STATUS
FUNCTIONING
SATISFACTION
EQUALS = REDUCTION OF HEALTH DISPARITIES

Cultural Competence Post-Test

Instructor/Facilitator:

Have printed copies of the Post-Test for each participant. Give the group 10-15 minutes to complete the test. Give the answers.

Ask if there is any discussion on the difference between the pre-test and the post-test. Ask for next steps in the journey for Cultural Competency.

1 **Cross-cultural misunderstandings between providers and patients can lead to mistrust and frustration, but are unlikely to have an impact on objectivity measured clinical outcomes.**

- True
- (False)

2 **When the patient and provider come from different cultural backgrounds, the medical history obtained may not be accurate.**

- (True)
- False

3 **When a provider expects that a patient will understand a condition and follow a regimen, the patient is more likely to do so than if the provider has doubts about the patient.**

- (True)
- False

4 **A really conscientious health provider can eliminate his or her own prejudices or negative assumptions about certain types of patients.**

- True
- (False)

5 **When taking a medical history from a patient with a limited ability to speak English, which of the following is LEAST useful?**

- (Asking questions that require the patient to give a simple "yes" or "no" answer, such as "Do you have trouble breathing?" or "Does your knee hurt?")
- Encouraging the patient to give a description of her/his medical situation, and beliefs about health and illness.
- Asking the patient whether he or she would like to have a qualified interpreter for the medical visit.
- Asking the patient questions such as "How has your condition worsened over the past days?' or "What makes your condition get better or worse?"

6 **During a medical interview with a patient from a different cultural background, which is the LEAST useful technique?**

- Asking questions about what the patient believes about his/her illness – what caused the illness, how severe it is, and what type of treatment is needed.
- (Gently explaining which beliefs about the illness are not correct.)
- Explain the "Western" or "American" beliefs about the patient's illness.
- Discussing differences in beliefs without being judgmental.

7 **When a patient is not adhering to a prescribed treatment after several visits, which of the following approaches is NOT likely to lead to adherence?**

- Involving family members.
- (Repeating the instructions very loudly and several times to emphasize the importance of the treatment.)
- Agreeing to a compromise in the timing or amount of treatment.
- Spending time listening to discussions of folk or alternative remedies.

8 **When a patient who has not adhered to a treatment regimen states that he/she cannot afford the media cations prescribed, it is appropriate to assume that financial factors are indeed the real reasons and not explore the situation further.**

- True
- (False)

9 **Which of the following are correct ways to communicate with a patient through an interpreter?**

- Making eye contact with the interpreter when you are speaking, then looking at the patient while the interpreter is telling them what you said.
- Speaking slowly, pausing between words.
- Asking the interpreter to further explain the patient's statement in order to get a more complete picture of the patient's condition.
- (None of the above.)

10 If a family member speaks English as well as the patient's native language, and is willing to act as an interpreter, this is the best possible solution to the problem of interpreting.

- True
- (False)

11 Which of the following statements is TRUE?

- People who speak the same language have the same culture.
- The people living on the African continent share the main features of African culture.
- (Cultural background, diet, religious, and health practices, as well as language, can differ widely within a given country or part of a country.)
- An alert provider can usually predict a patient's health behaviors by knowing what country he/she comes from.

12 Which of the following statements is NOT TRUE?

- Friendly (non-sexual) physical contact is an important part of communication for many Latin American people.
- Many Asian people think that it is disrespectful to ask questions of a health provider.
- (Most African people are either Christian or follow a traditional religion.)
- Eastern Europeans' are highly diverse in terms of customs, language, and religion.

13 **Because Hispanics have a lower incidence of certain cancers than the majority of the US population, their mortality rate from these diseases is correspondingly lower.**

- True
- (False)

14 **Minority and immigrant patients in the US who go to traditional healers and use traditional medicines generally avoid conventional Western treatments.**

- True
- (False)

15 **Providers whose patients are mostly European-American, US-born, and middle-class still need to know about health practices from different world cultures.**

- (True)
- False

16 **Which of the following is good advice for a provider attempting to use and interpret non-verbal communication?**

- (The provider should recognize that a smile may express unhappiness or dissatisfaction in some cultures.)
- To express sympathy, a health care provider can lightly touch a patient's arm or pat the patient on the back.
- If a patient will not make eye contact with a health care provider, it is likely that the patient is hiding the truth.
- When there is a language barrier, the provider can use hand gestures to bridge the gap.

17 **Some symbols – a positive nod of the head, a pointing finger, a "thumbs up" sign – are universal and can help bridge the language gap.**

- True
- (False)

18 **Out of respect for a patient's privacy, the provider should always begin a relationship by seeing an adult patient alone and drawing the family in as needed.**

- True
- (False)

19 **In some cultures, it may be appropriate for female relatives to ask the husband of a pregnant woman to sign consent forms or to explain to him the suggested treatment options if the patient agrees and this is legally permissible**.

- (True)
- False

20 Which of the following is NOT TRUE of an organization that values cultural competence?

- The organization employs or has access to professional interpreters that speak all or at least most of the languages of its clients.
- The organization posts signs in different languages and has patient education materials in different languages.
- The organization tries to hire staff that mirror the ethnic and cultural mix of its clients.
- (The organization assumes that professional medical staff do not need to be reminded to treat ll patients with respect.)


The
Win/Win
Solution


Who
we are
is why
we win!

Section 6.0 Appendices

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Appendix 1: CLAS Standards

National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:

Principal Standard:

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership, and Workforce:

1. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
2. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
3. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance:

1. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
2. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
3. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
4. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability:

1. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
2. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.

3. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

4. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
5. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
6. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
7. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

Think Cultural Health contact@thinkculturalhealth.hhs.gov

The CLAS standards are primarily directed at health care organizations; however, individual providers are also encouraged to use the standards to make their practices more culturally and linguistically accessible. The principles and activities of CLAS should be integrated throughout an organization and undertaken in partnership with the communities being served.

Culturally Competent Care:

- ✓ Health care organizations should ensure that patients/consumers receive from all staff members' effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.
- ✓ Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.
- ✓ Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

Language Access Services:

- ✓ Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.
- ✓ Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.
- ✓ Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

- ✓ Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

ORGANIZATIONAL SUPPORTS:

- ✓ Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.
- ✓ Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.
- ✓ Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.
- ✓ Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.
- ✓ Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.
- ✓ Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.
- ✓ Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.[6]

1. Respond to current and projected demographic changes;
2. Eliminate health disparities;
3. Improve the quality of services and health outcomes;
4. Meet legislative, regulatory and accreditation mandates;
5. Gain a competitive edge in the market place; and
6. Decrease the likelihood of liability claims

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Appendix 2: Tips for Improving the Patient-Provider Relationship across Cultures

1. Begin by being more formal with patients who were born in another culture. In most countries, a greater distance between caregiver and patient is maintained through the relationship. Except when treating children or very young adults, it is best to use the patient's last name when addressing him or her.
2. Do not be insulted if the patient fails to look you in the eye or ask questions about treatment. In many cultures, it is disrespectful to look directly at another person (especially one in authority) or to make someone disrespected by asking him or her questions.
3. Do not make any assumptions about the patient's ideas about the ways to maintain health, the cause of illness or the means to prevent or cure it. Adopt a line of questioning that will help determine some of the patient's central beliefs about health/illness/illness prevention.
4. Allow the patient to be open and honest. Do not discount beliefs that are not held by western biomedicine. Often, patients are afraid to tell western caregivers that they are visiting a folk healer or are taking an alternative medicine concurrently with western treatment because in the past they have experienced ridicule.
5. Do not discount the possible effects of beliefs in the supernatural effects on the patient's health. If the patient believes that the illness has been caused by embrujado (bewitchment), the evil eye, or punishment, the patient is not likely to take any responsibility for his or her cure. Belief in the supernatural may result in his or her failure to either follow medical advice or comply with the treatment plan.
6. Inquire indirectly about the patient's belief in the supernatural or use of nontraditional cures. Say something like, "Many of my patients from___believe, do, or visit___. Do you?"
7. Try to ascertain the value of involving the entire family in the treatment. In many cultures, medical decisions are made by the immediate family or the extended family. If the family can be involved in the decision-making process and the treatment plan, there is a greater likelihood of gaining the patient's compliance with the course of treatment.
8. Be restrained in relating bad news or explaining in detail complications that may result from a particular course of treatment. "The need to know" is a unique American trait. In many cultures, placing oneself in the doctor's hands represents an act of trust and a desire to transfer the responsibility for treatment to the physician. Watch for and respect signs that the patient has learned as much as he or she is able to deal with.

Whenever possible, incorporate into the treatment plan the patient's folk medication and folk beliefs that are not specifically contradicted. This will encourage the patient to develop trust in the treatment and will help assure that the treatment plan is followed.

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Appendix 3: Tools to Help Provide Culturally& Linguistically Appropriate Services.

Six Steps to Community Engagement

1) Go into the community and establish relationships, build trust, work with the formal and informal leadership, and seek commitment from community organizations and leaders to create processes for mobilizing the community.
2) Remember and accept that community self-determination is the responsibility and right of all people who comprise a community.
3) All aspects of community engagement must recognize and respect community diversity. Awareness of the various cultures of a community and other factors of diversity must be paramount in designing and implementing community engagement approaches.
4) Community engagement can only be sustained by identifying and mobilizing community assets, and by developing capacities and resources for community health decisions and action.
5) An engaging organization or individual change agent must be prepared to release control of actions or interventions to the community and be flexible enough to meet the changing needs of the community.
6) Community collaboration requires long-term commitment by the engaging organization and its partners.

Six Reasons to Develop Cultural and Linguistic Competency

1) Respond to current and projected demographic changes;
2) Decrease health disparities;
3) Improve the quality of services and health outcomes;
4) Meet legislative, regulatory and accreditation mandates;
5) Gain a competitive edge in the market place; and
6) Decrease the likelihood of liability claims

Six Steps to Enhancing Interpersonal Communication with Patients

1) Slow down.
2) Use plain, non-medical language.
3) Show or draw pictures.
4) Limit the amount of information provided and repeat it.
5) Use the teach-back or show-me technique.
6) Create a shame-free environment.

Enhancing Your Cultural Communication Skills as a Provider

The more accurate information we have about others, the more likely we will be able to develop appropriate opinions, feelings, and behaviors. How do we get information we need? Do we know if it is proper to ask questions of our patients? We can start by asking permission. Here are a few questions to help in the process of getting information you need:

Questions to Help with Patients and Families from Culturally Diverse Backgrounds:

The first statement is letting the patient know that you need them to help you. It is a thoughtful way of asking permission. The purpose of each question is to make communication respectful while establishing trust.

So that I might be aware of and respect your cultural beliefs...

1) Can you tell me what languages are spoken in your home and the languages that you understand and speak?
2) Please describe your usual diet. Also, are there times during the year when you change your diet in celebration of religious and other ethnic holidays?
3) Can you tell me about your beliefs and practices including special events such as birth, marriage and death that you feel **I** should know?
4) Do you use any traditional health remedies to improve your health?
5) Is there someone, in addition to yourself, with whom you want us to discuss your medical condition?
6) Are there certain health care procedures and tests that your culture prohibits?
7) Are there any other cultural considerations **I** should know about to serve your health needs?
8) Is there anything else you would like me to know?
9) Do you have any questions for me? (Encourage two-way communication)

Checklist for patient-friendly environment

During check-in:

1) Provide assistance filling out forms (can be very confusing)
2) Provide easy-to-read forms
3) Routinely review important instructions (ensure they understand what is going to transpire)
4) Use non-written modalities to explain (plain, simple language)

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4: Tips on Working Effectively with Interpreters

Step 1: Conducting a pre-session

- Ask the interpreter if he/she is familiar with concepts involved
- Encourage interpreter to ask questions when uncertain of meaning of any word, concept or issue
- Request that the interpreter interpret(speak) in the first person (to avoid "he said, she said")
- Tell interpreter what you hope to accomplish — alert to potential difficulties or bad news.

Step 2: The Interview

- Arrange seating so that you directly face the patient
- Speak directly to the patient
- Look at the patient to observe non-verbal signs
- Speak at an even pace in relatively short segments; pause so the interpreter can interpret.
- Be aware that many concepts you express have no linguistic, or even conceptual, equivalent in other languages. The interpreter may have to paint word pictures of many terms you use; this may take longer than your original speech.
- Avoid
    - Using unique or complex speech
    - Complicated sentence structure
    - Sentence fragments
    - Changing your idea in the middle of a sentence
    - Asking multiple questions at one time
- Do not hold the interpreter responsible for what the patient says or doesn't say; the interpreter is the medium, not the source, of the message
- Encourage interpreter to alert you to potential cultural misunderstandings that may come up
- ***Be patient.*** Providing care across a language barrier takes time. However, the time spent up front will be paid back by good rapport and clear communication that will avoid wasted time and dangerous misunderstandings down the line.

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Appendix 5: Terminology

The Child Ready Program realizes that definitions for some of these terms vary depending on geographic and demographic composition of their location. Therefore, the following terms are identified and adopted by the MT EMSC/Child Ready Program. These may need to be modified according to user state composition (population, diversity and applicability).

Acculturation:

The process that takes place when contact between two societies is so prolonged that one or both cultures change substantially. In regard to immigrant groups, acculturation is the process or incorporating values, beliefs, and behaviors from the host culture into the immigrants' cultural worldview.

Culture:

The learned and shared knowledge, beliefs and rules that people use to interpret experience and to generate social behavior. Culture is the dynamic and multidimensional context of many aspects of the life of an individual (gender, faith, sexual orientation, profession, tastes, age Socioeconomic Status (SES), disability, ethnicity and race).

Cultural Competence:

A set of practice skills, knowledge and attitudes that must encompass five elements:

- awareness and acceptance of difference
- awareness of one's own cultural values
- understanding of the dynamics of difference
- development of cultural knowledge
- ability to adapt practice skills to fit the cultural context of the client

Culturally Competent Health Care System

A culturally competent health care system is **committed** to acknowledging at all levels, the importance of culture, assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of services to meet unique cultural needs (working on a sustained goal of becoming **culturally proficient**).

Cultural Competency Training Toolkit

Toolkit designed to present background on each focus group. In addition, tools to facilitate site to assess their readiness to meet the goals of this program to include physical inventory needed to meet emergencies.

