Concept Paper: Cultural Competence: Solutions and Strategies for Emergency Medical Services

Prepared by Ana-Marie Jones
CARD - Collaborating Agencies Responding to Disasters

Purpose: To provide input to the National Project Advisory Committee (NPAC), for the design and definition of curriculum modules on culturally competent care for disaster preparedness and crisis response based on the corresponding subset of National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards.

This was a commissioned "concept paper" for the November 2007 Consensus Building Meeting for the Cultural Competence for Disaster Preparedness and Crisis Response (CCDPCR) project. Funding for the paper and the CCDPCR project was provided by the Office of Minority Health, Office of Public Health and Sciences, U.S. Department of Health and Human Services.

Acknowledgements
The author would like to extend her sincere gratitude to CARD staff members Barbara E. Wallace, Ph.D., Scott McCormick, and Zachary Blough-Orr for their invaluable efforts on behalf of this paper.

Introduction

The first professional on-scene responders for a wide range of emergencies, disasters and catastrophes are Emergency Medical Services (EMS) personnel. Their ability to quickly, appropriately, and effectively serve the myriad medical and disaster-response needs of our increasingly diverse society is critical, and poses both extreme challenges and great opportunities. With appropriate training, EMS personnel have the ability to put their patients on a path to culturally competent care, restoration or establishment of trust, as well as improvement in overall health and wellness. Absent that same training in cultural competence, patients can suffer great physical, mental, emotional, financial, and social trauma and loss – including loss of life. As the first official point of contact for many people in distress, the importance of the EMS role in the continuum of health care cannot be understated.

Few professional disciplines in our health care and emergency services systems are as adversely impacted by the lack of cultural competence as EMS personnel. The lack of cultural competence and the pervasive disparities in the American health care system continue to leave diverse communities and people with special needs more vulnerable. The marked lack of cultural competence in traditional emergency services and public preparedness and safety initiatives similarly leaves our diverse communities without the resources and information they need to protect themselves. So in times of crisis, when life-altering decisions must be made quickly (without the resources, staff and tools found in hospitals or care facilities), EMS personnel are charged with serving people whose most basic health needs have not been addressed. Often their patients do not have even the most basic level of personal preparedness, such as their medical

history, identification or emergency contact information on them. This paper seeks to offer guidance by providing some history, clarification of roles, definition of terms, new possibilities and distinctions, alternative contexts for action, and most importantly, some solutions concerning cultural competence and EMS personnel.

The Cultural Competence Movement in Health Care and CLAS Standards

Throughout American history there have been movements to bring about equal rights and equal access to services in a variety of areas. While many of these initiatives and social movements directly and indirectly impact this discussion, the present focus is on the more recent advances toward cultural competence in the American health care system.

Three decades after the modern Civil Rights Movement ended, health care researchers discovered that racial and ethnic disparities in health care continue to exist despite laws and assumptions to the contrary (Smedley, Stith, & Nelson, 2003). Disparities continue to exist even as our society is becoming increasingly diverse. Racial minorities now comprise over 30% of the American population, with estimates that this proportion will increase to 50% by 2050 (Bureau of the Census, 1996). American society is growing and diversifying faster than our health care and human services infrastructure can change and expand to accommodate this population. Health care disparities are complex issues, with roots in a wide range of factors such as socioeconomic status, education, and geographic location. These disparities reflect the fact that throughout American history, non-dominant racial groups, as well as other marginalized populations, have received by law or by custom inferior treatment in major societal institutions,

including health care (Williams & Rucker, 2000). Health care researchers have advocated for cultural competency training as one approach to eliminate or reduce health care disparities resulting from lack of cultural awareness (Smedley, Stith, & Nelson, 2003; Betancourt, 2006).

The persistence of racial and ethnic disparities in the American health care system has sparked various reform efforts to address these problems. To this end, the Office of Minority Health (OMH) of the U.S. Department of Health and Human Services (DHHS) undertook a multiyear analysis of practices and policies concerning cultural competence that resulted in the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care, issued in 2000. OMH intended that the CLAS Standards would act as one way:

> to correct inequities that currently exist in the provision of health services and make these services more responsive to the individual needs of all patients/consumers . . . . Ultimately, the aim of the standards is to contribute to the elimination of racial and ethnic health disparities and to improve the health of all Americans (OMH, 2001, p. x).

The "overarching definition" of cultural competence that shaped the CLAS Standards is the belief that:

> Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. 'Cultural' refers to integrated patters of human behavior that include the language, thoughts, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, and social groups. 'Competence' implies having the capacity to function effectively as an individual and an organization with the context of cultural beliefs, behaviors, and needs presented by consumers and their communities (OMH, 2001, p. x).

Despite the intent that a national standard for CLAS would result in "the replacement of the patchwork of different definitions and requirements with one universally understood set of guidance" (OMH, 2001, p. xv), OMH is aware that "given the tremendous variations in organization type, local populations, resources and expertise, the path to culturally responsive health services will be different for every health care organization" (OMH, 2001, p. xvii). Numerous health care entities have adopted cultural competency training, with varying results. However, EMS personnel and first responders have often been left out of cultural competence conversations, which focus heavily on hospital personnel. Medical and nursing schools typically require cross-cultural curricula (Betancourt, 2003), while the considerably shorter EMS training often has no cultural competence components. This paper suggests some paths that can be taken to improve cultural competence within the EMS community, especially in regards to individuals with special needs. This includes ways to help all of civil society build cultural competence into our ambient environment and social discourse.

The Emergency Medical Services (EMS) Community

The first official medical personnel to arrive at the pre-hospital scene, regardless of their individual credential or affiliation, fall under the blanket category of Emergency Medical Services. Those most commonly included in this category are Emergency Medical Technicians (EMTs), Paramedics, and Firefighters. The larger EMS community includes administrative personnel, dispatchers and other support services. While all aspects of the EMS community are important and necessary for the effective functioning of the overall EMS system, for the purposes of this paper, the major concentration is on

the frontline personnel with immediate and direct contact with the patients. A quick review of the job descriptions (see Resources) for EMS positions shows that the emphasis is on the mental and physical ability to learn and perform basic EMS functions. Cultural competence requirements to prove minimal levels of cultural sensitivity is not included nor mentioned in EMS job descriptions.

Special Needs and Vulnerable Communities

In the realm of EMS patients and consumers of services, special needs and vulnerable populations are likewise often overlooked when they do not neatly fit the categories prescribed by the CLAS Standards. The act of labeling and defining communities – even when done for the best of reasons – can still result in further marginalization for those not covered under these definitions. The challenge is to move from awareness, guidelines, and good intentions to implementing dynamic, sustainable, effective cultural competency protocols and policies.

