The National Society for Social Work
Leadership in Health Care

CULTURAL COMPETENCE IN HEALTH CARE SOCIAL WORK PRACTICE

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PREFACE

The United States has long been a "melting pot" for immigrants arriving from around the world. The number of foreign-born in our country currently totals 31 million, an increase of nearly 60% since 1990. Foreign-born comprise a larger segment of the U.S. population than at any time in the past five decades and the growth is expected to continue. The implications are significant.

The increasing racial, ethnic, cultural and linguistic diversity of America, coupled with continuing disparities in the incidence of illness and death among people of color presents a challenge to the delivery of social and health care services. Culture affects individuals' experiences, perceptions, decisions and relationships to others. It also influences the manner in which individuals, families and communities with unique characteristics utilize health care systems. Even more fundamental to how services are utilized, culture impacts how services are envisioned and delivered.

Sensitivity to the values, norms, traditions, beliefs and histories of different client populations is crucial if services are to be appropriately accessed and utilized. Lack of knowledge, understanding and considerations regarding differing client populations may result in services that are not readily available, accessible and/or acceptable. Underutilization and misuse of health care carry potentially long-term implications for the health, safety and well-being of entire communities. Cultural awareness and respect shown by health care providers, on the other hand, contributes to not only sustained client health, but also the prospect of productive participation in American society.

Cultural competence has been defined as a set of cultural behaviors and attitudes integrated into the practice of a system, agency, or its professionals that enables them to work effectively in cross cultural situations (*HHS, 2005*). It is predicated on providers' knowledge of cultural differences and their impacts on attitudes and behaviors, sensitive and non-judgmental interactions and flexibility in responding to differing cultural contexts and circumstances. Beginning with *Bertera's* insightful review of the impact of culture and race on social work practice in health care, *Cultural Competence in Health Care Social Work Practice* affords readers a unique opportunity to gain from the insight of eleven accomplished professionals familiar with serving multi-cultural, racial and ethnic populations. *Neuman* and her colleagues put forward a transactional model for pursuing cultural competency, while *Trachtenberg* emphasizes training as a strategy for promoting changes in organizations with diverse patient populations and care issues. *Anderson and Miller* address the particular challenges of assisting clients with limited English proficiency, focusing on effective utilization of interpreter services. Readers can benefit from the experience and techniques of *Fairchild and Reyes* as they implemented a new health service for an immigrant population, while Simon offers insight into the historic and contemporary role played by settlement houses in providing culturally sensitive community care. Prevalent throughout the text is a strong endorsement for social work to take the lead in promoting the health, safety and well-being of needy populations through culturally competent professional practice. The long range implications of such effort are profound for individual clients, communities and the nation as a whole.

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US Department of Health and Human Services, Administration on Aging (2004). Achieving Cultural Competence: A Guidebook for Providers of Services to Older Americans and their Families. Retrieved from: http://www.aoa.gov/prof/adddiv/cultural/addiv_cult.asp

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CULTURAL COMPETENCE
IN
HEALTH CARE SOCIAL WORK PRACTICE

OVERALL DESCRIPTION:

This edition presents the concepts and techniques contributing to cultural competency in health care social work practice.

LEARNING OBJECTIVES:

Readers will be able to:

1) Identify and articulate the fundamental issues underlying the need for cultural competency in health care social work.

2) *Recognize the importance of health literacy and gain familiarity with a transactional model emphasizing health and cultural literacy in communication in health care systems.*

3) Develop an understanding of a process for health care organizations to institute, design, deliver and evaluate cultural competency training programs.

4) Develop familiarity with a model that combines medical interpreting training and cultural competency training for the purpose of increasing standards of language access.

5) *Understand the issues associated with implementing a program providing interpreters and translation services to patients and families with limited English proficiency.*

6) Recognize the role of settlement houses in providing culturally competent service to ethnically and linguistically diverse populations and identify steps toward bridging gaps in service delivery.

CULTURAL COMPETENCE IN HEALTH CARE

Elizabeth M. Bertera, PhD, LCSW-C, BCD

Abstract

America's foreign-born population stands at 31 million, an increase of 57 percent over 1990. The proportion of foreign-born is presently 11.1 percent, or one in nine. The increasingly dramatic change in the diversity of the US population make cultural competency imperative for health care providers. Health care social workers, however, continue to approach diagnosis and treatment of diverse populations from a "color-blind" and cultureless point of view. As a result, ethnic and racial differences between health care social workers and patients often go unrecognized, and social workers may treat their patients using norms used to diagnose and treat white middle-class patients. These norms are often diametrically opposed to the culture values, behaviors, and family structures of ethnic minorities. This article highlights the demographic shift in the US population, the social work role in health care and the steps necessary toward culturally competent practice with an increasingly diverse clientele.

Introduction

The concept of cultural competency is no longer a strange or foreign one to social work practitioners, educators and policy makers. The question is no longer one of "whether" to provide culturally competent services to clients and/or patients, but rather "how" can we do it best (*Asamoah, 1996*). In recent years, recognition for the need for cultural-diversity awareness and skill has grown in many settings, such as the workplace, human service, academic, schools and health care.

Cultural awareness coupled with the skills needed to interact successfully with people of diverse cultural backgrounds is called *diversity competence or cultural competence. Cultural / diversity competence* refers to the process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, religions and other diversity factors in a way that recognizes, affirms and values the worth of individuals, families and communities and protects and preserves the dignity of each (*NASW, 2000*). These terms imply the underlying qualities of awareness, understanding and skill (*Hogan-Garcia, 1999*). *Culture* refers to society's beliefs, values, lifestyles, and patterns of adaptive behaviors (*Wright, et al., 1983*). How one communicates health problems, present one's symptoms, when and to whom one goes for care, how long one remains in care, and how one evaluates the care received are all affected by one's cultural beliefs (*Kleinman, et al., 1978*). All ethnic/racial groups explain illness and disease differently and have their own strategies for prevention and treatment. Each society's interpretation of health and approaches to health care are influenced by the different elements of the culture: religion, spirituality, psychosocial relations among members; kinship patterns; group composition; social roles; language; values and beliefs, and attitudes about health, suffering and death (*Wright, et al., 1983*).

Culture impacts health literacy. *Health literacy* is defined here as the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions (*Tatzan and Parker, 2000*). Health literacy gains greater importance in the context of culture and in turn impacts cultural competency in the health care delivery.

In the United States, the health care delivery system is designed to serve a relatively homogeneous population, which is representative of the dominant white Anglo-Saxon culture and other mainstream cultures. Its language, customs and behaviors are unfamiliar to many ethnic/racial groups who arrive at the health care facility with one set of expectations and are confronted with another. Language is the framework in which the worldview of a culture is molded. In the United States, however, retention of one's language (i.e., lack of English proficiency) is closely tied to older age, low educational levels, low income, and immigrant status, all of which falsely suggest cultural inferiority. Moreover, lack of English proficiency undermines the ability of those of other cultures to receive health information, communicate with health providers, and identify available health services in their community for themselves and their children. It thus becomes a major barrier to health care utilization (*Molina & Aguirre, 1994*).

Communication problems are compounded by modern medicine's emphasis on the biological and clinical aspects of illness and health and their objective observation, measurement and clinical quantification. Diverse populations, however, have their own ways of describing illness and may even use definitions for stomach, heartburn, palpitation, and lungs that differ considerably from those used by medical experts. Accordingly, social workers, and other health care providers need to develop communications skills to "decode" their patients and clients' cultural language, which may be expressed nonverbally as well as verbally; such skills reduce misunderstandings and the risk of incorrect diagnoses, and help to develop and convey treatment plans that are compatible with the patient's reality (*Leman, 1984*).

Equally powerful barriers exist in the social and racial discrimination and cultural insensitivity that pervade the medical care system. Providers who are predominantly white and middle class tend to have no knowledge of diverse cultural groups in this society (*Gregory. 1978*). Social workers and health care providers need to have at least, general knowledge of the ethnic diversity in America.

Demographics and Ethnic Diversity in America

As we enter a new century, people of color—First Nations people, African Americans, Latinos, and Asian and Pacific Islanders---will comprise the largest segment in the United States. According to the 2000 U.S. Census (*US Census, 2000*), America's foreign-born population stands at 31 million, an increase of 57 percent over 1990. The proportion of foreign-born is 11.1 percent, or one in nine. Latin Americans and Asians were more than three-quarters of those newcomers. Latinos now outnumber African Americans making them the largest minority group (*Johnson & Rhodes, 2005*). This increase is largely due to high immigration and birth rates. Latinos now make up 13 percent of the population while African-Americans account for 12.7 percent.

Latinos

Latinos can be divided along lines of class, race and culture. The dominance of the Spanish language, however, as well as a growing political awareness, is a unifying force among Latinos. About 85 percent of Latinos in the United States speak Spanish (*Wright, 2002*); others speak Portuguese, French, Dutch, English and Native American languages such as Quechua, Mayan, Aymara, Guarani, and Creole dialects (*Castex, 1994*). *Hispanic* is the term that has been used by the federal government for this minority group since 1978. The term *Latino/a* is preferred by most academics. It is geographically more accurate because it refers to people from Central and South America rather than to people from Spain. It is more politically correct because it affirms Latinos' native pre-colonial identity. Neither Latino nor Hispanic is a racial classification. Latinos may identify themselves racially as white, Native American, black or a mix of two or more these. Latinos usually do not refer to themselves as Hispanics or Latinos, but rather identify with their country of origin (e.g., *Cubanos, Mejicanos, Puertoriquenos or Boricuas, Boliviano, Peruano, Argentino (Schafer, 2003*). The term *Chicano/a* is commonly used in the West and Southwest for Latinos of Mexican decent who were born in the United States. *La Raza* (which literally means "the people") connotes pride in pluralistic Spanish, Native American, and Mexican heritage (*Schafer, 2003*). The majority (58.5 percent) of Latinos trace their roots to Mexico. The next most numerous in terms of national origin are Puerto Ricans (9.6 percent) and Cubans (3.5 percent). These proportions are quite different in various parts of the United States. For example, persons of Cuban origin account for nearly 70 percent of all Latinos in the greater Miami area and 30 percent of Dade County's population (*Grenier & Perez, 1999*). The largest numbers of Latinos live in California and Texas where they make up almost a third of the population (*Wright, 2002*).

The majority of Latinos now living in the country have come in the last century, with most arriving since World War II. The pattern of migration for the major Latino groups differs considerably. The proximity of Mexico encourages immigrants to maintain strong cultural and social ties with their homeland. All Puerto Ricans are U.S. citizens and as such move back and forth freely between their island and cities in the US mainland. More so than other Latinos, they sustain multiple familial, economic, and social relations that span geographic borders (*Falicov, 1998*). Most Cuban Americans came to this country as refugees either as a result of the Cuban Revolution in 1959, during the program of "freedom flights" between 1965 and 1973, or as part of the Mariel boatlifts in 1980. They were cut off from their culture of origin for a long time, and are the most assimilated group of Latinos.

The church is the most important formal organization in the Latino community and more than four out of five remain committed to Catholicism. Most Latinos embrace *familism*, or pride and closeness with their families.

African Americans

African Americans are now the second largest minority group in the United States (ranked just below Hispanics/Latinos in the 2000 census). There are more blacks in the United States than in any African country except Nigeria (*Wright, 2002*). The ancestors of most African-Americans came to this country not as immigrants or refugees but as slaves. Scholars disagree about how much African culture survived the slave experience. However, there are clear vestiges of religion, language, folklore and music in the African American culture. Strong kinship bonds are the most enduring cultural strength that African Americans brought with them from Africa. African-Americans are more likely than whites to care for children and older adults in an extended family network. Data shows that grandparent caregivers are most commonly African American grandmothers (*Fuller, Thompson, Minkler, & Driver 1997*). After the family, religion is the most important aspect of their lives. African Americans are more likely than Whites to attend church, with most of them being members of Baptist or Methodist congregations (*Schaefer, 2003*).

Native Americans

Native Americans refers to those indigenous peoples who are native to the North American continent. The term includes Native American Indians and Alaskan Natives, while Hawaiians, and natives of Guam and Samoa, who are indigenous peoples, are covered under the Pacific Islander category). Although some Native Americans prefer the term *American Indian*, because of the many legitimate objections to its use, the former term will be used. Other terms sometimes used for this population include *First Americans* or *Original Americans* and *First Nations.* The federal Bureau of Indian Affairs defines a Native American as a person whose "blood quantum" (i.e. proportion of native blood) is at least one-fourth of Native Americans tend to identify as members of a nation first and then as a member of a tribe. The term *tribe* is usually a designation for a kin-based group without political institutions, while a *nation* has a political organization (*Johnson & Rhodes, 2005*).

Native Americans are a heterogeneous population. They vary in terms of their language, residence (rural, urban, reservation), level of acculturation and socioeconomic status. Even though there are differences among tribes, including the degree of acculturation to the mainstream, there are some common characteristics of most Native American cultures. For example, Native Americans, like many other minorities, take a more collective view of society than the mainstream culture. That includes emphasis on the importance of family, group primacy, and noncompetitiveness. Individual achievement is not valued. Other important Native American values include sharing, cooperation, noninterference, harmony with nature, a present—and cyclical rather than linear—orientation, and a deep respect for elders. Native Americans like other minorities are reasserting pride in their ancestry. This is reflected in a surge in self-identified membership (almost quadrupling between the 1960 and 1990 censuses) and interest in restoring native languages to daily use. Although it has meant the loss of better educated Indians from the reservations, the movement of Native Americans to urban areas has contributed to the development of intertribal networks. Powwows, featuring dancing, singing, and competitions, are organized events that celebrate Native American culture and educate the general public (*Johnson & Rhodes, 2005*).