Cultural Humility

"Lifelong commitment to self-evaluation and self-critique, to redressing the power, imbalances in the patient-physician dynamic, and to developing mutually beneficial and nonpaternalistic clinical advocacy partnerships with communities on behalf of individuals and defined populations."
Tervalon, M. and Murray-Garcia, J. (Journal of Health Care for the Poor and Underserved (May 1998, 9:2))

Cultural Humility Evaluation Tool

A comprehensive evaluation tool designed to obtain background information on selected focus groups, examples and specific cultural barriers with potential options to meet the competence goals of this project.

your own attitudes, values, and skills, and those of the clients, makes for an effective encounter. **Cultural Intelligence**

Cultural intelligence is the ability to interact effectively with culturally different clients, and it relies on cultural metacognition – knowledge of

Cultural Proficiency

"The knowledge, skills, attitudes, and beliefs that enable people to work well with, respond effectively to, and are supportive of people in cross-cultural settings (ex. Better patient care). The process of cultural competency is taken a step further by employing staff and consultants, with cultural expertise, ensuring assessment and training efforts are developed and implemented, and reviewing policies to ensure the inclusion of culturally competent language".
www.aafp.org. and Rose, Patti R. (2013). Cultural Competency for the Health Professional. Burlington, MA. Jones and Bartlett Learning

Cultural Relativism:

Judging and interpreting the behavior and belief of others in terms of their traditions and experiences.

Cultural Responsiveness

"The ability to learn from and relate, respectively, with people of your own culture, as well as those of other cultures."
www.nuisileadscape.org and Rose, Patti R. (2013). Cultural Competency for the Health Professional. Burlington, MA: Jones and Bartlett Learning

Cultural Self-Awareness:

Understanding the assumptions and values upon which one's own behavior and worldview rests. The appreciation and acceptance of differences.

American College of Obstetricians and Gynecologists, Committee on Health Care for Underserved Women (May 2013).

Cultural Sensitivity

"An awareness of and respect for a person's (e.g., patient's) cultural beliefs and values".
Rose, Patti R. (2013). Cultural Competency for the Health Professional. Burlington, MA: Jones and Bartlett Learning

Culture Shock:

A form of anxiety that results from an inability to predict the behavior of others or act appropriately in a cross-cultural situation.

Ethnicity:

A group identity based on culture, language, religion, or a common attachment to a place or kin ties.

Ethnocentrism:

The interpretation of the beliefs and behavior of others in terms of one's own cultural values and traditions with the assumption that one's own culture is superior.

Multilevel analysis:

Analyses that conceptualize and examine associations at many levels, e.g., employ individual- and area-based data in relation to a specified outcome. These analyses typically entail the use of variance components models to partition the variance at multiple levels, and to examine the contribution of factors measured at these different levels to the overall variation in the outcome

Power:

The ability to produce intended effects on oneself, on other people, and on things or situations.

Race/ethnicity:

A social, not biological, category, referring to social groups, often sharing cultural heritage and ancestry, that are forged by oppressive systems of race relations, justified by ideology, in which one group benefits from dominating other groups, and defines itself and others through this domination and the possession of selective and arbitrary physical characteristics (for example, skin color). *Krieger N. A Glossary for Social Epidemiology, J Epidemiology Community Health 2001; 55:693-700.*

Social Stratification:

The division of members of a society into strata (or levels) with an unequal access to wealth, prestige, power, opportunity, and other valued resources.

Socio-Structural Factors:

The manner in which social ideologies influence individual access to services and opportunities provided by particular institutional systems, e.g. political, legal, education, health care, housing and economic systems.

Spirituality:

A direct relationship with the Creator, Higher Power. In general, it includes a sense of connection to something bigger than ourselves, and it typically involves a search for meaning in life. As such, it is a universal human experience—something that touches us all.

One's orientation or total response to oneself, others, and the universe. It reflects the human capacity to see, to feel, to act in terms of a transcendent dimension, to perceive meaning that is more than merely mundane.

Appendix 6: Cultural Liaison Team

EMSC SPROC Grant. This information or content and conclusions are those of the authors and should not be construed as the official position or policy of, nor should any endorsements by inferred by HRSA HHS or the U.S. Government. "

The resources in this toolkit were current at the time they were selected for inclusion. The content was reviewed by an expert panel to ensure relevance and importance. However, the resources were compiled from a variety of sources and we make no representation or warranty regarding the accuracy of information.

Montana EMS-Children/Child Ready Program Overview

Mission:

- *Implement a performance driven system of healthcare for pediatrics in Montana, including Cultural Humility, Trauma Informed and Health Literacy, ensuring that children, no matter where they live or play, have access to the right care at the right time with the right resources.*

Vision:

- *Develop and strengthen the systems of care to increase access, pediatric readiness, and strength-based approaches that are culturally proficient, and family/patient centered.*
- The mission of the Emergency Medical Services for Children (E.M.S.C.) Program is to reduce child and youth mortality and morbidity caused by severe illness or trauma. EMS for Children aims to ensure that;

- state of the art emergency medical care is available for the ill and injured child or adolescent;
- pediatric service is well integrated into an emergency medical service system backed by optimal resources; and
- the entire spectrum of emergency services, including primary prevention of illness and injury, acute care, and rehabilitation, is provided to children and adolescents as well as adults, no matter where they live, attend school or travel.
- Montana E.M.S.C.'s Program focuses on:

- Strengthening Montana's Pediatric Readiness
- Increasing the number of Montana Hospitals that are formally recognized as a Pediatric Prepared or a Pediatric Capable Facility.
- Increasing Montana's Emergency Medical Services Prehospital pediatric capabilities.

Availability, completeness, quality or adequacy of the resources

The MT Child Ready Cultural Liaison Team members are listed below along with a short bio for each. This team will develop and implement a replicable training program to ensure cultural competency throughout Montana. This team composed of individuals with tribal affiliations as well as the education and background necessary to move this program forward. This team represents collectively, approximately 100 years of experience in working to further cultural competency for Native Americans in Montana.

- **Robin Suzor-** Robin is the Emergency Medical Services for Children (EMSC)/Child Ready MT Program Manager with the MT Department of Public Health & Human Services (DPHHS.) She has a Bachelor of Science in Counseling Psychology/Public Health Education. She has received training as a Basic Emergency Medical Technician (EMT.) She has been a child advocate her whole career to help increase the health and well-being of children across Montana. She strives to ensure the right care at the right time at the right place no matter where children live, play, learn or travel. As a Native Montanan, she understands the diverse nature of our great state. rsuzor@mt.gov

- **John Wallace -** John is currently the Cultural Liaison Supervisor at Benefis Health System in Great Falls, MT. He oversees the Cultural Liaison Coordination Team created to provide Cultural Humility and Competency. John has many years of experience in managing projects to ensure customer satisfaction. John is noted for his exceptional vision and leadership in creating work cultures with a strong customer service and hospitality reputation. He has proven experience in building and leading a strong team to create outstanding results. johnwallace@benefis.org

- **Lisa Whitford (Chippewa Cree)** –enrolled member of the Chippewa Cree Tribe of the Rocky Boy's Indian Reservation. She has lived on the Reservation all her life except to attend college and work. She has a B.S. Degree in Healthcare Administration from the University of Great Falls (MT.) She is the mother of three beautiful children and Kokoom (Grandmother) to seven of the most awesome tiny human beings, her Grandchildren. She focuses on promoting healthy life choices for those who she crosses paths. She is currently the Director of the Chippewa Cree Senior Citizen's Programs for the Tribe. She strives to provide the best healthcare and lifestyles possible to our Native American communities. She thanks Our Creator daily for where she is at in life and she strives to do her best with all that she is given to do. lwatsonwhitford@gmail.com

- **Kassie Runsabove** is a program officer at the Montana Healthcare Foundation. Kassie supports Foundation's programming work in the American Indian Health focus area and initiatives. Kassie has over 12 + years of experience in healthcare ranging from public health to health administration. Her career began at Riverstone Health as a Prevention Health Specialist and grew to a Health Disparities Coordinator at St. Vincent Healthcare. In recognition of her work, Kassie earned the 2016 Billings Gazette 40 Under 40 Award and the National Catholic Healthcare Association 2016 Tomorrow's Leader Award. Kassie is enrolled Whiteclay from Fort Belknap, Montana. She is passionate about education, awareness, and collaboration so

that underserved populations have access to all the resources available. Kassie received her bachelor's degree in health promotion from Montana State University Billings. She currently lives in the Billings area with her husband and three children. Kassie.runsabove@mthcf.org

- **Shawna Cooper (Northern Cheyenne) – Shawna is** from Lame Deer, Montana. She has a Bachelor of Science in Native American Studies. She previously worked with Billings Clinic as the CAC Native Coordinator. Currently, employed with American Indian Cancer Society as the women's Health Equity Coordinator. scooper@americanindiancancer.orgSonya

- **CDR LeeAnn Bruised Head, MPH (Crow-Kainai)** LeeAnn is from Garryowen, Montana. CDR

LeeAnn Bruised Head, a Commissioned Corps Officer with US Public Health Service, brings 20+ years of vast experience from Urban & Tribal Communities, IHS, and State & National Organizations in the arena of Public Health. Her mission is to provide guidance, leadership and vision to meet the mission of the Indian Health Service in managing and developing the organization through collaboration and innovation. Initiating a change of the current system of care to Trauma Informed Integrated Health Care across the Billings Area. Her current role is with Billings Area IHS as the Public Health Advisor for Office of Urban Indian Health Programs. CDR Bruised Head received her undergraduate degree from University of Montana 1991; Master of Public Health Degree from University of Oklahoma Health Sciences Center 1994. She is an enrolled member of the Crow Tribe and Descendent of First Nations People of the Blood Tribe (Kainai) from Southern Alberta, Canada. Leeann.bruisedhead@ihs.gov

- **Lanette Perkins (Crow).** She spent her youth living in several different reservations and

native communities. Her Father was an enrolled member of the Crow Tribe and worked for the BIA. Her mother was German, however, she adapted to tribal traditional customs. The diversity of her family gave her a vast knowledge of different cultures and a respect for all people. Her passion has been in nursing and education. She graduated from Salish Kootenai College with an Associate of Nursing, Montana State University with a Bachelor of Nursing, Master of Nursing and a Health Education Certificate. Her Master's project was *Review and Comparison of Three Cultural Competency Education Programs for Nurses*. Throughout her life, she gained a wealth of experience regarding rural, urban and Tribal communities. She has worked with Indian Health Service, assisted with grant programs involving rural Montana communities, and was a member of the Montana Board of Nursing for eight years. She has been a strong advocate of spending quality time with patient, families and community members promoting learning opportunities. She is continuously pursing her interests in promoting health education in rural and underserved areas of Montana; including communities on the seven Montana reservations and surrounding areas. LanettePerkins@benefis.org

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Appendix 7: Additional Resources

If you could hear what they hear: https://www.youtube.com/watch?v=IQtOgE2s2xI

Dr. Warne: All my relations https://www.youtube.com/watch?v=3phTundagzQ

BIA:

https://www.bia.gov/about-us

https://www.bia.gov/programs-services

https://www.ihs.gov/

URBAN CLINIC:

https://www.ihs.gov/billings/includes/themes/responsive2017/display_objects/documents/IHSPressRelease_NADCtoServeBillings.pdf

http://tribalnations.mt.gov/urbanindian

RMTLC:
https://www.rmtlc.org/ihs/

https://www.ihs.gov/billings/staff/

http://cskthealth.org/index.php/locations

EXAMPLE OF CH/PRC:

https://hsc.unm.edu/health/patients-visitors/native-american-patients.html

TRIBAL SELF-GOVERNANCE PROGRAM LINKS:

https://www.ihs.gov/selfgovernance/aboutus/ ISDEAA Title I (25 U.S.C. § 450 et seq.):

https://www.govinfo.gov/content/pkg/USCODE-2010-title25/pdf/USCODE-2010-title25-chap14-subchapII.pdf Title I Regulations (25 C.F.R. Part 900):

https://www.govinfo.gov/content/pkg/CFR-2011-title25-vol2/pdf/CFR-2011-title25-vol2-part900.pdf

ISDEAA Title V (25 U.S.C. § 458aaa et seq.):

https://www.govinfo.gov/content/pkg/USCODE-2010-title25/pdf/USCODE-2010-title25-chap14-subchapII-partE.pdf Title V Regulations (42 C.F.R. Part 137):

https://www.govinfo.gov/content/pkg/CFR-2011-title42-vol1/pdf/CFR-2011-title42-vol1-part137.pdf

(adapted from Tervalon M et al (1998) *Tervalon, M. and Murray-Garcia, J. (Journal of Health Care for the Poor and Underserved (May 1998, 9:2))*

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Comparing Cultural Norms and Values

Aspects of Culture	U.S. Health Care Culture	Other Cultures
1. Sense of self and space	• Informal • Handshake	• Formal • Hugs, bows, and handshakes
2.Communication and language	• Explicit, direct communication • Emphasis on content -meaning found in words	• Implicit, indirect communication • Emphasis on context -meaning found around words
3. Dress and appearance	• "Dress for success" ideal • Wide range in accepted dress • More casual	• Dress seen as a sign of position, wealth, and prestige • Religious rules More formal
4. Food and eating and habits	• Eating as a necessity -fast food	• Dining as a social experience • Religious rules
5. Time and time consciousness	• Linear and exact time consciousness • Value on promptness • Time = money	• Elastic and relative time consciousness • Time spent on enjoyment of relationships
6. Relationship, family, friends	• Focus on nuclear family • Responsibility for self • Value on youth, age seen as handicap	• Focus on extended family • Loyalty and responsibility to family • Age given status and respect
7. Values and norms	• Individual orientation • Independence • Preference for direct confrontation of conflict • Emphasis on task	• Group orientation • Conformity • Preference for harmony • Emphasis on relationships
8. Beliefs and attitudes	• Egalitarian • Challenging of authority • Gender equity • Behavior and action affect and determine the future	• Hierarchical • Respect for authority and social order Different roles for men and women • Fate controls and predetermines the future
9. Mental processes and learning style	• Linear, logical • Problem-solving focus • Internal locus of control • Individuals control their destiny	• Lateral, holistic, simultaneous • Accepting of life's difficulties • External locus of control • Individuals accept their destiny
10. Work habits and practices	• Reward based on individual achievement Work has intrinsic value	• Rewards based on seniority, relationships • Work is a necessity of life

Lee Gardenswartz and Anita Rowe, Managing Diversity: A Complete Desk Reference and Planning Guide (Burr Ridge,Ill.: Irwin, 1993), p. 57.

