Resource ID# 4966

Cultural Competency: A Journey

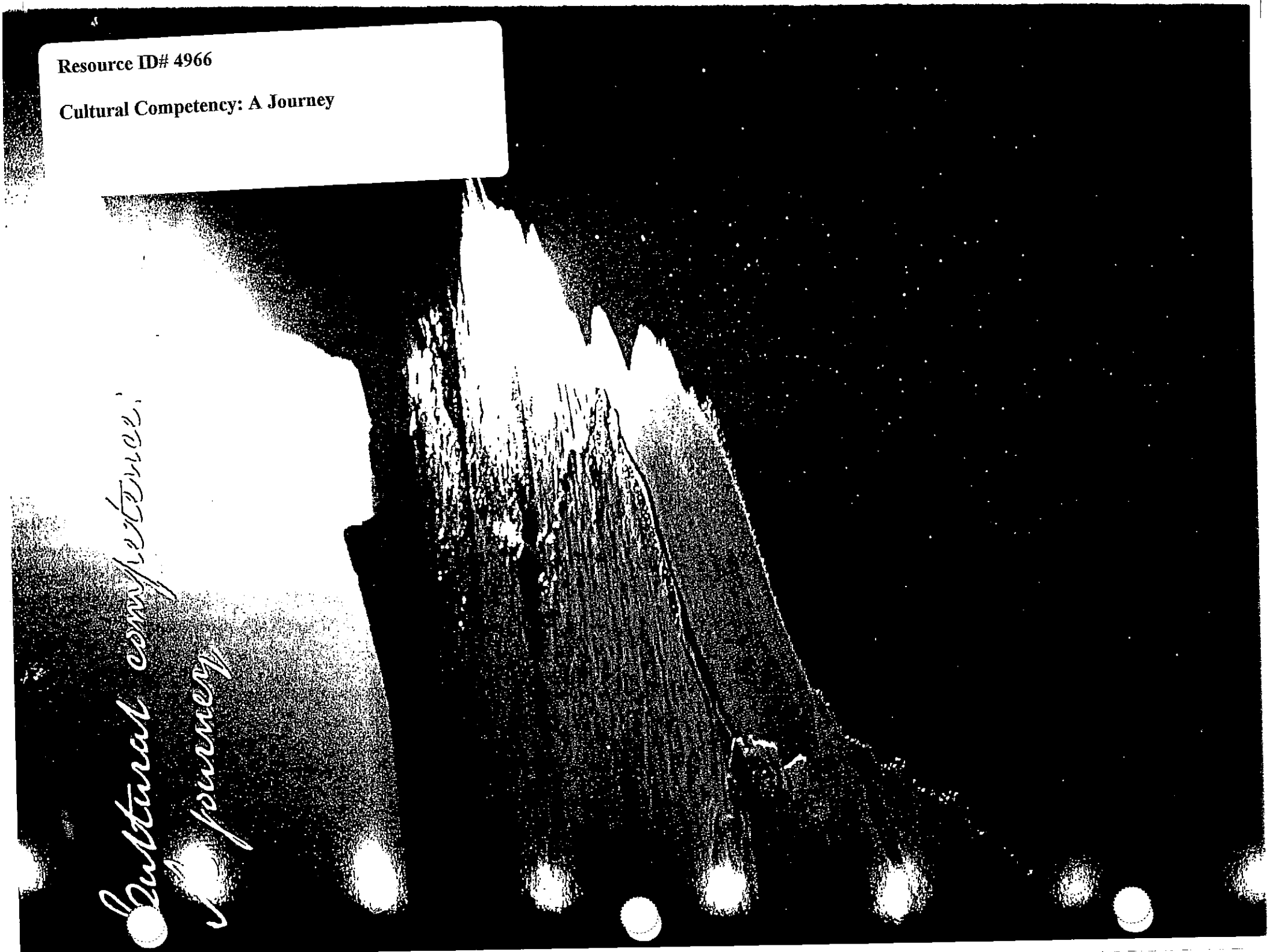
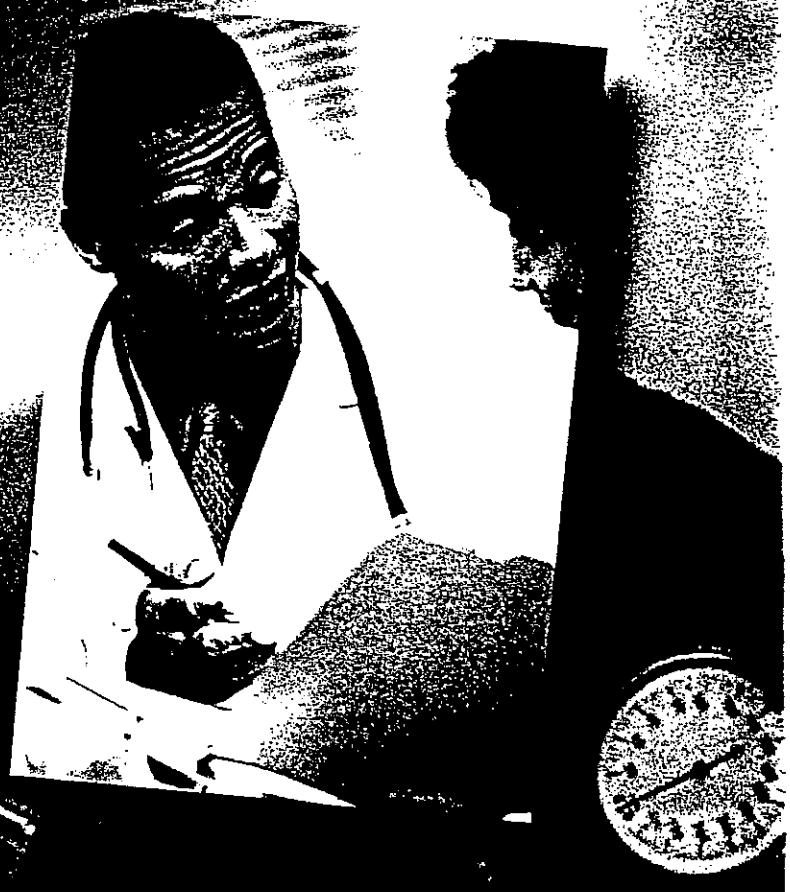


TABLE OF CONTENTS

Cultural competence: A journey

Cultural competence: A journey



Produced for Bureau of Primary Health Care, Health Resources and Services Administration, Department of Health and Human Services under contract # 98-0499 by Spectrum Unlimited, New Orleans, Louisiana. Project Officer: Leonard G. Epstein, M.S.W. Principal Writer: Katherine Hart. Design: Le'Herman Payton, Katherine Hart

Cultural competence: A journey

This publication summarizes the evolving experiences of community [illegible] affiliated with the Health Resources and Services Administration's Bureau of Primary Health Care providing services to culturally diverse populations. It reflects a growing need to provide culturally and linguistically accessible health services to an increasingly diverse national population. In just 30 years from now, 40% of Americans will belong to ethnic and cultural groups that are not predominantly European in origin. People who were once considered to be minorities will become emerging majorities.

