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Advancing Culturally and Linguistically Appropriate Services at all Phases of a Disaster

By C. Godfrey Jacobs[*]
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Introduction

Racial and ethnic minorities are disproportionately impacted by disaster due to a variety of factors, including: level of English proficiency, cultural insensitivities, acculturation level, immigrant status, lower incomes, fewer savings, greater unemployment, less insurance, poorer access to information, and community isolation.[1] Pre-existing issues of racism and

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1. *See* Dennis Andrulis, Director, Nadia Siddiqui, Health Analyst, & Jenna Gantner, Graduate Intern, Presentation at the National Emergency Management Summit, *Emergency Preparedness for Racially and Ethnically Diverse Communities* (Mar. 5, 2007), http://www.ehcca.com/presentations/emsummit/1_03_3.pdf (last visited Mar. 21, 2013) (The

social stratification within communities, including unequal access to health care and negative experiences with the health care system, continue and are reinforced during disaster relief and recovery.[2] Problems such as poverty, unemployment, and homelessness will likely exist after the disaster if they were present before the event.[3] Evidence has shown that through the provision of culturally and linguistically appropriate services (CLAS), more members of the community can receive vital messages, services and safety.[4]

Culturally and Linguistically Appropriate Services (CLAS)

Culturally and Linguistically Appropriate Services (CLAS) are services that are respectful of and responsive to individual cultural health beliefs and practices, preferred languages, health literacy levels, and communication needs and are employed by all members of an organization at every point of contact.[5] Employing CLAS will help to promote cultural

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literature shows that minorities suffer disproportionately before, during, and after an emergency due to cultural and linguistic barriers and fewer means of accessing information, among other factors.) (on file with WASH. & LEE J. CIVIL RTS. & SOC. JUST.); *see also* Alice Fothergill, et. al., *Race, Ethnicity and Disasters in the United States: A Review of Literature,* DISASTERS 23(2), 156–173 (1999).

2. *See* Alice Fothergill, et al., *supra* note 1; *see also* Howard Straker & Sheron Finister, *Not Business As Usual*, J. OF HEALTH CARE FOR THE POOR AND UNDERSERVED, 18(2) 241–246 (2007).

3. *See* Alice Fothergill, et al., *supra* note 1; *see also* Straker & Finister, *supra* note 2. Hurricane Katrina demonstrated that social problems for the medically underserved of New Orleans worsened after the disaster, as compared to before.

4. *See generally* INST. OF MED. OF THE NAT'L ACADEMIES, BD. ON HEALTH SCI. POL'Y, COMMITTEE ON UNDERSTANDING AND ELIMINATING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE, UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE, (Brian D. Smedley, et al. eds. 2003) *available at* http://www.nap.edu/openbook.php?record_id=10260&page=R1 [hereinafter UNEQUAL TREATMENT]; *see also* INST. OF MED. OF THE NAT'L ACADEMIES, BD. ON HEALTH SCI. POL'Y, IN THE NATION'S COMPELLING INTEREST: ENSURING DIVERSITY IN THE HEALTH-CARE WORKFORCE, (Brian D. Smedley, et al., eds. 2004) , *available at* http://www.nap.edu/openbook.php?recor_id=10885 &page=1; LISA A. COOPER & NEIL R. POWE, THE COMMONWEALTH FUND, DISPARITIES IN PATIENT EXPERIENCES, HEALTH CARE PROCESSES, AND OUTCOMES: THE ROLE OF PATIENT-PROVIDER RACIAL, ETHNIC, AND LANGUAGE CONCORDANCE, 2004, http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2004/Jul/Disparities%20in%20Patient%20Experiences%20%20Health%20Care%20Processes%20%20and%20Outcomes%20%20The%20Role%20of%20Patient%20Provide/Cooper_disparities_in_patient_experiences_753%20pdf.pdf (last visited Mar. 21 2013) (on file with WASH. & LEE J. CIVIL RTS. & SOC. JUST.).

5. *See* U.S. DEP'T OF HEALTH AND HUMAN SERVS., OFFICE OF MINORITY HEALTH, NATIONAL STANDARDS FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES IN HEALTH CARE: FINAL REPORT (2001) *available at* http://www.minorityhealth.hhs

competence, which is defined as effectively providing services to people of all cultures, races, ethnic backgrounds and religions, in a manner that respects the worth of the individual and preserves their dignity. The adaptation of preparedness response and recovery efforts to fit cultural contexts improves disaster personnel's ability to provide appropriate and effective services to best meet the needs of diverse communities.