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Bias Exercise

Read each question and enter your response in the appropriate box.		YES ✓	NO ✓
1.	Do you ask about a client's or patient's background or cultural beliefs?		
2.	Have you judged an individual due to his or her dress code?		
3.	Are you being sensitive to another person's fear of racism or prejudice?		
4.	Have you examined your personal ethnic and class background and how others may perceive you?		
5.	Have you ever felt different and/or separate from a majority ethnic group?		
6.	Do you feel more at ease treating client's/patients of your ethnicity, skin color, culture, or socio- economic class?		
7.	Do you utilize casual conversation to establish rapport with your client's or patients?		
8.	Have you stereotyped a client or patient based on his/her looks, language, dress and other outward appearances?		
9.	Do you ask the client or patient how they would like to be addressed?		
10.	Have you felt uncomfortable when there is a long pause in the conversation?		

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Affecting Health Care Assessment

Prepared by: Levanne r. Hendrix, MSN, RN, GNP, PhD

Note: Not all AI/AN elders will use these patterns, and not all AI/AN will use them all the time, depending on the situation. Euro-American patterns tend to be institutionalized within the health care culture.

AMERICAN INDIAN	EURO-AMERICAN
Avoidance of direct eye contact as a sign of respect	Direct contact considered sign of honesty and sincerity
Handshake lightly; some women touch only the fingertips	Firm handshake denotes power
Information passed by "word of mouth" rather than media, some Internet used	Lectures, newspapers, TV, Radio, and Internet used
Personal information not forthcoming	Self-disclosure valued, "Open and Honest" communication style
Ideas and feelings conveyed through behavior rather than speech	Verbal expression of ideas and feelings
Words are chosen carefully and deliberately, as the power of words is understood	Verbosity and small talk is appropriate behavior
Listening is valued over talking	Schools teach speaking over listening. Importance of expressing one's opinion
Use of observational skills and non-verbal communication	Verbal and written communication valued
Criticism communicated indirectly through another family member. Direct criticism considered disrespectful and rude	Direct criticism used to alter behavior
Withdrawal used as a form of disapproval ("voting with your feet")	Direct expression of disapproval
Request given through indirect suggestion	Directness of requests

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Competency Check Tools

5. Cultural & Linguistic Competency Survey
6. Cultural Diversity Test
7. Cultural Inventory for Individual Caregivers/Providers

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Cultural and Linguistic Competency Survey for Health Care Providers

Date of Survey:	**Site Location**: Click or tap here to enter text.	**Survey#** Click or tap here to enter text.

This survey is for internal use only. This survey will help us assess the cultural competency of your healthcare facility and providers serving your patients and families. This will help us assess and accommodate the cultural and linguistic needs in your service area. Your responses will be kept confidential and will not be shared with anyone outside of the Assessment Team and data evaluators. Your facility participation is voluntary and is greatly appreciated; it will help us determine effective strategies for providing culturally appropriate services to your patients while building a culturally competent workforce.

Section One: Training and Staff Development

For each statement, check "Yes" or "No". If you don't know or the statement is not applicable to your position, check the appropriate box.

1.	During the past year, our facility has provided at least one in-service or training that enhances our knowledge of the Indigenous population served by our Hospital/office.	☐ Yes	☐ No	☐ Don't know
2.	This past year, our facility has provided articles that have provided our staff with knowledge of the Indigenous patient population we serve.	Yes	No	Don't know
3.	As part of an in-service or other training, we have had the opportunity to evaluate our own cultural beliefs and potential biases.	Yes	No	Don't know
4.	Our facility is comfortable communicating with Indigenous patients and families without fear or anxiety.	Yes	No	Don't know
5.	We have been trained in how to properly work with a tribal interpreter while maintaining patient's confidentiality.	Yes	No	Don't know
6.	Our Hospital/office have books, videos, lists of websites and other resources that staff can use to enhance their knowledge and understanding of the Indigenous patients we serve.	Yes	No	Don't know
7.	Have your facility provided a visit to a local Indigenous site in the last year?	Yes	No	Don't know
8.	Is your facility affiliated with a Tribe and or Tribal Family?	Yes	No	Don't Know
Count the number of checked boxes in each column and enter the total here. **Section One Subtotal**		Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.

Section Two: Hospital capabilities				
For each statement, check "Yes" or "No". If you don't know or the statement is not applicable to your position, check the appropriate box.				
9.	At our hospital we use posted sign to help guide our patients of varied cultural backgrounds.	☐ Yes	☐ No	☐ Don't know
10.	We have trained interpreters easily available who speak the Indigenous language common in the service area.	☐ Yes	☐ No	☐ Don't know
11.	As a hospital, we have established connections with various community cultural groups to help us better serve our Indigenous patients/families.	☐ Yes	☐ No	☐ Don't know
12.	Our hospital has developed a list of various community resources we can use for referrals to better serve our Indigenous population.	☐ Yes	☐ No	☐ Don't know
13.	The décor and magazines in our waiting room(s) reflect the diversity of our Indigenous patient population.	☐ Yes	☐ No	☐ Don't know
14.	Our hospital has the capacity to meet the needs of Indigenous patients who are hearing or visually impaired.	☐ Yes	☐ No	☐ Don't know
15.	Our hospital has a list of Traditional Healing Practioners in the tribal communities we can use as referral sources to better serve our Indigenous patient population.	☐ Yes	☐ No	☐ Don't know
16.	Our hospital demonstrates its accessibility and willingness to help meet the needs of our Indigenous patient population by finding ways to assist our patients/families with transportation.	☐ Yes	☐ No	☐ Don't know
17.	Our hospital has an Indigenous Patient Advocate to assist Indigenous patients with their advocacy needs.	☐ Yes	☐ No	☐ Don't know
Count the number of checked boxes in each column and enter the total here. **Section Two Subtotal**		Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.

Section Three: Health Education

For each statement, check "Yes" or "No". If you don't know or the statement is not applicable to your position, check the appropriate box.

18.	Most client education materials and satisfaction surveys used by our health care providers are easy-to-read.	☐ Yes	☐ No	☐ Don't know
19.	Most forms completed by patients are presented in a simple and concise form.	☐ Yes	☐ No	☐ Don't know
20.	Most intake and forms completed by patients are available in the language spoken by Indigenous patients.	☐ Yes	☐ No	☐ Don't know
21.	Our hospital is committed to providing marketing materials that appeal to the various social, cultural, and special-needs of the Indigenous population we serve.	☐ Yes	☐ No	☐ Don't know
22.	Our hospital has a way to assess the quality, accuracy and cultural appropriateness of the material we use, including translated versions.	☐ Yes	☐ No	☐ Don't know
23.	Does your facility have Indigenous board representation of the Indigenous population served?	☐ Yes	☐ No	☐ Don't know
Count the number of checked boxes in each column and enter the total here. **Section Three Subtotal**		Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.

Section Four: Administrative Issues				
For each statement, check "Yes" or "No". If you don't know or the statement is not applicable to your position, check the appropriate box.				
24.	Our Hospital has developed relationships with Indigenous training programs, minority health agencies, and tribal communities to recruit new staff.	☐ Yes	☐ No	☐ Don't know
25.	Our Hospital collects data on patient race, ethnicity, in their health records.	☐ Yes	☐ No	☐ Don't know
26.	Our Hospital has a person/staff position with responsibility for implementing and monitoring cultural awareness/competency activities.	☐ Yes	☐ No	☐ Don't know
27.	We maintain an updated profile of the Tribes we serve. Including disease trends, demographic, and cultural information.	☐ Yes	☐ No	☐ Don't know
28.	Our Board of Directors has a general understanding of the Indigenous population we serve.	☐ Yes	☐ No	☐ Don't know
29.	Our clinical leadership and staff show appreciation and respect for all co-workers no matter their cultural and ethnic background.	☐ Yes	☐ No	☐ Don't know
30.	Our Hospital has a written plan to implement culturally and linguistically appropriate health care services.	☐ Yes	☐ No	☐ Don't know
31.	We have written policies to address concerns or complaints voiced by patients regarding unfair or inappropriate treatment due to their race, ethnicity, or the language they speak.	☐ Yes	☐ No	☐ Don't know
32.	Our hospital annually assesses our progress in implementing culturally and linguistically appropriates health care services.	☐ Yes	☐ No	☐ Don't know
Count the number of checked boxes in each column and enter the total here. **Section Four Subtotal**		Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.

COMMENTS: We appreciate your feedback. Please use the space provided to share any comments or suggestions you may have.

Thank you for taking the time to fill out this survey. Your answers will be analyzed, and an aggregate report generated with no identifiers to be shared with those who request a copy of the report. This information will help us improve the quality of care we provide to our patients and be a more culturally competent workforce.

If you have any questions regarding this survey, please contact:
the MT EMSC Program Manager, Robin Suzor at rsuzor@mt.gov
or the MT EMS & Trauma Systems section at 406-444-3895.

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Cultural Diversity Quiz

1. Explanations in a patient's native language increase understanding and can be more accurate.

   True/False

2. Some cultures favor directness in communications, and some communicate using more subtle, indirect cues.

   True/False

3. Demonstration of emotion is culturally influenced.

   True/False

4. Gestures usually mean the same thing for people, no matter their cultural preferences.

   True/False

5. Discussing personal matters outside the family is seen as embarrassing by some cultures.

   True/False

6. It is important to give reasons for any requests or directions given to patients.

   True/False

7. Making a human to human connection and building rapport is an important first step in relationship building.

   True/False

8. It is essential for all employees to incorporate understanding, and respect for patient's cultural values, beliefs and practices.

   True/False

9. Factors that may differ from patient to patient and call for specific responses include ethnicity, religion and occupation.

   True/False

10. Body language, facial expressions and other behaviors provide helpful clues to understanding other individuals.

    True/False

11. Smiles and laughter may indicate discomfort or embarrassment.

    True/False

12. Healthcare providers should avoid making judgments about the patient's beliefs and practices.

    True/False

13. In some cultures, it is normal for people to stand so close to others that the closeness may cause psychological discomfort.

    True/False

14. A handshake is generally accepted as a standard greeting in business, yet the kind of handshake may differ.

    True/False

15. Patient's religious rules can affect what they want for their healthcare.

    True/False

16. Healthcare providers can assume that a particular patient fits the general culture descriptions of his or her gender, values, health practices, race or ethnicity.

    True/False

17. Spending time to cultivate relationships by getting to know patients and families can establish comfort and rapport before beginning the task at hand.

    True/False

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Cultural Inventory for Individual Caregivers/Providers

Every statement should be answered by circling one number ranging from 5 (always) to 4 (frequently), 3 (occasionally), 2 (seldom), and 1 (never). Simply circle your score on the line under each numbered response. When completed, tabulate all scores and enter under ***Your Total Score*** at the bottom. The scoring grid is on the following page.

In working with ethnic minority clients, I …

Statement					
1. Realize that my own ethnic and class background may influence my effectiveness and/or judgement.					
Statement #1 Score	**5**	**4**	**3**	**2**	**1**
2. Make an effort to ensure privacy and/or anonymity					
Statement #2 Score	**5**	**4**	**3**	**2**	**1**
3. Consider it an obligation to familiarize myself with their culture, history, and other ethnic related responses to problems.					
Statement #3 Score	**5**	**4**	**3**	**2**	**1**
4. Can identify the links between systematic problems and individual concerns.					
Statement #4 Score	**5**	**4**	**3**	**2**	**1**
5. Am sensitive to their fear of racist or prejudiced orientations.					
Statement #5 Score	**5**	**4**	**3**	**2**	**1**
6. Am aware that lack of progress may be related to ethnicity.					
Statement #6 Score	**5**	**4**	**3**	**2**	**1**
7. Am able to explain clearly the nature of the problem to be solved.					
Statement #7 Score	**5**	**4**	**3**	**2**	**1**
8. Am respectful of their definition of the problem to be solved.					
Statement #8 Score	**5**	**4**	**3**	**2**	**1**
9. Am able to specify the problem in practical, concrete terms.					
Statement #9 Score	**5**	**4**	**3**	**2**	**1**
10. Am sensitive to treatment goals consonant to their culture.					
Statement #10 Score	**5**	**4**	**3**	**2**	**1**
YOUR TOTAL SCORE		Scoring: These 10 items represent cultural areas that should be considered when working with the cultural diversity of your demographic area.			

Scoring Grid

YOUR SCORE	CATEGORY	ACTION REQUIRED
45 – 50	Excellent	No action required. Good job. Keep it up.
40 – 44	Good	Need to look at areas with lower scores for possible improvement but doing well.
35 – 39	Sub-Par	Needs to develop Improvement Plan and Follow-Up to ensure that you deliver quality services to all.
30 – 34	Poor	A low score may indicate areas that can be improved on to better serve patients/clients in your area.
<29	Sub-Standard	Same as above, however the results may show where cultural sensitivity needs to be looked at for you to be more effective in your role in your community.

Informational Tools

8. Child Ready Family & Provider Guide
9. Cultural Diversity Document
10. SAMHSA's "A Guide to Build Cultural Awareness"
11. Understanding & Responding to Children in Crisis (Colorado)

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Family Structure

Families in indigenous (Native) and ethnic minority cultures tend to be extended and consist of multi-generational layers.

It is not uncommon for large numbers of family members to be present when Native children come to the hospital. This can become overwhelming to providers and possibly impact patient care.

The Cultural Liaison Coordinators are here to assist you in this situation. Simply ask for a Liaison to consult with the family and offer support.

Cultural Liaisons:

Through the State Partnership for the Regionalization of Care (SPROC) Grant, Montana has established a Cultural Liaison Group whose purpose is to work with organizations and groups to help determine workforce cultural competency. They will prepare and deliver trainings to ensure cultural competency is achieved and ensure that all children ***"receive the right care, at the right time, and with the right resources."***

Each of the Cultural Liaisons have extensive training and experience to assist organizations be prepared to work with indigenous patients and help decrease family/provider communication issues.