The urgency of this challenge is compounded by ever-increasing legal and ethical backlash towards first responders. While Hurricanes Katrina and Rita graphically depicted the failure of our response systems to serve the most vulnerable members of our communities, such failure was not new. The 1989 Loma Prieta earthquake in northern California showed an international audience that even the sophisticated, urbane, culturally progressive community of the Oakland – San Francisco Bay Area was entirely unprepared to address the basic emergency needs of its residents. This lack of preparedness also marked the San Francisco earthquake eight decades earlier.

During the centennial observances for the great 1906 earthquake, the Museum of Oakland hosted an exhibit called *Aftershock! Voices from the 1906 Earthquake and Fire*. The exhibit included information on how African American and immigrant communities faced discrimination from emergency services agencies in the aftermath of the earthquake. Gladys Hansen, a retired San Francisco librarian, and other historians are still working to correct the official records to accurately reflect the total number of people killed in the disaster. Various city officials and boosters engaged in an unofficial suppression of the numbers of casualties from the earthquake and subsequent fires in order to downplay the extent of the disaster. The official record from the San Francisco Board of Supervisors in 1907 claimed only 478 deaths, and many authorities today believe the real total is in the thousands. Many of the unacknowledged deaths were of minority and immigrant residents (Mosher, 2006). These populations continue to be vulnerable in disasters.

CARD – Collaborating Agencies Responding to Disasters – is a 501(c)3 nonprofit organization based in Oakland, California, that was created in the aftermath of the October 17, 1989, Loma Prieta earthquake. Created by local nonprofits, for local nonprofits, CARD's role is to help address the gap in culturally competent emergency preparedness and disaster response services for these communities and their service providers. Over the last 18 years of providing direct service and support to the agencies whose clients are overrepresented as victims in virtually every disaster, CARD's curriculum has evolved to address the fact that these groups are made more vulnerable by the way our health care and emergency management system defines and serves people

with special needs, and by the way basic health, safety and preparedness information is conveyed.

Originally, the CLAS Standards focused upon the needs and perspectives of minority and foreign-born populations. OMH later added gender, sexual orientation, age, disability, socio-economic status, linguistic-minority status, low literacy skills, and hearing impairment for consideration. There are still segments of the population who fall between these expanded definitions. "Special Needs" populations can include not only all of the above groups, but any people who are vulnerable in a crisis, including those who become vulnerable *because* of a crisis.

By CARD's definition, in the context of emergencies and disasters, "people with special needs" can simply mean members of the community with little or no ability (or in some cases willingness or desire) to address their own preparedness, response, and recovery needs. In times of emergency, community members who are unable to keep themselves healthy or safe become more reliant on EMS and other government services. Special needs also includes those whose current life circumstances leave them needing more than what traditional emergency response agencies can provide or are trained to provide. All patients need to communicate effectively with the EMS personnel providing assistance, so the need to communicate is not "special." Needing to communicate via an American Sign Language (ASL) interpreter or by special programmed assistive technology is special. Anything that prevents a person from following emergency instructions or fully using EMS or other traditional response services creates a special need in the community. The "Special Needs" community includes, but is not limited to:

- Seniors and/or frail elderly
- Poor, without resources, extremely low income

- Blind, visually impaired, low vision
- Single parents, lone guardians with no support system
- Deaf, hearing impaired, hard of hearing (HoH)
- Limited English Proficiency (LEP), monolingual
- Emergent special needs (new needs due to disaster)
- Children, unattended minors, runaways, latchkey kids
- Homeless or shelter dependent – including domestic violence shelters
- Chemically dependent – including legal and illegal drug dependence
- Medically compromised, low immune system, medically fragile, contagious
- Ex-convicts, registered offenders, or other clients of the criminal justice system
- Individuals fearful of (or refusing services from) government, Red Cross, or any other unfamiliar bureaucracy
- Physically disabled – from minor issues to complete dependence on life support
- Mentally/cognitively disabled – from minor issues to complete dependence on support systems
- Transient needs (tourists, people needing replacement hearing aids or glasses, etc.)
- Owners and guardians of pets/animals, people who make life and death decisions based on animal concerns
- Culturally isolated – little contact outside their chosen community (religion, sobriety, LGBTIQQ, geography-caused isolation, etc.)

Need for Cultural Competency for EMS Personnel

Often when the above list of "special needs" is shared, people in health care and traditional emergency services agencies such as FEMA, American Red Cross, Department of Homeland Security, or the Office of Emergency Services/Management, see it as insurmountable, a "Pandora's Box" of needs they cannot hope to fill. Using the traditional approach to training and upholding the status-quo approach to defining "responders," "experts," and "trainers," it is indeed unreasonable for EMS personnel to be trained to appropriately and effectively address even a few emergency situations for each of these special needs groups.

After emergencies and disasters, advocacy groups often request or demand more training for emergency services personnel on how to serve specific special needs communities. In the light of the breakdowns in serving these groups, EMS and traditional emergency response agencies often agree and commit to "more training." But, is it realistic, affordable, and sustainable (or even helpful) to embrace the typical trainings for each special needs group? Consider the needs of people with developmental disabilities. It is estimated that there are 4.5 million individuals with some type of developmental disability in the United States (Administration on Developmental Disabilities, 2005). This group includes people with autism, Cerebral Palsy, Down Syndrome, epilepsy and several other conditions. Each condition can have profound, moderate or mild effects – some of which can cause other medical needs. Many individuals with developmental disabilities use wheelchairs, assistive technology or other durable medical equipment. Many are animal owners and rely on these animals daily. People with developmental disabilities live independently, with family members, in group homes or in larger institutions, and some are homeless. Considering the realities of time constraints and budgets, how much traditional training can EMS personnel reasonably undertake so that they would be culturally appropriate, sensitive, or competent with members of their community with developmental disabilities? All of the factors listed above matter in creating appropriate emergency preparedness and safety plans for developmentally disabled consumers, which is why the one-size-fits-all model used by traditional disaster response agencies virtually always fails this community. Similarly, a one-size-fits-all

approach to cultural competency training will fail EMS personnel looking to serve this community.