Arab Americans

The firsts wave of Arab migration to the US began around 1875. There are about 3 million Arab Americans in the United States (*US Census, 2000*), with concentrations in metropolitan areas in or near Los Angeles, California, Detroit (Dearborn), New York (Brooklyn) and Chicago. On average Arab Americans are better educated and have higher median incomes than other Americans (*Suleiman, 1999*). The US Census Bureau does not use an Arab American classification. The government has considered Arab immigrants to be Asians or “other Asians”.

Arab Americans are one of the most rapidly growing minority groups in the United States and have experienced increased stress since September 11, 2001. Ali and Milstein (*2005*) found an increased need to counsel persons who were discriminated against. Arabs who are predominantly Muslims often rely on their “Imam” for counseling. Although Imams have little formal training in counseling, they are requested to assist congregants with mental health and social services issues. Imams need more support from mental health professional to fulfill a potentially vital role in improving access to services for minority Muslim communities. In studying health care needs among Arab-Americans living in California, Laffrey, Meleis et al (*1989*) found a predominance of upper respiratory infections, cardiovascular and hypertension as well as diabetes and family stress. They noted a general satisfaction with the medical care Arabs received and determined that the most important health service issues were health education, availability of Arab speaking health providers and referrals for appropriate treatment. Key informants were the clergy and community leaders. It is clear that Arab-Americans adhere to their cultural and religious beliefs and that health care providers must partner with religious leaders to provide access to health and social services.

Asian Americans and Pacific Islanders

Asian Americans are the fastest growing minority in the United States (*US Census, 2000*) and is the most internally diverse minority group representing a wide variety of religions and language. Asian Americans also experience diversity related to generational differences. Japanese Americans, for example, distinguish among *Issei* (first generation), the *Nisei* (second generation), the *Sansei* (third generation) and the *Yonsei* (fourth generation) and their experience in the United States. South Asians—people from India, Pakistan, Bangladesh and other South Asian countries—are culturally diverse as well. (*Schaefer, 2003*).

According to the U.S. Immigration and Naturalization Service (*INS, 1998*) immigration now occurs at a rate of about 7000,000 to 900,000 individuals per year—about 200,000 more people per year than the boom years of the 1880 through 1920s when 23.5 million immigrants came to America. Mexico, the Philippines, India, Vietnam, China and the Dominican Republic are the top six countries of émigrés to the United States. These recent immigrants are like the Germans, Italians, Slavs, Poles, Russians, and Greeks of a century ago, coming to this country with a multitude of cultures, and needs, and interacting with a society that is largely unprepared to understand many of their norms, behaviors, or beliefs (*Ewalt, 1999*).

In contrast to the first migration from Anglo-Saxon and European groups--who have successfully integrated with each other and become assimilated into the mainstream of American society and power, the new immigrants share the *color factor*. The color factor has been a barrier to African Americans, Latinos, Asian and Native Americans. The inability to "blend in" has made people of color targets for racism, discrimination and segregation, especially in the realm of health care (*Lum, 2000).*

Impact of Culture and Race on Social Work Practice in Health Care

It is imperative for social workers in health care settings to understand the impact of culture and race on social work practice. Despite discrete courses on diversity offered at many schools of social work, practicing health care social workers continue to approach diagnosis and treatment of diverse populations from a "color-blind" and cultureless point of view. As a result, ethnic and racial differences between health care social workers and patients go unrecognized, and social workers may treat their patients using the norms used to diagnose and treat white middle-class patients. Often these norms are diametrically opposed to the culture values, behaviors, and family structures of ethnic minorities (*Jacobs & Bowles, 1988*).

Health care social workers increasingly communicate with and treat patients with diverse cultural experiences. Patients from diverse race, ethnicity, gender, religion, age, physical and mental ability, as well as sexual orientation have their own unique experiences when they interface with the health care system. Coupled with the diversity that they bring to the interface with the health care system is the individual identity of the patients. Identity involves the personality and temperament of the patient, professional training, family and social roles, economic issues, beliefs about illness, treatment, death and dying, and expressions of spirituality. Health care social workers must be cognizant of how these factors impact their work and build the awareness, knowledge and skills necessary to work effectively with diverse populations. Such competence evolves by achieving the following:

- **Comfort** with the differences the patients brings to the health care setting.
- **Ability** to respond not only verbally but non-verbally to differences.
- **Flexibility** in thinking about differences, always keeping in checks our beliefs and stereotypes about differences.
- **Respect** and appreciation for the values and beliefs of those who are different.
- **Ability** to contain the stress caused by the encounter of differences.

The Importance of Language and Culture in Health Care Delivery

Language refers to the system of verbal communication that provides verbal categories assisting the perception of reality and communication among humans *Non-verbal communication* includes tone of voice, body stance, gestures, eye contact, facial expression, touching, time orientation. Non-verbal communication is a potent factor in giving rise to much misunderstanding between individuals that are different. Thus, language encompasses verbal as well as non-verbal communication. These are considered very important aspects of culture and ethnicity and as such should be kept in mind when working with diverse populations (*Hogan-Garcia, 1999*). Language or linguistic concordance then becomes paramount in health care settings where understanding of medical regimen and requirements of compliance can determine life or death.

Linguistic concordance is of utmost importance in the delivery of health care. *Linguistic concordance* refers to the process of matching individuals on the basis of their language as a way to achieve a higher degree of comfort in communicating health care information. The language gap can lead to delays or denial of service, costly invasive treatment of disease, unnecessary tests and/or procedures, mistakes in prescribing and using medication and deterrence in patient compliance of treatment.

Lack of language concordance is also a contributing factor in health care disparities among racial and ethnic minorities and in a lack of health insurance among immigrants and minorities. The Office for Civil Rights in the U.S. Department of Health and Human Services (HHS) states that language assistance should result in accurate and effective communication between provider and client, at no cost to the client (*Institute of Medicine, 2004 and HHS website:* http://www.hhs.gov/ocr/lep/revisedlep.html ***)***. Within the health and human services field, affected organizations include state and local health and welfare agencies, hospitals and clinics, managed care organizations, nursing homes, mental health centers, senior citizen centers, Head Start programs and contract ors. In three federal programs, federal agencies have approved reimbursement for language services to applicants and recipients with limited English proficiency. HHS, in a November 1999 brief (*Institute of Medicine, 2004 and HHS website:http://www.hhsgov /ocr/lep/revisedlep.html*), approved the use of federal Temporary Assistance for Needy Families (TANF) and state Maintenance-of-Effort (MOE) funds to provide language services.

In a 2000 letter to state Medicaid directors, the Centers for Medicaid and Medicare Services confirmed that federal matching funds for the State Children's Health Insurance Program (SCHIP) and Medicaid are available for state expenditures on interpretation and translation. At least nine states—Hawaii, Idaho, Maine, Massachusetts, Minnesota, Montana, New Hampshire, Utah and Washington—have obtained federal matching funds for these services (*Institute of Medicine, 2004*). Recently, other states have enacted legislation requiring interpreters in emergency departments and hospitals (Massachusetts and Rhode Island, respectively); a health care interpreters council (Oregon); and an office to address racial and ethnic disparities in health care, including language and cultural competency (New Jersey) (*Institute of Medicine, 2004*).

Concordance appears to have a positive impact on appropriate health care utilization and delivery. Patients from different multicultural groups may prefer to seek care from providers of their own race, ethnicity, or language group. Concordance can be obtained by securing staffing patterns that mirror the targeted service population. Incorporating a team that reflects the community dynamics can instill this assurance and assist in the development of culturally appropriate and acceptable health care. The literature particularly appears to support the benefits of language-concordance encounters, although further research should examine the differential impact of concordant encounters with those using interpreters (*Sawyer, et al., 1995*). In addition to language concordance, there is a need for integrating traditional healers practices into conventional medical encounters.

Cultural Competence in Health Care

In many diverse communities, health status, causes of diseases and health treatment may be defined or explained through traditional or folk models. These models may differ from conventional explanations in that illness could be caused by injuries, environmental factors, interpersonal conflicts, witchcraft, sorcery, spirits, or the result of violating cultural, religious, spiritual or traditional norms. Responses may differ in approach from that of conventional medicine, requiring the use of traditional healers. In some cultures, the use of traditional practices/healers may be the first and only approach to dealing with health related concerns, while some individuals may feel that an integration of both traditional and conventional approaches is beneficial. Cultural competence in health care requires an approach that emphasizes the latter. Understanding these alternative models may prove useful in uncovering potential barriers to service delivery while also providing the opportunity to integrate specific components into conventional practice (*US Dept. of Health and Human Services, 2004*)

Descriptive findings validate the need to integrate components of alternative systems and practices into conventional approaches to care if the delivery of culturally competent care is to be achieved. Findings from studies in this area suggests:

- Traditional healers are consulted for common medical conditions.
- Using alternative methods in conjunction with conventional methods can be an effective approach. (*US Dept. of Health and Human Services, 2004*)

Cultural and linguistic competence suggests ability by health care providers and health care organizations to understand and respond effectively to the cultural and linguistic needs brought by patients to the health care encounter. For example, an elderly Bosnian woman being admitted with terminal cancer may present the following challenges for health care staff and organizations: she and her family do not read, speak or understand English; her Muslim faith requires modesty during the physical examinations; and her family may have cultural reasons for not discussing end-of-life concerns or her impending death. A culturally and linguistically appropriate response could include interpreter staff; translated written materials; sensitive discussions about treatment consent and advance directive forms; clinical and support staff who know to ask about and negotiate cultural issues; appropriate food choices, and; other measures.

Provision of these types of services has the potential to improve patient outcomes and the efficiency and cost-effectiveness of health care delivery. Unfortunately, many health care providers feel they do not have clear guidance on how to prepare for or respond to these situations. As language about culturally and linguistically competent services proliferates in health policy discourse and practice, a common understanding of what this means is essential to assuring quality (*US Dept. of Health and Human Services, 2004*).

The Impact of Culture on Health Literacy

> *"Escorted by his teenage daughter, an elderly old Navajo grandfather was taken to the internal medicine clinic for an infection in his right leg. The granddaughter was fluent in English but had very limited Navajo speaking skills. Speaking English, the doctor informed the man that the infection in his leg would get worse if he did not take his medications as prescribed. The granddaughter could not translate the scientific concept of infection into Navajo language. The doctor asked one of the nurses for help, and although she tried as much as she could, she also was unsuccessful. The old man, becoming frustrated, just agreed that he understood everything that he had been told. He told the nurse he wanted to have a traditional ceremony performed for him within a couple of days, and for her to tell the doctor. The nurse translated this to the doctor, who restated the importance of taking the medicines. The grandfather insisted that he understood, but in fact because he felt that he did not understand the physician's explanation, he decided to go to a traditional medicine man instead. The medicine man helped him the best he could, but the grandfather's leg had to be amputated, which the doctor ascribed to noncompliance" (*Institute of Medicine, 2004*).*

This exert is a poignant example of the importance of linguistic and cultural competence in health care. As noted, *culture* is the shared ideas, meanings and values acquired by individuals as members of society. It is socially learned, not genetically transmitted, and often influences us unconsciously. Human beings learn through social culture such as books and television. Language is central to social life and mediates the acquisition of much cultural knowledge. Tens of millions of U.S. adults are unable to read complex texts, including many health-related materials. Arcane language and jargon that become second nature to doctors and nurses are inscrutable to many patients. These problems are exacerbated by language and cultural variation in our multi-cultural society (*Institute of Medicine, 2004*).

Differing cultural and educational background among patients and providers, as well as among those who create health information and those who use it, contribute to the problems with health literacy. The relationship between culture, patient-provider interaction and quality of care has been reviewed by Cooper & Rooter (*2002*). They found that linguistic differences were associated with differences in diagnoses, irrespective of symptomatology. African American patients frequently experience shorter physician-patient interactions and less patient-centered visits than Caucasian patients. For individuals whose native language is not English, issues of health literacy are compounded by the issues of language and the specialized vocabulary used to convey health information. According to the 2000 Census (*U.S. Bureau of the Census, 2000*), 11 million individuals in the U.S. indicate they either do not speak English well or do speak it at all. These individuals are linguistically isolated from any health information, which is for the most part in English. In addition, individuals with low English proficiency have varying levels of literacy and health literacy in their primary language. Individuals may be health literate in their own culture, but not in Western medicine's health system and style of health care (*Institute of Medicine, 2004*).

Evidence based research suggests the need to improve health literacy in diverse populations of older adults, rural communities. Hispanics, city employees with high blood pressure, nutrition education, African Americans, low-income pregnant women, and family planning clinics have showed significant improvement in health literacy (*Institute of Medicine, 2004*). Health care social workers need to familiarize themselves with this research and contribute to scholarly efforts in this area. In addition, social workers can incorporate in their psychosocial, assessment of health literacy using the Short Test of Functional Health Literacy in Adults (STOFHLA). This instrument developed by Chew et al., (*2004*) includes 16 health literacy screening questions on a 5-point Likert scale. The instrument has performed well to detect inadequate health literacy (*Chew et al, 2004*).

The Role of Social Work

Culturally competent practice is an increasing concern for all social workers engaging with the growing number of ethnic minority clients in the twenty-first century. Within the last couple of decades, social work, as well as other professional disciplines, has been concerned with the cultural appropriateness and effectiveness of services offered to ethnically diverse clients. It is crucial that social workers operating from an empowerment, strengths, and ecological framework, conduct assessments and implement interventions that are reflective of the client's cultural values and norms, congruent with their natural help-seeking behaviors and inclusive of indigenous solutions (*Fong & Furuto, 2001*).

Social work's involvement in health care has a long and honorable history. Rosen (*1974*) has suggested that the roots of social medicine, medicine that looks beyond the diseased body to the social antecedents and consequences of illness, are to be found in social work in health care. Since the early beginnings under Ida Cannon who initiated the social work department at Massachusetts General Hospital, dramatic changes have taken place in the health problems confronting the United States and other industrialized nations. Health care has become more complex, more specialized, and more fragmented and psychosocial problems often precede, accompany or follow illness. Health care social work is focused on these concerns as well as on issues of access and equity in health care (*Devore & Schlesinger, 1996*).