Community Cultural Liaisons: Lisa Watson-Whitford, Shawna Cooper, LeeAnn Bruised Head, Lanette Perkins and Kassie Runsabove.

For more information on this exciting project, or to schedule a cultural training, please contact John Wallace at **johnwallace@benefis.org**. He can also be reached at 406.455.5596.

"This project was supported by HRSA of the U.S. Department of Health and Human Services under the EMSC SPROC Grant. This information or content and conclusions are those of the authors and should not be construed as the official position or policy of, nor should any endorsements by inferred by HRSA HHS or the U.S. Government. "

CHILD READY MONTANA

Family and Provider informational guide to assisting indigenous and ethnic minority families

What is Child Ready Montana?

Child Ready Montana is a State Partnership Regionalization of Care (SPROC) Grant funded by the Federal Health Resource and Services Administration (HRSA). Montana is currently one of only three states in the nation to be awarded this prestigious grant.

The intent of the program is to develop an accountable culturally competent network to support providers and pediatric patients across the state, ensuring that all children ***"receive the right care, at the right time, and with the right resources."***

Culturally Competent Healthcare

Components of Cultural Competence

Caring for infants, children and their families in an emergent situation can be very scary. A genuine understanding of cultural and patient centered care concepts is critical in treating unique patient populations.

Five (5) Major Components:

- Employing culturally diverse staff that reflects the community and region that it serves
- Employing providers and translators
- Training providers of the importance of spirituality and language for patients
- Providing signage and instructional literature in the language(s) consistent with cultural norms
- Creating culturally specific healthcare settings when feasible

"A genuine understanding of cultural and patient centered care concepts is critical in holistically treating unique patient populations."

Indigenous Spirituality

Spirituality plays a large role in most families dealing with a difficult situation, especially when a child has an emergency. In consideration of your facility's guidelines, calm and open discussions allow healing to take place. This is a critical element for success.

Cultural Diversity

Montana has a diverse and dynamic population. Here, and across the country, people of racial, ethnic and cultural minorities; immigrant and refugee communities; and economically and socially disadvantaged groups often receive less or lower quality health care.

While each state has unique causes that contribute to disparities, some states have been successful in addressing disparities in overall health indicators and may serve as examples for other states. Our State is committed to improving the health and increasing access to care for all of our communities and individuals living within our borders.

Minority Americans frequently report higher rates of specific health problems, such as diabetes or obesity. The poorer health status of racial and ethnic minority Americans reflects higher death rates for chronic diseases.

Defining Culture and Cultural Competence

Culture is our way of life, the way we do things, the way we hear what others are saying and even the way we see what is around us. Culture is how we identify our experiences and give them meaning.

Many things shape our personal culture including gender, race, age, sexual orientation, nationality, ethnicity, religious and political associations, physical ability, socioeconomic class, current realities and life experiences.

The scope of culture is so large, it would be impossible to learn about so many things for everyone that we meet. Being culturally competent does not mean that you must be an expert on every culture.

a) It means that we use care and do not make assumptions about others.
b) It means that we ask questions to get information that will help us in providing care to the patient.

Cultural competence is sharing respect for each other and accepting that there are many ways of viewing the world. If everyone is unique with different views and languages, then how do we get quality care that will address differences?

This leads us to our definition of Cultural Competence:

- It is the ability to function effectively in the context of cultural differences
- It allows us to understand who we are so we can allow others the opportunity to share who they are with us.

Summary

- Population data presented by race and ethnicity has contributed to making health disparities a priority in our state and the nation. Data reveals that there are differences in health outcomes for racial, ethnic and cultural groups when compared to Caucasians.
- Personal culture is active and is ever changing. Cultural competence begins with the individual. It includes respect, awareness and acceptance of differences in worldviews. It is also important not to make assumptions about people and situations, but to look for accurate information from the patient, family or community member.
- Language and culture influence how we approach health and provide care. Successful health care systems work to put in place tools and processes that will benefit all patients. The CLAS Standards developed by the Office of Minority Health are an excellent road map to providing culturally and linguistically appropriate services.
- Providers and patients/clients bring their unique cultural backgrounds and expectations to the medical encounter. Cultural competence becomes a part of the process when information is successfully shared. This means that 3 different entities must interact in a seamless manner: patients, providers & systems.
- There must be effective communication between patients and providers for quality care to result. Providers and organizations must have systems, policy and processes in place to meet the challenges of patients who speak different languages, are non-English speaking (NEP) low English Proficiency (LEP), or have low literacy.

Family Centered Care

Family-Centered Care: is a systematic approach to building collaborative relationships between health care professionals and families and utilizes those relationships to assist in providing quality care along with promoting overall community health and safety.

Family-Centered Pre-Hospital Care: utilizes family-centered care principles during on-scene treatment, transport, and transition of care to in-hospital health care providers.

- Safety of the Team should always be the first concern.
- Identify a team member to interact with family members on each call.
    - Identify yourself by name and ask patients and family members how they would like to be addressed.
    - Use courtesy titles (Mr., Mrs,, Ms., Etc)
    - Avoid slang
    - Explain equipment and procedures in clear, factual terms
    - Avoid using medical jargon and acronyms
    - Do no assume that family members cannot understand explanations

- Whenever possible provide family members with options
- If possible, allow a family member to accompany the patient to the hospital.
- Be willing to listen and utilize the information given by the family regarding a patient (pertinent history, normal level of consciousness, special developmental concerns, dominate hand, best known IV sites, etc.).
- When the patient is an older child, ask caregiver about speaking openly in front of the child and including the child in the process.
- Introduce receiving hospital personnel to the patient and patent's family.
- Take time to answer any questions regarding your care and say good-by to the family.
- Be aware of cultural differences that may affect delivery of care
    - Do not judge another culture's way of providing care.
    - Acknowledge unusual practices without judgement, discuss them with family at the scene or during transport and document them on the patient care report.
- Identify possible language barriers within your response area.
    - Develop resources to assist in communicating with all members of your community
- Whenever possible, avoid using children as interpreters.
- Identify the children in your response area with special health care needs.
    - Visit the family and learn what needs and expectations they may have if they call for help.
- Develop polices on advanced directives for withholding or terminating prehospital resuscitation efforts.

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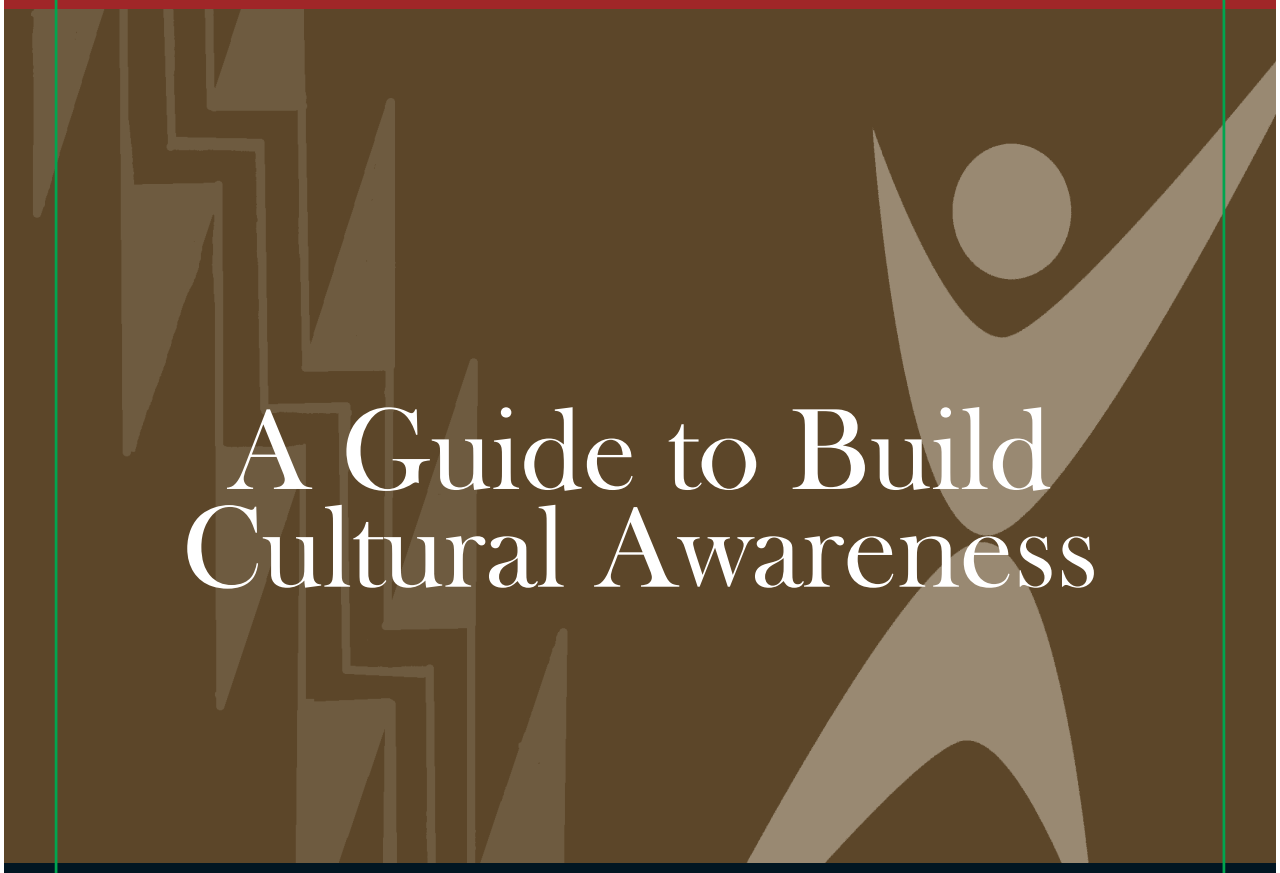
CultureCard



A Guide to Build Cultural Awareness

American Indian and Alaska Native

About this Guide

The purpose of this guide is to provide basic information for Federal disaster responders and other service providers who may be deployed or otherwise assigned to provide or coordinate services in American Indian/Alaska Native (AI/AN) communities.

This guide is intended to **serve as a general briefing to enhance cultural competence** while providing services to AI/AN communities. (Cultural competence is defined as the ability to function effectively in the context of cultural differences.) A more specific orientation or training should be provided by a member of the particular AI/AN community.

Service providers should use this guide to ensure the following Five Elements of Cultural Competence* are being addressed:

1. Awareness, acceptance and valuing of cultural differences
2. Awareness of one's own culture and values
3. Understanding the range of dynamics that result from the interaction between people of different cultures
4. Developing cultural knowledge of the particular community served or to access cultural brokers who may have that knowledge
5. Ability to adapt individual interventions, programs, and policies to fit the cultural context of the individual, family, or community

*Adapted from Cross, T., Bazron, B., Dennis, K., and Isaacs, M. (1989). Towards A Culturally Competent System of Care Volume I. Washington, D.C.: Georgetown University Child Development Center, CASSP Technical Assistance Center.

Myths and Facts

Myth: AI/AN people are spiritual and live in harmony with nature.
Fact: The idea of all AI/ANs having a mystical spirituality is a broad generalization. This romantic stereotype can be just as damaging as other more negative stereotypes and impairs one's ability to provide services to AI/ANs as real people.

Myth: AI/AN people have distinguishing physical characteristics, and you can identify them by how they look.
Fact: **Due to Tribal diversity, as well as hundreds of years of inter-Tribal and inter-racial marriages, there is no single distinguishing "look" for AI/ANs.**

Myth: Casinos have made AI/ANs rich.
Fact: Out of more than 560 Federally recognized tribes, only 224 operate gaming facilities. About three-fourths of those tribes reinvest revenue in the community. In 2006, only 73 tribes distributed direct payments to individual Tribal members.

Myth: The Bureau of Indian Affairs (BIA) and the Indian Health Service (IHS) are the only agencies responsible for working with tribes.
Fact: The U.S. Constitution, Executive Orders, and Presidential memos outline policy requiring that ALL executive departments have the responsibility to consult with and respect Tribal sovereignty.

Myth: AI/ANs have the highest rate of alcoholism.
Fact: While many tribes and AI/AN villages do experience the negative effects of alcohol abuse, what is less known is that AI/ANs also have the highest rate of complete abstinence. When socioeconomic level is accounted for in a comparison group, alcoholism rates are no different for AI/ANs than for other ethnic or racial groups. Most AI/AN-sponsored events ban the use of alcohol and even "social" drinking is often frowned upon.

Myth: AI/AN people all get "Indian money" and don't pay taxes.
Fact: Few Tribal members receive payments from the BIA for land held in trust and most do not get significant "Indian money." AI/ANs pay income tax and sales tax like any other citizen of their State while the U.S. Alaska Natives may get dividend payments from their Native Corporation or the State of Alaska as State citizens.

Tribal Sovereignty

Presently, there are more than 560 Federally recognized AI/AN tribes in the United States. Over half of these are Alaska Native villages. Additionally, there are almost 245 non-Federally recognized tribes. Many of those are recognized by their States and are seeking Federal recognition.

There is a unique legal and political relationship between the Federal government and Indian tribes and a special legal relationship with Alaska Native Corporations.

The U.S. Constitution (Article 1 Section 8, and Article 6), treaties, Supreme Court decisions, Federal laws, and Executive Orders provide authority to the Federal government for Indian affairs with Federally recognized tribes.

As sovereign nations, Tribal governments have the right to hold elections, determine their own citizenship (enrollment), and to consult directly with the U.S. government on policy, regulations, legislation, and funding.

Tribal governments can create and enforce laws that are stricter or more lenient than State laws, but they are not subservient to State law. State laws cannot be applied where they interfere with the right of a tribe to make its own laws protecting the health and welfare of its citizens, or where it would interfere with any Federal interest.

Criminal legal jurisdiction issues are very complex, depend on a variety of factors, and must be assessed based on the specific law as applied to a specific tribe. In general, the Federal law applies.

The Indian Self-Determination Act (Public Law 93-638) gives the authority to Tribal governments to contract programs and services that are carried out by the Federal government, such as services provided by the BIA or IHS.