Superficially, it may seem that the example of developmentally disabled consumers is particularly complex. But many of the other special needs groups listed above have multiple considerations – some of which are less obvious than others. There is a great tendency, for example, for traditional emergency services agencies and health care providers to over-simplify the needs of Spanish-speaking, Limited English Proficiency (LEP) audiences. Health and safety pamphlets and emergency preparedness brochures created by traditional institutions, for middle-class, English-speaking, American audiences are routinely translated directly into Spanish. The fact that the messenger is not reflective of the community nor trusted by the community, that the message does not speak to the most relevant needs and concerns of the LEP audience, and that the medium of delivery is not viable, is rarely addressed by those producing such brochures.

In reality, almost every variable matters to the recipient of emergency medical services. For example, one's country of origin matters. Residents from Puerto Rico, Cuba, and Mexico have special needs and concerns simply because of the political landscape that involves these three countries. Puerto Rico has Commonwealth status with the United States, so people born in Puerto Rico have the protections of U.S. citizenship. Cuba remains under a U.S. embargo and the strained relations between these two countries are known world-wide. And at a time of rising political passions and anti-immigrant sentiment, those of Mexican ancestry remain the easiest group to target based on their sheer numbers. There are an estimated 10 million Mexican immigrants in the

United States, and of the 39 million Latinos in the United States, 67% can claim Mexican ancestry (Wallace, Gutiérrez, & Castañeda, 2005). Although the Mexican immigrant population has been subject to more criticism, their sizable numbers also translate into greater social services, infrastructure, and the presence of networks to support this community. Another important difference stemming from country of origin is the level of expectation related to emergency services. Cuba's hurricane response plan, for instance, is known in emergency management circles around the world for its effectiveness in protecting and saving lives. Mexico, like California, has experienced several major earthquakes with massive loss of life and devastation to the local economy. Legal status is but one of the many factors influencing whether these LEP communities would be willing and able to engage with EMS personnel effectively in a crisis situation, much less follow their directives.

CARD's approach to disaster preparedness has relevance for implementing effective cultural competence among EMS workers, especially when they encounter people with special needs. In the CARD model, agencies serving people with any special need would be assisted in providing culturally competent emergency preparedness support to their consumers and supported in maintaining mutually beneficial partnerships with EMS, local government, and the overall traditional disaster services community. This would include, but is not limited to having culturally appropriate health, safety and emergency preparedness services as part of their curriculum; providing safe locations where EMS personnel can have hands-on learning experiences with various special needs groups; and supporting consumers in having basic supplies on them at all times (identification, medical information, whistle, etc.).

EMS personnel interact with patients in a situation marked by crisis and intense pressure and of relatively short duration. EMS understandings of cultural competence, or lack thereof, will translate into how these consumers are served. If EMS workers are completely ignorant about cultural competency, distinctions and nuances, their actions or treatment could actually be wrong or inappropriate for that consumer, which could compromise the consumer's health. EMS workers do not have the benefit of long-term decision making, nor the ability to conduct research or consult with experts to determine the appropriate course of action. The very nature of EMS work requires immediate prioritization, decision making, and action. EMS responders are often forced to make key decisions based upon incomplete or inaccurate information. The IOM 2002 landmark study *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, found that situations characterized by time pressure, resource constraints, and high cognitive demand promote stereotyping due to the need for cognitive "shortcuts" and lack of complete information. Stereotyping can be defined as "the process by which people use social categories (e.g. race, sex) in acquiring, processing, and recalling information about others" (Smedley, Stith, & Nelson, 2003). In general, individuals are frequently not aware of the activation or the impact of stereotyping on their perceptions, emotions and behavior. Stereotype-linked bias is an automatic and unconscious process, and can occur even among persons who are not outwardly prejudiced (Devine, 1989; van Ryn & Fu, 2003). Since EMS personnel are subject to all of the factors that promote a reliance on stereotyping, it is even more important that they receive effective training in cultural competency. This is especially important when seemingly innocuous failures in cultural competence can lead to disastrous outcomes for all parties involved.

In a 1995 incident in Washington, D.C., for instance, city paramedics responding to the site of an automobile accident reacted inappropriately after discovering that the accident victim being helped was not a female but a male transvestite. Paramedics stopped treatment to laugh and make disparaging jokes at the expense of the accident victim, angering local neighborhood residents who witnessed the exchange (Fernandez, 1998). Another fire crew that arrived on the scene resumed treatment. The victim, 24 year old Tyrone Hunter, who identified as Tyra Hunter, faced further problems at the hospital. Misdiagnosed by the emergency room doctor, Hunter did not receive the correct medical treatment and died a few hours after reaching the hospital. Hunter's mother later won a $2.9 million wrongful death lawsuit against the city (Fernandez, 1998; Miller, 2000). Note that this was a simple car accident, not a major disaster where far greater pressures would be at issue. Despite promises of swift cultural competency reform by the city's fire chief, the following year two gay men victimized in a homophobic attack in DuPont Circle were denied treatment by responding paramedics and forced to walk to a local hospital (Wheeler, 1996).

In Philadelphia in 2001, John Gill Smith called paramedics after experiencing severe chest pain. Once the EMS workers discovered Smith had AIDS, one pulled her shirt up over her mouth and left the house and never returned. The two remaining EMS workers refused to touch Smith in any way. Smith's partner and a neighbor helped him walk down the stairs and to the ambulance, where the EMS workers still would not help him. When Smith attempted to lie down on a gurney inside the ambulance, the EMS workers prevented him from doing so. Once at the hospital, the EMS workers told him to walk into the emergency room on his own, and they quickly drove off without offering

any further assistance. Smith won a judgment of $50,000 from the city in November 2006 (*Good Counsel*, 2006; Slobodzian, 2006).

One EMS responder, in an article entitled "Crazy or Not Crazy," (Smith, 2006) urged his fellow EMS colleagues to be wary of associating the term "mental illness" with "crazy." The author admitted that he himself had developed a bias towards mental illness before encountering a patient who challenged his stereotypes. He had also witnessed other providers "change their demeanor" when finding a medication used to treat mental illness among a patient's belongings, and along with this changed demeanor came a discounting of patient complaints. This author raised a flag of awareness concerning the ripple effect of words and actions: "How often does good medicine take a backseat when this kind of bias takes over?" (Smith, 2006).

More recently, a woman filed a $30 million suit alleging that anti-Latino and anti-immigrant sentiments led paramedics to disregard the severity of her infant son's condition. The paramedics did not take the infant to the hospital, and three hours later, the infant's condition worsened. At that point, he was taken to a hospital, where doctors found that he had suffered permanent brain damage as a result of the untreated infection (Bauza & Quintanilla, 2007). The lawsuit alleges that the paramedics "failed to take the baby (to the hospital) in an environment where there was an effort to limit services to undocumented immigrants of Hispanic descent" (Bauza & Quintanilla, 2007).