On Becoming Culturally Competent

Devore and Schelsinger (*1996*) developed a paradigm for ethnic-sensitive generalist social work practice that is congruent with the values of the profession. It includes layers of understanding to guide social workers in their practice in health care:

- **Values**

Social work *values* have profound importance for the social worker in health care who is constantly in a position to consider issues within a values framework. Advocating for health–related resources is a constant concern for social workers in health care and other settings. Ethical issues loom large as more and more people question the prolonging of life when the patient is comatose or has incurred major neurological damage. Social workers can guide discussions to maximize the interests of all parties. The social work value system serves practitioners working in this arena, always considering what is culturally appropriate and acceptable to their patients.

- **Self-awareness**

It is crucial that the professional remain self-disciplined and aware. The ability to be non-judgmental, to reach out, and make use of one's self-awareness to help others cope is essential. In health care, self-awareness is focused on understanding one's own feelings about physical disability, pain emotional turmoil, disfigurement, the changes in quality of life engendered by much illness and death itself. Also important is a sense of professional identity, for health-care social work is an interdisciplinary endeavor that inevitably challenges the practitioner's sense of identity and competence (*Devore & Schlesinger, 1996*).

- **The Ethnic Reality**

In situations involving health and illness, the ethnic reality forms an integral part of people's responses to their health problems and becomes an integral component of resolution. Health care practitioners need to be aware of patient's ethnicity, class, literacy level, family dynamics that are dictated by one's own ethnicity, and beliefs about illness and death.

- **The Route to the Social Worker**

The route to the social worker in health care settings is usually somewhat coercive. When people go to health care facilities, they do so because of significant physical or mental health problem. Many do not expect to see a social worker. In the hectic settings of most contemporary health care settings, the social worker is one other person who appears at the patient's bedside to ask questions or make suggestions. Health care social workers need to be aware of the fact that their patients have not come seeking them. Culturally appropriate case-finding techniques are necessary to effectively reach patients. (*Devore & Schlesinger, 1996*).

The culturally competent social worker in health care must be knowledgeable about the diverse responses to illness and must call on community-based caring networks in the effort to generate a more humane health care environment. This may include the inclusion of folk medicine and healers to partner with for the benefit of the patients. (*Devore & Schlesinger, 1996*).

Conclusion

Race and ethnicity intersect with health. Race and ethnicity matter when it comes to accessing and utilizing health care services. Continuing demographic shifts suggest minorities are becoming "majorities" in many areas of United States and that health care providers should anticipate working with diverse populations. It will be crucial that health care professionals recognize and understand cultural, ethnic, racial, religious and social differences manifest among these populations. Successful health care promotion and service use will hinge on the combination of providers' clinical competence and their cultural sensitivity during interactions with patients, families and other involved parties.

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The Spirit Catches You: A Transactional Model of Cultural Competence and Health Literacy

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Abstract

A transactional model is proposed for patient/provider relationships stressing mutual understanding of culture and beliefs regarding health. Illustrations from Fadiman's book *The Spirit Catches You and You Fall Down* are used to demonstrate "collisions of cultures" that occur when U.S. physicians care for a Hmong family. Failures in understanding and communication ultimately impede patient care and frustrate those individuals committed to the patient's well-being. By contrast, other examples are afforded of successful interventions by a culturally competent social worker seen as the child and family's sole advocate. A review of recent literature on cultural competence and health literacy is provided with recommendations for improving health care interactions and outcomes for diverse client populations.

Introduction

> I was watching them…and they looked very resolute…like you know, we are doing what we think is right. They weren't about to take any garbage. I felt they really cared for Lia, and they were doing the best, the absolute best they knew how as parents, to take care of the kid… I don't remember having a feeling of anger, but I remember having a little bit of a feeling of awe at how differently we looked at the world. It was very foreign to me that they had the ability to stand firm in the face of expert opinion… and that they seemed to accept things that to me were major catastrophes as part of the normal flow of life. For them, the crisis was the treatment, not the epilepsy. (*Fadiman, 1997, p. 53*).

Anne Fadiman's (*1997*) acclaimed book *The Spirit Catches You and You Fall Down: A Hmong Child, her American Doctors and the Collision of Two Cultures* explores the conflict between doctors in a small county hospital in Merced, California and a Hmong refugee family over the care of Lia Lee, a beautiful and favored child who develops uncontrollable epilepsy. The quote above, taken from the book, beautifully illustrates a physician's compassion as well as his bewilderment when faced with the challenge of providing care to a child from a culture that is totally foreign to him.

Recognizing the increasing diversity of the population, social work and other caring professions have advocated for developing culturally competent practitioners to serve individuals from various cultures, ethnicities, and backgrounds. More recently, health literacy, which the authors view as a dimension of culture, has been recognized as another important condition that potentially facilitates or impedes understanding of and compliance with health care services. Consequently, contemporary health care social work practice requires not only a set of culturally sensitive skills and attitudes but also a deeper understanding of the client system's health literacy including their beliefs, values, and practices pertaining to health and illness.

This chapter explores and critiques current definitions of health literacy within the context of culture and proposes a transactional model that stresses provider as well as patient cultural competency and health literacy. Throughout the chapter, illustrations from *The Spirit Catches You* will be used to demonstrate the collisions of cultures and mutual failings in understanding health beliefs and practices (i.e., health literacy) that occur between the members of the American health care system and the Hmong clan. These failures ultimately impede the care of Lia and frustrate individuals uniformly committed to her well-being. Other examples from Lia Lee's story will present the successful interventions of the social worker, who was seen as the child and family's sole advocate. Finally, recent literature on cultural competence and health literacy will be used to support our transactional model of cultural competence and health literacy and to offer recommendations for improving health care interactions and outcomes for diverse clients.

Cultural Competency

> But most patients accept the doctor's explanations as to why they get sick in the first place, and even if they resist the recommended treatment, they at least believe that their doctor has prescribed it in good faith and that it is not designed to hurt them. Doctors who deal with the Hmong cannot take this attitude for granted. (*Fadiman, 1997, p. 51*).

The federal Office of Minority Health (OMH) defines culturally and linguistically competent services (CLAS) as:

> …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. "Culture" refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. "Competence" implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities. (*OMH, 2001, p.5*).

This definition is consistent with NASW's Standards for Cultural Competence in Social Work Practice (*2000*), which conclude that competent cross cultural practice requires learning new patterns of behavior and effectively applying them in appropriate settings. Further, this learning is not static and requires frequent relearning and unlearning about diversity. This description of cultural competence as a continual work in progress necessitating a commitment to ongoing self-assessment and professional development permeates the NASW standards. Although our definitions of cultural competence continue to evolve, Niemeier (*2004*) has observed that common elements of cultural competence include:

- The adjustment or recognition of one's own culture in order to understand the culture of the patient;
- Appreciation and respect for cultural differences and similarities within, among and between groups;
- The development of a set of attitudes, behaviors, skills and policies that help providers work effectively in cross cultural situations.

Kleinman, Eisenberg, and Good (*1978*) stress the importance of negotiating discrepancies between patient and physician explanations of illness. The authors developed eight culturally sensitive assessment questions (also presented in Fadiman) that are now familiar from many discussions of cross-cultural medicine:

1. What do you call the problem?
2. What do you think caused the problem?
3. Why do you think it started when it did?
4. What do you think the sickness does? How does it work?
5. How severe is the sickness? Will it be a short course or a long course?
6. What kind of treatment do you think the patient should receive? What are the most important results you hope are received from this treatment?
7. What are the chief problems the sickness has caused?
8. What do you fear most from the sickness?

When presented with the Lees' answers to these questions, Lia's attending physicians were shocked. They had never thought to explore the disease, its treatments, and its meaning from the perspective of the family.

Health Literacy

The Institute of Medicine's (IOM) Committee on Health Literacy 2004 report (*Nielsen-Bohlman, Panzer, & Kindig, 2004*) defines health literacy as "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions" (*p.32*). We have taken an expansive view of health literacy and understand it to be directly influenced by the client system's culture – that is their world-view, beliefs about health and illness, and traditional healing practices**.** Further, we have extended this perspective on health literacy to include the interactional dynamics of the patient/provider relationship. That is to say that the medical care is at least as influenced and directed by the health literacy (world-view, beliefs, and values about health) of the physician, team, and health care system as it is the client's.

While the term health literacy was originally used to refer to reading and writing ability in health care contexts, the recent IOM report (*Nielsen-Bohlman, Panzer, & Kindig, 2004*) aims to expand understanding of health literacy skills to include cultural and conceptual knowledge, oral literacy, and numeracy skills in addition to print literacy skills. It is important to note that much of the exploration of health literacy so far has been in the medical and adult literacy fields, without participation of social work. Much work on the topic to date has focused on raising treatment compliance and puts the onus for improvement on the patient.

Although the IOM's definition is oriented to the individual's information-processing capacities related to health services and decision-making, the Committee also recognizes that additional social environment dimensions, including culture and the educational systems, impact health-literacy which, in turn, may impact health outcomes. However, when suggesting interventions to address cultural and social forces, the Committee's target appears to be the treatment-seeker. The problem is attributed to the patient, rather than more broadly recognizing that the health care system is embedded within its own unique culture that interfaces with and impacts the broader social systems and the treatment-seeker. There seems to be limited conceptual attention in the IOM report to the transactional linkages between and among relevant system-based constituencies and the health care system (e.g., community-based organizations, community cultural brokers, educational systems).

When the IOM report endorses an interactive approach among these entities, it does so with the purpose of distributing the responsibility for health literacy improvement among these various groups in order to reduce the burden shouldered by the health care system alone (*Nielsen-Bohlman, Panzer, & Kindig, 2004*). We would caution that if the intended outcome of a health literate patient is compliant behavior rather than a patient/provider relationship rooted in evolving understanding of each other's culture of healing, the likelihood of success and mutual satisfaction with care is diminished.

We believe there is a need for a more comprehensive health literacy model that attends to literacy equally across both patients and providers. Our transactional model of health literacy is designed to incorporate a more balanced contextual framework, suggesting that entering into the health care system is a cross-cultural experience. The type of experience and navigational abilities of patients and providers will be influenced by their cultural background, history, and expectations around health. Kleinman defines this as a "concern for the psychosocial and cultural facets that give illness context and meaning" (as cited in *Fadiman, 1997, p. 265*).

Examples of such cross-cultural perturbations as evidenced in "The Spirit Catches You" include beliefs about mind-body dualism, biases towards or against nontraditional medicine and health behaviors, orientation to control and coping, and understanding of and receptivity to Western science and its place in the healing process. It is precisely at the point of intersection between culture and health literacy that difficulties arise between the Lees and the health care system. And, as the Lia Lee story suggests, it is the mutual willingness to explore this intersection that leads to cultural understanding and mutual literacy within the health care system.

Consequently, there is a significant role for social work in promoting greater awareness of individual and cultural understandings of and preferences for health and health care, and of how these conditions interact with mainstream U.S. healthcare perspectives. It is particularly fitting for the profession of social work to advocate for a more equitable understanding of patient-provider communication and responsibility. The profession's skills, coupled with its knowledge of the social context, uniquely position social work to assume the critical function of facilitating mutual understanding between the patient and provider with respect to each other's culture, customs, health beliefs, and practices.

A Transactional Model of Health and Cultural Literacy

The recent literatures on cultural competence and health literacy have taken different approaches to looking at the same phenomenon: communication between health care providers and health care consumers. As suggested earlier, the literature on cultural competence has, in the main, focused on the cognitive processes (about culture) the provider brings to the communication, and the literature on health literacy has focused primarily on the cognitive processes (about health) that the consumer brings to the communication. Certainly, these literatures provide important conceptual tools for understanding communication in the health care system. For example, the literature on cultural competence would suggest that health care providers serving the Lee family should understand the traditional Hmong hierarchy and what that means for who has power to make decisions. The literature on health literacy would call attention to the limited English proficiency of the Lees and to their lack of knowledge of Western science. These are important factors in the sad health outcomes for Lia Lee, and indicate that a much more comprehensive approach is needed for facilitating mutual communication and understanding.

We propose that a transactional model of understanding communication in the health care system will help to keep the focus on the ultimate goal of such communication: the health and well-being of individuals, families, and communities. A transactional model assumes that any communication, and any health outcome, occurs from the confluence of a number of factors, all of which influence and are influenced by each other and evolve together (*Aldwin, 1994; Altman & Rogoff, 1987; Farmer, 1999*). The actions of one person can only be understood in the context of the actions of another person, and in the context of the circumstances in which the interaction occurs (*Churchman & Ginosar, 1999; Shonkoff & Phillips, 2000*). The health care communication, and a given health outcome, are events which take place within the context of a confluence of social institutions, including the health care institution. In this model, cultural competence and health literacy are two of many mutually influential factors. Four themes form the crux of a transactional model of health and cultural literacy:

- Theme 1: Health literacy is a form of cultural competence that is a mutual product of health care providers and health care consumers.
- Theme 2: Health and cultural literacy are influenced by and influence a number of personal and environmental factors.
- Theme 3: All these factors interact and affect each other.
- Theme 4: The confluence of factors produces change in health care communications, service access, service delivery, and health outcomes over time.

Each of these themes are discussed below as well as the implications for social work:

Theme 1: Health literacy is a form of cultural competence that is a mutual product of health care providers and health care consumers. To be culturally competent to work with the Lee family, the health care providers in Merced, California must understand the Hmong culture, but they also need to understand Western health care as a culture of its own, and most importantly, they must understand what happens at the intersection of these two cultures. Kleinman puts it this way: "if you can't see that your own culture has its own set of interests, emotions, and biases, how can you expect to deal successfully with someone else's culture?" (as cited in *Fadiman, 1997, p. 261*). In "The Spirit Catches You", only a few health care providers learned, through their interactions with the Hmong, to accommodate, with competence, to the intersection of cultures. Some of the physicians who provided care to Lia took the time to research the Hmong culture, but had trouble translating what they learned into guidelines for working with the Lee family. Jeanine Hilt, the child protective social worker in the story, is the best example of cultural accommodation over time. She was able to work as a "cultural broker" at the intersection of the two vastly different cultures, with progressively increasing competence.