Professionals devoted to the promotion of health and the prevention, early intervention, and treatment of acute and chronic diseases and associated disorders need to equip themselves to respond to the major demographic changes that we are experiencing. As healers devoted to the well-being of the communities with which we serve, we need to assure 100% access and zero health disparities for all of the people we serve. An understanding of culturally and linguistically competent principles, policies, and practices is vital for all members of our healing professions.

There are many definitions of cultural competence. The following definition contains essential principles that are helpful for all providers to assimilate and put into practice:

> *A set of attitudes, skills, behaviors, and policies that enable organizations and staff to work effectively in cross-cultural situations. It reflects the ability to acquire and use knowledge of the health-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. Cultural competence also focuses its attention on population-specific issues including health-related beliefs and cultural values (the socioeconomic perspective), disease prevalence (the epidemiologic perspective), and treatment efficacy (the outcome perspective).*[1]

The journey begins

The patient coming into the exam room could be a migrant farm worker who has recently arrived from Guanjato, Mexico, or an African-American father who has lived all his life in a Kansas City housing development. She could be a Russian immigrant in Brooklyn, a Vietnamese grandmother in Seattle, a member of the Northern Cheyenne Nation living in Minneapolis, or a pregnant teenager living on the streets of Hollywood.

The Bureau of Primary Health Care (BPHC), part of the Health Resources and Services Administration (HRSA) in the Department of Health and Human Services, is charged with insuring that these individuals—and others who may be part of an underserved or unserved population—receive the best possible primary and preventive health care.

Cultural competence in every aspect of service delivery and program administration is an essential part of this mission. Cultural competence in primary care programs eliminates barriers to care and improves quality and health outcomes. At HRSA, the BPHC has joined with the Maternal and Child Health Bureau to expand the National Center for Cultural Competence (NCCC). "The NCCC is one of several ways to enhance our culturally and linguistically competent services," says Marilyn H. Gaston, M.D., Assistant Surgeon General and HRSA's Associate Administrator for Primary Care.

To achieve 100% access and zero health disparities, BPHC-supported programs continually search for ways to eliminate financial, geographic, or cultural barriers to health care.

The BPHC administers a range of activities including community health center (CHC) programs for targeted populations such as migrant farm workers, recent immigrants, the homeless, children, and public-housing residents. These programs recognize the intrinsic relationship between the physical and emotional health of individuals and the economic and social health of their neighborhoods and their communities.

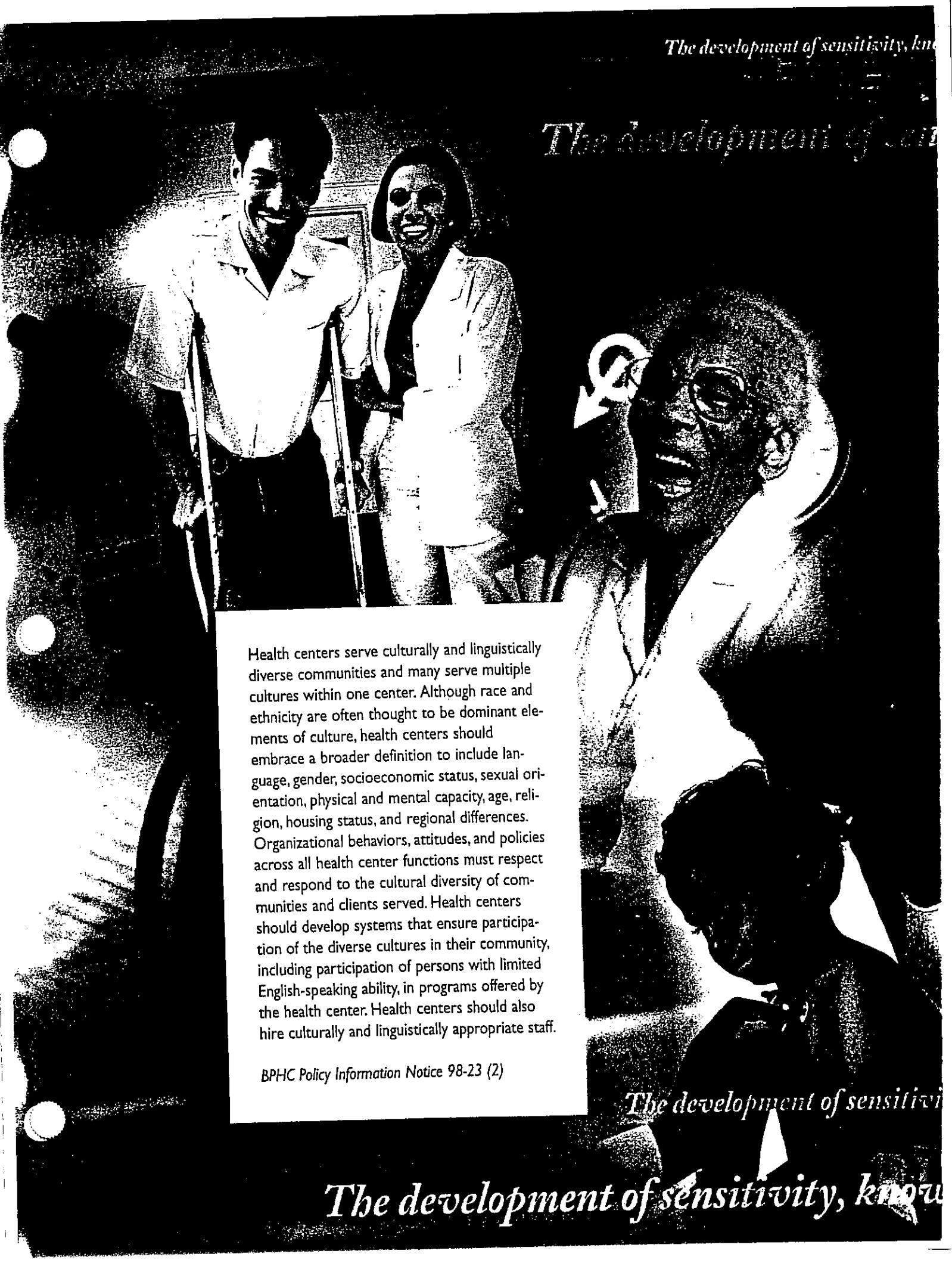
Culture shapes how people experience their world. Decisions on quality of work and family life and how to relate to others are determined in part by culture.