The level of cultural competency expected from EMS personnel must be carefully considered in light of the unique difficulties they face as part of their everyday work environment. Nonetheless, as the first professional health care providers that patients encounter, it is of the utmost importance that EMS responders have a strong, effective,

and sustainable level of cultural competence and an equally strong understanding of the consequences of not being culturally competent.

What does this mean for EMS personnel at a practical level? Blair (2001) found that raising awareness of the factors that play into stereotype activation, as well as an understanding of an individual's own potential for biased judgment and behavior, is a key first step to successfully challenging stereotyped behavior. Additionally, greater success is predicted for individuals who have a high level of motivation, as well as sufficient time and cognitive resources (Wegener, Dunn, & Tokusato, 2001). CARD services and guidance to emergency response organizations endorses and supports the concept that cultural competency and awareness are not learned only once – rather they are constantly learned, and require a lifelong commitment to self-evaluation and self-critique (Tervalon & Murray-Garcia, 1998).

True cultural competence is dynamic and ever changing. A word or an image can be appropriate in one community on one day and then be offensive the next. On September 10th, 2001 a comedian could have joked about terrorists in New York City and gotten laughs. The same joke told the next day, would be seen as hurtful, inappropriate and offensive.

Beyond individual cultural competence, EMS personnel must be sensitive to another factor: that medical professionals work within a specific culture of their own. Medicine as a whole has its own language and assumptions and is often associated with a specific power position (Surbone, 2004). Medical education tends to promote the notion of medicine as a "culture of no culture," and that "culture" issues are exclusive to patients (Taylor, 2003). Medicine as a system tends to "place higher value on technical

competence" than on "patient centeredness," according to Berntsen (2006). All medical support personnel need to acknowledge the professional culture in which they operate, as well as their own individual cultural perspective.

Appropriate Training to Create Successful Cultural Competency

There are no standards as to what constitutes effective cultural competency training or what makes a qualified, culturally competent trainer. Effective cultural competency training has to be wary of stereotypical representations of different racial and ethnic groups and provide more than simply the trials and tribulations of specific minority populations (Fuller, 2002, Kagawa-Singer & Kassim-Lakha, 2003). Training also tends to overlook the heterogeneity within cultural groups – individuals and groups do not always conform to their own culture (Surbone, 2004). Overly simplistic approaches to cultural competence can do more harm than good (Fuller, 2002).

In the Bay Area after the 1989 Loma Prieta earthquake and 1991 Oakland Hills Firestorm, "cultural sensitivity training" became a hot topic. Attempts to bring cultural sensitivity to some traditional emergency services agencies amounted to presenting one-time classes on "serving the diverse community." Some of the most egregious violators left the class emboldened to continue their inappropriate behavior – they simply added "oh, but that's not culturally appropriate" after their offensive remarks or behavior. Also, the focus on providing appropriate care for racial and linguistic minorities overlooks other groups not traditionally defined as "cultures" (Dysert-Gale, 2006). In CARD's model, any self-organized group can be seen as having its own "culture." Tervalon and Murray-Garcia (1998) found that the emphasis on promoting understanding of the

client's worldview typically neglected to address the provider's own worldview. In Tervalon and Murray-Garcia's model, the problems are not defined by a lack of culturally specific knowledge, as much as a provider's failure to develop and practice self-awareness and reflection.

CARD's position on cultural competency is that it is not something to be acquired and possessed, unchanging, ever after – it must grow and develop in step with changing times and situations, and it must always reflect the landscape of the community. As Tervalon and Murray-Garcia state in "Cultural Humility versus Cultural Competence" (1998), "cultural competence in clinical practice is best defined not by a discrete endpoint but as a commitment and active engagement in a lifelong process that individuals enter into on an ongoing basis with patients, communities, colleagues, and with themselves" (p. 118).

In particular, CARD emphasizes the role of community and faith agencies in the development of a sustainable model for public engagement. While it is impossible to reach, track and meaningfully engage many individual members of any given community, it is possible to form sustainable, mutually beneficial relationships with community agencies whose missions, services and structures support the most vulnerable members of any community. Rather than getting a random smattering of public feedback, this model fosters the ongoing input of individuals with a broad spectrum of knowledge, skills and experiences with a given community. These groups also have organizational resources to contribute to efforts to serve the health and wellness of the community.

It is not reasonable to expect that each EMS responder would take numerous classes in order to become intimately aware of every sub-category of special needs groups, but it is reasonable to expect that an ongoing level of cultural competence could be maintained, with cultural humility as a goal. The format and delivery of such training should reflect the ever-changing landscape of contemporary American society. Standardized classes and approaches assume that the content would be equally relevant to every individual participating. Further, reliance upon written materials, as was found in one study of organizations in California, also promotes a one-size-fits-all mentality (Brach, Paez, & Fraser, 2006). It is difficult to gauge how much cultural competence an individual has gained from such training experiences. How could it be determined if a seemingly culturally competent person will respond appropriately under stress or with every group?

The CARD model encourages raising the ambient level of cultural competence in the community and creating a sustainable platform for the ongoing development of EMS personnel in partnership with the community. CARD's philosophy is to use the community as experts and to respect and seek out local wisdom and knowledge. CARD also believes in encouraging communities to flex their capacity to render self-care and in helping build community capacity to work as full partners with EMS and others in emergency services disciplines.

Even the most well-funded, well-staffed, well-trained EMS department cannot hope to address all community issues and needs. And while population-specific training yields some benefits, there is a limit to how much of this type of training any individual EMS worker can absorb and recall. The shift therefore must be multifold, with suggested

primary goals of learning how to work with diverse community groups and how to access their knowledge and resources.

CARD's approach to training classes is to first ensure that the material is absolutely relevant to the everyday realities of the audience. Giving generic information that is virtually never needed wastes both time and resources. Adult learning dynamics dictate that courses focus on issues the **learner** finds appropriate, useful, and valuable, especially in the short term. Several of CARD's training concepts, policies and guidelines are appropriate and applicable to EMS cultural competency training needs. Five examples include:

- *Emphasize Universal Skills*. Learning effective listening and questioning skills will provide benefit in virtually every situation. Similarly, practicing peer-debriefing techniques allows for greater learning and helps build stronger relationships. By contrast, learning the rudiments of American Sign Language could help EMS workers to better serve some deaf and Hard-of-Hearing (HoH) consumers, but would be of limited value serving others outside this community.
- *Make Learning Multi-Sensory*. Use graphics, charts, pictures and colors to engage visual learners. Include group exercises and team-building to engage students who learn best through social interaction. Use tools, objects and props to support kinesthetic learners.
- *Nurture Emotional Intelligence*. Training in medical disciplines often centers on technical skills and medical knowledge. Emotional intelligence by contrast refers more to the ability or capacity to perceive, assess, and consequently effectively manage emotions (in self, others, or groups). For example, CARD advocates

emotional preparedness – being emotionally prepared to respond to the needs, concerns and upsets of your loved ones and community. Even the poorest communities, with no ability to purchase kits, write plans or take classes can embrace being emotionally ready to keep their community whole and calm in the event of an emergency.