Given their greater power and privilege, the larger responsibility for managing the intersection of cultures should fall to the health care system, but the Hmong also need some understanding of Western health culture, as well as their own culture as a distinct culture, and they need some competence at working at the intersection of the two. The Lee family showed some signs of learning to accommodate at the intersection of cultures; they learned to provide precise birth dates to health care providers even though their knowledge of their birth dates was no more precise than being born during the season in which rice stalks are stacked in their native Laos (*Fadiman, 1997, p. 7*). They continued to practice their traditional healing rituals but they also used selected aspects of Western medicine, a "little medicine and a little *neeb*" (*Fadiman, 1997, p. 100*).

It is a sad fact that if the accommodations on both sides had moved at a faster pace, there would have been a much more positive health outcome for Lia Lee. There is no doubt, however, that parties on both sides influenced and were influenced by the health and cultural literacy of the other. The relationships between the health providers and the Lee family were dynamic, not static.

Theme 2: Health and cultural literacy are influenced by and influence a number of personal and environmental factors. It is beyond the scope of this chapter to provide an exhaustive discussion of these factors, but we do want to identify some key personal as well as environmental factors. In the personal realm, the literatures on both cultural competence and health literacy emphasize the important role of cognition and information processing. This exclusive emphasis on cognition obscures the important role that emotions play in health communications and health outcomes.

For the health care consumer, challenges to health typically arouse strong emotions that may interfere with information processing (*Goleman, 2003*). Furthermore, disruptions in health can invoke a grief process that may involve a great deal of denial, which also interferes with information processing. Aspects of the grief process can masquerade as poor health literacy (*Kaplan & Sadock, 1998*). In addition, trust is an important factor in health communication. For the Lee family, there was some question about which sources of information regarding Lia's health condition were trustworthy. Their view of trustworthiness had been conditioned by generations of putting their faith in traditional healers and by the many upheavals they had undergone in their recent refugee experience.

Often, health care providers also must manage strong emotions in the health communication. Particularly they must manage the anger, frustration, and fear that are aroused by medical situations that turn very bad, as happened in the case of Lia Lee. Dr. Philp describes the strong emotions aroused by her work with Lia Lee:

> Ohhhhh, you would just get so frustrated! When she came to the emergency room in status, there would be sort of like a very precipitous peak of anger, but it was quickly followed by the fear of having to take care of a horribly sick child who it was very difficult to put an IV in. (*Fadiman, 1997, p. 57*).

Providers may also experience an erosion of trust in their own medical competencies and technologies and in their ability to control the disease process, if they feel they are being compromised by a family's "noncompliance." Such strong emotions on the part of health care providers are, no doubt, exacerbated by language and cultural differences; they also can impede cultural competence and undermine consumer trust.

Health care communications occur in an organizational context. In their native Laos, the Hmong were accustomed to shamanistic healers, *txiv neebs*, who spend hours in the sick person's home, attending to both body and spirit. When Lia became ill in the United States, however, her family rushed her to the Merced County Medical Center

(MCMC). MCMC is a rural county hospital that also serves as a teaching hospital for the Family Practice Residency at University of California at Davis. At MCMC, Lia was often treated, at least initially, by young residents who were tired after many hours on duty, and who often rushed in response to a clinic schedule that limited appointments to 15 minutes. Although the hospital's facilities are modern and clean, it has battled serious financial problems for decades, problems caused by the particular mix of payer arrangements:

> …only twenty percent are privately insured, with most of the rest receiving aid from California's Medi-Cal, Medicare, or Medically Indigent Adult programs, and a small (but to the hospital, costly) percentage neither insured nor covered by any federal or state program. (*Fadiman, 1997, p. 24*).

Because of these financial problems, there were no funds in the budget for language interpreters during the time of Lia Lee's health crisis. Although the hospital tried to compensate by hiring Hmong staff, there were usually no Hmong-speaking employees on duty during the night, when Lia's seizures often occurred. This led one MCMC physician to say that all he could do at such times was to "practice veterinary medicine" (*Fadiman, 1997, p. 25*).

Recently, the literature on culturally competent social work practice has noted that individual efforts will not go far unless the vision of culturally competent practice is encoded into the fabric of service systems. Several guidelines are applicable to health care organizations (see *Green, 1999; Hutchison, 2003b; Lum, 2003; Mor Barak, 2000*):

- Diversity should be reflected in all levels of the organization from clients to board of directors.

- The organization should conduct and support ongoing training and communication about diversity issues and multicultural communication.

- Staff should be actively engaged in learning about the community, its norms, values, and formal as well as informal resources. Particular attention should be paid to preferences for care giving and care receiving.

- Staff should be engaged in active outreach, attending local functions, giving talks at community organizations, etc., particularly when the targeted population is suspicious of Western bioscience.

- The staff should maintain working relationships with other organizations that serve the targeted population, such as ethnic agencies.

The organizational context of health care communications occurs in the larger context of a national health care institution. For the past three decades, a number of developments in U.S. health care have been influencing organizations and provider-consumer communication. Some of these trends have the potential for positive impact on the process of cultural and health literacy, but other trends have the potential to impede this process. Perhaps the most positive trend has been an increased emphasis on culture in the publications of physicians and other health care providers, including social work, and in the national training guidelines for a number of health care disciplines, including social work (see, e.g., *Like, Steiner, & Rubel, 1996*). Another trend with potential positive outcomes is the trend for mental health screening in primary care settings, a trend that recognizes the interconnectedness of physical and mental health (see, e.g., *Williams, Pignone, Rairez, & Stellato, 2002; Whooley & Simon, 2000*).

These potentially positive trends are countered by two major trends that may undermine sincere efforts to move toward mutual cultural competence and health literacy between providers and consumers. First, for three decades, the cost of health care as a proportion of the gross national product has been increasing at a rapid rate, and various experiments with cost containment have instituted gate-keeping mechanisms to limit access to health care providers, limit the time providers spend with consumers, and refuse payment for time health care providers spend in health education (*Nielsen-Bohlman, Panzer, & Kindig, 2004; Reinhardt, 2003*). These cost containment experiments contributed to the financial problems of MCMC as well as other health care organizations.

Currently, about 35% of the total health care costs in the United States are covered by private insurance, about 46% are covered by various governmental programs, and about 19% are paid out of consumers' pockets. Approximately 40 million people in the United States are without health insurance coverage at any given time, and as cost containment efforts continue, more and more people have shallow coverage with higher and higher deductibles and co-payments (*Reinhardt, 2003a*). Health care economist Uwe Reinhardt (*2003b*) predicts that these trends are evolving into a four-tier health care system where health care is severely rationed for uninsured low income people, partially rationed for people receiving health care paid by government, mildly rationed for the middle class by managed care cost containment methods, and free of rationing for the top 5-10% of the population. In the process of cost cutting, there is an increased expectation for consumers to be partners in their health care despite economic forces that hurry provider-consumer communications.

Increasing complexity is the second important trend in the health care institution. The IOM report on health literacy indicates that "all but the most sophisticated health policy experts have difficulty understanding the many facets of health and health care" (*Nielsen-Bohlman et al., 2004, p. 170*). Bioscience knowledge and bioscientific technology are becoming more and more sophisticated and beyond the reach of understanding of non-scientists. Health information can be gleaned from increasing numbers and types of sources, from health education, informal networks, print and electronic media including the internet, product marketing, as well as health care providers. In contrast to other western nations with a single payer system, there are over a thousand private insurance carriers in the United States, making for a very complicated system of payment (*Reinhardt, 2004*). Consumers must locate health information, evaluate its credibility, analyze risks and benefits, express health concerns clearly by describing symptoms, understand the complex mix of health financing, and advocate and appeal for remuneration for out-of-pocket expense or health care bills. This is becoming a challenge for even native, college-educated U.S. citizens.

These trends in the health care institution must be placed alongside trends in other social institutions. The increased complexity of the health care institution has not been met by increased general literacy in the educational institution (*Nielsen-Bohlman et al., 2004*). Trends in the family institution, with decreasing fertility and mass longevity, are resulting in a new family structure known as the beanpole family characterized by more generations but fewer members in each generation. This trend must be reconciled with the increasing responsibility to manage health care being assigned to consumers and their families, and with a trend toward greater rates of chronic disease. Practitioners must be prepared to work with families of various cultures, ethnicities, and structures in order to successfully involve them in caregiving activities that are required to meet the needs of their patients.

Theme 3: All these factors interact and affect each other. We hope this theme is becoming clear from the above discussion. Cognitions are affected by emotions, and emotions are affected by cognitions. The behaviors of health care providers and health consumers are affected by both cognitions and emotions. The behaviors of providers affect the behaviors of consumers and vice versa. Communications between providers and consumers are influenced by the organizational context, health care organizations are influenced by trends in the health care institution, and trends in the health care institution are influenced by trends in other social institutions, including the family institution, the economic institution, and the political institution.

Theme 4: The confluence of factors produces change in health care communications, service access, service delivery, and health outcomes over time. As multiple interconnected factors interact, they change each other and the whole. The health care system at MCMC and the Lee family became more competent at the intersection of cultures over time. No doubt, numerous examples of culture clashes between western medicine and immigrant families across the country influenced health care professional organizations to research and develop curriculum guidelines for culturally competent practice. No doubt, as well, health care economics has a tremendous influence on the nature of interactions between health care providers and consumers. Many factors are influencing health care economics, but what is currently needed is collective effort on the part of those professions that care about a more fair system of access to the health care institution.

Case Study of Social Work Intervention with the Lee Family

> Jeanine… was the only American I ever heard (the Lees) refer to by name. They called her Jenny. She responded by learning the names of all eight of Lia's siblings… Jeanine's empathy for the Lees may have been

> deepened by two factors: she understood what it was like to live with a chronic illness…and she admired the closeness of Hmong families. Unlike the MCMC nurses who considered Lia a burden and a pest, Jeanine thought she was a delightful child. (*Fadiman, 1997, p.113*)

In addition to providing an insightful glimpse into a culturally complex case, Fadiman's book presents an uncommon portrayal of social work that is decidedly positive and inspiring. The social worker, Jeanne Hilt, is not only culturally competent but also able to recognize and build upon the strengths of the family. She does not view Lia as a tiresome burden, but sees her as a "beautiful child" and ultimately comes to love her. She intuitively extends her approach to address the family's health literacy by exploring the family's world-view, understanding of the causes of illness, health beliefs and practices. What is most obvious about Ms. Hilt's interventions is her willingness to engage the family in their world. She attends Lia's birthday parties (even lighting the candles on the cake) as well as various healing rituals and sacrifices performed on Lia's behalf. She is invited to observe the family's final and perhaps most elaborate healing ritual for Lia demonstrating the extent of her cultural knowing and willingness to creatively bridge into the community. This nonjudgmental approach, natural curiosity, capacity to recognize and build upon the family's strengths, and willingness to go to the client's home provides the social worker with a unique a position of respect that results in an all too brief window of success with controlling Lia's seizures. The following discussion highlights some of the general strategies used by the social worker in the case.

Social Work Assessment

> Once I asked… why Merced's doctors never seemed to ask their Hmong patients how they treated their illness and he replied that because the Hmong dressed at least approximately in American clothes, had driver's licenses and shopped in supermarkets it never occurred to his colleagues – and only rarely to him – that they might practice esoteric healing arts…The only American who did ask and who therefore learned of the $1,000 amulets and at least some of the animal sacrifices was Jeanine Hilt (the social worker). Despite having been an official representative of the agency that had confiscated their daughter for foster care ...The family chose to categorize her not as Lia's abductor, but as her patron. (*Fadiman, 1997, p. 112*)

When the Lees initially sought medical help for their daughter, it seemed reasonable to assume that they would indeed accept the physician's explanation for the illness and trust that treatment provided was in her best interest. However, there was no basis for this assumption. The Lees concluded (along with others) that the treatment, rather than helping their daughter, worsened her condition. Although well meaning, a number of the health care providers in the book are baffled in their encounters with the Hmong. It is interesting to note that the physician of preference in the Hmong community in Merced is looked down upon and considered to be a physician of marginal skill by other doctors. His success is attributed to his willingness to respect Hmong preferences, including avoidance of intrusive interventions such as drawing blood and "cutting" and practicing with the attitude that ultimately "it's their body."

Beginning with a culturally competent assessment, Jeanine Hilt, the Lees' social worker, begins developing a "deep" understanding of their culture, family, and clan system. More than a decade before the IOM studied the concept of health literacy, she fully explores the family's health beliefs and practices and is permitted to observe a number of ritual healing activities including animal sacrifice conducted by a Hmong shaman. Ms. Hilt clearly went beyond a typical bio-psycho-social assessment to develop this deep understanding and respect for the family. The level of mutual respect was such that the family was able to continue to see the social worker as an ally, despite her involvement in removing their child from the home.

Social Work Interventions and Outcomes

> [In the opinion of the physician] Jeanine was a 'large pain in the ass' who nagged him for information about Lia or for prescriptions for medical equipment he considered unnecessary. (*Fadiman, 1997, p. 114*)

Although we aren't informed as to the details of Ms. Hilt's interventions, we know that her work involved numerous home visits and contacts with the various members of the family and clan. When roles and customs were unclear, Ms Hilt asked the parents for explanations and engaged clan leaders, thereby learning about the healing practices and belief systems of the Hmong. She acknowledged the family as experts in their world and its ethnic reality. In turn, she was granted access to their world and instructed in it. Granting the client system the position of "expert" directly conflicts with the culture of American medicine and the socialization of physicians who are trained to see themselves as experts in all aspects of health, and to dismiss those practices outside the Western tradition of their training.