The development of sensitivity, knowledge, and skills around cultural issues have become priorities for BPHC-supported programs. "In light of current and projected demographic changes in the U.S. population," Gaston says, "we recognize the need to effectively respond to the health care needs and preferences of culturally and linguistically diverse groups. For example, faith-based organizations offer a powerful context to improve the health and well-being of culturally diverse communities, and we actively partner with faith-based groups.

"Our vision involves being part of a national network. We intend to transform the health care delivery system to exceed the expectations of those we serve," Gaston continues. For more than 30 years, primary health care systems have been in the forefront of delivering culturally competent services to uninsured and underserved consumers. Developing culturally competent programs is a process, an ongoing journey. The purpose of this report is to celebrate this journey by sharing stories of some of BPHC-funded programs' accomplishments.[2]

Culture shapes how people experience their world. Decisions on quality of work and family life and how to relate to others are determined in part by culture. Culture is the shared values, traditions, norms, customs, arts, history, folklore, and institutions of a group of people. Culture is a vital factor in both how clinicians deliver services and how patients respond to medical services and preventive interventions. Culture is determined not only by ethnicity but by factors such as geography, age, religion, gender, sexual orientation, and socioeconomic status.

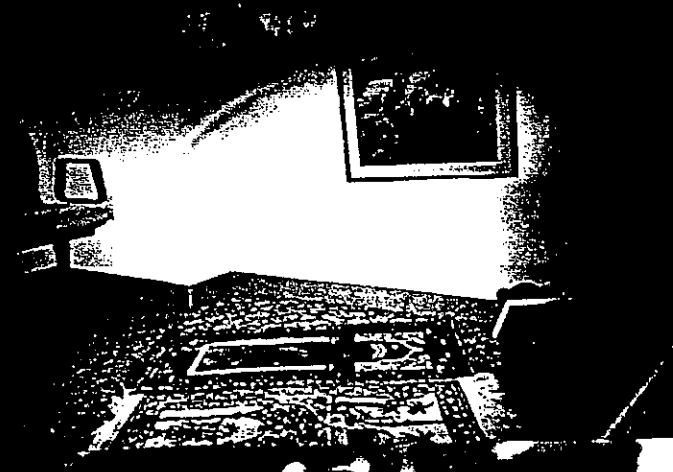
In a society as culturally diverse as the U.S., medical providers and others in health care delivery need the ability to communicate with diverse communities and the knowledge to understand culturally influenced health behaviors. This is part of the cultural competence illustrated by the examples within this report.



Health centers serve culturally and linguistically diverse communities and many serve multiple cultures within one center. Although race and ethnicity are often thought to be dominant elements of culture, health centers should embrace a broader definition to include language, gender, socioeconomic status, sexual orientation, physical and mental capacity, age, religion, housing status, and regional differences. Organizational behaviors, attitudes, and policies across all health center functions must respect and respond to the cultural diversity of communities and clients served. Health centers should develop systems that ensure participation of the diverse cultures in their community, including participation of persons with limited English-speaking ability, in programs offered by the health center. Health centers should also hire culturally and linguistically appropriate staff.

BPHC Policy Information Notice 98-23 (2)

In the center of the waiting room at the Park Ridge Family Health Center, for example, is a fish tank. It improved the atmosphere, officials thought, helped patients to relax, . . .



Five essential elements contribute to a system's, institution's or agency's ability to become more culturally competent. These include:

1. valuing diversity;
2. having the capacity for cultural self-assessment;
3. being conscious of the dynamics inherent when cultures interact;
4. having institutionalized cultural knowledge; and
5. having developed adaptations of service delivery reflecting an understanding of cultural diversity.

These five elements should be manifested at every level of an organization, including policy making, administration, and practice. Further, these elements should be reflected in the attitudes, structures, policies, and services of the organization.

National Center for Cultural Competence, Georgetown University Child Development Center

Gold fish are lucky

Gold fish are lucky

Gold fish are lucky

Chinese, Spanish, Arabic, and English are not sufficient, officials at Sunset Park Family Health Center Network knew when they replaced the signage in the network's six health centers. So they made sure there was space for another language.The signs were barely in place when this blank space had to be filled with directional and informational signs in Russian.

"A community health center must reflect the community it serves," says Jim Stiles, Sunset Park's Executive Director. For the south Brooklyn community, that means a continually changing reflection.

In the late 1980s, Sunset Park's patient base was largely Spanish speaking, mainly transplanted Puerto Ricans and recent immigrants from Mexico and Central America. Yet south Brooklyn was also becoming the new Chinatown. Crowded out of Manhattan's Chinese community, groups of low-income Asians were settling a subway ride away in the Sunset Park area.

When these Sunset Park residents needed medical attention, they were going back to Manhattan instead of coming into the neighborhood health center. Health center officials wanted to change that. "Our goal is to improve the well-being of the entire community," Stiles says. "We did a myriad of things that show that we want to be a provider for our neighborhood."

One of them was to make the neighborhood health facilities more welcoming and attractive to the patients. Chinese lettering went up on the facade of the Family Physician Health Center. The interior was also redesigned, incorporating Feng Sui. The center administration used these principles, based on belief in an energy flow that is affected by the physical environment, when making decisions about placement and color in the rooms.

In the center of the waiting room at the Park Ridge Family Health Center, for example, is a fish tank. It improved the atmosphere, officials thought, helped patients to relax, and provided a Feng Sui element of water and sound.

But when Chinese patients came to the center, which serves a wide ranging mix of ethnicities, they were uncomfortable with the tank. It held the wrong kind of fish—gold and yellow fish are needed for luck. So out went the tropicals and in went the gold fish. But there was something else wrong. The tank was sitting under a skylight, and the sun streaming in removed the color and the fortuity from the fish. A shade was installed to cover the skylight.

The same center attracted a substantial Arabic population, who had their own specific cultural needs. "As we served more and more Muslim patients, we noticed that when they needed to pray, they had to find a corner somewhere," says Molly McNees, a medical anthropologist on the staff at Sunset.

The roots of the Sunset community network go back to 1883 when its parent, the Lutheran Medical Center, formed to address the health care needs of an immigrant population that was then Scandinavian. While it has adapted to each wave of new immigrants into south Brooklyn, Christian chapels have traditionally been incorporated into the facilities. But how can they accommodate Christians and not Muslims? Space was cleared out in the Park Ridge center and, with input from the Arab community, an Islamic prayer room was added.