The Department of Health and Human Services (HHS), Office of Minority Health (OMH) promotes the provision of culturally and linguistically appropriate services as one way to improve the health of racial, ethnic, and linguistic minority populations through the development of health policies and programs that will help eliminate health disparities.[6] One such initiative is the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards). The Standards, originally launched in 2000 and scheduled to be re-released in 2013, are intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services.[7] The National CLAS Standards align with the HHS Action Plan to Reduce Racial and Ethnic Health Disparities[8] and the National Stakeholder Strategy for Achieving Health Equity,[9] which also aim to promote health equity through providing clear

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.gov/assets/pdf/checked/finalreport.pdf (last visited Mar. 21, 2013) (stating that the definition comes from the U.S. Department of Health and Human Services' Office of Minority Health's National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (on file with WASH. & LEE J. CIVIL RTS. & SOC. JUST.).

6 *See* U.S. DEP'T OF HEALTH AND HUMAN SVCS., OFFICE OF MINORITY HEALTH, *About OMH*, http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=1&lvlID=7.

7. *See* U.S. DEP'T OF HEALTH AND HUMAN SERVS., OFFICE OF MINORITY HEALTH, NATIONAL STANDARDS FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES IN HEALTH AND HEALTH CARE (2013), https://www.thinkculturalhealth.hhs.gov/Content/clas.asp (showing that the standards are designed to help health and health care organizations provide high quality and responsive services to all individuals, regardless of cultural or linguistic background).

8. *See* U.S. DEP'T OF HEALTH AND HUMAN SERVS., HHS ACTION PLAN TO REDUCE RACIAL AND ETHNIC HEALTH DISPARITIES: A NATION FREE OF DISPARITIES IN HEALTH AND HEALTH CARE (2011), http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf (last visited Mar. 21, 2013) (on file with WASH. & LEE J. CIVIL RTS. & SOC. JUST.).

9. *See* National Partnership for Action to End Health Disparities, *National Stakeholder Strategy for Achieving Health Equity*, U.S. DEP'T OF HEALTH AND HUMAN SERVS.: OFFICE OF MINORITY HEALTH (2011) http://www.minorityhealth.hhs.gov/npa/templates/ content.aspx?lvl=1&lvlid=33&ID=286, (last visited Mar. 21, 2013) (stating that The National Stakeholder Strategy is an initiative from the U.S. Department of Health and Human Services to outline goals and objectives for improving the health of racial and ethnic

plans and strategies to guide collaborative efforts that address racial and ethnic health disparities across the country. Adoption of these Standards will help advance better health and health care in the United States.

Relationship between CLAS and Disparities

Culturally and linguistically appropriate initiatives lead to substantial increases in provider knowledge and skill acquisition, and improvements in provider attitudes toward culturally and linguistically diverse patient populations.[10] Research also indicates that patient satisfaction increases when culturally and linguistically appropriate services are delivered.[11] At the organizational level, hospitals and clinics that support effective communication by addressing CLAS have been shown to have higher patient-reported quality of care and more trust in the organization.[12] Preliminary research has shown a positive impact of CLAS on patient outcomes,[13] and a growing body of evidence illustrates the effectiveness of culturally and linguistically appropriate services in improving the quality of care and services received by individuals.[14]

The prevalence of health disparities has been well-documented both within and outside the disaster context. These disparities can impact a

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minorities) (on file with WASH. & LEE J. CIVIL RTS. & SOC. JUST.).

10. *See* M. C., Beach, et al., *Strategies for Improving Minority Healthcare Quality*, AGENCY OF HEALTHCARE RESEARCH AND QUALITY, http://archive.ahrq.gov/clinic/epcsums/minqusum.htm (last visited Mar. 21, 2013) (reviewing strategies for improving the healthcare quality to minority patients and strategies to provide cultural competence (on file with WASH. & LEE J. CIVIL RTS. & SOC. JUST.).

11. See L. A. Cooper, et al., *Designing and Evaluating Interventions to Eliminate Racial and Ethnic Disparities in Health Care*, J. GEN. INTERNAL MED. 17(6), 477–86 (2002) *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC149 5065/.

12. *See* M.K. Wynia, et al., *Validation of an Organizational Communication Climate Assessment Toolkit*, AM. J. OF MED. QUALITY 25(6), 436–443 (2010) (employing a set of assessment tools to measure organizational communication climate as it related to patients' perceptions of their quality of care).

13. *See* D.A. Lie, et al., *Does Cultural Competency Training of Health Professionals Improve Patient Outcomes? A Systematic Review and Proposed Algorithm for Future Research*, J. OF GEN. INTERNAL MED. 26(3), 317–325 (2010).