The Alaska Native Claims Settlement Act was signed into law on December 18, 1971. Settlement benefits would accrue to those with at least one-fourth Native ancestry, and would be administered by the 12 regional corporations within the State.

Regional and Cultural Differences

Prior to European contact, AI/AN communities existed throughout various areas of North America. Federal policies led to voluntary and forced relocation from familiar territory to the current day reservation system.

When the reservation system was formed in the late 1800s, some bands and tribes were forced by the U.S. government to live together. In some instances, these groups were related linguistically and culturally; in others, they were not closely related and may even have been historic enemies.

On reservations where different AI/AN groups were forced to co-exist, repercussions occurred that still can be experienced today in those communities. **Historic rivalries, family or clan conflicts, and "Tribal politics" may present challenges for an outsider unaware of local dynamics who is trying to interact with different groups in the community.**

While there is great diversity across and within tribes, there are within-region similarities based on adaptation to ecology, climate, and geography (including traditional foods); linguistic and cultural affiliations; and sharing of information for long periods of time.

Differences in cultural groups are closely related to regional differences and may be distinguished by their language or spiritual belief systems. They are also a result of the diversity of historic homelands across the Nation and migration patterns of Tribal groups.

Cultures developed in adaptation to their natural environment and the influence of trade and interaction with non-Indians and other AI/AN groups.

Urban Indian communities can be found in most major metropolitan areas. These populations are represented by members of a large number of different tribes and cultures that have different degrees of traditional culture and adaptation to Western culture norms. They form a sense of community through social interaction and activities, but are often "invisible," geographically disbursed, and multi-racial.

Cultural Customs

Cultural customs can be viewed as a particular group or individual's preferred way of meeting their basic human needs and conducting daily activities as passed on through generations.

Specific cultural customs among AI/AN groups may vary significantly, even within a single community.

Customs are influenced by: ethnicity, origin, language, religious/spiritual beliefs, socioeconomic status, gender, sexual orientation, age, marital status, ancestry, history, gender identity, geography, and so on.

Cultural customs are often seen explicitly through material culture such as food, dress, dance, ceremony, drumming, song, stories, symbols, and other visible manifestations.

Such outward cultural customs are a reflection of a much more ingrained and implicit culture that is not easily seen or verbalized. **Deeply held values, general world view, patterns of communication, and interaction are often the differences that affect the helping relationship.**

A common practice of a group or individual that represents thoughts, core values, and beliefs may be described by community members as "the way we do things" in a particular tribe, community, clan, or family. This includes decision-making processes.

Respectful questions about cultural customs are generally welcomed, yet not always answered directly.

Any questions about culture should be for the purpose of improving the service provider's understanding related to the services being provided.

Many AI/AN people have learned to "walk in two worlds" and will observe the cultural practices of their AI/AN traditions when in those settings, and will observe other cultural practices when in dominant culture settings.

Sharing food is a way of welcoming visitors, similar to offering a handshake. Food is usually offered at community meetings and other gatherings as a way to build relationships.

Spirituality

A strong respect for spirituality, whether traditional (prior to European contact), Christian (resulting from European contact), or a combination of both, is common among all AI/AN communities and often forms a sense of group unity.

Many AI/AN communities have a strong church community and organized religion that is integrated within their culture.

Traditional spirituality and practices are integrated into AI/AN cultures and day-to-day living.

Traditional spirituality and/or organized religions are usually community-oriented, rather than individual-oriented.

Spirituality, world view, and the meaning of life are very diverse concepts among regions, tribes, and/or individuals.

Specific practices such as ceremonies, prayers, and religious protocols will vary among AI/AN communities.

A blend of traditions, traditional spiritual practices, and/or mainstream faiths may coexist. It is best to inquire about an individual's faith or beliefs instead of making assumptions, but be aware that many AI/AN spiritual beliefs and practices are considered sacred and are not to be shared publicly or with outsiders.

Until passage of the Indian Religious Freedom Act in 1978, many traditional AI/AN practices were illegal and kept secret.

Social/health problems and their solutions are often seen as spiritually based and as part of a holistic world view of balance between mind, body, spirit, and the environment.

It is a common practice to open and close meetings with a prayer or short ceremony. Elders are often asked to offer such opening and closing words and given a small gift as a sign of respect for sharing this offering.

Communication Styles

Nonverbal Messages

- **AI/AN people communicate a great deal through non-verbal gestures.** Careful observation is necessary to avoid misinterpretation of non-verbal behavior.

  • AI/AN people may look down to show respect or deference to elders, or ignoring an individual to show disagreement or displeasure.

- A gentle handshake is often seen as a sign of respect, not weakness.

Humor

- **AI/AN people may convey truths or difficult messages through humor**, and might cover great pain with smiles or jokes. It is important to listen closely to humor, as it may be seen as invasive to ask for too much direct clarification about sensitive topics.

- It is a common conception that "laughter is good medicine" and is a way to cope. The use of humor and teasing to show affection or offer corrective advice is also common.

Indirect Communication

- **It is often considered unacceptable for an AI/AN person to criticize another directly.** This is important to understand, especially when children and youth are asked to speak out against or testify against another person. It may be considered disloyal or disrespectful to speak negatively about the other person.

- There is a common belief that people who have acted wrongly will pay for their acts in one way or another, although the method may not be through the legal system.

Storytelling

- **Getting messages across through telling a story (traditional teachings and personal stories) is very common** and sometimes in contrast with the "get to the point" frame of mind in non-AI/AN society.

This guide was developed by an ad hoc group of U.S. Public Health Service Commissioned Officers, American Indian/Alaska Native (AI/AN) professionals, and family advocates working together from 2006-2007. The abbreviation AI/AN is used for American Indian/Alaska Native in the interest of space and consistency.

The authors of this guide wish to thank the many AI/AN professionals and community members across the country who contributed their thoughts and comments to this guide. The challenge in developing a basic guide for an incredibly diverse group of people such as AI/ANs cannot be understated. The authors hope the result is accurate, respectful to the communities, and helpful for the users.

January 2009

Historic Distrust

Establishing trust with members of an AI/AN community may be difficult. Many Tribal communities were destroyed due to the introduction of European infectious illnesses. Similarly, many treaties made by the U.S. government with Tribal nations were broken.

From the 1800s through the 1960s, government military-style boarding schools and church-run boarding schools were used to assimilate AI/AN people. Children were forcibly removed from their families to attend schools far from home where they were punished for speaking their language and practicing spiritual ways in a stated effort to "kill the Indian, save the child." Many children died from infectious diseases, and in many schools physical and sexual abuse by the staff was rampant. Boarding school survivors were taught that their traditional cultures were inferior or shameful, which still affects many AI/AN communities today.

The Federal "Termination Policy" in the 1950s and 1960s ended the government-to-government relationship with more than 100 Federally recognized tribes. The result was disastrous for those tribes due to discontinued Federal support, loss of land held in trust, and loss of Tribal identity. Most of the tribes terminated during this time were able to re-establish Federal recognition through the Congressional process in the 1980s and 1990s.

The Federal "Relocation Policy" in the 1950s and 1960s sought to move AI/AN families to urban areas, promising jobs, housing, and a "new life." Those that struggled and stayed formed the core of the growing Urban Indian populations. Ultimately, many families returned home to their reservation or home community. Today, many families and individuals travel between their home community and urban communities for periods of time to pursue education and job opportunities.

Churches and missionaries have a long history of converting AI/AN people to their religions, and in the process often labeled traditional cultural practices such as songs, dances, dress, and artwork as "evil." Today there is a diverse mix of Christian beliefs and traditional spirituality within each AI/AN community.

Cultural Identity

When interacting with individuals who identify themselves as AI/AN, **it is important to understand that each person has experienced their cultural connection in a unique way.**

An individual's own personal and family history will determine their cultural identity and practices, which may change throughout their lifespan as they are exposed to different experiences.

The variation of cultural identity in AI/AN people can be viewed as a continuum that ranges between one who views himself or herself as "traditional" and lives their traditional culture daily, to one who views himself or herself as "Indian" or "Native", but has little knowledge or interest in their traditional cultural practices.

Many AI/AN families are multicultural and adapt to their surrounding culture.

From the 1950s to the 1970s, the Federal government, adoption agencies, state child welfare programs, and churches adopted out thousands of AI/AN children to non-AI/AN families. The Indian Child Welfare Act was passed in 1978 to end this practice. There are many AI/AN children, as well as adults, who were raised with little awareness or knowledge of their traditional culture; they may now be seeking a connection with their homelands, traditional culture, and unknown relatives.

When asked "Where are you from?" most AI/AN people will identify the name of their tribe/village and/or the location of their traditional or family homeland. This is often a key to self-identity.

It is important to remember that most Alaska Natives do not refer to themselves as "Indians."

Age is another cultural identity consideration. Elders can be very traditional while younger people can either be multicultural or non-traditional. In many communities, leaders and elders are worried about the loss of the use of the traditional language among children and young adults. Still, in other communities, young people are eagerly practicing the language and other cultural traditions and inspiring older generations who may have felt shame in their identity growing up as AI/AN.

Historical trauma and grief events, such as boarding schools or adoption outside of the tribe, may play a dramatic role in shaping attitudes, sense of identity, and levels of trust.

Role of Veterans and Elders

Elders play a significant role in Tribal communities. The experience and wisdom they have gained throughout their lifetime, along with their historical knowledge of the community, are considered valuable in decision-making processes.

It is customary in many Tribal communities to show respect by allowing elders to speak first, not interrupting, and allowing time for opinions and thoughts to be expressed.

In group settings, people will often ask the elder's permission to speak publicly, or will first defer to an elder to offer an answer.

Elders often offer their teaching or advice in ways that are indirect, such as through storytelling.

When in a social setting where food is served, elders are generally served first, and in some traditional Alaska Native villages, it is the men who are served first by the women. It is disrespectful to openly argue or disagree with an elder.

AI/AN communities historically have high rates of enlistment in the military service. Often, both the community and the veteran display pride for military service.

Veterans are also given special respect similar to that of elders for having accepted the role of protector and experienced personal sacrifice. AI/AN community members recognize publicly the service of the veteran in formal and informal settings.

AI/AN community members who are veterans are honored at ceremonies and pow wows, and by special songs and dances. They have a special role in the community, so veterans and their families are shown respect by public acknowledgment and inclusion in public events.

The AI/AN community's view of Uniformed Service members being deployed to an AI/AN community in times of crisis or disaster (such as the U.S. Public Health Service Commissioned Corps or National Guard) will vary greatly. There may be respect for the uniform similar to that shown to a veteran, but there may also be feelings of distrust related to the U.S. government's and the military's historical role and presence in AI/AN communities.

Strengths in AI/AN Communities

It is easy to be challenged by the conditions in AI/AN communities and to not see beyond the impact of the problems or crisis.

Recognizing and identifying strengths in the community can provide insight for possible interventions. Since each community is unique, look to the community itself for its own identified strengths, such as:

- **extended family and kinship ties;**
- **long-term natural support systems;**
- **shared sense of collective community responsibility;**
- **physical resources (e.g., food, plants, animals, water, land);**
- **indigenous generational knowledge/wisdom;**
- **historical perspective and strong connection to the past;**
- **survival skills and resiliency in the face of multiple challenges;**
- **retention and reclamation of traditional language and cultural practices;**
- **ability to "walk in two worlds" (mainstream culture and the AI/AN cultures); and**
- **community pride.**

Health and Wellness Challenges

Concepts of health and wellness are broad. The foundations of these concepts are living in a harmonious balance with all elements, as well as balance and harmony of spirit, mind, body, and the environment. Health and wellness may be all encompassing, not just one's own physical body; it is holistic in nature. AI/ANs define what health and wellness is to them, which may be very different from how Western medicine defines health and wellness.

Many health and wellness issues are not unique to AI/AN communities, but are statistically higher than in the general population. It is important to learn about the key health issues in a particular community.

Among most AI/AN communities, 50 percent or more of the population is under 21 years of age.

Health disparities exist with limited access to culturally appropriate health care in most AI/AN communities.

Only 55 percent of AI/AN people rely on the Federally funded IHS or Tribally operated clinics/hospitals for care.

Suicide is the second leading cause of death among AI/AN people age 10-34. The highest rates are among males between the ages of 24 and 34 and 15 and 24, respectively.

Following a death by suicide in the community, concern about suicide clusters, suicide contagion, and the possibility of suicide pacts may be heightened. A response to a suicide or other traumatic occurrence requires a community-based and culturally competent strategy.

Prevention and intervention efforts must include supporting/enhancing strengths of the community resources as well as individual and family clinical interventions.

Service providers must take great care in the assessment process to consider cultural differences in symptoms and health concepts when making a specific diagnosis or drawing conclusions about the presenting problem or bio-psychological history.

Every effort should be made to consult with local cultural advisors for questions about symptomology and treatment options.

Self-Awareness and Etiquette

Prior to making contact with a community, **examine your own belief system about AI/AN people related to social issues, such as mental health stigma, poverty, teen suicide, and drug or alcohol use.**

You are being observed at all times, so **avoid making assumptions and be conscious that you are laying the groundwork for others to follow.**

Adapt your tone of voice, volume, and speed of speech patterns to that of local community members to fit their manner of communication style.

Prefered body language, posture, and concept of personal space depend on community norms and the nature of the personal relationship. Observe others and allow them to create the space and initiate or ask for any physical contact.

You may experience people expressing their mistrust, frustration, or disappointment from other situations that are outside of your control. **Learn not to take it personally.**

If community members tease you, understand that this can indicate rapport-building and may be a form of guidance or an indirect way of correcting inappropriate behavior. **You will be more easily accepted and forgiven for mistakes if you can learn to laugh at yourself and listen to lessons being brought to you through humor.**

Living accommodations and local resources will vary in each community. Remember that you are a guest. Observe and ask questions humbly when necessary.

Rapport and trust do not come easily in a limited amount of time; however, don't be surprised if community members speak to you about highly charged issues (e.g., sexual abuse, suicide) as you may be perceived as an objective expert.

Issues around gender roles can vary significantly in various AI/AN communities. Males and females typically have very distinct social rules for behavior in every day interactions and in ceremonies. **Common behaviors for service providers to be aware of as they relate to gender issues are eye contact, style of dress, physical touch, personal space, decision making, and the influence of male and/or female elders.**

Careful observation and seeking guidance from a community member on appropriate gender-specific behavior can help service providers to follow local customs and demonstrate cultural respect.