Ms. Hilt was a community-based social worker and was not considered to be a member of the health care team itself. Her role did not formally include educating the physicians about Hmong culture or sharing her knowledge about the family with them. The perception of social work advocates such as Ms. Hilt as difficult, the physicians' ignorance about the family's beliefs about illness and treatment, the conflict between the providers and family, and the ultimate demise of Lia, confirm the need for an intervention strategy that promotes cultural understanding and health literacy for the providers as well as the patients. Both systems must understand each other's culture of healing, but in this case, the burden of understanding was placed entirely upon the family. In her most important goal…

> Jeanine had achieved a stunning success. Blood tests showed that Lia was maintaining a therapeutic level of Depakene. During her first four months at home she only had one seizure, her best record since infancy. (*Fadiman, 1997, pp. 115-116*).

Using a combination of intensive case management, patient education, and behavioral techniques, Ms. Hilt achieves a brief window of success with the family. This success was achieved due in large part to the social worker's willingness to forgo traditional, bureaucratic models of service provision and to go beyond the walls of the office to truly "start where the client is." In this case, working with the client necessitated creative home and community based outreach and interventions. Further, Ms. Hilt assumed a position of "not knowing" (*Anderson & Goolishian, 1992*), relegating the role of expert to the clients and permitting them to teach her about the family's cultural practices, beliefs, language, and life meanings. This was uncharted territory and not without risks for the worker and family. In less capable hands, this style of intervention could have led to potential values and boundary issues, worker burnout, and client dependency.

However, the approach taken by Ms. Hilt results in some success and for a few months, Lia receives her medication as directed and her seizures are lessened. Unfortunately, her condition dramatically worsens following a fall and probable head injury. Despite her total dependency and fragile condition, the family refuses to allow her to remain hospitalized. They take her home, where she lives for years in a vegetative state, living long beyond the expectations of her physicians. There is some resolution between the mother and Lia's physician, who had distanced himself from the case but continued to monitor her condition. For the physician, the last visit reported in the book

> …was very significant (and) emotional for me…it was hard for me to see Lia the way she was… and I was saying that I was sorry…but the mother showed me compassion…she understood…somehow…she thanked me. And she hugged me and I hugged her'" (*Fadiman, 1997, p. 213*).

Conclusions

With its historic sensitivity to client cultural beliefs and practices; theoretical orientation comprised of the strengths perspective, systems theory, and the ecological model; and its values base, social work has a critical role to play in providing care, training others, and promoting organizational change that is responsive to culturally diverse clients. Social work is particularly well-suited to educate and advocate on issues such as different cultural understandings of health and health treatment; beliefs and practices around death and dying; individual vs. collective health care decision-making; differing perceptions of the patient-provider relationship and communication; spirituality as it relates to health; and blending of traditional and modern health interventions by individuals from different cultural groups.

We offer broad recommendations for social work professionals working in the health care field that expand upon the general recommendations found in the IOM Committee on Health Literacy report. These recommendations advocate for a more explicit inclusion of an interactive and contextualized approach to health literacy efforts, with the fundamental belief that there is a need for advancing an aware and "empowered" health care environment, not just an empowered client navigating within the health care system. These recommendations reflect the transactional nature of our approach and target the client, provider, community, and organization in order to promote culturally competent and health literate care:

- Take a community wellness perspective where literacy is one component of a larger multi-faceted contextual framework that promotes health behavior and negotiated cultural understanding both internal and external to the health care system. Consider community health outcomes, in addition to individual health outcomes.

- Recognize the health care system as a cultural field, itself, with its own unique set of shared ideas, meanings, symbols, language, and values that shape health messages and information and contribute to barriers and access to health care services.

- Design, implement and evaluate curricula that prepare social work, allied health, and medical students for expansive culturally competent practice that acknowledges the cultural context, beliefs, and values of the health care community in the United States as well as those of the client system.

- Develop, implement, and evaluate complementary intervention strategies designed to promote cultural competence and health literacy in patients as well as providers of care.

- Engage and prepare leaders in the community to act as “cultural brokers” intervening to facilitate cultural understanding at both micro (case) level and macro (organization) levels.

- Identify the indicators or practice principles of health literate and culturally competent health care systems, to understand the transactional interface between and among different cultural groups and the health care system, and to examine the cultural transactional processes that are influential in facilitating positive health outcomes.

- Routinely conduct an environmental scan of the community within which the health care system is embedded; to include key community leaders from various represented populations on health care task forces charged with conducting this scan. Activities of such committees might include needs assessments oriented around health care access, quality, community-based outreach, health management, and provider trainings.

- Identify community access points. Integrate health management education into the community at these points, rather than waiting for the community to access the health care system (e.g., health fairs at local houses of worship, etc.).

- Develop an integrated data management system that is coordinated with the department of education, health and mental health departments, substance abuse services, and child welfare system. Utilize standardized set of measures for data collection across public agencies, and encourage ethical family-centered data sharing.

At the conclusion of *The Spirit Catches You*, Fadiman interviews Kleinman. Although he wrote his seminal piece on culture, illness, and care in 1978, perhaps we are now at the point of developing interventions that embody his approach and insights. Certainly his reflections suggest important directions for the future. When asked what he would do in a case such as this, Kleinman states:

> First get rid of the term compliance. It's a lousy term that implies hegemony rather than colloquy. Secondly, instead of looking at a model of coercion, look at a model of mediation. Finally, understand that even as strong of an influence Hmong culture is on this case, understand that the culture of biomedicine is equally powerful. If you can't see that your own culture has a set of interests, emotions and biases, how can you expect to deal successfully with someone else's culture? (*Fadiman, 1997, p. 261*).

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ORGANIZING AND DESIGNING CULTURE CHANGE: USING TRAINING AS A STRATEGY

Judith Trachtenberg, MSW, LCSW

Abstract

This chapter defines a process for health care organizations to institute, design, deliver and evaluate cultural competency training programs. It stresses that training, although important to growth and change, is only one aspect and describes it in the context of a whole change methodology. Specific examples are given from practice so that readers can utilize components best suited to their organizations' culture change needs. In addition, the role of social work in the organizational culture change process is discussed, highlighting potential change agent and training roles.

Introduction

Rapid and widely changing cultural demographics are affecting most parts of the United States. In significant numbers, people are coming to the United States with languages, ways of life, and cultural practices that are very different from one another. All aspects of life are impacted and while these changes often create a culturally rich environment in health care, there are also demands and challenges as caregivers, patients and their families face experiences new to them. At their simplest, these experiences involve language differences and misunderstandings. In the more complex arena of delivering health care, they often present a clash of cultures with differing beliefs about causes of illness, types of treatment, use of hospitals, roles of family and physician, beliefs about life and death, and the like.

This chapter discusses training to enable health care organizations to meet the evolving challenges of providing quality care to a diverse patient population by an increasingly diverse work force. The underpinnings for successful training in this arena must include three aspects: (1) a broad organizational commitment to change, (2) a focus on cultural competence, and (3) an interdisciplinary educational approach.

Organizational change is a circular process that involves full institutional assessment, action planning, interventions (which include, but are not limited to, classroom training) and follow-up evaluations. The evaluation will lead to reassessment, further planning and new interventions. The circularity of this approach is critical for an issue that is itself in constant flux. However, too often an intervention such as training is embraced as the primary tool for organizational change. "Training is necessary for change but not sufficient to make it happen" (*Gardenswartz and Rowe, 1998, p.195*). Its value is as a catalyst for the desired change and growth rather than the actual change vehicle. Indeed, organizational decision-makers often institute a training program in the absence of other processes and then wonder why the desired change has not occurred.

The terms *diversity* and *competence* are both widely used when talking about culture and both are used as platforms for cultural training. Cultural competence, however, is the preferred method for organizational change. *Diversity training* is the process of learning about the cultural differences and variations that are at play in health care (*Kamen, Wildemuth and Collins, 2003*). It provides a knowledge base but does not focus on self-awareness, attitude or behavior change. *Competence training*, on the other hand, is the process by which individuals and systems learn to *respond* "effectively and respectfully to peoples of all cultures… in a way that recognizes, affirms, and values the worth of individuals, families and communities and protects and preserves the dignity of each" (*NASW, 2000*). This is where the value lies for health care organizations, because positive outcomes are dependent upon cooperation and partnerships between patients and providers and among providers themselves. A definition of cultural competence specifically relating to health care systems is "… the ability of systems to provide care to patients with diverse values, beliefs, and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs" (*Betancourt, Green and Carrillo, 2002 p.2*). The aim of cultural competence training is to provide tools and skills that will "foster understanding, acceptance, and receptivity to others and to varying points of view" and to enable health care practitioners to become capable of delivering required and appropriate health care to all (*Kamen, et al., 2003 p.1*).

The third component of successful training is that it needs to be interdisciplinary and span the entire work force, rather than focusing on a specific work area. This concept is critical, firstly because all staff impact patient care. While certain groups of employees have much more "face time" with patients than others (e.g., nurses, physicians, social workers, rehabilitation therapists), any staff member's interaction can be significant to the patient and the clinical outcome. Cultural awareness and use of appropriate communication skills and attitudes are as important for the radiology technician, security guard, food deliverer, and housekeeper as they are to clinicians. Secondly, staffs also represent diverse cultures and need to learn ways to work compatibly with one another. Interdisciplinary training enables staff to learn from one another and, through shared experiences, to create the common understanding and respect critical to excellent patient care.

Cultural Competency: A Model for Organizational Change

This chapter describes a cultural competency change process utilizing an interdependent, four-phased approach:

1. Defining why cultural competency change needs to be addressed within one's setting and knowing how to make the case
2. Delineating key considerations in a successful cultural competency change process
3. Defining the competencies that need changing

4. Developing cross cultural training models for successful interpersonal change

Defining Why the Change

A critical first step in obtaining buy-in for systemic change is to show a compelling institutional need. All levels of the organization must be clear about why cultural competency is a concern and how it is linked to the institution's strategic vision, business strategies, and ability to carry out its mission. Below are seven generic reasons why cultural competence may emerge as an institutional issue:

- The institution is serving new populations who present new needs and practice issues.
- Language differences create barriers to the effective delivery of care.
- Changing employee demographics create communication challenges with patients and among employees.
- Problems in care delivery come to the attention of the Board of Directors or senior management via satisfaction surveys, regulators or complaints.
- Problems in care delivery or staff relations are recognized by staff members.
- A risk of losing patients and/or staff is heightened due to competition from other healthcare organizations.
- A need to improve the quality of care and decrease the potential for errors is an organizational imperative.

The need for change is often driven by outside forces. The way these forces are presented within a community and an organization is critical to how they will be received and utilized. They must be specific to an organization as, for example, where rapid increases in the Hispanic population created totally new challenges in the delivery of healthcare. In the Midwest, the Hispanic population grew 81% from 1990-2000 (as reported in this book by Anderson and Miller)**,** and in the state of North Carolina (in a chapter by Fairchild and Reyes) the figure for the same period was an amazing 730%. Such population changes mean new use of health care facilities and require organizations to examine how their practices may need to be altered.

Delineating Key Considerations for Successful Training

The following considerations are critical to the successful implementation and outcome of organizational cultural competency training: (1) anticipating trends and needs, (2) setting realistic goals, (3) creating a realistic timeline and budget for training, and (4) assuring senior management commitment.

- *Anticipating Trends and Needs*
  Initiation of a training program should be based on a proactive understanding of culture shifts within the community served by the organization. Although awareness of training needs is often based on situations, problems or complaints that have

already occurred, this is insufficient for program development. A program based on past data alone will soon be outdated. To meet evolving needs, it is important for the organization to assess population trends within its community and to understand their likely impact on the organization. Ideally, this is done with input from community members such as politicians and/or representatives from key community organizations. The chapters in this book by Fairchild et al. and Anderson et al. provide solid examples of an academic medical center and a community studying and using trends to build culturally competent work forces. Another example is Maimonides Medical Center, a large health care facility situated in a historically religious Jewish community in Brooklyn, New York. As the community began changing, the hospital used data and projected trends to plan ways to meet the diverse needs of growing Russian, Chinese, Hispanic and Indian communities. Changes included multi language availability 24/7, multi language patient educational materials, purposeful hiring for gender and cultural diversity, flexible visiting hours to accommodate the needs of the populations and ways for staff to share aspects of their cultures with one another.

- *Setting Realistic Goals*

  The goals for a cultural competency training program should clarify why change is needed and demonstrate understanding of the community's cultural demographic trends. Unfortunately, when these steps are bypassed, training is too often seen as a "quick fix" or a program developed for "problem employees" rather than for the growth of the organization as a whole. In many health care organizations this may occur because of institutional blinders created by a lack of diversity at the management level.

  Cultural competency training goals can be general, broad stroke thinking or focused on specific organizational imperatives. The following is an example of four general goals that can lead to significant individual and organizational benefits (*Gardenswarz and Rowe, 1998, p.195-196*):

  1. Enable [staff] to gain self awareness by learning about themselves
  2. "Encourage participants to engage in dialogue and explore complex issues that really have no right and wrong answers"
  3. "Build understanding that helps [staff] establish rapport" they can use when difficult situations are presented
  4. Create management staff with increased ability to resolve conflicts and problems, hold effective performance reviews, solicit feedback, conduct effective meetings and more.

- *Creating a Realistic Timeline and Budget*

  A realistic timeline includes assessment and preparation time, as well as course delivery time, evaluation, and follow-up. Follow-up is particularly important because institutional change does not happen overnight, especially where long-held beliefs and unconscious biases and practices are involved. Also, people translate new learning into behaviors over time. Training, therefore, cannot be a one-time venture;

it must include time in between sessions for participants to put into practice their new awareness and skills and then return to the classroom setting to build on their experiences through discussion and further training. Follow up sessions and group discussions must be built into the training program schedule for real change to occur and new behaviors to become a part of the everyday work environment.