14. *See supra* note 10; *see also* T.D. Goode, et al., *The Evidence Base for Cultural and Linguistic Competency in Health Care*, THE COMMONWEALTH FUND, http://www.commonwealthfund.org/usr_doc/Goode_evidencebasecultlinguisticcomp_962.pdf (last visited Mar. 21, 2013) (reviewing the evidence base for cultural and linguistic competence as demonstrated by primary research articles in *Medline* on health outcomes and well-being) (on file with WASH. & LEE J. CIVIL RTS. & SOC. JUST.).

community's resilience and an individual's ability to prepare, respond and recover from a disaster or traumatic event.[15] Racial and ethnic minorities have disproportionately higher rates of chronic disease and disability, higher mortality rates, and lower quality of care, compared to non-Hispanic whites.[16] In addition, even with expanded insurance coverage, racial minorities are less likely to receive needed behavioral health services comparable to non-Latino Whites.[17] Health disparities exist beyond racial and ethnic groups; for example, individuals with lower incomes are more likely to experience preventable hospitalizations compared to individuals with higher incomes.[18]

The provision of culturally and linguistically appropriate services is increasingly recognized as a key strategy to eliminating disparities in health and health care.[19] Among several other factors, lack of cultural competence

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15. *See* Anita Chandra, et al., *Building Community Resilience to Disasters: A Way Forward to Enhance National Health Security*, THE RAND CORPORATION (2011), *available at* http://www.rand.org/pubs/technical_reports/TR915.html. Key components or "building blocks" of community resilience that affect both a community's pre-event vulnerability to disaster and its adaptive capacity to recover include the physical and psychological health of the population, social and economic well-being, individual, family, and community knowledge and attitudes regarding self-reliance and self-help, effective risk communication, level of social integration of government and nongovernmental organizations in planning, response, and recovery, and the social connectedness of community members.

16. *See Building a Culturally Competent Organization: The Quest for Equity in Health Care*, HEALTH RESEARCH & EDUCATIONAL TRUST: INSTITUTE FOR DIVERSITY IN HEALTH MANAGEMENT (2011), *available at* http://www.hret.org/quality/projects /cultural-competency.shtml ("[M]inorities frequently encounter more barriers to care, greater incidence of chronic disease, lower quality of care, and higher mortality rates than white Americans."); *see also* UNEQUAL TREATMENT, *supra* note 4.

17. *See* Margarita Alegria, et al., *The Impact of Insurance Coverage in Diminishing Racial and Ethnic Disparities in Behavioral Health Services.* 47(3) HEALTH SERVS. RESEARCH, 1322–44 (2012). ("[E]ven with expanded insurance coverage, approximately 10 percent fewer African Americans with need for behavioral health services are likely to receive services compared to non-Latino whites while Latinos show no measurable disparity.")

18. *See* U.S. DEP'T. OF HEALTH AND HUMAN SERVS.: CTRS. FOR DISEASE CONTROL AND PREVENTION, CDC HEALTH DISPARITIES AND INEQUALITIES REPORT 60 (2011) ("Rates of preventable hospitalizations increase as incomes decrease. Data from the Agency for Healthcare Research and Quality indicate that eliminating these disparities would prevent approximately 1 million hospitalizations and save $6.7 billion in health-care costs each year").

19. Joseph R. Betancourt, *Cultural Competence Marginal Or Mainstream Movement?*, NEW ENGLAND J. OF MED., 351, 953–955 (2004); *see also* Joseph R. Betancourt, *Improving Quality and Achieving Equity: The Role of Cultural Competence in Reducing Racial and Ethnic Disparities in Health Care*, THE COMMONWEALTH FUND (2006), http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2006/Oct/Improving%20Quality%20and%20Achieving%20Equity%20%20The%20Role%20of%20Cultural%20Competen

and sensitivity among health and health care professionals has been associated with the perpetuation of health disparities.[20] This is often the result of miscommunication and incongruence between the patient or consumer's cultural and linguistic needs and the services the health or health care professional is providing.[21] The provision of culturally and linguistically appropriate services can help address these issues by providing health and health care professionals with the knowledge and skills to manage the provider-level, individual-level, and system-level factors referenced in the Institute of Medicine's seminal report, *Unequal Treatment*, that intersect to perpetuate health disparities.[22]

Disparities & Disasters

Culture can be a mediating factor in the perpetuation or reduction of disaster related disparities. For example, Andrulis and colleagues[23] noted