Etiquette – Do's

Learn how the community refers to itself as a group of people (e.g., Tribal name).

Be honest and clear about your role and expectations and be willing to adapt to meet the needs of the community. Show respect by being open to other ways of thinking and behaving.

Listen and observe more than you speak. Learn to be comfortable with silence or long pauses in conversation by observing community members' typical length of time between turns at talking.

Casual conversation is important to establish rapport, so be genuine and use self-disclosure (e.g., where you are from, general information about children or spouse, personal interests).

Avoid jargon. An AI/AN community member may nod their head politely, but not understand what you are saying.

It is acceptable to admit limited knowledge of AI/AN cultures, and invite people to educate you about specific cultural protocols in their community.

If you are visiting the home of an AI/AN family, you may be offered a beverage and/or food, and it is important to accept it as a sign of respect.

Explain what you are writing when making clinical documentation or charting in the presence of the individual and family.

During formal interviews, it may be best to offer general invitations to speak, then remain quiet, sit back, and listen. Allow the person to tell their story before engaging in a specific line of questioning.

Be open to allow things to proceed according to the idea that "things happen when they are supposed to happen."

Respect confidentiality and the right of the tribe to control information, data, and public information about services provided to the tribe.

Etiquette – Don'ts

Avoid stereotyping based on looks, language, dress, and other outward appearances.

Avoid intrusive questions early in conversation.

Do not interrupt others during conversation or interject during pauses or long silences.

Do not stand too close to others and/or talk too loud or fast.

Be careful not to impose your personal values, morals, or beliefs.

Be careful about telling stories of distant AI/AN relatives in your genealogy as an attempt to establish rapport unless you have maintained a connection with that AI/AN community.

Be careful about pointing with your finger, which may be interpreted as rude behavior in many tribes.

Avoid frequently looking at your watch and do not rush things.

Avoid pressing all family members to participate in a formal interview.

During a formal interview, if the person you are working with begins to cry, support the crying without asking further questions until they compose themselves and are ready to speak.

Do not touch sacred items, such as medicine bags, other ceremonial items, hair, jewelry, and other personal or cultural things.

Do not take pictures without permission.

NEVER use any information gained by working in the community for personal presentations, case studies, research, and so on, without the expressed written consent of the Tribal government or Alaska Native Corporation.

This publication may be downloaded or ordered at www.SAMHSA.gov/shin. Or, call SAMHSA's Health Information Network at 1-877-SAMHSA-7 (1-877-726-4727) (English and Español).

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January 2009

Engage – Calm – Distract

Understanding and Responding to Children in Crisis

A Resource Kit for EMS and Emergency Department Providers

Table of Contents

Section 1 - Understand

"EMS 3, please respond to a car/pedestrian accident involving an eight-year-old female." Suddenly your heart starts pounding and palms begin sweating, knowing that you are headed into a scene that can tax your resources and skills. As you exit the vehicle, you see a bent bike and a huddle of adults in the middle of the street. The driver of the car is standing over the child repeating, "I'm so sorry, I'm so sorry." You have to move other people out of the way, including two other children. A woman who identifies herself as the child's mother is screaming and crying as she holds her daughter's hand. Another adult is trying to remove her bike helmet. Although the child appears to have significant injuries, she is conscious, crying and screaming. As you move in she tries to push you away and yells "No, no! Don't touch me!"

Children pose particular challenges to EMS and emergency department providers. They can compensate for injury and illness better than adults, then unexpectedly decompensate. In addition to the unique physical differences and medical needs, children have different emotional needs providers find difficult to address. Pediatric patients can trigger responders' own emotions, interfering with their information processing and decision making. Children typically come with caregivers who can escalate an already stressful situation. Between addressing immediate medical needs, calming the distressed child, and dealing with a distraught or intrusive parent, pediatric patients can quickly raise anyone's anxiety.

In a recent survey of EMS professionals on the factors perceived to contribute to pediatric patient safety events, heightened anxiety when caring for children ranked second only to airway mismanagement issues. Responders reported their own emotional responses, lack of experience in responding to children, and the emotions of family members can negatively affect the quality of care when responding to pediatric emergencies. Guise, J., et al. (2015).[1]

While general lack of clinical experience with children is an important factor, lack of training about how to respond to children in emotional crisis plays a role. We brought together experts in child trauma, emergency medical services, and pediatric emergency care to create this resource kit and fill this significant gap in pediatric training and resources.

The kit provides information, strategies, and activities to help both prehospital and hospital emergency providers respond more quickly and effectively to the emotional needs of children and parents in crisis. This kit is intended as a job aid: a structure that helps guide your actions during a pediatric emergency. Just as your actions to address medical emergencies improve with practice (and your anxiety decreases), so does practicing the use of these strategies and activities. Providing comfort, listening, and reducing traumatic stress reactions in children, as well as their caregivers, allows you to focus more on providing needed medical treatment and can lead to better immediate and long-term outcomes for your patient. Using these resources can help children and the adults around them feel more in control and less helpless and hopeless. We know that this can lead to better emotional, as well as physical, outcomes.

Overview and Organization

This resource kit is divided into threee convenient sections to provide easy access to its various components. We have also identified three main categories to help you find the specific resource you need:

Information: It's important to understand why children react the way they do and the rationale for implementing the strategies and activities. You want to know why it's critical to address the emotional distress experienced by children and their caregivers during a medical emergency.

Strategies: We will identify specific approaches and practices for addressing the emotional needs of children and provide a framework for specific actions.

Activities: Drawing from the experience of a broad range of professionals, the resource kit provides specific activities and materials shown effective in reducing distress in children and adults. We encourage you to identify and develop activities that work for you and to borrow from and share your ideas with others.

Designed and formatted so pages contain specific topics, you can print each separately for easy reference or to share with others. In addition, we have prepared a reference system that identifies stress reactions by age with specific actions to help calm and distract children.

Inside "Understanding and Responding to Children in Crisis" you will find the following sections:

Section 1: Understand	• Stress and the brain • Child psychological traumatic stress • Trauma-informed approach
Section 2: Identify	• Common pediatric distress reactions by age and developmental level • Common responder reactions to pediatric patients • Description of **Pediatric Emotional Distress Reference system**
Section 3: Respond	• Engagement • Safety • Calming • Distraction • Strategies for managing responder reactions

The strategies and activities provided in this resource kit are designed to be used by professionals in both the field and the emergency department. We have worked to keep activities simple and referenced supplies inexpensive and accessible. Keeping supplies and activities in a backpack or duffle, along with the *Pediatric Emotional Distress Reference System,* increases the likelihood responders will use them—just another piece of medical equipment available when the need arises. You can assemble your own kit from our included supply and vendor lists or make your own materials.

Please review and discuss this resource kit as part of your ongoing training and departmental meetings. Adapt freely and develop your own protocols for implementation and use. Implementing these simple strategies can help improve the immediate outcomes for your youngest patients and support children's recovery long after the end of your direct care.

Stress and the Brain

When sensory information enters the brain, it is routed to the thalamus in the limbic system. The thalamus acts as a switching station and sends the information to the appropriate area of the cortex for processing:

- Occipital Lobe (Green) – visual processing and visual memory;
- Temporal Lobe (Orange) – auditory processing, language, and emotional regulation;
- Parietal Lobe (Purple) – sensory processing and integration, location of parts of the body, interpreting visual information and processing language and mathematics; or,
- Frontal Lobe (Red) – motor function, problem solving, memory, language, judgement, planning, and impulse control.

Before routing to the cortex occurs, the thalamus quickly checks to see if any of the sensory information signals danger. If so, the thalamus sends that information through a single neural pathway to the amygdala, also located in the limbic system. This area of the brain is responsible for emotional memory and survival instincts. Once activated, the amygdala triggers the physiologic changes we define as the fear or stress response.

In addition to physical changes to the heart, respiration, and circulation, stress and fear affect the brain. Among the most significant changes: several parts of the cortex begin to shut down. The frontal lobe goes first, affecting our executive functions such as the ability to plan, judge, problem solve, make decisions and control impulses. Next, the right and left temporal lobes shut down, reducing our ability to process and use language and regulate our emotions. While the process seems counter-intuitive, it makes a lot of sense for our survival.

The fear response prepares us to respond to danger immediately. Taking time to process information, make a plan, and decide upon a course of action delays our response and increases opportunities for injury or death. While these brain changes support an individuals' physical survival, they make interacting with him/her more difficult. Your patient has difficulty following your directions, understanding your explanations, explaining what is going on (language processing), making decisions (executive functions), regulating emotions, and controlling impulses. Because all these activities are already less developed in children, your job becomes even more difficult and stressful. Your brain can shut down as well. Having resources and job aids, such as the ones in this kit, helps responders keep functioning when situational stress shuts down cognitive capability.

Children, like adults, tend to respond to fear and stress with the fight, flight, freeze, or faint responses. These responses look different in children of different ages. We will cover common fear and stress responses in the section, “Trauma Reactions in Children: Developmental Considerations.”

Remember that the brain functions very differently during an acute fear reaction. Extreme stress reduces a child’s ability to cope. Normal cognitive functions slow or even shut down. These include the ability to understand and use language, organize thoughts, and make decisions.

Helping pediatric patients and their caregivers reactivate brain areas that process language and sensory information makes it easier to provide medical care. Reducing stress and anxiety increases everyone's ability to think and act to improve outcomes.

This resource kit will cover actions and activities in four core areas:

- *Engagement* – making initial contact and building rapport
- *Safety* – restoring the sense of physical and emotional safety
- *Comfort* – calming and reorienting to here and now
- *Distraction* – keeping the focus on something other than the medical procedure

In addition to the four commonly identified fear responses, we now know that people also "tend and befriend" when faced with danger. During stressful situations, people become more social. They seek out others and can show greater empathy and caring, especially if they are parents or caregivers. The strategies provided here engage this natural tendency of parents and help direct their energies to supporting rather than hindering or interfering with the medical response.

Child Traumatic Stress

Children's past experiences can influence their reactions to the current crisis. For children and families with a history of physical or psychological trauma, a medical emergency can trigger additional and more intense fear reactions. Several studies suggest over 60 % of children experience a potentially traumatic event by age 16.[2]

Child traumatic stress occurs when children—including adolescents—are exposed to traumatic situations that overwhelm their ability to cope. Traumatic stress reactions can interfere with daily life and the ability to function and interact with others.[3]

Potentially traumatic situations

- *Physical or sexual abuse*
- *Witnessing community or domestic violence*
- *Neglect or abandonment by a parent or caregiver*
- *Automobile or other types of accidents*
- *Physical violence, including bullying*
- *Witnessing police activity or having someone close arrested*
- *Witnessing another person being killed or seriously injured*
- *Death or other loss of someone close*

While full-blown post-traumatic stress disorder (PTSD) is fairly rare in children, over 20 % of those with previous trauma exposure exhibit some emotional or behavioral difficulties. This increases to over 50 % in children exposed to more than one traumatic event.[3] In particular, children living in stressed communities with higher rates of community and domestic violence, alcoholism, child abuse, mental illness and other adversities experience multiple traumas from an early age. Many of the children and families you see will come with histories that affect their reaction to the present emergency.

Pediatric mental health emergencies represent a large and growing segment of pediatric emergency medical care.[4] In many cases, children's past traumatic experience fuels the current mental health crisis. Differentiating between a medical emergency and a mental health emergency can be difficult, as many symptoms can mimic each other. Agitation, non-responsiveness, psychotic-like symptoms and confusion can indicate a medical or mental health issue. Physical symptoms such as illness or pain might be a manifestation of the underlying psychological trauma or mental health issues and not have an actual physical basis. Always address such symptoms as medical complaints until you can rule out physical causes. As you address potential medical issues, you can use the strategies and activities identified in this resource to calm and distract the child. This allows you to simultaneously address the symptoms as both physical and emotional.

Trauma over-activates the survival parts of the brain. Children who have experienced trauma can begin to see the world as dangerous. The loss of control can result in helplessness and hopelessness, a sense of vulnerability and distrust of others. They can view helping behaviors such as touch or eye contact as threatening. As with fear, trauma reactions are an automatic reaction to a threat. They help the child cope with and survive overwhelming events, whether present or past. Unfortunately, these behaviors often interfere with providing care and can make it hard for the provider to stay cool and not overreact. Children's fear and emotional distress often mask as anger and that anger can feel targeted, cruel, and unwarranted.

Whether addressing a medical or mental-health emergency, your words, tone, and actions can positively or negatively influence trauma reactions in your patients and their caregivers. Because you can never know your patients' backgrounds, assume they have experienced some level of trauma. Using a trauma-informed approach with every patient can help lessen their fear and trauma reactions and the chances of re-traumatization or of triggering additional trauma reactions.

Trauma-Informed Approach

A trauma-informed approach to care recognizes trauma symptoms and the role trauma plays in all aspects of a child's life. Caring for traumatized children requires a new understanding of the roots of their behavior. Their "normal" is not necessarily our "normal." Their behavior is normal for their internal state of distress. Acknowledging children's distress and helping them understand what they are feeling is common can be calming and reassuring. For example, "You seem pretty scared right now. It's pretty common for kids going through what you are to scream when we're trying to check you over." At this point, you can try one of the strategies or activities from this kit to engage and calm or distract the child. Common stress reactions by age and developmental level are found in *Section 2: Identify*.

A trauma-informed approach includes creating an environment supporting safety, trust, choice, and collaboration. Safety is first and foremost: as long as the child feels unsafe, the fear response remains activated. Children are safe when they believe they are safe, not when we believe they are safe. The feeling of trust (the belief by the child and family that you will not endanger them physically or emotionally and will provide competent care) relates closely to safety. Children and families experiencing a crisis can feel out of control, helpless, and hopeless. Providing choices, even simple ones, helps children regain their sense of control and autonomy over the situation and helps them calm and reorient. Collaboration provides children and families with a sense they are working with you rather than just having something done to them. Giving the child and caregiver a job provides them a focus away from you, allowing you to provide needed medical care.

Whether on scene, in the back of an ambulance, or in the emergency department, opportunities arise to implement each of these principles. Even seemingly small actions can have a large impact on overall medical and emotional outcomes.