- *Use Positive Contexts for Action*. Traditional emergency services training and health education is awash in negative contexts for action. The warning mantra in preparedness is familiar: "Do what we say because terrible things – earthquakes, pandemics, storms, fires, terrorist attacks, etc. – will happen sometime in the unspecified future." Using fear and threat-based messages to inspire long-term behavioral change does not work. Private sector corporations spend billions of dollars using positive images and contexts for action when they want to establish long-term habits and relationships with consumers – because it works. The CARD curriculum uses no fear or disaster-threat messages as contexts for preparedness actions. The CARD philosophy is "Prepare to Prosper!"
- *Question Basic Assumptions*. EMS and other traditional disaster responders have long believed that the public will do as they are told in emergency situations. There is an assumption that people will listen to government representative as "the experts" and "the officials." CARD has much anecdotal and empirical evidence to the contrary. Further, scientific research conducted by the New York Academy of Medicine validates this evidence (Lasker, 2004). Unquestioned, these beliefs will leave EMS responders unprepared for the realities they will face in their communities during emergencies and disasters.

Resistance to Cultural Competency

Despite studies and incidents that show the need for cultural competency in the health care and emergency services fields, the concept has encountered resistance. Many organizations, especially small or cash-strapped ones, worry about the cost of instituting new procedures. Of course, the Hunter and Smith cases discussed previously underscore that not being culturally competent has high costs, suffering and long-term implications as well. Errors due to "cultural or linguistic misunderstandings in health care encounters can lead to repeat appointments, extra time spent rectifying misdiagnoses, unnecessary emergency room visits, longer hospital stays, and canceled diagnostic or surgical procedures" (OMH, 2001, p. xiv).

Resistance is also encountered due to the very nature of cultural competency training. Such training usually requires a measure of inner assessment, and many people are uncomfortable or unwilling to confront or acknowledge their own privilege. Others may be uncomfortable or unfamiliar in dealing openly with issues of discrimination. Some believe that after Civil Rights era of the 1960s (because of laws like the Civil Rights Act of 1964), society is now equal and no "special" efforts are needed to accommodate any particular group. The cultural competency training advocated by CARD, which would involve redistributing power from traditional authority figures to the community as a whole, can also be perceived as threatening to those in power.

Due to lack of standardization concerning cultural competency training, some cultural competency classes themselves can be the root of the problem. The reasons cultural competency classes are instituted can shape the likely success of the program.

As the Blair (2001) study above noted, individuals with a high degree of motivation had a greater chance of success in cultural competence training. In the Hunter case mentioned previously, the fire chief initially announced that classes would be instituted within a month – but his announcement came in an environment of community protest and negative media attention. The classes were not actually instituted until fall of 2007, several years later (City of Washington, D. C., 2007). The delays could also have signaled that the top echelon within the fire department did not take the training seriously. Diversifying and training lower levels of staff without a corresponding clear commitment to changing the policies and the culture of the organization virtually guarantees failure. It is the equivalent of having McDonald's hire organic chefs and fund organic gardens, and then expecting the Big Mac to be an organic meal.

The employees expected to take such classes may well have been resistant from the outset, as they may have felt "forced" to take to the class to address problems they were not willing to acknowledge they have. The Smith lawsuit settlement also included a promise by city of Philadelphia to conduct mandatory training for EMS personnel, as well as offer proof that training was provided (Slobodzian, 2006).

Another concern with cultural competency training is that those who undertake such classes may feel themselves fully "culturally competent" by virtue of having attended one or more classes. Tervalon and Murray-Garcia (1998) relate a case in which a nurse who had attended a cross-cultural course in nursing school misdiagnosed the presenting symptoms of the patient in front of her based upon her "self-proclaimed cultural expertise" (p. 119).

Some medical professionals deny the very existence of racial and ethnic health disparities at all, thus rendering cultural competency classes irrelevant. Sally Satel, M.D. and Jonathan Klick's 2006 *The Health Disparities Myth: Diagnosing the Treatment Gap* set out to directly challenge the findings of the much-cited 2003 Institute of Medicine report *Unequal Treatment*. Satel and Klick, both of the American Enterprise Institute, argue that no racial disparities exist in health care, but that geography and socioeconomic factors drive what they term "the treatment gap." Satel is also the author of *PC, M.D.: How Political Correctness is Corrupting Medicine* (2001), which asserted that the field of medicine was overrun by "indoctrinologists" whose dream is to "equalize power in society", all in the "name of health" (p. 10). Satel accuses public health researchers of promulgating a "social justice agenda" by focusing on racism and poverty rather than health education and disease-fighting strategies.

EMS leaders, rather than simply accepting that this resistance will make diverse and special needs members of the public become underserved EMS patients, need to speak up as advocates of cultural competency training and education.

CLAS Standards and Implementation

In researching the implementation of CLAS Standards, it quickly becomes obvious that many organizations of varying types and sizes are actively looking to serve their ever-diversifying consumer base. Examples of organizations translating materials and attempting to recruit diverse staff members and volunteers are easy to find. Many hospitals and major healthcare organizations located in areas with diverse populations have long provided translators and multilingual printed materials, cultural sensitivity

training, and other traditional approaches. However, an organization looking to find a sister agency that has successfully implemented cultural competency in line with CLAS Standards that includes significant community participation will face some challenges. One challenge is that many organizations have not labeled or identified their activities as part of an initiative to achieve CLAS Standards. For example, the Black Infant Health Coalition of the Solano County Department of Public Health (SCDPH) in California was established in 1991 to improve access to care and birth outcomes for African-American women and their babies. A community advisory board included representatives from the local African-American community. This type of community-based outreach to ensure equal access to health care is an example of the CLAS Standards in action, yet this Coalition is not formally linked to the Standards themselves on SCDPH's website. The Coalition was formed, of course, before the CLAS Standards were developed, and perhaps SCDPH simply never thought to update its site to include CLAS Standards. When organizations actually engage in community outreach as part of cultural competency, but do not identify those efforts as in alignment with CLAS Standards, it makes it harder to identify good models for others to emulate.