With these experiences in mind, Sunset formed a community partnership before it began designing its newest facility, the Caribbean-American Family Health Center in the Flatbush section of Brooklyn. Decisions on what the community wanted, they learned, had to be in the hands of the community.

"We understand about community health and primary care, but we don't understand about the Caribbean population," Stiles says. "We're good at designing exam rooms, but we need to have the community integrally involved with designing the center."

Sunset's partner, the Caribbean Women's Health Association, had input and final approval on the design and decoration of the center, which opened in September 1998, so that it would appeal to the people Sunset is committed to serve.

"What we have here is a patient-focused approach," Stiles says. "That is the driving force behind cultural competence."

Healing with culture

Healing ceremonies, vision quests, herbal remedies, and visits to a sweat lodge are among the medical services offered through the Indian Health Board of Minnesota. Through its Red Tail Training and Health Center in Minneapolis, the health board gives its patients access to a traditional healer and the holistic, spiritually oriented care their ancestors knew.

"Indian people are returning to their old spiritual ways," says Margaret Monroe, L.S.W., an Ojibway Indian and a counselor with the Indian Health Board of Minnesota.

Health centers in Hawai`i have the ability to link up with native healers in the community, referring patients to a lomi-lomi specialist for massage, a ho'oponopono practitioner for dispute resolution, or to an expert in herbal medicine. "These networks allow for continuity of care," says Hardy Spoehr, Executive Director of Papa Ola Lokahi, the umbrella organization for five health care systems throughout the Hawaiian Islands. The network's physicians routinely ask what herbal remedies the patient is using before prescribing a medication.

"A number of the doctors in the rural areas have been surprised at how effective the herbal remedies have been," Spoehr says. "They also understand that underneath the healing practices is an important spiritual base. You have to have a belief system that is compatible. Whether your origins are in Africa, Asia, Europe, the Americas, the Pacific, or the Caribbean, many of us still turn to our grandmothers and grandfathers for health care—in the form of herbs, roots, chicken soup, and hugs."

Indigenous people living in urban areas may be physically removed from their native culture. "Even for these urbanites who have left ancestral lifestyles behind, combining traditional healing with Western medicine is often effective, particularly with conditions such as alcoholism and depression," says Monroe of the Indian Health Board of Minnesota. The health board started the Red Tail Center a few years ago after a patient survey confirmed the need for traditional healing.

Smaller American Indian communities in rural areas have their own set of primary health care needs, says Gary Leva, former director of the Benewah Medical Center and Wellness Center in northern Idaho, owned and operated by the Coeur d'Alene Tribe. Leva and members of the Coeur d'Alene are concerned that the knowledge and traditions of the healers are not being passed along to new generations. Although

this spiritually based training usually occurs informally, the center began a formal process to keep the traditions alive.

"One Wednesday of every month we invite our tribal elders to teach us about the Coeur d'Alene way," Leva says. "Tribal members now have the opportunity to become health care professionals so that they may continue the tradition of serving their community through healing."

Walk down the hall

For many immigrant patients, a community health center is their first encounter with Western medical practices. Health centers such as International District Community Health Services (ICHS) in Seattle work from two directions. While helping patients to better understand the Western system, they need to incorporate some elements of nontraditional practices in their service delivery.

ICHS uncovered an unmet need with a patient survey two years ago. The majority Chinese patient population showed a strong interest in on-site acupuncture and herbal medicine.

Initially, the center ran into difficulty finding the funding for these services, which are not covered under Medicaid or most private plans, says Dorothy Wong, Executive Director of ICHS. So they have patients pay out-of-pocket for the services, according to an income-based sliding scale.

While avoiding stereotyping and the misapplication of scientific knowledge, culturally competent clinicians, whether learning about their patients' traditional methods or helping patients learn about Western methods, understand both their own world views and those of their patients.

With Southeast Asian refugees among its patient population, for example, ICHS practitioners were very aware of post-traumatic stress disorder. Providers also knew there could be a cultural resistance to treatment that involves sharing personal and emotional concerns with strangers.

"In some of the Asian cultures, there is a stigma attached to receiving mental health services," Wong says.

That's why ICHS provides mental health services on site rather than relying on outside referral. If a primary care provider finds that a patient needs treatment for post-traumatic stress or another psychologically based disorder, it's just a matter of walking down the hall with the patient.

"Patients know that they are going to talk with someone who can better understand what is happening," Wong says. "Then once they establish a relationship with the counselor, the stigma disappears."

Working with patients who are accustomed to non-Western medical treatment also involves knowledge and sensitivity to health behaviors, knowing when choices made by individuals and families are based on cultural forces.

This means, for example, understanding that charcoal markings on a Native American patient were applied by a tribal healer for protection. Or it could mean an awareness of potential risk factors, such as the use of mercury for both health and religious purposes in some Latin American cultures.

A physician in the Community Health Centers of South Dade County in Florida, for example, found that one of her patients, a diabetic, had stopped taking her insulin pills, using instead a tea made from a ground root, a remedy from her native country. Rather than insist the patient go back on the prescribed medicine, the physician told her to keep taking the tea and come back to test her blood sugar. If the level was down, she could continue with the herbal remedy.

"In the end, the patient went back on insulin. More importantly, she did so with a different attitude," says Hilda Bogue, R.N., M.S., Coordinator for Migrant Health at South Dade County. "The patient now thinks, 'What a good doctor that is, she understands and cares about me.'"

Communities heal

A group of women meets regularly at a Kansas City hotel conference center for lunch. They come for the food and gossip and socializing as well as the educational program. This is not, however, the usual women's club or professional association.

The Ladies' Lunch is part of the homeless outreach program offered by Swope Parkway Health Centers in Kansas City, Missouri. It started as an HIV/AIDS education effort targeted to prostitutes and continues with other health issues, as well as AIDS, as the meeting focus.

"The attendees set their own agenda," says E. Frank Ellis, Chairman of Swope Parkway, which operates seven health centers in Kansas and Missouri. "They talk about what they want to talk about. It was our way of providing culturally specific information to this target base," Ellis says. It's helped to bring more members of this community into the HIV clinic and into the primary care clinic.

"Community input at the planning and development stage is essential to the success of any program," Ellis says. Using both advisory boards and focus groups to guide program redesign and development, Swope Parkway has reached populations that often avoid traditional medical services.

Swope Parkway has 12 advisory boards that concentrate on target populations, and holds patient focus groups to formulate new programs and assess ongoing programs.