Small actions can also have detrimental effects if they trigger a trauma reaction. Attending to our own behavior and avoiding actions that a child or family could interpret as threatening, or even dismissive, is an important aspect of the trauma-informed approach.

Section 2 – Identify

Common Pediatric Emotional Distress Reactions

The following list of distress reactions is arranged by developmental stage. While not exhaustive, the list does include many of the common and typical reactions experienced by children. Reactions can vary significantly within developmental stages and are influenced by past experience, family patterns, culture, and biology. While some children might exhibit reactions typical of earlier or later developmental periods, most will exhibit behaviors typical of their age. However, when distressed, many children will regress to behaviors typically found in earlier developmental stages. If a parent/caregiver is present, ask if their child seems stressed or is showing changes in behavior. For children exhibiting distress, provide appropriate calming strategies and activities. Please note that children who have experienced previous trauma could react to the current crisis with much stronger and more extreme reactions (see 1-6).

Birth – 1 Year (Infant) 3 – 9 kg
The range and number of distress reactions increase across the first year of development.

- **Crying/screaming** – can become so intense that the infant turns red and can briefly stop breathing
- **Biting** – becomes more pronounced as infant begins teething
- **Sucking**
- **Turning away/avoiding eye contact when handled**
- **Increased startle response**
- **Arching back/leg or arm extension**
- **Clinging** – not letting go or clinching fist
- **Difficulty separating from caregiver**
- **Freezing** – conscious but non-reactive to stimuli, staring "off into space"
- **Hiccupping**

1 – 2 Years (Toddler) 10 -14 kg

- **Crying/Screaming**
- **Difficulty separating from caregiver** – holding on tightly, reaching, grab back on when pulled apart
- **Hitting**
- **Biting**
- **Pushing away**
- **Throwing objects**
- **Easily startled**
- **Withdrawal** – not answering questions, not looking at you, showing no interest in toy or comfort item presented
- **Freezing** – blank stare, non-responsive

3 – 6 Years (Preschool) 15 -23 kg

- **Crying/screaming**
- **Temper Tantrums**
- **Aggression** – hitting, biting, throwing things
- **Grabbing on/holding on to stationary objects to avoid being moved**
- **Physical symptoms not directly related to current medical issues** – stomach ache/headache
- **Wetting pants**
- **Difficulty separating from caregiver**
- **Freezing** – conscious but non-reactive to stimuli, staring "off into space"

Common Pediatric Emotional Distress Reactions

7 – 11 Years (School Age) 24 – 36 kg

- **Difficulty paying attention/easily distracted**
- **Easily startled**
- **Asking questions about the event/what you are doing/what things are**
- **Physical complaints not directly related to medical condition (stomach ache/headache)**
- **Difficulty with authority/following directions/being redirected**
- **Easily angered/temper tantrums**
- **Sad/crying**
- **Screaming uncontrollably**
- **Withdrawal/refusal to answer questions**
- **Difficulty separating from caregiver**
- **Freezing/unresponsive**

12 – 17 (Adolescent) 36 + kg

- **Difficulty paying attention/easily distracted**
- **Easily startled**
- **Asking about the event/what you are doing/what things are** (perseverating on a question)
- **Wanting to know how bad it is/what will happen to him/her**
- **Focused on cell phone/social media/contacting friends**
- **Physical complaints not directly related to medical condition** (c/o stomach ache/headache)
- **Difficulty with authority/following directions/being redirected**
- **Aggressive behavior** – verbal and/or physical
- **Sad/crying**
- **Withdrawal/refusal to answer questions**
- **Freezing/unresponsive**

Parent/Caregiver

Rarely will you work with a pediatric patient without also having to work with his/her parent or caregiver. You will frequently see distress reactions among this group, as well.

Overly intrusive – wanting to know everything you are doing and why
Difficulty separating from child – hanging on to child/hovering – making it difficult to gather information from child or perform medical intervention
Inability to focus/answer questions
Easily distracted
Giving too much or unrelated information
Worry/concern about what is going to happen
Panic (May be valuable to define further. Panic is an uncommon, but frequently misunderstood response)
Crying
Anger/verbal aggression
Withdrawal
Freezing/Unresponsive

Responder Reactions

As a responder, you can experience your own stress reactions when working with children and their parents or caregivers. We often hear from providers that they find working with children difficult. Frequent explanations include: fewer opportunities to practice; less time spent on training on pediatric care; children have unique medical needs; and children can go from doing "OK" to being in crisis more quickly than adults. For these same reasons, responders often find it difficult to deal with children's unique emotional needs. The belief that children are hard to work with, whether from experience or hearing it from others, can increase anxiety when dealing with a pediatric patient.

In a recent report, the Emergency Medical Services for Children Innovation and Improvement Center found that:

"Primary and continuing education related to pediatric patients is provided at a lesser extent than adult related education. This leads to an unfamiliarity with effective pediatric care and a lack of comfort in patient assessment and management of children. Qualitative studies have shown that paramedics have provider anxiety, discomfort, and unfamiliarity with pediatric patients, which contributes to a delay in treatment." [6]

Another statement common in pediatric care comes in the form of "Wait until you have your own kids." The meaning of this statement seems somewhat ambiguous. It could mean that the experience of dealing with your own child will make it easier to work with pediatric patients, or, that having you own child can make it more difficult, as you imagine your child going through the experience of your pediatric patient.

Understanding your own stress reactions when confronted with a pediatric patient is important for both you and the child. You might find that your reactions vary based on the child's age, presenting medical problems, behavior, and caregiver's reactions. By identifying the specific factors that contribute to your anxiety, you can focus on improving your skills and identifying strategies to manage your stress reaction. This will help increase your own sense of confidence in working with children and potentially improve both the child's experience and his/her medical outcomes. We have provided some activities in Section 3 designed to help manage your own stress and anxiety.

Common Responder Reactions

Below are some common reactions to stress. Identifying how you react under stress can provide cues that you are in a stressful situation and need to take action.

- Shortness of breath or rapid breathing
- Muscle tension – particularly in the chest, neck, shoulders, or back
- Increased heart rate
- Increased perspiration
- Headache or upset stomach
- Increased irritability
- Fear
- Difficulty focusing or paying attention
- Difficulty making decisions

This short assessment is designed to help you identify factors that increase your discomfort in working with children. This is designed solely for your own use. The information provided can help you identify areas where you might want to focus your initial efforts. Look for any patterns or areas where you score 4 or 5, as these indicate a higher level of discomfort.

Rank each of the statements below from 1 (Never), 2 (Infrequently), 3 (Sometimes), 4 (Often), to 5 (Very Often).

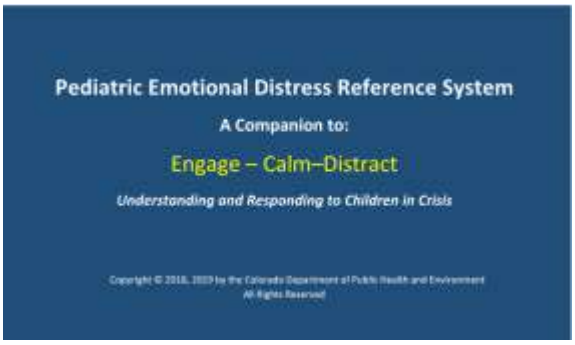
1. I have difficulty dealing with a child based upon his/her age:					
Infant (0-1 year)	1	2	3	4	5
Toddler (1-2 years)	1	2	3	4	5
Preschool (3-5 years)	1	2	3	4	5
School Age (6-11 years)	1	2	3	4	5
Adolescent (12-17 years)	1	2	3	4	5
2. I have difficulty dealing with a child based upon his/her gender:					
Female	1	2	3	4	5
Male	1	2	3	4	5
3. I have difficulty dealing with a child based upon his/her behavior:					
Hostile	1	2	3	4	5
Aggressive	1	2	3	4	5
Refusing to answer questions	1	2	3	4	5
Screaming	1	2	3	4	5
Crying	1	2	3	4	5
Refusing to let go of parent/caregiver	1	2	3	4	5
Conscious but non-responsive	1	2	3	4	5
Throwing a tantrum	1	2	3	4	5
Fighting you off (not letting you do an assessment or provide care)	1	2	3	4	5
Asking a lot of questions or perseverating on one question	1	2	3	4	5

Pediatric Emotional Distress Reference System (PEDRS)

The **Pediatric Emotional Distress Reference System (PEDRS)** is a quick reference for identifying common emotional distress reactions and age-appropriate calming and distraction activities by developmental level.

- Cross-reference by age, developmental level, weight and color code
- Information presented for five developmental levels: infant; toddler; preschool; school age; and adolescent
- Strategies and activities for working with parents and caregivers
- Sized to be included with other pediatric reference systems

Weight ranges and color code are only estimates of age and developmental level. The list of common reactions is not exhaustive, but does provide those we have found to occur most frequently. Not all calming and distraction activities will work with all children. You might need to try several different strategies/activities. You can also try using ones identified with other developmental levels. As you get more comfortable in working with children, we encourage you to experiment and find strategies/activities that work for both you and the child. The more a strategy/activity fits with your style, the more effective you will find it for the child or parent/caregiver.



Instructions for Use

The **PEDRS** is designed to be carried as part of your pediatric medical kit. If you know the age of the child, use it to refer to developmental level. Only refer to weight and/or color code if the child's age is not available. Refer to the card with the corresponding age, weight, or color code for common distress reactions and calming and distraction activities.

Developmental level can vary higher or lower than a child's chronological age. You might find some children exhibiting behaviors either above or below their age. Distress can also result in children regressing to a lower developmental level. If a child is exhibiting distress reactions different than predicted by the **PEDRS** for their age, try using the calming and distraction activities from the developmental level that matches the distress reactions you are observing.

We suggest that you review the material in "Engage – Calm – Distract: *Understanding and Responding to Children in Crisis"* before using the **PEDRS.**

Printing Instructions – Electronic Version Only

Set printer to print on both sides and flip on long edge. Card stock is recommended.

Section 3 – Respond (Engage, Calm, Distract)

Engaging the Child

Your first contact with a child is an opportunity to show a presence of calm, support and safety. Quickly building rapport can reduce the child's distress and make it easier to get the information you need, make your assessment, and begin providing medical interventions. Positive engagement can also help reduce your own anxiety.

Quickly Building Rapport

- Get on the child's physical level
- Speak softly and gently, using age appropriate, honest language
- Introduce yourself**,** ask her or his name and explain you are there to help
- Let the child know you need to touch her or him in order to find out how you can help
- Keep instructions simple and give only one at a time.
- Practice medical procedures with a caregiver or stuffed animal first to show the child it's OK
- Ask questions about pets, friends, and favorites, such as a toy, the comfort item they chose, etc.
- When possible, give the child choices (this or this – "Do you want me to use your left hand or right hand?") but a choice should not include the opportunity to say "no"

Talking to Children

General tips when talking to kids:

- Be honest and sensitive
- Use developmentally appropriate language in a soft voice
- Ask what questions they have. (Don't ask if they have questions, but instead what questions they have
- Provide a sequence of events with examples (medical items you are going to use demonstration on yourself, caregiver, stuffed animal, etc.)
- Only make promises you can keep
- Offer choices only when choices are available
- Have just one person talk to the child
- Acknowledge that it's OK to cry. Avoid telling kids to be "brave" or "a big kid"
- Watch for physical cues: body language, facial expressions
- Give them a simple job to do

Language	
Avoid:	Try:
"Don't move while I do this."	"Your job is to hold as still as you can."
"It's a needle that goes in your arm."	"I am going to slide this straw under your skin into your vein/blue line."
"The blood pressure cuff feels like a hug."	"You're going to feel a tight squeeze for just a few seconds."
"The IV will hurt …"	"You'll feel a quick poke or pinch."
"The medicine will burn …"	"The medicine might feel cold or warm going in."
"Show me how brave you are (or what a big kid you are)."	"It's OK to cry." "I know that this is really scary."

Dealing with Difficult Questions

- Never give life changing news to children. They deserve to be in a calm, safe environment with loved ones when given bad news.
- When children ask questions which you cannot or should not answer:
  - Validate the concern and difficulty in not knowing.
  - Say that you do not have the answers.
  - Assure them that when more is known, they will be told what is happening or what happened.
  - Shift the focus to what is happening right now. Examples:
    - **Paralysis, possible amputation, etc.:** "We don't know for sure yet what might happen. I know it's really hard not to have answers. When we know more we will tell you. For now, we need to focus on helping you by …"
    - **Fatality:** "I don't know exactly what happened because I have been with you. I know it's really hard not to know what's happening with ___. Once we know more we will tell you. For now, we need to focus on helping you by …"

Safety

Restoring children's sense of physical and emotional safety sets the stage for all other response efforts. Remember that children experiencing fear and stress have difficulty processing information and understanding what you are saying. Reducing fear and helping instill a sense of safety can make it easier for you to provide care.

There are different types of safety. We tend to focus on physical safety, but children need to feel emotionally and socially safe as well - the sense that they trust those around them. What might feel safe for one child, or for you, might feel unsafe to another child. As adults, it is easy to think that once a child is away from the event in either space or time, he or she will automatically feel safe. It is important to remember that children feel safe when they think they are safe, not when we think they are safe.

Promoting Safety

- If the child is in an unsafe setting, get her or him away as quickly as possible
- Limit the number of people around the child
- Use the parent or caregiver to help in comforting the child
- If a parent or caregiver is interfering with medical care or seems to be upsetting the child, have another responder pull him or her aside to get additional information
- Have the parent or caregiver get an object the child finds comforting (stuffed toy, blanket, pacifier, etc.)
- Get the child into the ambulance as quickly as possible
- Let the child know you are there to keep him or her safe and help. Have one person take charge of talking to the child
- Determine if a parent or caregiver can help comfort the child, take instructions from you during transport, and be allowed in back of ambulance. Keep caregiver and child together unless otherwise indicated
- Have parent ride up front or follow if it appears that they could interfere with medical care or further distress the child

Calming and Distraction

Calming and distraction activities are listed by developmental level. Not all strategies and activities will work with every child. You might have to try out several before the child responds. As previously mentioned, children often regress to earlier stages of development when distressed. Your responses can be adjusted based upon the child's current level of distress and behavior.