In some cases, the absence of the CLAS Standards branding could indicate that some institutions have simply not yet embraced a formal process to implement or follow CLAS Standards. Some agencies may not have invested the resources in posting their information so that it is accessible to the public. Whatever the reason, it is not clear that the pursuit of CLAS Standards has been given the full support and recognition it needs to succeed.

Actions Beyond Training

As noted earlier, CARD's approach to disaster preparedness and cultural competency in general contains a heavy emphasis upon community participation and utilizing those being served as experts on their own lives and conditions. Most vulnerable communities have never received the support or information they need in order to avoid becoming victims, nor have their chosen service organizations been given what they need to provide appropriate services to their consumer base. Additionally, many traditional agencies whose resources are almost entirely focused on disaster response depend upon a fear appeal to attempt to motivate compliance with their preparedness suggestions. This strategy of relying upon fear-based disaster threat messages is one that can be not only ineffective, but counterproductive as well (Witte, 1998; Witte & Allen, 2000; Ruiter & Kok, 2005). The strategy is consistent with the fact that these organizations have the vast majority of their resources and experience tied to serving the disaster-caused needs of the general population. This model is inherently flawed when seeking to serve the preparedness and response needs of our most vulnerable communities.

Other models that seek to tap into the knowledge base of local communities do exist. In 2002, the Center for the Advancement of Collaborative Strategies in Health at the New York Academy of Medicine sponsored the *Redefining Readiness* Study (Lasker, 2004), which sought to address the "fundamental flaw" undermining emergency preparedness efforts: the development of emergency instructions for people "without finding out whether it is actually possible for them to do so or whether the instructions are even the most protective action for certain groups of people to take"

(http://www.redefiningreadiness.net/). The *Redefining Readiness* Local Demonstration Project, begun in 2005, offered community residents a way to contribute their knowledge and expertise to emergency preparedness efforts. The demonstration sites, in New Mexico, Illinois, Georgia, and Oklahoma, relied upon 2000 participants who closely resembled the overall demographic profile of each community, and discussions were held at convenient times and places where people felt most comfortable. The purpose of this approach and process was to both draw upon local knowledge in order to determine what communities needed to protect themselves, as well as build resilience among community members by given them the opportunity to think about emergency situations in advance.

As a second example of cultural competence in conjunction with community participation, the Alameda County Public Health Department (ACPHD) has embraced strategies to more effectively address special needs and vulnerable communities in emergency preparedness and disaster response. In 2006, the ACPHD conducted an in-depth survey of residents in low-income and senior housing complexes in the Irvington neighborhood of the city of Fremont, California. All residents participating in the survey received disaster preparedness kits. After analyzing the results, the ACPHD contracted with CARD to provide culturally appropriate trainings, tailored to the identified concerns of the community.

As detailed in the final presentation after the trainings (see Resources), both residents and staff from the apartment complexes had powerful and positive responses to the alternative approach. CARD's community education tools (see samples in Resources) were shared in multiple languages, interpreters (Spanish, Russian, Cantonese and ASL) were provided, and snacks were served. EMS staff and local volunteers from the City of

Fremont's Community Emergency Response Team (CERT) program provided support throughout the trainings. With no fear-based messages, with materials designed for this audience, and with the audience positioned as dynamic participants, the staff and volunteers from the Public Health Department, EMS and the Fire Department were positioned as resources, supporters and "the wind beneath the wings" of a community learning how to become more prepared and resilient. This is a stark contrast to the traditional approach of authority figures telling passive recipients of knowledge about scary things they cannot control.

The true depth of partnership and ongoing engagement of the apartment managers, traditional emergency services agencies, CARD, and multiple divisions from inside the Alameda County Public Health Department is unusual for public health or traditional emergency services outreach initiatives.

An example of a positive, proactive move toward cultural competence is the recent effort in Contra Costa County in California. In 2003, Contra Costa Health Services adopted a Reducing Health Disparities Initiative and worked to apply it throughout its health care system (Contra Costa Health Services, 2003). However, the program did not specifically include EMS workers. The EMS director initially was not clear how the Reducing Health Disparities Initiative would (or could) apply to his program, and he found little literature on the impact of cultural issues on pre-hospital services. The director then had his staff conduct focus groups within the Contra Costa community, as well as interviews with first responders in order to get a clearer sense of what cultural issues needed to be specifically addressed in the community. Based upon the answers, the department developed a training curriculum to help EMS workers

address cultural barriers. The EMS director himself, Art Lathrop, believed it "may be the first in the nation" (Contra Costa Health Services, 2000-2007).

More recently, on September 19th, 2007, Alameda County EMS, Public Health Department held a regional Bay Area conference *Meeting the EMS-C Challenge - Enhancing Pediatric Care: Evolve and Improve Pediatric System Capability*. Through a brief CARD presentation, the audience was exposed to the concept of working with community agencies as a way to extend reach into underserved communities, and to build the capacity for EMS personnel to work effectively with diverse community partners.

Beyond preparedness and EMS in particular, there are other models of effective community collaborations in the service of cultural competence in the public health field in general. The San Francisco Department of Public Health has developed numerous partnerships with groups representing various aspects of the city's diverse population. The city's website has a clearly marked section, "Cultural & Linguistic Competency Policy," that discuss the Department of Public Health's (DPH) commitment to adhering to CLAS Standards in addition to the many programs it has implemented to facilitate health care access for all. One of those programs includes the Community Action Model (CAM) training, which seeks to create change by building community capacity. According to the DPH website, the goal of CAM training is to:

> work in collaboration with communities and provide a framework for community members to acquire the skills and resources to investigate the health of the place where they live and then plan, implement, and evaluate actions that change the environment to promote and improve health (http://www.sfdph.org/CHPP/CAM/cam.htm).

The Cross Cultural Health Care Program (CCHCP) in Seattle, Washington, also offers a model for more expansive efforts that reach broader sections of the community.

The CCHCP, established in 1992, serves as a bridge between underserved communities and health care organizations to ensure access to culturally and linguistically appropriate health care. In particular, CCHCP considers the role of culture – of the various populations it serves as well as the culture of health care institutions – in its development of programs. The CCHCP also has a multi-tiered approach that acknowledges the complexity of the interplays of cultures, and it includes community outreach, advocacy and education in addition to cultural competency and interpreter trainings. CCHCP also conducts research in order to further develop and improve models for cross cultural health care, and has expanded some of its efforts nationwide.

