Cultural Competency

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Cultural Competency Learning Objectives

- What culture and cultural competency is,
- Evaluating ourselves,
- Why it is important to our work:
  - Demographics of America
  - Disparities in Health Status
  - Access to Health Care
  - Quality
- How to implement cultural services.
- Closing the Gap/Development of Competency.
- Amish, Burmese, Indian, Asian and Hispanic overview.
- Post Test.
Cultural Competency in the Health Care Setting

What is Cultural Competence?

Cultural competence is a set of attitudes, skills, behaviors and policies that enable organizations and staff to work efficiently in cross-cultural situations. It reflects the ability to acquire and use knowledge of health care related beliefs, attitudes, practices and communication patterns of clients and their families to improve services, strengthen programs, increase community participation and close the gaps in health status among diverse population groups. MSH (Management Sciences for Health)

Other terms for cultural competence include cultural proficiency and cultural humility.

Effective cross-cultural competency equates to tailoring the delivery of health care to meet the patient’s social, cultural and linguistic needs.
What is culture?

- The learned, shared, transmitted values and beliefs and practices of a particular group that guide the thinking, actions, behaviors, interactions, emotions and view of the world.

- Art
  - Beliefs about:
    - Family obligations

- Relationships
  - Beliefs about:
    - Gender Roles

- Customs
  - Beliefs about:
    - Preventative Health

- Clothing
  - Beliefs about:
    - Illness and death

- Environment
  - Beliefs about:
    - Sexuality

- Economics

- Religion

- Diet
What are your attitudes, knowledge and skills in relation to cultural and linguistic competence?

What are some barriers and opportunities that you have?

How aware are you of the prevalence of significant health care disparities?

Do you have an honest desire to not allow biases keep you from treating every individual with respect and optimum care?

Are you honestly capable of looking at your negative and positive assumptions about others?

Learning to evaluate our own level of cultural competence must be a part of improving the health care system.
Culture and Language may Influence

- Health, healing and wellness belief systems,
- Illness, disease and how causes are perceived,
- How health care treatment is sought and attitudes toward providers, impacting treatment,
- Delivery of health care services by providers who may compromise access for patients from other cultures.
How well prepared are you to work with patients of diverse populations?

- Do you consider the individual’s culture when planning and coordinating care?
- Do you ensure that individuals who do not speak English have trained certified medical interpreters?
- Do you modify your educational and printed materials to meet the unique needs or learning styles of a diverse population?
- Are you knowledgeable of the culturally and racially diverse population in our area?
- What is your degree of proficiency in performing culturally competent tasks?
- Is the educational support and communication present for you to meet best practice standards?
Researchers have found classic negative and racial stereotypes

We have a health system that is the pride of the world, but the March 20, 2002 study entitled “Unequal Treatment Confronting Racial and Ethnic Disparity in Health Care” demonstrates that the playing field is clearly not equal.

David R. Williams, Professor of Sociology, U of Michigan

It found that racial and ethnic minorities in the United States receive lower quality health care than whites even when their insurance and income are the same.
Demographics of America

Our diverse nation is expected to become substantially more so over next the several decades.

The U.S. Census Bureau projects that by 2050, populations historically termed “minorities” will make up 50% of the population.

The Hispanic–origin population will be the fastest growing ethnic group doubling by 2050.

The fastest growing racial group will Asian and Pacific Islander population. Asian American elders will increase by 300%.

Marked differences in education, income with a greater number of blacks and Hispanics being considered “near poor” (100-200% of poverty level). This is remarkable in that income significantly influences health status, access to health care and health insurance coverage.

One–sixth of the U.S. population speaks a language other than English at home.
Disparities in Health Status

- Racial and ethnic minorities experience persistent and often increasing disparity across a number of health care variables.
- Members of minorities suffer disproportionately from cardiovascular disease, diabetes, asthma, TB, HIV/AIDS and cancer.
- Variations in a patient’s ability to recognize symptoms of disease and illness, thresholds for seeking care, barriers related to mistrust, expectations of care, including preferences for or against treatment plans, diagnostic testing and procedures and the ability to comprehend what is prescribed may influence the health care providers decisions.
- Causes of disparity are multi-factorial and often are related to social determinants external to the health care system.
Disparity in Access to Health Care

- Assessing high quality health care is often influenced by the lack of an ongoing relationship with a provider, thus reducing use of specialty services and preventative care.
- Increased use of ED as their regular place of care.
- Geographic isolation, transportation, child care may be problematic.
- Non-English speaking patients may be reluctant to seek treatment in a timely manner.
Disparities in Health Insurance Coverage

- One in six Americans is uninsured and those without coverage is growing.
- Cost is the major barrier and many low income uninsured families are not eligible for public programs or lack the knowledge and literacy for enrollment.
- Confusion and fear inhibit immigrants from obtaining coverage.
- More than one/three Hispanics and American Indians/Alaska Natives do not have health insurance – triple that for whites.
Disparities in Quality

- The Institute of Medicine indicates that health care should exhibit 6 key quality components: safe, timely, effective, efficient, patient-centered and equitable. All six must be present for it to be high quality and in all these areas there are significant disparities in care delivered to racial and ethnic minorities.