Some of the activities listed are more appropriate for specific ages and developmental levels. You will find others that will appeal to multiple age groups. Sometimes it is a matter of experimentation or trial and error to find something that works. Developmental level can also vary within age ranges. Every child is different and might respond to different activities at different times.

Plan ahead and get a variety of child friendly, developmentally appropriate objects to keep handy. We have included examples of some of our favorites, but encourage you to find ones that work for you. Most toys will identify their appropriate age range on the packaging. At times, you might need to improvise and look for things available around you (a set of keys, sunglasses). We have also included activities that don't require specific toys or items. Of course, suggestions or strategies provided in this kit cannot take priority over life-saving procedures. We know you will use your experience and clinical judgement to best serve your patients.

Activities provided below are a few that we have found effective with children. Please adapt, change, and add your own. As you practice using the strategies and activities, you should find yourself becoming more comfortable in working with children. You will identify actions, activities, and materials that best suit your own style and the resources available to you. We encourage you and your organization to experiment and be creative.

Calming

Children whose distress makes it difficult for them to respond to your questions or directions will need help calming down. Calming activities are designed to reduce children's fear, help them focus on the here and now, and reactivate the thinking and language centers of the brain. Calming activities are designed to reduce children's immediate distress, allowing you to ask questions, do your initial assessment, and provide medical care. Spending a little time calming children can make care go more easily and quickly. Going a little slower during your initial contact can make it easier to go faster as you begin to provide aid.

Distraction

Distraction activities can help when performing a medical procedure, especially one that might be painful. Distraction can begin once a child is responsive to directions. Some activities can serve to both calm and distract. There is a lot of crossover between the two strategies but you should begin with activities designed to calm.

We have listed calming and distraction activities by developmental level for easy reference. The same information is available on the **Pediatric Emotional Distress Reference System (PEDRS).**

Supporting Children during a Procedure

Creating a plan:

When beginning a medical procedure, give children the choice to either watch what you are doing or to look away. This has two benefits: children gain some control in the situation; and they get to create their own coping plan. Remind children that either way, their job is to hold very still during the procedure. If they chose to watch, it is important to normalize that "Some kids want to watch but they find it hard to hold still when they're looking at what's happening. If you forget to hold still, I'll remind you or help hold your body still so you are safe." Whichever choice they make, you can then introduce an item or activity to support them with distraction.

Utilizing Distraction Support:

You can use items (page **3-12**) for both distraction and to block children's view of equipment and procedures that might frighten them. When using an I-Spy book, pushbutton book, tablet, etc., hold the item over the arm in which you are placing the IV. This can prevent them from seeing the supplies and needle. Similarly, you can use a "view finder" to cover their eyes, so they see the pictures and not what is coming. When children change their mind and begin squirming in order to see what you are doing, ask if they would like to watch and remind them their job is told very still and to take slow, deep breaths.

You can also utilize the parent or caregiver to comfort and hold children during the procedure. We call this "positioning for comfort". This engages the parent, comforts the child, and decreases the need for staff to hold the child down. Though sometimes necessary, being held down by adults during a painful and frightening medical procedure is distressing for the child and upsetting for the parent. If possible, have the parent sit on the pram with the child. The parent sits fully on the pram with the back raised. The child sits in-between the parent's legs and the parent wraps their ankles together to enclose the child in the comfort hold. The parent or a staff member can hold the distraction item while the procedure takes place. For infants or toddlers, ask the parent to hold the child chest-to-chest during the procedure.

Explaining what is happening:
Use a method called "One Voice" for giving information and support to children. This helps maintain a calm/quiet atmosphere and allows the child to focus on only one voice. Before beginning a procedure, identify one person to provide all information and comfort to the child. This person could be the parent, the paramedic, a nurse, a child life specialist, etc. Even though the team may be well-meaning, multiple people speaking at once raises the stress level of everyone.

Ask the child if he or she would like for you to tell the steps of what will happen. You can also give the child the choice of having you count before the main part of the procedure. If the child wants information, try not to pull his or her focus from the distraction item. Just give quick, simple steps. For example, when starting an IV say "Cold soap. Tight rubber band on your arm for a few seconds. 1-2-3, quick pinch. Ok, the straw is in your arm and I'm just covering it up. You're done."

Calming/Distraction Activities by Developmental Level

Birth – 1 Year (Infant)

Calming

If parent/caregiver is available and able to respond to your directions, have him/her hold or caress the infant during the initial assessment and/or during medical procedures
Talk to infant in soft soothing voice
Gently caress the infant's arm or leg
Wrap the infant in a blanket
Provide a pacifier. (If you provide one, ask parent permission before giving it to their child.)
Bottle (provided by parent)

Distraction

Hold up a stuffed animal/colorful object in infant's visual field and slowly move it from side to side
Provide a bottle or pacifier
Have parent/caregiver talk quietly, using his/her normal language
Allow parent/caregiver into child's visual field
Talk to child in a quiet, soothing voice
Play peek-a-boo
Give something to shake (rattle, toy keys)
Sing softly

1 – 2 Years (Toddler)

Calming

- Allow parent to stay with child when possible
- Raise the back of the ambulance cot to let the child sit up
- Provide a stuffed animal or have parent get the child's favorite object
- Talk in a quiet, soothing voice
- Sing softly
- Have child sing his/her favorite song
- Cover child in a blanket

Distraction

- Interactive books/musical light up toys (can be used to block view of needle as well as distract)
- Singing
- Stuffed Animals
- Ask parent/caregiver to play a favorite game
- Give child a penlight and show him/her how it works (pretend the penlight is a candle and have child blow it out)
- Use a hand puppet to talk to the child or give instructions
- Talk in a funny voice
- Ask what sound a _____ (cat, dog, cow, etc.) makes.

3 – 6 Years (Preschool)

Calming

Have child take deep, slow breaths with you
Ask child about a favorite toy, stuffed animal, pet, etc. (Get specifics such as color, name)
Let parent hold child's hand or stroke arm, leg
Give child a stuffed animal or have parent get child's favorite object
Ask child to tell you how to play her/his favorite game
Have child identify 5 things he/she can see/hear. (Make sure in a safe place without distressing stimuli)
Use a pin wheel or blow bubbles to facilitate breathing

Distraction

Provide a glitter wand or Meteor Storm
Interactive books/musical light up toys (can be used to block view of needle as well as distract)
Have child sing you a song. (Sing along if you know it.)
Show the child how to use a kaleidoscope.
Give the child a job – something simple he/she can do.
Give a stuffed animal, have the child name it, tell a story about where it came from, wrap it in a blanket, etc.

7– 11 Years (School Age)

Calming

- Deep breathing (in through nose out through mouth)
- Ask child if she/he would like a stuffed animal
- 5 things child sees/hears/touches/feels (Make sure the child is away from distressing stimuli)
- Squeeze a stress ball
- Plastic slinky
- Play I-spy
- Ask child what she/he does to calm down when upset
- Give the child a koosh ball, tangle, or fidget spinner
- Let child listen to music on his/her phone. (Provide headphones if needed)
- Let child know that it is normal to feel scared, stressed, worried

Distraction

- Glitter wand with items floating
- Meteor Storm
- I-spy
- Listen to music on their phone/play video game
- Kaleidoscope
- Give child a job– something simple he/she can do
- View-Master
- Seek and find/20 questions/*Where's Waldo*

12 – 17 Years (Adolescent)

Note: This age range cuts across a variety of activities/strategies. What may work with younger teenagers might not appeal to older.

Caution on texting: Texting can be effective for helping calm and distract older teens. Try to keep them from taking pictures, especially of medical procedures like an IV. If texting becomes disruptive to you or the child, ask to take the phone. Say something like you want to keep it safe while transporting him/her to the hospital. If the event might be reported on the news or if there were fatalities, do not let her/him online.

Calming

- Ask child what she/he does to calm down when upset
- Let child listen to music on his/her phone. (Provide headphones if needed)
- Have child focus on you and do deep abdominal breathing (in through nose, out through mouth)
- Tangle/sensory item
- Koosh ball/stress ball (ones shaped like the brain work well)
- Texting (try to prevent sending pictures). Talk to child about what and who she/he is texting
- Ask child questions about favorite activities
- 5 things child sees/hears/touches/feels (Make sure the child is away from distressing stimuli)
- Let child know that it is normal to feel afraid, stressed, worried

Distraction

- Let child listen to music on his/her phone. (Provide headphones if needed)
- Texting (no pictures)
- Watch video or play game on his/her phone
- Fidget spinner or tangle
- Seek and find/20 questions/*Where's Waldo* (younger adolescent)
- Have child tell you about his/her favorite movie
- Koosh or stress ball

Working with a Parent or Caregiver

Parents or caregivers can serve as a primary advocate in working with a pediatric patient. They can provide comfort and support for the child and help distract during painful procedures. We recognize that the behavior of some parents and caregivers can increase their child's distress and interfere with your work.

Parents and caregivers face their own fear and distress when their child is injured or ill. Just like with children, engagement, calming, and distraction can help turn the panicked, disruptive, or intrusive parent into a helpful one. Including or excluding a parent or caregiver from attending to their child depends upon your experience, clinical judgment and personal preferences. However, we suggest you include parents, especially during transport, when possible. Separating children from their parent or caregiver can cause further distress, especially for infants and younger children. Use your judgment as to whether their presence will be calming or more distressful for your patient. You can ask older school-aged children and adolescents if they would like for their parent or caregiver to ride in the back of the ambulance or up front with the driver. In some cases, it might be necessary to ask the parent or caregiver to follow in another vehicle.

If a parent is unable to calm themselves, have another first responder pull the parent aside, saying you need more information from him or her. This can provide an opportunity to calm parents that need additional support. Remind the parent or caregiver that he or she needs to present a calm presence for their child. Once the parent or caregiver calms, return her or him to the child's side. Let parents and caregivers know that if they feel overwhelmed when bedside in the emergency department, they should step away to collect themselves. If a parent or caregiver begins interfering with medical care or becomes hostile or threatening, get law enforcement involved. In the case of suspected child abuse, always follow your agency and state guidelines.

Calming/Distraction Activities for Parent or Caregiver

Engagement

- Introduce yourself
- Assure the parent/caregiver that his/her child is being cared for
- Get basic information about the child
- Ask parent about what helps to calm and distract the child
- Give parent a role in the child's care (holding his/her hand, guiding patient in deep breathing, talking or singing to child)

Calming

- Ask parent to look at you and take deep, slow abdominal breaths (in through nose, out through mouth)
- Touch or gently hold parent's forearm between wrist and elbow (ask permission)
- Give parent something to hold – pen, koosh ball, stress ball, paper clip, anything handy
- Have parent close his/her eyes and describe the feeling against skin (ground, breeze, etc.) (Avoid this activity unless removed from any distressing stimuli.)
- Let parent know it is normal to feel afraid and concerned

Distraction

- Ask parent for information you need to better help the child
- Ask parent/caregiver to retrieve a favorite object that comforts the child
- Ask parent how he/she comforts and calms the child
- Give parent/caregiver a task or job to do
- Have parent fill out a form with personal and medical information about the child (even it is not required)
- Ask if there is someone the parent would like to call (or have you call) for support
- Give parent a role in the child's care

Pediatric Backpacks

Creating a Pediatric Backpack of calming and distraction toys can provide quick access and a convenient way to organize material.

We have listed items below that we have found effective. Most items are easily available at local toy or big-box stores. Most can be easily cleaned and reused. Consumable items like stuffed animals can be purchased in bulk from many online stores. We have tried to identify items that are not expensive. Look for other toys you think would be helpful.

Suggested Contents (see back of page for pictures of some of these items)

- Meteor Storm (one of our favorites)
- Glitter wand
- Interactive books
- Kaleidoscope
- Variety of stuffed animals
- Headphones – kind that comes with cell phones
- *Where's Waldo* books – pages can be cut out and laminated for easy cleanup.
- I-spy items – stickers (2-3 inches) attached to the roof of the ambulance can be great.
- Small blankets (or soft towels) – great for calming child or as distraction by having child wrap up and take care of the stuffed animal
- Koosh ball
- Stress ball – often giveaways from vendors – brain shaped can be particularly appealing
- Pen light – cover one with colored plastic to dim and become more attractive to infants.
- Infant toys – plastic keys, rattle, etc.
- Infant pacifier – unopened for single use only
- Pinwheel
- Bubble pen/small container of toy bubbles – recommend small wand to keep bubbles small
- View Master
- Plastic slinky
- Hand puppet

Calming/Distraction Toys – Ideal for including in distraction kit or backpack

Meteor Storm

I-Spy items

Tangle

View-Master

Glitter Wand

Where's Waldo?

Pin Wheel

Fidget Spinner

Interactive Books

Bubble pen

Kaleidoscope

Managing Responder Reactions

Managing your own reactions can improve your ability to respond to the medical and emotional needs of your pediatric patient. Below are a few actions and activities that you can do before and during a pediatric response, as well as activities that can help your overall well-being in the long-term. Identify activities that work for you. What do you already do that helps you reduce your stress?

Activities that can reduce the immediate effects of stress

Deep Breathing
Tightening and loosening muscles (legs, abdomen, back, shoulders, face)
Eating a good snack – nuts, dark chocolate (≥ 70 % cocoa), avocado, yogurt, fruit
Imagining yourself being successful
Listening to music
Chewing gum – reduces cortisol levels
Drinking water – avoid dehydration

Activities that support long-term emotional well-being

Mindfulness
Gratitude journal
Physical exercise
Daily journal
Writing poetry
Gardening
Dancing
Hugs
Talking
Having fun
Humor (including work-related dark humor)

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Authors

Lynn Garst, M.Ed.

Jenaya Gordon, MA, CCLS, NCC

Ezekiel Peters, Esq., NRP

Additional Contributors

Curt Drennen, PsyD, RN

Nicolena Johnson, NRP

For More Information:

Office of Emergency Preparedness & Response

Colorado Dept. of Public Health & Environment

4300 Cherry Creek Dr., South, Denver, CO 80246

Email: lynn.garst@state.co.us

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MONTANA EMS FOR CHILDREN/CHILD READY CULTURE of CARE TOOLKIT

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