"The process is the answer. If you have the process in place, you can solve the problems," Ellis says. "This is democracy in action."

A 30-bed residential treatment facility for drug and alcohol addiction, for example, has shown good compliance and good outcomes in a community where past substance abuse treatment efforts failed. Before the new program was developed, focus groups examined why these past efforts had not been well received.

> "The process is the answer. If you have the process in place, you can solve the problems. This is democracy in action."
>
> *E. Frank Ellis, Chairman*
> *Swope Parkway*
> *Health Centers*

"The patients said the counselors were not culturally sensitive. They didn't understand their needs and talked down to them," Ellis says. "If you are in the business of providing services, you have to know the norms and values of the target population. Folks who have chemical dependencies have their own set of norms and values."

Community members also need to hold influential positions on boards of directors and on staff, a belief echoed in other community health centers across the country.

That is the case for health centers under Papa Ola Lokahi in Hawai'i. "Unless the community itself feels ownership for these programs, they don't succeed very well," says Papa Ola Lokahi's Spoehr.

A celebration of native culture is part of the drug and alcohol treatment programs under both Papa Ola Lokahi and Swope Parkway. At Swope Parkway, an Africentric element that worked well in the behavioral health component of their children's program was adapted for at-risk adults.

Weaving African artwork, music, activities, and history into the environment and programming helps to build self-esteem for both children and adults in these two programs, which are majority African American. "Cultural identity is extremely important," Ellis says.

"With cuts in both private and public funding for health care, well-designed and targeted prevention, education, and treatment programs become more critical," Ellis says. "When you identify a community, they have to feel you can relate to them on their terms and show them respect."

Radio waves

On the walls of the bright, open reception area of the Everglades Health Center, one of 11 delivery sites of the Community Health Centers of South Dade County, Florida, there are signs in three languages, Spanish, English, and Creole Haitian. The brochures and other educational materials are also multilingual.

Still, this does not help those who cannot read the brochures no matter what the language.

Like many community health centers, Everglades has literacy programs for its community. At the same time, everyone, regardless of reading skills, needs health education.

Toward this end, audio cassettes recorded by community health promoters are used. These are not just in Spanish, English, and Creole but in a Honduran dialect, three Mexican dialects, and two that are commonly spoken in Guatemala.

Audio cassettes providing information on subjects such as diabetes and prenatal care can be circulated among the migrant farm worker community.

Educational materials also have to capture the attention of their audience. This was one consideration when the South Dade center decided to broadcast its message over the radio waves.

Concerned over a rise in HIV cases among farm workers, the CHC officials developed a series of mini soap operas for the radio to educate their community on the importance of condom use. This message was too urgent to wait until people came into the health center. It had to go where they gathered, into the kitchens of their homes.

"You have to know the community to know which kinds of materials will hit them," says South Dade County CHC's Hilda Bogue. The farm workers may not own a television and may not read, but they do listen to the radio.

The information was presented in vignettes, using stories that can tug at the heart strings. "As Latin Americans, we like to cry a lot," says Bogue, who grew up in rural Mexico. As a follow-up, health educators went into homes and community centers to talk about the issues.

All services at the migrant health centers are provided with the underlying knowledge that many of these patients have left family and community behind to work in the U.S. "If they were back home they would have their mother and aunts and grandmother," says Bogue. "Now it's up to us to provide that support."

Knock on your neighbor's door

"Why don't you jog?" suggested a health educator to a group of hypertensive women in the Fruitvale neighborhood of Oakland, California.

"They said 'no way,'" says Cassandra Hernandez-Vives, Supervisor of Community Health Education for La Clinica de la Raza, a community health center that has served the largely Latino community since 1971.

Of course they wanted to improve their health—that's why they attended the education program. But jogging? The neighborhood was too dangerous, and, besides, who would be seen in public dressed like that? Aerobics? Again, no way! For one thing, they hated the music.

Then one of the promotores de la salud (center-trained community health promoters) had an idea. Who doesn't love to dance? A dance class with salsa music at the community center was somehow different than an aerobics class at a gym. They could just kick off their shoes and dance in street clothes if they wanted.

So La Clinica de la Raza staff members found a Latino dance and aerobics teacher to lead a twice-a-week dance class, put together a cooperative child care arrangement, and obtained grant money to pay the instructor.

That was four years ago. Now the classes are larger and held more often. Most importantly, the regular participants have lost weight and lowered their blood pressure.

"As a group, they've lost hundreds of pounds," Hernandez-Vives says. "The doctors were thrilled." The same group, plus some hypertensive males, produced a cookbook of heart healthy adaptations of the foods they love.

La Clinica is typical of BPHC-funded programs in that it finds ways for the community to take the lead in health education. In another Oakland neighborhood, for example, Asian Health Services found that women were not getting Pap smears and breast exams, says Linda Okahara, Community Service Director for Asian Health Services.

The patient population includes large numbers of Vietnamese, Laotians, Chinese, Filipino, and other ethnicities as well as Korean. The first initiative promoting early detection of cervical and breast cancer, however, focused on the Korean community so that cultural factors could be isolated.

First they surveyed patients to determine their beliefs, their practices, and the risk factors when it comes to testing for breast and cervical cancer. Then, at the suggestion of the Korean Advisory Board, they found a health educator at each of the Korean churches, someone who could understand and gain the trust of the Korean women. As a result, the health center is doing more mammograms and more Pap smears.

"While public health efforts need to be community directed, the center also has had to take the lead," Okahara says. "Public health issues like HIV/AIDS need to be addressed, although the community does not accept this as a health priority. Our mission is to be an advocate for the community and also to provide health services. There is a balance here that we need to strike, between what the community says and what we as public health advocates know we need to do."

Hernandez-Vives found similar resistance when La Clinica initiated an anti-smoking campaign. The response from the promotores was that, considering the high rate of substance abuse, tobacco use could not be a priority. But when it was pointed out that local stores were selling cigarettes to minors, the group rallied together, eventually setting up a sting operation to stop the practice.

"Community health educator programs can assure that the programs are culturally appropriate," Hernandez-Vives says. Plus, they bring health issues into the neighborhood every day in ways clinic personnel cannot. The promotores, for example, see the center's patients in church, in the Laundromat, while waiting in line at the grocery store, or picking up their children at school.

"They are catalysts for change," Hernandez-Vives says. "They can build coalitions by just knocking on their neighbor's door. That's what it's about."

Seven Domains of Cultural Competence

1 Values and attitudes
Promoting mutual respect . . . awareness of the varying degrees of acculturation . . . a client-centered perspective . . . acceptance that beliefs may influence a patient's response to health, illness, disease and death . . .