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ce%20in%20Reducing%20Racial%20and%20Ethni/Betancourt_improvingqualityachieving equity_961%20pdf.pdf (last visited Mar. 21, 2013) ("Although the evidence base has yet to be fully developed, experts posit that cultural competence is an essential part of a portfolio of activities to improve quality and eliminate racial and ethnic disparities in health care.") (on file with WASH. & LEE J. CIVIL RTS. & SOC. JUST.); *see also* C. Brach & I. Fraser, *Can Cultural Competency Reduce Racial and Ethnic Health Disparities? A Review and Conceptual Model*, 57 MED. CARE RES. AND REVIEW, 181–217 (2000) (discussing how cultural competency techniques may be implemented by health systems to help reduce health disparities*; see Building a Culturally Competent Organization*, *supra* note 16 (discussing the critical role cultural and linguistic competency plays in reducing disparities and increasing equity, in hospitals and health care organizations).

20. *See* H. Jack Geiger, *Racial Stereotyping and Medicine: The Need for Cultural Competence*, CANADIAN MED. ASS'N J., 164, 1699–1700 (2001) (discussing the need for cultural competence given the intransigent existence of racial bias and stereotyping); *see also* Rachel L. Johnson, et al., *Racial and Ethnic Differences in Patient Perceptions of Bias and Cultural Competence in Health Care*, J. OF GEN. INTERNAL MED., 19, 101–10 (2004) ("To date, other than for interpreter and linguistically appropriate services, there has been only indirect evidence to support the assertion that a lack of cultural competence among providers contributes substantively to the racial and ethnic disparities in health and health care that are so pervasive in the United States' health care system.").

21. *See* Ruth E. Zambrana, et al., *Cultural Competency As It Intersects with Racial/Ethnic, Linguistic, and Class Disparities in Managed Healthcare Organizations*, AM. J. OF MANAGED CARE 10, SP37 SP44 (2004) ("Health disparities are associated with factors such as patients' perceived discrimination and mistrust of the healthcare system, poor or ineffective communication between patient and physician, and healthcare providers' lack of cultural competence and sensitivity.").

22. *See* UNEQUAL TREATMENT, *supra* note 4.

23. *See* Dennis P. Andrulis, et al., *Emergency Preparedness for Racially and Ethnically Diverse Communities*, Presentation at the National Emergency Management Summit, New Orleans, LA, Mar. 5 2007, http://minorityhealth.hhs.gov/assets/pdf/checked

that minority communities often recover more slowly after disasters compared to White communities, because they are more likely to experience cultural barriers and receive inaccurate or incomplete information because of language barriers. Aptekar[24] argues that upper-middle-class disaster victims are more likely to receive aid than minorities and the poor because they are more adept at maneuvering and negotiating the government and relief system, and are more likely to know how to fill out standard forms. Culture can also serve as a means to help promote healing and resilience for victims. Cultural identities can serve to validate individuals' experiences through the disaster.[25] This is a way to heighten and emphasize a community's strengths and not their weaknesses. By helping to restore cultural customs, rituals, and physical and social environments, disaster mental health workers can support survivors in the aftermath of a disaster.[26] This has not always been the case, as the following examples illustrate:

> In October 2007, a series of wildfires broke out across Southern California. Due to the multitude of ethnic groups represented and the amount of people affected, first responders faced challenges in providing culturally and linguistically appropriate services. Despite the linguistic diversity of Southern California and the technological availability to accommodate this diversity, the reverse 9-1-1 calling system utilized during the wildfires to notify people of evacuation orders delivered messages only in English. As a result, the Latino population in

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/1/OMH_NMAC_5_06_Final_Report_No_Appendices.pdf (last visited Mar. 21, 2013) (on file with WASH. & LEE J. CIV. RTS. & SOC. JUST.).

24. *See* Lewis Aptekar, *A Comparison of the Bicoastal Disasters of 1989*, 24 BEHAVIOR SCI. RES. 1, 7 (1990), *available at* http://www.sjsu.edu/faculty/laptekar/download/bicoastaldis.pdf ("The upper-middle class victims, after their immediate fears were over, had either from private insurance or from savings the resources to rebuild or at least to begin again. Being more familiar with how to work with government, with filling out forms and making connections, they were more likely to receive aid than the very poor and the nonwhite victims. In both communities, old wounds and tensions were rekindled between those who had power and those who sought it.").

25. *See* Deborah DeWolfe, *Training Manual for Mental Health and Human Service Workers in Major Disasters*, DEP'T. OF HEALTH AND HUMAN SERVS.: CTR. FOR MENTAL HEALTH SVCS., SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN. 127 (2000) *available at* http://www.samhsa.gov/dtac/FederalResource/Response/4-Training_Manual_MH_Work ers.pdf ("Cultural values and traditions cultural groups have considerable variation regarding views of loss, death, grieving, property, home, rebuilding, religion, spiritual practices, mental health, healers, and helping. The disaster itself may be viewed as punishment, an act of God or other deity, or the result of another event or action".).