- *Assuring Senior Management Commitment and Involvement*

  Mandates for organizational change must begin with a commitment from the top. The best outcomes for change programs involve senior management participation throughout the process: defining why change is needed, setting or sanctioning goals, approving the time and budget, and participating in the training program. It is this author's contention that the latter is particularly important for cultural competency training, though it is often neglected. Senior management's participation in training conveys the importance of the change expectations and process and is very meaningful to staff. Senior management will often have their own abbreviated training, but ideally, mid-level managers and supervisors should participate alongside staff, even if that staff is from areas other than their own. Employees, regardless of their title or level of responsibility, are equal in this undertaking; all bring unique thoughts, beliefs, life-long practices and blind spots related to culture and all should have the same level of commitment to growth and change.

  In addition, the organization's Board of Directors should be involved in some capacity. Often their community affiliations and contacts can be particularly helpful in the study phase of the endeavor and their involvement in some aspects of training makes an important statement to the institution and the community.

Defining the Competencies that Need Changing

The third phase in creating a successful training program is to define the competencies that are important and relevant to the institution's goals. Competencies are abilities, skills, or qualities that enable an individual or organization to function in a particular way. Both competencies and the desired outcomes they lead to are measurable. Below are three examples of cultural competencies.

The Commonwealth Report (*Betancourt, et al, 2002*) defines three big picture cultural competencies: organizational, systemic, and clinical. *Organizational competencies* refer to leadership competence, primarily through assuring the promotion and hiring of minorities into leadership positions. First and foremost, this competency requires organizational receptivity and the will to develop internal capacities for modeling, mentoring and precepting, all of which can be incorporated into a broad-based training program. *Systemic cultural* competencies ensure communication competence through the presence and use of on-site interpreters for patients with limited English proficiency (LEP) and the availability of patient/family written and verbal health information that incorporates appropriate levels of health literacy, language proficiency and cultural norms. *Clinical practice competencies* address both the employee's awareness of cultural issues and beliefs and ability to practice in a culturally sensitive way, regardless of position or title.

One way to look at clinical competencies is the "three-legged stool" approach described by Joseph Betancourt (*2001, p.561*). Three competencies - attitudes, knowledge and skills - represent the three legs of a stool. Each leg "plays a crucial role but is unable to support any weight when not fully supported by the other two (*Betancourt, 2001*). Also fitting into this schema is the conceptualization by Gardenswartz and Rowe (*1998*) who refer to three change areas that need to be addressed simultaneously: individual attitudes and beliefs, managerial-staff relationships, and organizational systems.

A final, more global approach to defining cultural competencies comes from the Columbia University Medical and Health Science Schools' Curriculum Development Committee, an interdisciplinary group that includes representation from the Columbia University School of Social Work. This group delineated five core competencies for "cultural and linguistically responsive services" listed below (*Meyer, et al., 2003 p. 12*).

- *Self Awareness*: Understanding one's own personal cultural values and beliefs and their impact on health and health care delivery.
- *Cross Cultural Knowledge*: Understanding how beliefs, cultures, and ethnic practices can influence health behaviors and health status. These cultural factors affect both the individual patient's/families' perspective as well as that of groups and populations.
- *Language Diversity*: Assuring the provision of information, referrals and services in the language appropriate to the patient. Included in this competency must be the provision of well-trained interpreters when needed.
- *Delivery of Care*: Assuring the provision of culturally and linguistically appropriate and competent services, programs and interventions that meet the needs of the "community of interest." This community, while usually starting with the patient seeking care, must be broad enough to capture the needs of the community in which the patient resides.
- *Advocacy*: Working for public agendas, policies and programs that promote and support culturally and linguistically sensitive and responsive services and include individuals, groups and agencies that reflect the diversity of the community being served.

Developing and Implementing Training Models

The fourth and final step in the model for organizational change is the development and implementation of a training program. It should be undertaken only after an organization has made a commitment to change and has studied, discussed, and come to consensus regarding its goals. This is the time to get specific about the training program's objectives and content. Much of the understanding and insights gained in the previous three steps will be incorporated into the training, most specifically the knowledge and behavioral clinical competencies the organization desires for its staff.

The *content* for virtually all examples of cultural change training include four basic objectives: (1) increased self awareness and appreciation of differences (2) knowledge of culturally diverse populations, especially those in one's own organization and community (3) recognition of how attitudes, values, and socio-cultural backgrounds can influence interactions and hence, health care delivery and (4) improvement in cross cultural communication skills (*Welch, 1998*).

The *process* for designing and implementing a training program is described by a model referred to as ADDIE, an acronym for helping to insure the inclusion of all key process steps.

A - analysis and assessment
D -design
D -development of program
I - implementation or delivery of the program
E - evaluation or measurement of the success and continued learning needs

The ***A**nalysis* has occurred if the first three phases of the change model presented here have been completed and the organization knows why change is needed, what its key considerations are, and the competencies it wants to initiate or improve. If done well, the analysis included input from a range of staff areas, perhaps by a multi-department/multi-staff level working group or by a management group that solicited staff input. A number of healthcare organizations now have standing Diversity Departments or Diversity Workgroups, acknowledging that cultural changes in their institutions and communities are important, ongoing and need to be managed proactively. Frequently, Social Work is very involved in these efforts because its strong systems, ethics, and clinical knowledge bases include cultural understanding.

The ***D**esign* segment focuses on (1) identifying, and having all parties agree upon, training objectives and measurable outcomes (2) clarifying such key training decisions as time lines, frequency and schedule of training program, resources needed, the budget, and (3) obtaining the final go ahead from senior leadership.

The ***D**evelopment* segment includes the curriculum content development, making decisions about teaching methods, creating teaching and participant workbooks and developing an institutional communication plan for the training program.

***I**mplementation* is the segment in which the final decisions about content and training methods are made. What content will be communicated by lecture, what by video and what by discussions, role-plays or small group work? How much time will be spent on each topic? These are the lesson plans, the training session plans that give the training its structure. Thought must be given to the participants and how they learn best. For most adults, learning does not result solely from the transmission of content, but rather from engaging participants in a process of self-inquiry and self reflection. Components of adult learning theory (*Knowles, 1972; Pfeffer and Sutton, 2000*) include setting a climate conducive for adults to learn and assuring that the learning is interactive and focused on application of the knowledge to the work to be done. Unfortunately, this implementation segment can be the one in which trainers invest most of their energy, often to the exclusion of the previous steps. Such misplaced use of time and energy results in many unsuccessful training programs. If segments other than implementation are incomplete, training may be “fun,” “a break from work” or “a change of pace” for the participants but will rarely achieve its goals.

As referenced above, the final segment, ***E****valuation,* actually starts during analysis and design, when training objectives and competencies are developed. Decisions are made regarding what will be measured, for example, teaching effectiveness, attitude changes and new skills applied in the work area. Evaluation is the only way to ascertain the impact of the training program, to learn whether behavioral changes occurred and to identify further learning needs. Evaluations that produce the most reliable and valid results are those that occur over time: at the end of training and again usually some four to six months later. This second evaluation point provides the opportunity to learn whether attitudes and behaviors have changed and how they have been incorporated into the work. This author recommends that evaluation tools (usually questionnaires or assessments by patients or supervisors) be designed with the assistance of organizational staff or outside consultants who are knowledgeable about evaluation. The resulting data is critical to the program. It will be reported to senior management and others within the organization to determine whether training funding was well spent, to inform next steps and to offer some understanding of why there may be differential results across the organization. Readers are especially referred to Donald Kirkpatrick’s classic book on evaluation (*Kirkpatrick, 1998***)**.

Training Program Models

The following two training program illustrations incorporate the ADDIE steps and can be adapted for use by most health care organizations.

OASIS

The first example is based on work initiated at NewYork Presbyterian Hospital, a major academic teaching hospital in New York City. It brought together training for two of the organization’s newly developed “Service Excellence” principles with an external cultural competence change program called OASIS (*Von Eron, 2004*). The training for the two principles, *Treat Everyone with Respect* and *Communicate Compassionately and Effectively*, was integrated into OASIS, the organization’s method for addressing the growing multicultural nature of the staff and patients.

A four hour program was designed to train all hospital employees over a one to two year period, beginning with department heads and front line supervisors. Using lectures, participant discussions, small group exercises and videos, OASIS teaches self-awareness and effective communications. Its congruent parts include the following:

O-Observable data
This process teaches how to identify and describe actual behavior and facts.

A-Awareness of assumptions, feelings and backgrounds
This process enables participants to become aware of the assumptions and beliefs we all have and how they often prevent us from seeing individuals or groups for who they are. Both the O and A steps use videos and vignettes to encourage participants to see the difference between "'I see' and 'I notice'" and "'I assume' or 'I feel'". Questions about the vignettes are asked, starting with "What is the situation/observable data?" and "How do you feel about it?"

S-Suspend response to judgment and inquire
This step teaches how to ask questions before evaluating or judging the other person's behavior. Staff members are taught how to use questions to clarify what the other person is thinking and reacting to and to understand why certain behaviors are occurring. (*See Appendix for questions*)

I-Identify common ground and shared purpose
This process teaches how to look at commonalities among treating staff and patient. What are the patient's needs? What are the staff's needs? What is common between them? How can the needs be satisfied? What are some of the options? The creator of OASIS defines four skills to help identify common ground, all of which are basic to social work education and practice. They include mirroring, empathizing, asking empowering questions, and taking the other person's perspective. Participants are taught to ask "what" and "how" rather than "why" which is more likely to create resistance and defensiveness. In this segment it becomes clear why understanding language differences and having well trained interpreters available is so critical.

S-Select behavior
This final step involves coming to a meeting of the minds:

- What am I going to do
- What are you going to do
- What is someone else going to do

This step involves asking, making offers, and making agreements that are meaningful for both parties. For example, "It sounds as if you and your mother are OK about meeting the home health aide? If so, we can have it scheduled for…and plan her discharge home for the next day. Is that OK?" OR "I'm hearing you say that you are ready to have the MRI. Am I right? I can schedule it for… and should have the test results and talk with you by Monday afternoon."

Because one four-hour program cannot enable participants to learn everything needed for cultural competence, it is important to involve managers first, as they will be in positions to work with staff so that both they and staff continue to grow. Here, evaluation is critical to learn what has been put into practice, what remains to be learned and what methods for continued growth need to be instituted.

A Medical Communications Model

The second example is a cross-culturally based training program originally designed for medical students and residents. The goal was to improve patient satisfaction and compliance with medical recommendations, and to emphasize communication and the physician-patient relationship as the primary means of reaching that goal (*Carrillo, Green and Betancourt, 1999*). This training program offers solid methods and learning processes. However, it raises an important issue - the use of the word "compliance." Compliance can imply an inequality, giving greater credence to the health care community's thinking and recommendations than to the beliefs, issues, needs, etc of the patient/family complex. "Partnership" is a more apt concept in which the health care team brings a set of knowledge and recommendations as does the patient/family. In the best mode, the patient and family are central members of the health care team.

This training model highlights an important concept in cultural competency education; its focus is "patient-based." The cross-cultural curriculum combines interviewing techniques and "socio-cultural and ethnographic tools of medical anthropology." It does not focus on ethnicity because it sees as a "stereotypic oversimplification" the idea that patients of similar cultures can be readily placed in cohorts of like characteristics, values, customs and responses to medical diagnoses and treatment recommendations (*Carrillo, et al, 1999, p.*829).

This five-part, eight-hour training, with some alteration, is an excellent framework for interdisciplinary training. It was developed specifically for health care and incorporates the understanding of illness and wellness as individual and cultural issues. The five modules of this training, summarized below, utilize lecture, large and small group discussions, readings, case studies and vignettes, and role-plays. The role-plays focus on learning how to ask open-ended questions and to fully hear the answers that are essential to understanding the patient-family constellation in relation to the diagnosis, illness and possible treatments.

1. Basic Concepts

Included in this module are definitions of culture and medical culture, understanding one's own cultural heritage and its influence on illness and healthcare, and a beginning look at attitudes that are fundamental to a successful cross-cultural interchange: "the triad of empathy, curiosity, and respect (*Carrillo, et al, 1999*)."

2. Core Cultural Issues

Defined as "situations, interactions, and behaviors that have potential for cross-cultural misunderstanding," (Carrillo, et al, 1999) they include such issues as authority, gender, sexuality, family, communication styles, meaning of bodily functions and physical contact. The learning pertains to how individuals and families respond to these core issues and how health care personnel can identify and understand the issues as they arise. Learning to ask questions as a means of discovery is a key component of this module.

3. Understanding the Meaning of Illness

Health care providers, patients and families all give meaning to illness. The key learning here is to understand the patient's perspective regarding what caused the illness, what s/he understands about its severity and prognosis, his/her expectation for treatment and how the illness and treatment is or will affect his or her life. Many factors determine answers to these questions including culture, economics, education, age, other social factors, and mental status. The key focus is learning how to explore these issues. Case vignettes and a set of questions originally developed by Kleinman, Eisenberg and Good (*1978*) form the interactive direction of this module (*See Appendix for questions*)

4. Determining the Patient's Social Context
This module designates four sets of social context that can give meaning to an illness: control over one's environment, changes in the environment, literacy and language, and social stressors and support systems. The significance of each will vary depending upon the patient, but each needs to be evaluated. Like a traditional review of systems and a traditional psycho-social-environmental evaluation they are used selectively in a focused, problem-oriented manner *(Carrillo, et al, 1999). (See Appendix for social context questions*)

5. Negotiating across Cultures
To this point, the learning modules have focused on *understanding* thoughts, ideas, beliefs, and perceptions on the part of the patient/family and health care personnel. This module shifts the focus to communicating, negotiating and coming to agreement about the plan of care. A six-phase process--relationship building, agenda setting, assessment, problem clarification, management and closure--forms the basis for this crucial step which is taught primarily through case vignettes and role-play. (*See Appendix for negotiation themes and issues*)

The five-module training is progressive, primarily case-based and taught over four distinct two-hour programs. The goal is clear: to improve patient care by opening up the discussion of issues that, if left unspoken, often interfere with health care. Implemented with physicians and medical students, the program has enabled participants to gain self-awareness while learning about the impediments of social and cultural misunderstanding.