- Differences may be the result of differential treatment by providers but studies are indicating that physicians who treat blacks primarily have more difficulty in obtaining high quality ancillary services, specialists, diagnostic imaging, etc.
Quality Being Addressed

- Healthy People 2010 – a national initiative to promote equity and eliminate health disparities among different segments of the population.
- United States Department of Health and Human Services is requiring by 2010 that health care facilities provide culturally competent care.
- The Joint Commission is also requiring facilities to provide documentation of culturally competent care.
- There are clear links between cultural competence and quality improvement and overcoming disparities.
- “Cultural Competence is being talked about a lot and it is a beautiful goal, but we need to translate this into quality indicators or outcomes that can be measured, monitored, evaluated or mandated.” – Administrator, Community Health Center
Barriers to be overcome

- **Institutional:**
  - Socioeconomic, The Health Care System, Inadequate Infrastructure, Discrimination
  - Lack of diversity in leadership and workforce

- **Community Level Barriers:**
  - Philosophical Beliefs, Health Attitudes, Patient Provider Relationship, American Medical Model, Modesty

- **Provider Level Barriers:**
  - Service Delivery Approach, Health Care Provider Attitudes
  - Inadequate learning and assessment of knowledge, attitudes and skills
Promising Communication Strategies

- **LEARN**: Guidelines for Overcoming Obstacles in Cross Cultural Communication…
  - Listen with empathy for the patient’s perception of the problem
  - Explain your perception of the problem
  - Acknowledge and discuss the similarities and differences
  - Recommend the treatment
  - Negotiate agreement
ETHNIC: A Framework for Culturally Competent Clinical Practice

- **Explanation**
  - What do you think may be the reason you have these symptoms?
  - What do friends and family say about these symptoms?
  - Do you know anyone else with this problem?
  - What have you heard on the TV or radio about the condition?

- **Treatment**
  - What medicines, home remedies or other treatments have been tried?
  - Is there anything you eat, drink or avoid to stay healthy?
  - Please tell me about it. What treatment are you seeking?

- **Healers**
  - Alternative or folk healers. Tell me about it.

- **Negotiate**
  - Negotiate mutually acceptable options that incorporate your patient’s beliefs.

- **Intervention**
  - Determine an intervention which may include alternative treatments – spirituality, healers, etc.

- **Collaboration** … with family, health care team, healers, community resources.
BATHE: Useful for Eliciting Psychosocial Context

- **Background**
  - What is going on in your life?

- **Affect**
  - How do you feel about what is going on?

- **Trouble**
  - What about the situation troubles you the most?

- **Handling**
  - How are you handling that? (provides direction for intervention)

- **Empathy**
  - That must be very difficult for you. (legitimizes patient’s feelings)
Language Barriers

- Use of trained certified medical interpreters:
  - M.D.s who have access to trained interpreters report significantly higher patient-physician communication/adherence

- Discharge instructions in a language preferred by the patient. Written materials developed in other languages.

- Serving patients in their primary language including notices, etc.

- Signage and Wayfinding to help reduce stress and facilitate timely care.

- Develop written language assistance plans.

- Hispanics with language-discordant M.D.s are more likely to omit medications, miss appointments, visit emergency rooms for care than those with Spanish-speaking doctors.
Basic Strategies

- Speak clearly and slowly without raising your voice, avoiding slang, jargon, humor, idioms.
- Use Mrs., Miss, Mr. Avoid first names which may be considered discourteous in some cultures.
- Avoid gestures – they may have a negative connotation.
- Sign Language is not mutually understandable.
- Some individuals believe illness is caused by supernatural or by environmental factors like cold air. Do not dismiss as they play an important role in some people’s lives.
- Many carry or wear religious symbols – Sacred threads worn by Hindus, native Americans - medicine bundles.
Limited English Proficiency (LED)

- Determine language needs at the point of contact.
- A wide variety of language interpreters are available through Language Line Services.
- Using phone interpreters:
  - Confidentiality – private room with a speaker phone
  - Setting the Stage – summarize the situation
  - Time Constraints – plan ahead with questions and allow for extra time
- On-site interpreters:
  - Position Interpreter beside patient facing you
  - Address patient directly, not interpreter – ask interpreter to speak in first person so he/she can melt into the background
- Family members as translators is least desirable option: equates to error, lack of knowledge, biases, selective communication.
Bridging the Gap – Applying Your Knowledge

- RHFW Resources
- Internet Resources
- Community Resources
  - Learn about communities we serve and their health seeking behaviors and attitudes.
- Office Environment
  - Develop training and appropriately tailored care-giving
  - Perform self audits
  - Ask staff to assist with designing ways to provide a supporting and encouraging environment
  - Provide staff with enriching experiences about the role of cultural diversity
The Asian American Patient