26. *See id.* ("It is essential that disaster mental health workers learn about the cultural norms, traditions, local history, and community politics from leaders and social service workers indigenous to the groups they are serving").

> San Diego County, which accounts for 30 percent of the total population, did not receive adequate notification of the evacuation.[27]

Too frequently the needs of culturally and linguistically diverse populations are overlooked, which in times of a disaster can be fatal. Researchers have noted that pre-existing issues of racism and social stratification within communities, including unequal access to health care and negative experiences with the health care system, continue and are reinforced during disaster relief and recovery.[28]

Increasing Diversity

When the growing diversity of the United States is coupled with persistent inequities and long-standing health disparities, the compelling need for culturally and linguistically appropriate services becomes evident. Indeed, demographic changes are one of the most frequently cited reasons behind organizations implementing culturally and linguistically appropriate services.[29] The data presented in Table 1, illustrates the demographic shifts that are consistent with the long-standing population change predictions.[30] The largest amount of growth between 2000 and 2010 was among individuals self-identifying as Hispanic or Latino.[31] In addition, there was a significant increase in Asian populations.[32] In contrast, there was a decrease in the percentage of individuals identifying as White, and among

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27. Jill Hammond, *Reports: Migrants Mistreated During Wildfires*, EL TECOLOTE, Dec 02, 2007, http://news.newamericamedia.org/news/view_article.html?article_id=bdf638bcb49d9a687508100c616b89d4 (last visited Mar. 21, 2013) ("According to the American Civil Liberties Union (ACLU), Immigrant Rights Consortium, and Justice Overcoming Boundaries, the reverse 911 calling system provided during the wildfires to notify people of evacuation orders delivered messages only in English, despite available technology that could have easily accommodated other languages. As result of this, San Diego County's 30 percent Latino population was not adequately notified of the evacuation.") (on file with WASH. & LEE J. CIV. RTS. & SOC. JUST.).

28. *See* Alice Fothergill, et al., *supra* note 1; *see also* Straker & Finister, *supra* note 2.

29. GEORGETOWN UNIVERSITY: CTR. FOR CHILD AND HUMAN DEV., *The Compelling Need for Cultural and Linguistic Competence*, THE NAT'L CTR. FOR CULTURAL COMPETENCE, http://nccc.george town.edu /foundations/need.html (last visited Mar. 21, 2013) (on file with WASH. & LEE J. CIV. RTS. & SOC. JUST.).

30. *See* U.S. CENSUS BUREAU, OVERVIEW OF RACE AND HISPANIC ORIGIN: 2010 (Mar. 2011), *available at* http://www.census.gov/prod/cen2010/briefs/c2010br-02.pdf.

31. *Id.* at 3 ("More than half of the growth in the total population of the United States between 2000 and 2010 was due to the increase in the Hispanic population.").

32. *Id.* at 4 ("The Asian population grew faster than any other major race group between 2000 and 2010.").

those belonging to two or more races.[33] Finally, the statistics indicate that the percentages of Black and Native Hawaiian/Other Pacific Islander (NH/OPI) individuals remained stable over the past decade, while the number of American Indian/Alaskan Native (AI/AN) individuals remained the same.[34]

Table 1: Demographic Changes from 2001-2010		
	2001 (2000 Census Data)	**2010 (2010 Census Data)**
Gender		
Male	49.1%	49.2%
Female	50.9%	50.8%
Race		
White	75.1%	72.4%
Black	12.3%	12.6%
AI/AN	.9%	.9%
Asian	3.6%	4.8%
NH/OPI	.1%	.2%
Two or More Races	2.4%	2.9%
Ethnicity		
Hispanic	12.5%	16.3%
Not Hispanic	87.5%	83.7%
Spoken Language at Home		
English only	82.1%	79.4%
Language Other Than English	17.9%	20.6%

33. *Id.* at 3 ("While the non-Hispanic White alone population increased numerically from 194.6 million to 196.8 million over the 10-year period, its proportion of the total population declined from 69 percent to 64 percent.").

34. *Id.* at 4 (noting in Table 1 that the Black population rose from 12.3 to 12.6 percent, the Native Hawaiian/Other Pacific Islander population rose from 0.1 to 0.2 percent, and the American Indian/Alaskan Native population remained at 0.9 percent).