Overall, CARD advocates that cultural competency is inextricably bound with active and consistent community participation. Organizations may be best served by seeking ways to develop or improve collaborative strategies within the communities they serve in order to most effectively resolve issues relating to health and other areas (Lasker & Weiss, 2003). CLAS Standards can provide a helpful framework from which to start this process with the ultimate goal of empowering communities and reducing disparities within health care access, as well as other deeply-rooted problems facing many vulnerable communities.

Conclusion

As noted in the introduction, few professional disciplines are as adversely impacted by the lack of cultural competence and cultural humility as EMS personnel. Training EMS workers in cultural competency and working toward cultural humility will certainly impact the consumers of EMS services as well as the other providers in the

continuum of care. However, to truly shift the entirety of cultural competence conversations, advocacy from the EMS community will be necessary. As other initiatives are created to increase cultural competence in health care fields, it will be important to document the processes and outcomes for both the successes and failures. It is human nature to tout successes and to bury failures. As noted earlier, examples of problematic cultural competency trainings can be found in overly simplistic or "cookie-cutter" approaches, assumptions that one training is sufficient, or from a lack of organizational commitment. A community committed to the health and well-being of all must learn from (and leverage) every project and every experience. The shameless promotion of superficial successes and its evil twin, the hiding and denying of failures, forces other communities to repeat mistakes rather than build from a life-long learning, constant quality improvement approach.

As a nation, we have invested billions of dollars building our capacity to deploy medicines and personnel in a medical emergency. We develop systems to stand up high-tech Points of Distribution that will serve hundreds of millions of people in a pandemic or bioterrorism attack. Nonetheless, even if someone invented a simple, inexpensive, 100% effective remedy for an urgent public health problem, we would not have the capacity to reach many minority and special needs residents with dosages or advice. Public health officials would have to get past language, literacy, access, ability, and trust barriers in order to disseminate key messages, and even then it is not clear that emergency medical services would be able to successfully engage these communities. These barriers are the same ones faced by EMS personnel every day, during emergencies large and small, and

to successfully overcome them will take an ongoing investment of resources, time and a sustained commitment.

Due to its ongoing and dynamic nature, cultural competence - and its higher iteration, cultural humility - is a journey rather that a destination. The level of cultural competence in the EMS community is inextricably linked to the level of cultural competence in society at large. As America becomes less tolerant of discrimination and disparities or less willing to endure their costs and threats, EMS personnel will need to be increasingly culturally competent. Given the strategic placement of EMS personnel in the continuum of health, their ability to lead other health care disciplines in this conversation is great. This initiative to provide effective cultural competency training to EMS personnel has the potential to help break the disaster victim cycle for minority and special needs communities across the country, and create a truly humane, resilient, healthy society.

Bibliography

AIDS Law Project of Philadelphia. (2006, Fall). Déjà vu: AIDS law project wins ambulance case (*again*). *Good Counsel: Newsletter of the AIDS Law Project of Philadelphia.* Retrieved September 14, 2007, from http://www.aidslawpa.org/GCfall06.pdf.

Administration on Developmental Disabilities – U.S. Department of Health and Human Services. (2005). ADD fact sheet. Administration for Children and Families. Retrieved on September 12, 2007, from http://www.acf.hhs.gov/programs/add/Factsheet.html/.

Bauza, V. & Quintanilla, R. (2007, September 19). Lawsuit: Village bias hurt her son. *Chicago Tribune*, p. 1.

Berntsen, K. J. (2006). Implementation of patient centeredness to enhance patient safety. *Journal of Nursing Care Quality, 21*(1), 15-19.

Betancourt, J. R. (2003). Cross-cultural medical education: Conceptual approaches and frameworks for evaluation. *Academic Medicine, 78*, 560-569.

Betancourt, J. R. (2006). Improving quality and achieving equity: The role of cultural competence in reducing racial and ethnic disparities in health care. The Commonwealth Fund. Publication No. 961. Retrieved September 18, 2007, from http://www.commonwealthfund.org/usr_doc/Betancourt_improvingqualityachievingequity_961.pdf?section=4039.

Blair, I. V. (2001). Implicit stereotypes and prejudice. In G. B. Moskowitz (ed.), *Cognitive social psychology: The Princeton Symposium on the legacy and future of social cognition*, (pp. 359-374). Mahwah, N.J.: Erlbaum.

Brach, C., Paez, K., & Fraser, I. (2006). Cultural competence California style. Agency for Healthcare Research and Quality. Working Paper No. 06001. Retrieved September 16, 2007, from http://gold.ahrq.gov.

Bureau of the Census. (1996). *Population projections of the United States by age, sex, race, and Hispanic origin: 1995-2050.* Washington, D.C.: U.S. Department of Commerce.

City of Washington, D.C. (2007, June 19). Press release: D.C. Fire/EMS appoints new LGBT liaison officer. Retrieved September 18, 2007, from http://www.newsroom.dc.gov/show.aspx/agency/fems/section/2/release/11362/year/2007/month/6.

Contra Costa Health Services. (2003). Reducing Health Disparities Initiative: Diversity and cultural and linguistic competence at Contra Costa Health Services. Retrieved September 10, 2007, from http://www.cchealth.org/groups/rhdi.

Contra Costa Health Services. (2000-2007). Ambulance response and cultural issues. Retrieved on September 10, 2007, from http://www.cchealth.org/groups/rhdi/ambulance.php.

Devine, P. G. (1989). Stereotypes and prejudice: Their automatic and controlled components. *Journal of Personality and Social Psychology, 56,* 5-18.

Dysart-Gale, D. (2006). Cultural sensitivity beyond ethnicity: A universal precautions model. *Internet Journal of Allied Health Services and Practices, 4*(1), 1-5. Retrieved on September 13, 2007, from http://ijahsp.nova.edu/articles/vol4num1/dysart-gale.pdf.

Fernandez, M. E. (1998, December 12). Death suit costs city $2.9 million: Mother of transgendered man wins case. *Washington Post*, p. C1.

Fuller, K. (2002). Eradicating essentialism from cultural competency education. *Academic Medicine, 77*(3), 198-201.

Kagawa-Singer, M. & Kassim-Lakha, S. (2003). A strategy to reduce cross-cultural miscommunication and increase the likelihood of improving health outcomes. *Academic Medicine, 78*(6), 577-587.

Lasker, R. D. & Weiss, E. S. (2003). Broadening participation in community problem solving: A multidisciplinary model to support collaborative practice and research. *Journal of Urban Health, 80*, 14-47.