Both OASIS and the physician based program offer the reader possibilities for developing and implementing an interdisciplinary cross-cultural training program, involving multiple staff levels and professions. They provide tools, techniques and methods that can be modified to address differing organizational needs and cultures.

The Role of Social Work

Other chapters in this book refer to the multifaceted role of social work in striving for a culturally competent organization. As a profession, we must look to develop new practice methods that incorporate and work with shifting populations. We can use our skills to both “advocate for and monitor whether clients are receiving culturally competent services” (*Pecukonis, Cornelius and Parrish, 2003*) and to lead or participate in culture change processes. Each health care system has its own culture, dictating, in part, the role for social work. Each reader, however, is encouraged to think broadly and creatively about social work involvement in institution-wide cultural change efforts.

- Can social work offer knowledge about the patient populations, how they are changing and what issues such changes are creating for the work force?
- What can social work bring to the table, perhaps along with human resources, about the changes in the work force, e.g., culture, language, education, background and the effect these changes are having on health care delivery and the ability of staff to work together?
- Can social work bring together the forces needed to initiate the effort to become a culturally competent organization?
- Can social work take the lead in such an initiative or influence the outcome by advocating an interactive participatory approach?
- What can social work contribute to the actual training? While we often have the knowledge and skill to teach, might the results be more effective with an interdisciplinary facilitation/teaching cadre, perhaps a trio of training staff, nursing and social work?

Conclusion

These are challenging and exciting times in relation to the many social and cultural groups utilizing health care institutions. Social work is rich in the roles we can play to influence organizational cultural competence. While our education helps us to be self aware, open, and non-judgmental in our practice, we are also human, and attaining self-awareness is a life long process. It is for each of us to analyze and evaluate, to propose change options, to think as a member of a broad interdisciplinary team, to listen carefully to institutional needs and individual concerns and, above all, to take the risks necessary to bring about productive organizational change.

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Appendix

Questions and themes from J. Emilio Carrillo
Cross –Cultural Primary Care: A Patient—Based Approach

Exploring the Meaning of the Illness
Explanatory Model
- What do you think has caused your problem? What do you call it?
- How do you think it started when it did?
- How doe s it affect your life?
- How severe/serious is it?
- What worries you the most?
- What kind of treatment do you think would work?

The patient's agenda
- How can I be most helpful to you?
- What is most important for you?

Illness behavior
- Have you seen anyone else about this problem other than a physician?
- Have you used non--medical remedies or treatments for your problem?
- Who advises you about your health?

Social Context "Review of Systems"
Control over the environment
- Is money a big problem in your life? Are you ever short of food or clothing?
- How do you keep track of appointments?
- Are you more concerned about how your health affects you right now or how it might affect you in the future?

Change in environment
- Where are you from?
- What made you decide to come to this country (city/town)?
- When did you come here?
- How have you found life here compared to life in your country (city/town)?
- What was health care like there as compared to here?

Social stressors and support network
- What is causing the most difficulty or stress in your life? How do you deal with it?
- Do you have friends or relatives whom you can call on for help? Who are they? Do they live close to you?
- Are you very involved in a religious or social group? Do you feel that God (or a high power) provides a strong source of support or guidance in your life?
- Literacy and language
- Do you have trouble reading your medication bottles or appointment slips?

- What language do you speak at home? Do you ever feel that you have difficulty communicating everything you want to say to the doctor? To me? To others here?

Negotiation Themes and Issues

Negotiating explanatory models

- Explore patient’s explanatory model
- Determine how the explanatory model differs from the biomedical model and how strongly the patient adheres to it.
- Describe the biomedical explanatory model in understandable terms, using as much of the patient’s terminology and conceptualization as necessary.
- Determine the patient’s degree of understanding and acceptance of the biomedical model as it is described.
- If conflict remains, reevaluate core cultural issues and social context (for example, bringing in the family members to maximize interpretation).

Negotiating for management options

- Describe specific management options (tests, treatments, or procedures) in understandable terms.
- Prioritize management options.
- Determine the patient’s priorities
- Present a reasonable management plan.
- Determine the patient’s level of acceptance of this plan (do not assume acceptance- inquire directly).
- If conflict remains, focus negotiation on higher/ more meaningful priorities for the patient.

TRAINING SOCIAL WORKERS AND INTERPRETERS IN HEALTH CARE SETTINGS TO ASSIST CLIENTS WITH LIMITED ENGLISH PROFICIENCY (LEP)

Catherine Anderson, M.A
Brandi Miller, B.A.

Abstract

Jewish Vocational Service of Kansas City, Missouri has developed a successful model of combining medical interpreting training and cultural competency training with the goal of raising the standard of language access in both the state of Missouri and Kansas. The Midwest region is attractive to newcomers, with an increase of 81% in the Latino population since 1990. The need for trained interpreters and trained social workers skilled in collaborating has risen dramatically with this growth in the newcomer population. The obstacles in providing training programs addressed in this article include: geographical distances; various kinds of interpreting curricula; filling the need for qualified interpreters; finding financial backing for training programs and the need for a clear Code of Ethics in interpreting. The primacy of quality interpreting in maintaining communication between the client and provider is also discussed with suggestions for how social workers can assist in conducting interpreting sessions that encourage professionalism.

Introduction

The rise of the Latino population and the overall expanding numbers of refugees in the Midwest has catalyzed health and human service providers to seek training opportunities in foreign language interpretation and cultural competency. A model developed by Jewish Vocational Service of Kansas City for training foreign language interpreters and their social work colleagues in the field is useful for communities straddling the urban/rural divide. This unique program provides both an intensive 40-hour training in medical/social services foreign language interpreting for beginning and intermediate interpreters and a 16-hour training in cultural competency for social workers and other staff who work directly with limited English proficient (LEP) communities. As trainers in both programs, we offer approaches useful in reaching rural and urban communities with increasing needs for language interpretation and cultural competency.

Changing Communities in the Midwest

> *The prairie, in all its expressions, is a massive, subtle place, with a long history of contradictions and misunderstanding. But it is worth*

> *the effort at comprehension. It is, after all, at the center of our national identity.* (*Fields, 1988*)

The lower Midwest and other traditionally homogenous regions of the country are witness to a quiet transformation in education, health care, social services and commerce as more newcomers are permanently resettling in the region. Latino immigrants and refugees from Somalia, the Sudan, countries of the Middle East, Asia and Eastern Europe (often secondary migrants) are adding to the cultural mix while revitalizing formerly neglected cities, towns and regions that make up this mostly rural region of the country. Within the last ten years, the Midwest has emerged as a national magnet for Latinos. According to census figures from 1990 –2000, the Midwest had an 81% increase in its Hispanic population, the largest of the four census regions from 1990 – 2000 (*Driever, 2003*).

New immigrants and refugees are resettling all over the Midwest for a very good reason: access to jobs in the meatpacking and service industries, in landscaping and construction, all areas of familiarity for this hard-working cohort. Kansas City, Missouri, as an example, is particularly attractive to Latinos because it has one of the oldest Mexican American communities in the Midwest. Many newcomers have family connections that date back for generations, and have worked to replenish a once stagnant core that has become, in recent years, a vibrant center for Latino culture. This strong presence of Mexican culture and community was the primary reason the Mexican Consulate relocated to Kansas City, Missouri from St. Louis in 2002. Census figures from 2000 document that within the whole Kansas City MO/KS Metropolitan Service Area, the Latino population grew to 92,910, representing a 105% increase in the population rate.

This population surge is experienced everyday by Kansas City hospitals attempting to provide interpreter services to limited-English proficient individuals. In 2000, for example, the Truman Medical Center provided 14,675 interpreter sessions – a number that by 2003, had increased 138% to 35,000 sessions. Truman employs a staff of 19 interpreters (eight full-time) who speak Spanish, Arabic, Somali, Farsi, Kurdish, Swahili, Vietnamese and Serbo-Croatian. Other Kansas City area hospitals note a similar leap in the need for interpreters' services. Kansas University Medical Center's interpreting department has tracked the increase interpreter requests over ten years, noting a rise from 260 in 1994 to over 17,000 in 2004. Since Children's Mercy Hospital began tracking interpreting sessions in the early 1990's, the number of hours contracted has increased tenfold. Additionally, the hospital records the number of various target languages served as having risen from 17 to 34. Refugees resettling in Kansas City come from a wide range of ethnicities, and speak languages not commonly represented historically in the Midwest; therefore, hospitals and social service agencies depend heavily on the expertise of community interpreters.

Towns and cities within the neighboring state of Kansas have also witnessed the growth of new immigrants and refugees who are slowly shaping a new landscape on the prairie. Dodge City, Garden City, Emporia, and Wichita, known also by their county affiliation: Ford, Finney, Lyon, and Sedgwick counties respectively, register astounding rates of growth among limited English proficient individuals. Sedgwick County experienced an increase of 119.5 percent in the immigrant population from 1990 to 2000 (*Grantmakers Concerned with Immigrants & Refugees, 2001*). Between 1990 and 2000, the foreign-born population in Kansas grew 114.4 percent, much higher than the national growth rate of 57.4 percent. Mexicans ranked as the largest population of newcomers, with 47 percent of all newcomers born in Mexico. Much further behind fell Vietnam with 6.8 percent and India with 3.7 percent (*Migration Policy Institute, 2004*).

As trainers who travel the roads to rural Kansas towns and within the metropolis of Kansas City, we have discovered an enthusiastic interest in the new cultures that are adding to this changing the state landscape. Training has become a fruitful meeting ground for health care providers, social workers, educators, as well as community interpreters to learn and teach each other about new communities. Our course in medical interpreting, *Bridging the Gap,* is designed to be taught over five days in English, with supplemental materials provided in the participant's target language. Most classes train about 15-25 people. Authored and licensed by Cross Cultural Health Care Program of Seattle Washington, the curriculum provides a solid background for beginning and intermediate interpreters and is easily adaptable to courses where more than one language pair is represented. Our training in Cultural Competency, geared toward staff who work with limited-English proficient (LEP) individuals, covers in two days how to work with an interpreter, LEP individuals' rights to an interpreter, and how to assess federally-funded programs for compliance with the Title VI Civil Rights law barring discrimination on the basis of national origin and language. A major part of the training is devoted to cultural practices and examining other cultures' perceptions of "good health." The principal goal is to raise the standard of health care and services for limited English proficient newcomers.

In Kansas, trainings are held in rural towns and regions, attracting attendees who would otherwise be unable to give up work and family time to travel and concentrate on learning new information and approaches. Participants indicate the time and effort committed to coming to their own region reinforces the value of their work as interpreters and community advocates. This practice serves as one of the underlying keys to a successful training program. Marketing of the trainings relies heavily on community networks: local newspapers, the area social rehabilitation services office, postings in colleges, schools, and churches. Word of mouth represents a particularly important marketing tool. At trainings, participants are encouraged to pass the word along about our next stop and provide us with new contacts. To illustrate, at our fall medical interpreting training in Emporia, Kansas, participants told us about supervisors, family members, coworkers and friends eager to take the training, but unable to enroll in previous classes. We quickly arranged another class in December, offered it to approximately fifteen people and scheduled it for the same location in Emporia. This flexibility builds credibility and guarantees as many people as possible receive training to accommodate the growing needs of a community.

The six trainings in medical interpreting and six in cultural competency receive support from the Kansas Department of Health and Environment, Office of Rural Health. Such support allows training to be made available without charge to rural communities and has proven critical to program success. The state of Kansas is to be commended for its assistance to new communities. *Bridging the Gap* is frequently offered at our office for a reduced rate to Kansas City Metro interpreters. The State of Missouri, through a health foundation, supports medical interpreting training by funding collaboration between our organization and the Language Metro Access Project of St. Louis, which also holds a *Bridging the Gap* license. This partnership seeks to provide training in rural regions that may have not previously received such attention. It is important to note that funding sources prefer supporting initiatives that emphasize collaboration and community investment. While funding is often elusive, continued promotion of interpreting is crucial as it has significant impacts on community response to health care needs and subsequent program use.

Constructing a Frame for Change

> *Communication is at the very heart of health care. A patient describes her symptoms, a doctor asks careful questions, a diagnosis in suggested, a treatment plan is negotiated. Listening and understanding what was said is the basis of the entire process. What happens, then, when provider and patient come from different cultures, speak different languages, and can't understand each other at all? (Roat, March 2000).*

Quality interpreting for limited-English proficient individuals is necessary to guarantee equal access to medical, social and legal services. As Cynthia Roat, principal author of *Bridging the Gap, A Basic Training for Medical Interpreters,* and nationally recognized trainer of medical interpreters, asserts above, communication is central to the doctor/patient relationship, and as the foundation for a more stable health care system that benefits all. Equally important is health care providers' understanding of the essential aspects of the patient's cultural background, and their knowledge of how to effectively work with interpreters. While Roat (*1999*) provides clear, shorthand rules for good interpretation, they are often difficult to implement in every health care setting:

1) Never use family or friends of the patient/client as interpreters;
2) Do not use untrained, non-interpreter staff;
3) Interpreters should relay the message of the patient and doctor accurately: do not omit, change, or add anything;
4) Interpreters are facilitators of communication, and should position themselves unobtrusively, and;
5) Interpreters respect a patient's privacy and confidentiality.

Too often these basic rules are skirted to save time or money and often providers do not understand how to work collaboratively with interpreters. Relying on providers' native- or second- language expertise, for example, may seem like an efficient solution at the time, but it often introduces or contributes to problems. While a person may be conversant in a second language, such as Spanish for example, they may not fully understand idiomatic usage of the language within various Spanish-speaking cultures. A case study cited by Ross (*2001*) highlights problems associated with not understanding the nuances of a patient's language usage. In one instance, a University of Massachusetts Memorial Medical Center physician stated he knew Spanish and did not need an interpreter. However, the report notes "….the physician failed to pick up that the patient had been fasting due to religious beliefs. The patient was in a much more serious sugar crisis than the physician was aware of. Luckily, the interpreter stayed in the room as a precaution" (*Ross, 2001, p.4*).