Speaks English		
Less Than "Very Well"	8.1%	8.7%

In addition to the demographic changes illustrated in Table 1, the number of individuals who are proficient in multiple languages continues to grow.[35] While statistically the proportion of individuals who speak a language other than English at home at the beginning of the 21st century was comparable to the proportion of individuals who spoke a language other than English at the beginning of the 20th century, the visibility of this issue has certainly grown in magnitude since that time. According to current estimates, over 23 million Americans are limited English proficient.[36] It is likely that these demographic shifts will continue in the coming decades, such that Whites will comprise less than 50% of the total U.S. population by 2050 and maybe as early as 2040 depending on rates of birth and immigration.[37] At present, four states (Hawaii, New Mexico, California, and Texas) plus the District of Columbia are comprised of populations where the percent of racial and ethnic minorities exceeds that of White inhabitants.[38]

To reiterate, one must be aware of cultural issues when dealing with disasters since, as previously stated, using the cultural strengths of the community can help mitigate the effects of a disaster. The following chart defines culture and depicts its various elements. When dealing with disasters, first responders need to be aware of these elements and prepared to respond to them appropriately.

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35. *See* U.S. CENSUS BUREAU, LANGUAGE USE IN THE UNITED STATES: 2007 5–6, (April 2010), *available at* http://www.census.gov/hhes/socdemo/language/data/acs/ACS-12.pdf ("In 1980, 23.1 million people spoke a language other than English at home, compared to 55.4 million people in 2007 (a 140 percent increase, during which the U.S. population grew 34 percent.")).

36. *See* Melanie Au et al., MATHEMATICA POL'Y RES., INC., *Improving Access to Language Services in Health Care: A Look at National and State Efforts* 1 (Apr. 2009) *available at* http://www.mathematica-mpr.com/publications/PDFs/health/languageservicesbr.pdf ("More than 23 million Americans have limited English proficiency (LEP), which complicates their ability to obtain quality health care.").

37. Sam Roberts, *Projections Put Whites in Minority in U.S. by 2050*, N.Y. TIMES, December 19, 2009, http://www.nytimes.com/2009/12/18/us/18census.html (last visited Mar. 21, 2013) (on file with WASH. & LEE J. CIV. RTS. & SOC. JUST.).

38. Hope Yen, *Minority Population Growing, Census Says*, ASSOCIATED PRESS, June 11, 2010, http://www.boston.com/news/nation/washington/articles/2010/06/11/minority_population_growing_census_says/ (last visited Mar. 21, 2013) (on file with WASH. & LEE J. CIV. RTS. & SOC. JUST.).

<table>
<tr><td colspan="2">Culture: The integrated pattern of thoughts, communications, actions, customs, beliefs, values, and institutions associated, wholly or partially, with racial, ethnic, or linguistic groups, as well as with religious, spiritual, biological, geographical, or sociological characteristics. Culture is dynamic in nature, and individuals may identify with multiple cultures over the course of their lifetime.</td></tr>
<tr><td>Age
Cognitive ability or limitations
Country of origin
Degree of acculturation,
Dialects or regional variants
Educational level attained
Environment and surroundings
Family and household composition
Gender identity
Generation
Language(s) spoken, written, or signed
Literacy levels
Military affiliation,
Occupational groups
Other related communication needs
Perceptions of family and community
Perceptions of health and well-being
Perceptions/beliefs regarding diet and nutrition</td><td>Physical ability or limitations
Political beliefs
Racial and ethnic groups include — but are not limited to — those defined in the U.S. census and other communities
Religious and spiritual characteristics (beliefs, practices, and support systems related to how an individual finds and defines meaning in his or her life)
Residence (i.e., urban, rural, or suburban)
Sex
Sexual orientation
Socioeconomic status</td></tr>
</table>

Individuals do not experience their lives or their health through a single lens of identity (e.g., solely race, solely gender, or solely religious); rather, many elements inform their perceptions, beliefs, customs, and reactions[39]. Figure 1 depicts various aspects of culture through which an individual may frequently experience his or her cultural identity. For example, an individual's religious/spiritual characteristics often overlap with and are informed by the sociological and racial/ethnic groups with which he or she identifies (e.g., an African-American Christian male may experience the world simultaneously by his race, sex, and religious beliefs). Each of the circles within the model shown in Figure 1 represents a very broad area of culture, as described within the definition.[40] These areas are by no means exhaustive, as there are many other aspects of cultural identity. Being aware and open to these areas of culture will produce more effective responses to disasters.