Lasker, R. D. (2004). Redefining readiness: Terrorism planning through the eyes of the public. New York, NY: The New York Academy of Medicine. Retrieved October 12, 2007 from http:// www.redefiningreadiness.net/pdf/RedefiningReadinessStudy.pdf.

Miller, B. (2000, August 11). D.C. settles bias suit in 1995 death: Rescue workers mistreated, mocked injured transvestite. *Washington Post*, p. B1.

Mosher, M. (2006, April 14). 100 years later, quake's dead still being counted: Woman makes it her mission to make sure no San Franciscan is forgotten. MSNBC.com. Retrieved September 15, 2007, from http://msnbc.msn.com/id/12301877.

Office of Minority Health – U.S. Department of Health and Human Services. (2001). National Standards for Culturally and Linguistically Appropriate Services in Health Care: Executive Summary. (Contract No. 282-99-0039). Rockville, MD.

Ruiter, R. & Kok, G. (2005). Saying is not (always) doing: cigarette warning labels are useless. *European Journal of Public Health, 15*(3), 329.

Satel, S. (2001). *PC, M.D.: How political correctness is corrupting medicine*. New York: Basic Books.

Satel, S. & Klick, J. (2006) *The health disparities myth: Diagnosing the treatment gap.* Washington, D.C.: AIE Press.

Slobodzian, J. (2006, November 14). City settles with AIDS patient. *Philadelphia Inquirer,* p. B4.

Smedley, B. D., Stith, A. Y., & Nelson, A. R. (eds). (2003). *Unequal treatments: Confronting racial and ethnic disparities in health care.* Washington, D.C.: National Academies Press.

Smith, M. (2006, July). Crazy or not crazy?: Don't let bias against your patient impact your care. *Emergency Medical Services*. Retrieved September 14, 2007, from http://www.emergencyresponder.com/print/Emergency--Medical-Services/Crazy-Or-Not-Crazy/1$3692.

Surbone, A. (2004). Editorial: Cultural competence: Why? *Annals of Oncology, 15,* 697-699.

Taylor, J. S. (2003). Confronting 'culture' in medicine's 'culture of no culture.' *Academic Medicine, 78*(6), 555-559.

Tervalon, M. & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved, 9*(2), 117-125.

van Ryn, M. & Fu, S. (2003). Paved with good intentions: do public health and human service providers contribute to racial/ethnic disparities in health? *American Journal of Public Health, 93*, 248-255.

Wallace, S., Gutiérrez, V., & Castañeda, X. (2005). Health policy fact sheet: Demographic profile of Mexican immigrants in the United States. California-Mexico Health Initiative, UCLA Center for Health Policy Research. Retrieved September 20, 2007, from http://www.healthpolicy.ucla.edu/pubs/files/2005cmhi_demo_profile.pdf.

Wegener, D. T., Dunn, M., & Tokusato, D. (2001). The flexible correction model: Phenomenology and the use of naïve theories in avoiding or removing bias. In G. B. Moskowitz (ed.), *Cognitive social psychology: The Princeton Symposium on the legacy and future of social cognition*, (pp. 277-290). Mahwah, N.J.: Erlbaum.

Wheeler, L. (1996, August 29). D.C. Fire Department accused of gay bias. *Washington Post*, p. D5.

Williams, D. R. & Rucker, T. D. (2000). Understanding and addressing racial disparities in health care. *Health Care Financing Review, 21*(4), 75-90.

Witte, K. (1998). Fear as motivator, fear as inhibitor: Using the Extended Parallel Process model to explain fear appeal successes and failures. In Anderson, P. A., & Guerro, L. K. (eds). *Handbook of communication and emotion: Research theory, applications, and contexts, (*pp. 423-450*).* San Diego, CA: Academic Press.

Witte, K., & Allen, M. (2000). A meta-analysis of fear appeals: Implications for effective public health campaigns. *Health Education & Behavior* (formerly *Health Education Quarterly*), *27*, 608-632.

Wynia, M. & Matiasek, J. (2006). Promising practices for patient-centered communication with vulnerable populations: Examples from eight hospitals. The Commonwealth Fund. Publication No. 947. Retrieved October 12, 2007 from http://www.commonwealthfund.org/usr_doc/Wynia_promisingpracticespatientcentered_947.pdf?section=4039.

APPENDIX 1

Continuum of Value Education and Training Tools

11: Everyone Survives and Thrives
It is fundamentally embedded in our culture that ALL people should be, can be, and ARE as safe and sustainably prepared as possible in a positive, empowering context.
Example: Utopia.

10: Universal Preparedness Training Academy
A national or international system of skilled and experienced Preparedness Educator-Trainers spreading best practices and building networks among all stakeholders.
Example: None.

9: Development Forum
An established forum for development of Train-the-Trainer programs and curricula, and peer education between experienced preparedness educators.
Example: None.

8: Train-the-Trainer classes
An intentionally-designed curriculum to prepare and empower community educators to deliver fully effective preparedness trainings to diverse audiences.
Example: CARD Train-the-Trainer (under development).

7: TtT-in-absentia materials
A next-best substitute for proper Train-the-Trainer classes; designed to be read and studied by potential trainers who have no access to proper TtT classes.
Example: SKIP Kit Trainer Guide (under development).

6: Preparedness Training
Empowering preparedness education classes, designed and delivered to suit the learning dynamics and needs of the target audience.
Example: Appropriately tailored personal preparedness class.

5: Tools Plus Context
Useful preparedness items delivered WITH explanation about how to use them.

Example: Whistles and flashlights accompanied by training and/or an appropriate handout.

4: Training Materials
Educational materials designed to accompany a preparedness class delivered by a qualified trainer – NOT a substitute for the class.
Example: Personal preparedness class booklet.

3: Stand-Alone Handouts
Slightly more sophisticated educational materials designed to be of genuine value even without a trainer.
Example: Well-written tip sheets.

2: Tools without Context
Useful preparedness items, but delivered with no explanation about how to use them.
Example: a Vial of Life with no explanation.

1: Educational Components.
The smallest bit of useful information; stand-alone but potentially combined.
Example: "Dial 9-1-1 in an emergency."

0: Preaching to the Choir
Putting generic information into the hands of the people who are already aware and engaged.
Examples: Basic supplies lists on complicated websites that appeal to disaster aficionados.

-1: Useless Swag
Giveaway items of no inherent value that just fill landfills and make people jaded.
Example: foam footballs with "Get Prepared!" written on the side.

-2: Misleading Information
Wrong advice that causes unsafe behavior or misleading claims that give false hope and foster dependency.
Examples: Fear-based messages, "Triangle of Life", or slogans conveying impossible promises.