2 Communications styles
Sensitivity . . . awareness . . . knowledge . . . alternatives to written communication . . .

3 Community/consumer participation
Continuous, active involvement of community leaders and members . . . involved participants are invested participants, health outcomes improve . . .

4 Physical environment, materials, resources
Culturally and linguistically friendly interior design, pictures, posters, and artwork as well as magazines, brochures, audio, videos, films. . . literacy sensitive print information . . . congruent with the culture and the language . . .

5 Policies and procedures
Written policies, procedures, mission statements, goals, objectives incorporating linguistic and cultural principles . . . clinical protocols, orientation, community involvement, outreach. . . multicultural and multilingual staff reflecting the community . . .

6 Population-based clinical practice
Culturally skilled clinicians avoid misapplication of scientific knowledge . . . avoid stereotyping while appreciating the importance of culture . . . know their own world views . . . learn about populations . . . understand sociopolitical influences . . . practice appropriate intervention skills and strategies . . .

7 Training and professional development
Requiring training . . . nature of cultural competence training . . duration and frequency of professional development opportunities . . .

Knock on your neighbor's door

Crossing borders

Crossing borders

The four-year-old girl was to return to Mexico during the harvest season. Her family could not afford to keep her in Oregon while they worked. But the child had tuberculosis, probably contracted from her grandfather in Mexico, and sending her back to her native country meant compromising her condition.

TBNet, a program of the Migrant Clinicians Network, found a physician and a clinic in Mexico that could provide free continuing care for the four-year-old's TB. By the time the girl returned to her family in Oregon, the doctors in the county health department declared her free of tuberculosis.

Farm workers are six times more likely to develop TB than the general population, according to the Centers for Disease Control and Prevention. And while TB is on the decline in the general U.S. population, it is rising among historically underserved groups. For migrant workers, consistency in treatment is a major problem.

"The biggest issue for providers in migrant settlements is that they are dealing with a population that is mobile," says Adolfo Mata, director of the BPHC's Migrant Health Program. "In that one opportunity they have to see them, they have to bridge the gap, allay the fears, and develop trust."

The Migrant Clinicians Network had this, as well as other clinical and cultural challenges, in mind when it designed TBNet, a tracking network and data transfer program. It's a case management tool for front-line physicians helping patients complete adequate regimes for TB infection.

TB patients are given a medical record that can fit in a pocket or wallet and a toll-free number to call for information and referrals. The developers avoided using data files that rely on electronics, according to Deliana Garcia, director of binational research for the Austin, Texas-based association. "We tried to make it as low-tech as possible," Garcia says. "We have health centers that don't have fax machines."

The program has nearly 60 participating clinics in the U.S. and Mexico, with more being pulled in to aid workers with TB. It involves tracking patients through what has been an informal network.

"They'll say, 'We're going to do Christmas trees in Pennsylvania,'" Garcia says. "They may not have any relative or friend nearby and may not know where the health center is. People really do want to finish their treatment, but they need to leave to find more work."

Another program, Migrant Health Promotion (Promoviendo Vidas Saludables), based in Michigan, trains members of the migrant community as Camp Health Aides. The skills and the knowledge then can go everywhere the Camp Health Aides go. Whether they are in northern Illinois, southern Florida, western New Jersey, or central California, they can talk to their neighbors about prevention, about possible health problems, and about finding health care when they need it.

There's no recipe

Employees of the Mid-County Health Center Primary Care Division, part of the Multnomah County Health Department, Oregon, tell stories at their staff meetings.

They bring tales from the front, stories about their day-to-day cultural dilemmas, challenges and triumphs. They question their decisions and their policies and procedures from a cultural point of view.

"There is never a day when there isn't something we learn from each other. We blow it sometimes, but that's part of learning. We look at the underlying strengths in a situation rather than the problems," says Chareundi Van-Si, Program and Clinic Manager at Mid County.

Van-Si says he makes a strong effort to hire staff that reflect the clinic's population, which is about 80% foreign-born, mostly Russian, Cuban, Somalian, and Vietnamese with the remaining 20% primarily Native American and African American.

The culture awareness efforts are part of a system-wide program within the county health department. Van-Si says the program, based on annual goals, is continually evolving. It includes recruitment and hiring, training, and involving the multicultural staff in a continual assessment at the meetings and at staff retreats.

At the Benewah Medical Center and Wellness Center in northern Idaho, prospective new employees are interviewed by the entire Benewah staff. "They spend a whole day with us in order for the community fit to be right," says Gary Leva.

"There is no recipe for cultural competency. It's an ongoing evaluation," says Van-Si. "Basically, it's obtaining cultural information and then applying that knowledge. This awareness can take different approaches."

As the clients change, the clinic has to continually adapt and reevaluate the way things are done. Ten years ago, the patient population at the Mid-County Health Center Primary Care Division was primarily Asian. While some of these original clients are still coming in, mainly because they feel comfortable with the clinic staff, the Asian population is now a smaller percentage. More recently, there are many new patients from war-torn Southeastern Europe.

Adapting to each of these cultures requires a flexibility and a respect for other view points. "Cultural awareness allows you to see the entire picture," Van-Si says, "not just one channel."

"As a culturally competent manager, I am capable of interacting positively with people who do not look like, talk like, think like, believe like, act like, live like . . . me!"

Multnomah County Health Department, Oregon

"If you speak English, press 1."

The telephone recordings at community health centers from Miami to Seattle are, more likely than not, bilingual or multilingual. And when they request that the caller press 2 for Chinese or Spanish or whatever language the center's patient population may speak, the request is made in that language.

Conversations between patients and providers, however, are more complex and more personal than setting up an appointment or providing the hours and address of a clinic. BPHC guidelines advise that, whenever a significant percentage of the target community is more comfortable in a language other than English, skilled bilingual and bicultural interpreters are to be used.

This guideline applies to more and more BPHC-funded programs. A large and growing portion of the U.S. population have limited English-speaking proficiency. According to the U.S. Census Bureau, 14% of the nation's population speak a language other than English in their home, and this percentage is greater than 40% in some major cities. There are more than 6.7 million persons with limited or no English skills in the U.S., Census Bureau estimates show.

This demographic phenomena is occurring as traditional sources of health care funds are shrinking, limiting the ability to hire professional interpretation services and produce multilingual materials as the diversity in the languages spoken in the U.S. continues to grow. Health centers have shown creativity in finding ways to communicate with all of their patients.

In-house diversity

At International Community Health Services in Seattle, officials were proud of the two centers' ability to handle clientele with 14 different languages. Now they are finding that is not enough, says Executive Director Dorothy Wong.