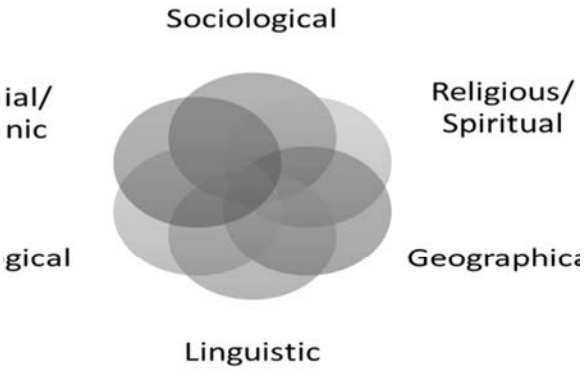

Figure 1: Interrelationship of Culture

Disaster Related Disparities

Eliminating health care disparities is one of the ultimate goals of advancing health equity. In the United States, the combined cost of health disparities and subsequent deaths resultant from receiving inadequate and/or inequitable care was approximately $1.24 trillion.[41] Each dollar represents the diminished quality of life an individual will experience.[42]

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39. *See, e.g.*, Deborrah E.S. Frable, *Gender, Racial, Ethnic, Sexual, and Class Identities*, 48 ANNUAL REVIEW OF PSYCH. 24, 139 (1997) *available at* http://maxweber.hunter.cuny.edu/pub/eres/SOC217_PIMENTEL/frable.pdf.

40. *See* Darci Graves, *Your Golden Rule Might Not Be Mine and Other Lessons Learned from Cultural Competence*, Address at the University of Missouri-Kansas City School of Medicine (Fall 2001).

41. THOMAS LAVEIST ET. AL., THE JOINT CENTER FOR POLITICAL AND ECONOMIC STUDIES, THE ECONOMIC BURDEN OF HEALTH INEQUALITIES IN THE UNITED STATES 1,

Disaster-related disparities exist across many culturally diverse groups, with individuals who identify as racial or ethnic minorities being less likely to receive preventive health services, even when insured. For instance, as cited earlier regarding the California wildfires of 2007, examples exist of disaster evacuation information not being disseminated in languages spoken in affected communities, thus delaying the receipt of important information by non-English speaking residents in disaster zones.[43] In addition, disaster-related disparities exist because typical indicators of disaster preparedness such as stocking emergency supplies, making structural reinforcements to homes, and purchasing certain types of insurance (i.e., earthquake or flood) can be prohibitively expensive for poorer households than for wealthier ones. Often, racial and ethnic minorities and other underserved populations, are more likely to reside in unsafe housing, which increases their risk of poor outcomes during and after disasters. Racial and ethnic minorities frequently experience a slower and more difficult disaster recovery process compared to White individuals, which is exacerbated by their limited access to financial resources and insurance to help rebuild, reluctance to seek Federal aid, fear and/or mistrust of government agencies, and real or perceived discrimination from aid agencies.[44]

There are numerous examples of culturally inadequate, improper, or insufficient delivery of emergency services, among which are the following: Following Hurricane Andrew in 1992, early relief information was only provided in English, resulting in the Latino and Haitian populations not receiving necessary food and other assistance.[45]

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available at http://www.jointcenter.org/sites/default/files/upload/research/files/The%20Economic%20 Burden%20of%20Health%20Inequalities%20in%20the%20United%20States.pdf

42. David E. DeLaet et al., *Receipt of Preventive Services Among Privately Insured Minorities in Managed Care Versus Fee-for-Service Insurance Plans*, J. GEN. INTERNAL MED., 17, 451–457 (June 2002), *available at* http://download.springer.com/static/pdf/476/art%253A10.1046%252Fj.15251497.2002.10512.x.pdf?auth66=1365522647_1d5842b34d06f727c00882d04351d56d&ext=.pdf.

43. *See generally* U.S. DEP'T OF HEALTH AND HUMAN SERVS.: OFFICE OF MINORITY HEALTH, CULTURAL COMPETENCY IN DISASTER RESPONSE: A REVIEW OF CURRENT CONCEPTS, POLICIES, AND PRACTICES, Feb. 2008, https://www.thinkculturalhealth.hhs.gov/pdfs/DisasterPersonneEnvironmentalScan.pdf (last visited Mar. 21, 2013) (on file with WASH. & LEE J. CIVIL RTS. & SOC. JUST.).

44. *Id.* at 3 (noting that the "disparities are due to a number of reasons, including level of English proficiency, cultural insensitivities, acculturation level, immigrant status, lower incomes, fewer savings, greater unemployment, less insurance, poorer access to information, and community isolation").

45. *See* HURRICANE ANDREW: ETHNICITY, GENDER, AND THE SOCIOLOGY OF DISASTERS 92–114 (Walter Ellis Peacock et al. eds., 1997).