- Diverse population – Chinese, Filipino, Vietnamese, Korean, Japanese
- Traditional Asian definition of causes of illness is based on harmony expressed as a balance of hot and cold states or elements
- Practices:
  - Coining – coin dipped in metholated oil is rubbed across skin – release excess force from the body
  - Cupping – heated glasses placed on skin to draw out bad force
  - Steaming
  - Herbs
  - Chinese Medical Practices – acupuncture
- Norms about touch… head is highest part of body and should not be touched
- Modesty highly valued
- Communication based on respect, familiarity is unacceptable
Burmese Refugees

- As of 2000, most of the estimated 20-30,000 Burmese living in the U.S. were immigrants of religiously, ethnically and linguistically diverse populations (150 separate sub-groups). Buddhists comprise 89% of the population.
- Burma is one of 22 countries with a high burden of TB.
- Burma has one of the worst health systems in the world.
- In the past two years, Burmese refugees have settled in Syracuse, Phoenix, Minneapolis, Dallas and Ft. Wayne (largest population) – many from rural villages.
- Challenging population to work with because of history of persecution and mistrust of the government.
- Burmese culture may be described as a more collectively-oriented, favoring indirect, nuance style communication:
  - Discuss communication with interpreter and involve “cultural bridge” if possible
Burmese Refugees – continued

- Burmese traditional medicine is based on the classical health care system of India where health is related to interactions between:
  - The physical body
  - Spiritual elements
  - Natural world
  - Dat system: Wind, Fire, Water, Earth and Ether elements
  - Illness is considered an physiological imbalance until final stages when it is classified as a disease

- Burmese Spiritualism linked with beliefs about cause, progression and treatment of illness.

- Treatment may incorporate spiritual healing and exorcism of ghosts, witches, demons and nats.

- Muslim Burmese may use amulets – a verse based on Muslim Numerology and Burmese Astrology written on paper and tied up tightly with a thread and worn about a part of the body.

- Karen Practitioners diagnose disease by wrist pulses and examining face and eyes.
Amish Society

- There are four groups of Amish:
  - Swartzentruber and Andy Weave Amish practice strict shunning and are ultra-conservative in their use of technology
  - Old Order Amish is largest group – little or no modern technology
  - Beachy Amish more relaxed discipline
  - New Order Amish have liberal views but high moral standards
- Life is given and taken by God.
- Disability is feared more than death.
- Elderly ration care during end of life to not burden the community or church’s resources.
- Usually don’t have health insurance as it is considered a worldly product; the community comes together to pay costs.
- Speak to both husband and wife – partners in family life.
Amish Society – continued

- Four Basic Rules:
  - More health professionals will come in contact with Amish population – growing population.
  - Beliefs and behaviors are specific to the particular church district of which they are a member.
  - Amish consider health care preferences from a holistic view – skill as well as their relationship and reputation with Amish patients count.
  - Amish will continue to change, as will their health care needs and preferences.
Amish Health Beliefs

- Powwowing-physical manipulation/therapeutic touch/draws illness from body.
- Illness endured with faith and patience.
- Technology in the hospital for treatment is generally accepted.
- Belief in fate is common/ recognize external locus of control.
- Three generational family structure/they care for their elderly.
- Photographs are not permitted; mirrors are not permitted.
Hispanic Health Beliefs and Practices

- Preventative care may not be practiced.
- Illness is God’s will and recovery is in His hands.
- Hot and Cold Principles apply.
- Expressiveness of pain is culturally acceptable.
- Family may not want terminally ill told as it prevents enjoyment of life left.
- Being overweight may be seen as a sign of good health and well being.
- Diet is high in salt, sugar, starches and fat.
- High respect for authority and the elderly.
- Provide same sex caregivers if at all possible.
Asian Indian

- Health encompasses three governing principles in the body:
  - Vata – energy and creativity
  - Pitta – optimal digestion
  - Kapha – strength, stamina and immunity
- Herbal Medicines and treatments may be used.
- Modesty and personal hygiene are *highly* valued.
- Right hand is believed to be clean (religious books and eating utensils): left hand dirty (handling genitals).
- Stoic/value self control; observe non verbal behavior for pain.
- Husband primary decision maker and spokesman for family.
Asian Indian - continued

- Courtesy and self-control are highly valued.
- Close family units/may desire to stay in hospital and be included in personal care of the patient.
- Very important to provide privacy after death for religious rites.
- Generally vegetarians. Beef is forbidden.
- Fasting is significant and crucial to consider in diet teaching.
- Many clients are lactose-intolerant.
New and Emerging Knowledge

- Cultural Competency Development is a Journey – not a goal.
- Linking Communication to health outcomes.
  - Communication
  - Patient Satisfaction
  - Adherence
  - Health Outcomes
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