The client base is from all parts of Asia, and now the centers also treat those who have recently arrived from African nations and Latin America. To accommodate these patients, Wong makes a strong effort to hire multilingual staff and supplements these services with the use of a multilingual phone service.

Relying on the friends and family members for interpretation services is avoided at the centers and programs. The relationship between the patient and interpreter could cloud or obstruct the communication. And these volunteers may not be aware of—and are not obligated to follow—any code of ethics.

A popular alternative is to hire staff members who interpret in addition to performing their job. When needed to interpret, these staff members stop filing medical records, taking blood, answering phones, or doing whatever they were hired to do in order to facilitate communication with a patient.

Maintaining interpreters for all languages and cultures in a single center is an ongoing priority for BPHC programs. "Obviously you can only staff so many languages," says Wong. "I become concerned when we do not have someone, say a Somalian staff member, or when our one person from that community leaves. You can lose a population if you are not connected to the community."

Understanding what you hear

Another concern is whether these interpreters are proficient in other aspects of medical interpretation, whether they understand the medical language and issues, and their role and responsibilities as a interpreter.

They also may not be aware of the cultural issues at play in the interaction. As Bruce M. Riegel of the HRSA Region 3 field office in Philadelphia says: "Just because you speak the language doesn't mean that you understand what they are saying."

Because of these concerns, most BPHC programs are supplying specialized training for everyone involved in the interpretation process. An example is Asian Health Services in Oakland, California, where "every effort is made to recruit bilingual staff members and give them the training they need," says Linda Okahara, the CHC's Community Services Director.

Staff interpreters receive 50 hours of training, which includes information on the appropriate role of an interpreter, the legal and ethical


Reception B
B
NOI ĐANG KY B
접수 B
ขอมถอมรับ - B
Free or Low Cost
Family Planning Services
Servicios de planificación
familiar gratis ó de bajo costo
免費提供低廉家庭計劃服務
Chương Trình Kế Hoạch Hóa Gia Đình
Miễn Phí hoặc Giảm Giá
"If you speak English, press
If you speak English, press 1.

issues, and the development of medical interpretation skills.

"There's an assumption that if you are bilingual you can interpret," Okahara says. "We also do team training with experienced interpreters and health care professionals. When it comes to cultural training, there is a continuum of knowledge. They need to understand that you can't just take this and generalize from it. You always need to avoid stereotyping a particular patient."

Medical and cultural context

The Cross-Cultural Health Care Program at Pacific Medical Center in Seattle serves as a nationwide clearinghouse for cultural issues in health care, including training health care providers and interpreters.

"Physicians and other providers who are involved in the interpretation experience also need to be trained if the process is going to be effective," says Bookda Geisar, M.S.W., Director of the Cross Cultural Health Care Program.

Trainers lead the providers to understand the role of culture by helping them to understand their culture. "They need to understand that medicine has its own set of values and a culture that is different from all others," Geisar says. And just as doctors cannot practice without addressing the cultural context, interpreters cannot practice without understanding the medical context.

The mission of BPHC programs calls for proficiency in the language and culture of the target population. Linguistic competence is also required under the Title VI of the Civil Rights Act, which bars exclusion based on

national origin from programs receiving federal funds.

Staff development is essential to both cultural and linguistic competence. At Sunset Park Family Health Network in Brooklyn, for example, officials identified an untapped population within their target community to recruit. Among a Chinese population who had recently immigrated to Brooklyn were experienced nurses who, educated in China, needed English language proficiency to update their skills and take the board examinations.

Sunset, part of the Lutheran Medical Center, already had English as a Second Language training in place. The Chinese nurses were brought into the ESL program and, at the same time, hired as nursing assistants. These efforts also helped Sunset to attract more of the neighborhood's Chinese population into their clinic.

Sunset makes efforts to hire staff from their community populations, largely for their language skills. "I can understand the culture, but unless I have people who are language proficient, I'm not doing my job," says Jim Stiles, Sunset's Executive Director.

Beyond staff

Using staff for interpretation purposes has its complications, however. When that staff member is assisting with a clinical situation, his or her job is not getting done. It puts a strain on the interpreter's coworkers, the interpreter, and the operation of the health facility.

Contracting with professional medical interpreters is an attractive option, but cost prohibits regular use of these professionals at most programs for the underserved. Staff interpreters are another option, but only if the population, the facility, and the budget call for such a position.

More often the use of bilingual staff members is supplemented with a professional interpretation service or with the use of telephone language lines. These are generally used as backups and for language skills that are not otherwise available.

Video interpretation services are also available at some centers, which allows the use of long-distance interpreters without giving up the face-to-face interaction that can help the interpreter understand the nuances of the situation. This involves expensive technology, and some patients have been uncomfortable with its use. Many of the recent Russian immigrants at the Mid-County Health Center in Oregon, for example, have been leery of committing private information to video tape, says Chareundi Van-Si, the center's clinic manager.

Any interpretation process needs to incorporate cultural interpretation into the interpretation of the language. Although linguistic and cultural competencies involve some specific skills, they are intrinsically connected.

"This is not a linear process. I do not believe that people can become truly linguistically competent without cultural competency," Geisar says. "Cultural competence means really listening and caring enough to find out the health beliefs of a community and of an individual patient."

References

1. Cross T, Bazron, B., Dennis, K., and Isaacs, M. *Toward a Culturally Competent System of Care, Volume 1.* Washington, D.C.: Georgetown University. 1989. Lavizzo-Mourey R., Mackenzie, E. "Cultural competence: Essential measurements of quality for managed care organizations." *Annals of Internal Medicine*,124: 919-921. 1996. "Cultural Competence: Addressing a Multicultural Society: The ABIM Report 1997-1998" and "Societal Forces Reshaping American Medicine: Implications for Internal Medicine and the Board." Philadelphia: The American Board of Internal Medicine. 1998.
2. Reports are based on site visits conducted June 1998 and telephone interviews conducted from August 1998 to February 1999.
3. Goode, T. *Promoting Cultural Diversity and Cultural Competence in Primary Health Care.* Washington, D.C.: Georgetown University, National Center for Cultural Competence. 1997.
4. Sue, S. "In Search of Cultural Competence in Psychotherapy and Counseling." *American Psychologist*, April 1998.

Additional references include:

Cohen, Elena, and Goode, Tawara D. *Rationale for Cultural Competence in Primary Health Care*, (Policy Brief 1). Georgetown University: National Center for Cultural Competence. 1999.