Another issue raised by researchers and investigators was the low education level among some minority populations that prevented them from properly filling out the required assistance paperwork and receiving help in a timely manner.[46]

Additionally, there have been reported cases of house tags (notices about a building's safety status) being printed in English only, or instances in which translations did not convey the same message across languages.[47] Following an earthquake in California, signs reading "Not Fit for Occupancy" were placed on buildings with English-speaking tenants, while signs for buildings in Spanish-speaking areas read "Entry Illegal."[48]

It must be recognized that disasters are not uniform, nor are the people who prepare for, respond to, or recover from them. From an individual and organizational perspective, it is very important for disaster responders to understand their own personal biases and beliefs, and to start exploring the importance of assessing the community in which they work. This type of understanding will also help to achieve a more effective response.

Conclusion

Disasters are an ever-present danger in our lives. Indeed, as global warming and other forces become more pronounced, it is anticipated that the level of and intensity of disasters will increase. It is therefore imperative that first responders become better equipped to deal with such events. The utilization of CLAS initiatives can assist in this regard. Following the implementation of CLAS initiatives, there are substantial increases in provider knowledge and skill acquisition and improvements in provider attitudes toward culturally and linguistically diverse patient populations.[49]

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46. *See* Amy Goodman, Interview with Brenda Dardar-Robichaux, Principal Chief of United Houma Nation and Charles Verdin, Chairman of the Pointe-au-Chien Indian Tribe, *Indian Tribes and Hurricane Katrina: Overlooked by the Federal Government, Relief Organizations and the Corporate Media*, DEMOCRACY NOW, Oct. 10, 2005, http://www.democracynow.org/article.pl?sid=05/10/10/1335220 (last visited Mar. 21, 2013) (on file with WASH. & LEE J. CIVIL RTS. & SOC. JUST.).

47. Brenda Phillips & Mindy Ephraim, *Living in the Aftermath: Blaming Processes in the Loma Prieta Earthquake*, (The Natural Hazards Research and Applications Info. Ctr., Working Paper No. 80, 1992) *available at* http://www.colorado.edu/hazards/publications/wp/wp80.pdf.

48. F. Cooper & L. Laughy, Managing Hazards in a Changing Multinational World (1994) (unpublished manuscript) (on file with WASH. & LEE J. CIVIL RTS. & SOC. JUST.).

49. *Strategies for Improving Minority Healthcare Quality*, AHRQ EVIDENCE REPORTS (US DEP'T OF HEALTH AND HUMAN SERVS.: AGENCY FOR HEALTHCARE RES. AND QUALITY)

Research also indicates that patient satisfaction increases when culturally and linguistically appropriate services are delivered.[50] At the organizational level, hospitals and clinics that support effective communication by addressing CLAS have been shown to have higher patient-reported quality of care and more trust in the organization.[51] Preliminary research has shown a positive impact of CLAS on patient outcomes,[52] and a growing body of evidence illustrates the effectiveness of culturally and linguistically appropriate services in improving the quality of care and services received by individuals.[53,54]

(Jan. 2004) [hereinafter Minority Healthcare Quality] http://www.ncbi.nlm.nih.gov/books/NBK37173/ (concluding that there is "excellent evidence to suggest that cultural competence training can increase the knowledge of healthcare providers . . . and good evidence that cultural competence training can improve the attitudes and skills of healthcare providers . . . .").

50. *Id.* (noting that there is also "good evidence from three studies to suggest that cultural competence training can raise patient satisfaction.").

51. Matthew K. Wynia et al., *Validation of an Organizational Communication Climate Assessment Toolkit*, THE AM. J. OF MED. QUALITY, 25(6), 436–443 (May 5, 2010), *available at* http://ajm.sagepub.com/content/early/2010/04/30/1062860610368428.full.pdf+html.

52. Désirée A. Lie et al., *Does Cultural Competency Training of Health Professionals Improve Patient Outcomes? A Systematic Review and Proposed Algorithm for Future Research*, 26(3) J. OF GEN. INTERNAL MED. 317–325 (2010).

53. *See* Minority Healthcare Quality, *supra* note 49 and accompanying text.

54. Tamara D. Goode et al., *The Evidence Base for Cultural and Linguistic Competency in Health Care*, THE COMMONWEALTH FUND, October 18, 2006, http://www.commonwealthfund.org/usr_doc/Goode_evidencebasecultlinguisticcomp_962.pdf (last visited Mar. 21, 2013) ("The current evidence related to the impact of cultural and linguistic competence on health outcomes and well-being, as well as on cost-benefits to the system, is promising, but is only in the preliminary stages of development.") (on file with WASH. & LEE J. CIVIL RTS. & SOC. JUST.).