Department of Health and Human Services (DHHS). *Cultural Competence Series.* Monograph Series sponsored by the Bureau of Primary Health Care, Health Resources and Services Administration; Center for Substance Abuse Prevention (SAMHSA); and the Office of Minority Health, DHHS. 1992-1999.

Goode,Tawara D. *Getting Started: Planning, Implementing and Evaluating Culturally Competent Service Delivery Systems in Primary Health Care Settings, Implications for Policy Makers and Administrators.* Georgetown University: National Center for Cultural Competence. 1999.

Health Resources and Services Administration. *Health Care Rx: Access for All* (President's Initiative on Race Chart Book). 1998.

Photo credits:

Page 6. Waiting room and prayer room: Courtesy of Sunset Park Health Care Network, Lutheran Medical Center, Brooklyn, New York.

Page 14. Farmworkers in Temperance, Mich. Courtesy of David Smith Photography, Ann Arbor, and Migrant Health Promotion, Monroe, Mich.

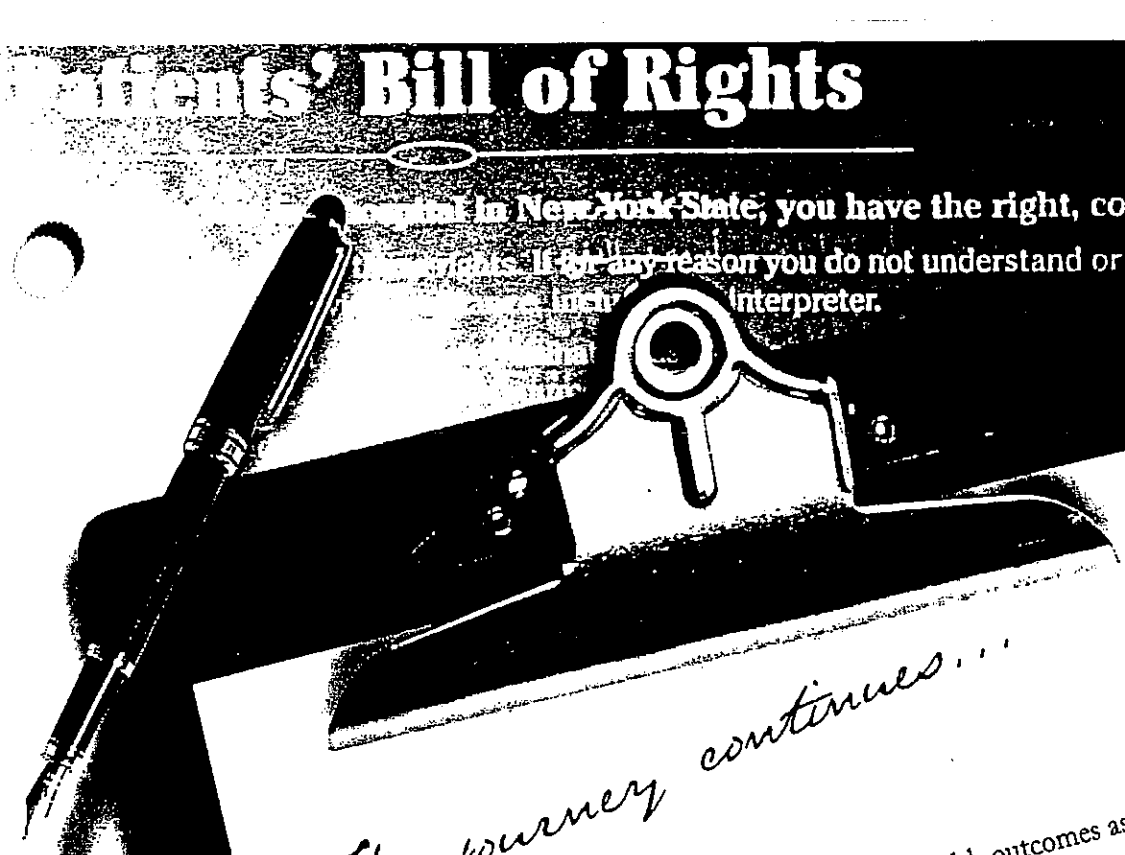
Page 17. Waiting room: International District Community Health Services, Seattle, Washington. Signage and clinical interpretation session: Asian Health Services, Oakland, California. Photos courtesy of Helen Kavanagh, Bureau of Primary Health Care, Health Resources and Services Administration.

Special thanks to Helen Kavanagh for her substantive contributions to the design, coordination, implementation, and monitoring of this project.

Patients' Bill of Rights

As a patient in New York State, you have the right, consistent with law, to:

...ceive information ... If for any reason you do not understand or ...ed help, the ... interpreter.



The journey continues...

Public health studies consistently show improved health outcomes as providers bridge cultural gaps between themselves and their patients.

1. Communication and understanding lead to improved diagnoses and treatment plans, and the improved patient satisfaction leads to greater compliance with those plans and fewer delays in seeking care.
2. Cultural competence allows the provider to obtain more specific and complete information to make an appropriate diagnosis.
3. Cultural competence facilitates the development of treatment plans that are followed by the patient and supported by the family.
4. Cultural competence reduces delays in seeking care and allows for improved use of health services.
5. Cultural competence enhances overall communication and the clinical interaction between the patient and provider.
6. Cultural competence enhances the compatibility between Western and traditional cultural health practices.
7. Cultural competence and building healthy communities through community development programs go hand-in-hand.

For more information . . .

Bureau of Primary Health Care
http://www.bphc.hrsa.dhhs.gov

Centers for Disease Control and Prevention
http://www.cdc.gov

DHHS Initiative to Eliminate Racial and Ethnic Disparities in Health
http://www.raceandhealth.hhs.gov

DIVERSITYRX
http://www.diversityrx.org

ETHNOMED
http://www.hslib.washington.edu/clinical/ethnomed/index.html

Health Care Financing Administration
http://www.hcfa.gov

HRSA
http://www.hrsa.gov

Indian Health Service
http://www.ihs.gov

National Center for Cultural Competence
http://www.dml.georgetown.edu/depts/pediatrics/gudc/cultural.html
1-800-788-2066

National Clearinghouse for Alcohol and Drug Information
http://www.health.org
1-800-729-6686

National Clearinghouse on Primary Health Care
1-800-400-2742

National Institutes of Health
http://www.nih.gov

Office of Civil Rights
http://www.hhs.gov.progorg/ocr/ocrhmpg.html

Office of Minority Health Resource Center
http://www.omhrc.gov
1-800-444-6472

Substance Abuse and Mental Health Services Administration
http://www.samhsa.gov

"It is good to have an end to journey towards;
but it is the journey that matters in the end."

Ursula K. LeGuin