Even more subtle language nuances can slip by an interpreter's alert ear and contribute to a crisis. Our office recently heard the chilling story of an interpreter assisting with a woman who was about to receive an injection from a physician. The physician, holding the needle, asked her through the interpreter, if she had any allergies. The woman responded, "Only to needles." Both the interpreter and the physician smiled, thinking the woman was making a joke. Unfortunately, the woman was referring to a previous episode when she experienced an allergic reaction to medicine injected by *needle*!

Additional hazards exist when using family members as interpreters or unskilled bilingual staff as incidental interpreters. These practices, unfortunately, are still common in hospitals and clinics across the country. Our attention was drawn recently to the story of a child interpreting for her mother diagnosed with a "tumor." The child interpreted the word as "cancer" when, in fact, the mother simply had a benign tumor that needed removal. There is no substitute for thorough interpreter training that provides not only clear information on the roles of an interpreter, medical terminology and anatomy, but also provides interpreters with a code of ethics emphasizing best practices in this growing field.

The National Council on Interpreting in Health Care identifies five training models that extend beyond incidental, on-the-job training:

1) academic training programs;
2) bilingual health care employee training programs;
3) community training programs;
4) intensive training of at least 40 hours, and;
5) agency training programs (*NCIHC, 2002*).

The medical interpreter-training curriculum, *Bridging the Gap*, designed and promoted by the Cross Cultural Health Care Program of Seattle, Washington, is a combination of models three and four identified above. *Bridging the Gap* was developed as a response to the lack of available training for medical interpreters and is targeted to the community beginning and intermediate interpreter. A five-day, forty-hour course that requires a pre-test and post-test before a certificate of completion is awarded, *Bridging the Gap* is widely recognized in the United States. The curriculum originally sought to improve access to quality health care by breaking down language barriers faced by various immigrant and refugee communities. This comprehensive material orients interpreters to the various techniques that facilitate communication between English speaking providers and limited English-speaking service consumers. Although NCIHC has noted that some topics may be omitted or covered insufficiently, and the qualifications of the instructor may vary (*NCIHC, 2002, p.8*), the curriculum has received wide-spread praise from communities employing the model. Instructors in the curriculum must attend a five-day “train the trainers” session offered by the Cross Cultural Health Care Program and be evaluated by CCHCP before they can train. The organization sponsoring the instructor holds the instructional license for this curriculum and thereby controls consistency in the standard of instruction.

The main goal at JVS is to utilize the five-day *Bridging the Gap* course to train “grassroots” interpreters so that they can perform with expertise and confidence. The curriculum addresses all aspects of what it takes to become an efficient and effective interpreter in the medical or social service arena. It begins by establishing a foundation of basic interpreting skills in its introduction of different interpreter roles. It further offers an in-depth discussion of the interpreter’s code of ethics. These two areas, the roles and the code of ethics, serve as a fundamental basis for responding to questions that arise throughout the training. During this section, the various modes of interpreting are covered, including how to manage the flow of an interpreting session and techniques for memory development. The curriculum progresses into a third day devoted specifically to medical interpreters. Ample discussion is assured of the United States health care system and how the system often proves difficult to navigate for new migrants. Emphasis is placed on terminology building in the respective languages, while lesions are provided in anatomy, physiology, common problems and medical procedures.

A unique aspect of *Bridging the Gap* is the attention to culture and communication as an integral part of developing cultural competency. To that end, the fourth day is dedicated to analyzing culture and its impact on interpreting. The goal is to help interpreters not only serve as a linguistic bridge, but also as cultural brokers in times of need. Students learn about the variety of culture-bound illnesses and diseases, as well as of the different traditional healers and forms of healing from their culturally diverse peers in the classroom. By helping participants recognize basic cultural frameworks and the many differences between individuals within the same community, the course provides a fluid idea of the impact culture can have on an interaction, particularly when the primary participants do not share a common language.

While the majority of participants in our medical interpreting training are Spanish-speaking, many share diverse cultural, social and economic backgrounds and benefit by examining these differences within their own communities. Classes typically include speakers of other languages such as Vietnamese, Chinese, Arabic, Somali or Sudanese. One rural Kansas class recently instructed interpreters from Puerto Rico, Mexico, Ecuador, Paraguay, Guatemala, Ukraine and Sudan. Such variety contributes significantly to training as each person shares his or her own individual experiences and sensitizes students to the impacts of cultural differences. Participants learn not only from those of other cultures, but also from those who they identified as one of their own. As each shares his or her cultural experience, younger participants learn about different traditions that have taken place within their culture for years, and older individuals become aware of the newest trends of healing. This participatory approach to learning encourages leadership development because it invites individual interpreters to examine their own cultural sources of healing in the context of aiding their specific community.

Significant overlap appears in the forms of treatment and beliefs that span from Asia to Africa to the Americas. Participants speak of traditional healers from Vietnam to Mexico who perform similar ceremonies to cure the inflicted of disease or illness. Many forms of healing, ranging from use of pendants or amulets to ward off spirits to the utilization of herbs and plants found in the surrounding environment, appear very much alike as together we "travel" the world through our fellow participants. Such information is carefully recorded, and with participants' permission, used to explain cultural practices among communities in the cultural competency trainings provided throughout the state.

The fifth and final training day focuses on enhancing communication skills, professionalism and self-care. It examines the controversial and hard to maneuver role of the interpreter as advocate. Participants take a final examination consisting of fifty multiple-choice questions. Training concludes with informal networking among group participants based on their desire to keep in touch, as well as share resources available in varying regions of the state.

The two-day training in cultural competency focuses on the power of communication between cultures and the impact of culture on the healing process. Geared to social workers, advocates, administrators, health care providers and social services workers, we develop skills in communicating with LEP individuals. Advance research is conducted on local demographics of the town or region, including any economic changes, such as new plants, hospitals, or a loss of facilities. Research is conducted on new populations that have moved into a region, with an effort on identifying variations among these populations. Participants in class are often the best experts in describing cultural changes within their own communities and the inherent challenges to providing services. We recommend allowing sufficient time for attendees to network with each other to learn about local resources. Participants can apply for continuing education units, although we do not provide a certificate as we do for *Bridging the Gap* training. We additionally offer abbreviated (less than two-day) sessions on cultural competency for advocacy groups, social service agencies and providers.

Training, Service, Leadership

Social workers can take a major leadership role in promoting the use of trained interpreters. As advocates for limited-English proficient individuals who need access to services, social workers know firsthand the barriers experienced by someone new to the United States and our health care/social services system. Social workers and advocates who are gifted with fluency in more than one language, and those who come from non-

English speaking cultures are perhaps the most valuable resource for understanding the dynamics of change. However, a social worker does not have to be a bilingual speaker or a practicing interpreter to step up to the plate; in fact, a monolingual speaker who promotes equal access to care for all can make a memorable impact. Communication is a shared bridge, open to all who traverse it.

Social services professionals and health care providers who want to improve services within their institutions and agencies often encounter major barriers. Although the Civil Rights Law of 1964 and numerous recent guidelines spell out requirements for compliance for federally funded institutions (*including the need for skilled interpreters*), hospitals and agencies often claim they are insufficiently funded to fully implement these regulations. Smaller medical offices also claim they cannot afford to hire interpreters on a consistent basis.

The likelihood that discussion will focus on an organization's bottom line is a catalyst for social workers to emphasize providing interpreting services. Benefits to the hospitals or agencies by using interpreters typically include one or more of the following:

- Increase provider market value;
- maximize retention rates;
- avoid or reduce costs;
- reduce medical errors;
- encourage primary and preventive care;
- increase patient satisfaction;
- increase compliance;
- reduce ER use;
- reduce unnecessary admissions; and
- decrease costs for diagnostic testing (*HRSA, 2003*).

A strong argument for the hiring of well qualified, trained interpreters is the documented prevalence of medical errors in interpreting. A 2003 study in *Pediatrics* reported that on average, 31 interpreting errors were determined in 13 recorded sessions. Of even greater significance, about 22 percent of sessions with untrained interpreters (family members or friends) had interpretation errors of potentially serious medical consequence, compared with 12 percent for those with a staff interpreter (*Flores, G., 2003*). Drawing concerns about use of non-trained interpreting personnel to hospital or agency risk management office may be good first step. Other steps include surveying the needs of the LEP communities (oral and written materials) and surveying agency/hospital staff to determine training needed in medical interpreting and/or cultural competency.

The National Council on Interpreting in Health Care (NCIHC) (see: www.ncihc.org) is an excellent resource for social workers and advocates who are researching interpreter training programs and policies. NCIHC promotes culturally competent care and use of a standard code of ethics. As a multidisciplinary organization open to interpreters, trainers, clinicians, policymakers and researchers, NCIHC serves as a clearinghouse on programs and policies to improve access for LEP persons. The Cross

Cultural Health Care Program of Seattle (www.xculture.org) not only offers training in not only *Bridging the Gap* and the training of trainers to instruct the curriculum, but training in cultural competency. It maintains useful resources in cultural practices and cultural policies. The National Health Law Program (NHELP) (see: *www.healthlaw.org*) also serves as a clearinghouse on policy regarding language access to health care. Along with The Access Project (see: *www.accessproject.org*), NHELP issues a very useful "Language Services Action Kit" detailing federal laws supporting LEP access to health care and federal funding available to help pay for services. The kit identifies which states are using these reimbursement funds, provides ideas on how to collect data on language access in communities, how to write an op-ed article or letter as offers data on LEP populations.

Interpreters, social workers, advocates and supporters need not work in isolation. Interpreter associations represent excellent professional resources by offering network opportunities and developing the leadership skills needed to inspire community awareness of interpreting and cultural competency. Regional chapters of the American Translator Association, (ATA) and state associations such as the Massachusetts Medical Interpreters Association (MMIA) are open to non-resident memberships. The MMIA hosts a very useful Web site: www.mmia.org and offers an annual conference attracting members from all over the country. At the national level, the NCHIC provides a very active listserv, is taking leadership in promoting an interpreters' code of ethics and is moving toward a certification testing process.

At the local level, however, interpreters still need ongoing skills advancement seminars and opportunities to share and analyze interpreting issues. Limited staffing, full workloads, night shifts, weekend hours and the nature of free-lance work make it difficult for interpreters to exchange ideas with colleagues. In Kansas City, interpreters have formed an interpreters' association in affiliation with the Kansas Association of Interpreters – a group founded to assist sign-language interpreters. An independent group of about eight interpreters meet to plan a one-day conference in collaboration with the Kansas Association of Interpreters, offer quarterly "Interpreters Night Out" sessions where small interpreter groups within one language pair, such as English-Spanish, learn about a particular area of health or law. Additionally, members keep in touch through a listserv.

While the field of medical interpreting is relatively young, it is rapidly expanding. At this time, only three states, Oregon, Indiana, and Iowa have passed legislation to certify medical interpreters and they are still in the implementation process. The state of Washington has had a certification process since 1992, originating from a court order. Other states are beginning to examine whether legislation is warranted or are considering implementation of certification policies. The certification process is an arduous task. The keystone needed for a solid certification foundation is a qualifying test for interpreters adaptable to all target languages. The Massachusetts Medical Interpreters Association (MMIA) has been funded to design the test through the Office Of Minority Health, NCIHC and the California Healthcare Interpreters Association, but it will take a few more years before the test can be used. The Office of Minority Health currently publishes a report of the certification progress on its web site.

Interpreter associations are serving to fill the role of "state certifier" by emphasizing professionalism among its members. A positive step is the promotion by the NCIHC of a revised Interpreters Code of Ethics. Cross Cultural Health Care Program also promotes this revised code through the *Bridging the Gap* training and other trainings offered from the organization. In brief, the Code emphasizes the following issues: confidentiality; accuracy and cultural content; impartiality, maintenance of boundaries; awareness of own culture and biases; respect for all parties; advocacy when necessary; advancement of skills and knowledge; and professionalism (*NCIHC, 2004*).

Although the Interpreters Code of Ethics is too comprehensive to detail thoroughly in this article, the common thread running through the Code is respect for the patient/provider (client/social worker) relationship. Social workers can advocate for a patient's right to an interpreter by making it clear that an accurate, impartial interpretation strengthens this essential relationship. While this relationship ideally is one of strict confidentiality, exceptions occur if a patient is threatening violence, or if the interpreter suspects child or elder abuse. Beyond these exceptional situations, disclosure by the interpreter to anyone regarding content of any session is prohibited. An interpreter cannot, for example, go home after a long day and discuss cases he/she had encountered with their spouse or family. Confidentiality may be more difficult to sustain if the interpreter is asked to appear in court, or if the interpreter believes a patient's health is threatened. Even in these difficult, gray-area cases, starting from the premise of confidentiality provides an equal footing for all involved parties.

When working with an interpreter, a social worker can emphasize the priority of the client/social worker relationship with a few key reminders at the beginning of a session:

> 1) Ask the interpreter to sit next to and a little behind the client. This position strengthens the communication flow between the social worker and the client.
> 2) The social worker should ask that the interpreter interpret everything said in the session (omit nothing, add nothing, change nothing).
> 3) The social worker should feel confident in asking for clarification of cultural information that is pertinent to understanding the problem.

In addition to confidentiality, the Code reinforces the idea of respect for all parties involved by requiring "accuracy" and "completeness" in all aspects of interpreting. Interpreters trained through *Bridging the* Gap are given numerous models and role-playing scenarios so that interpreters gain practice reading all levels of communication: changes in phrasing, nuances of specific words, body language, vocal tone, expressions, etc. The Code encourages interpreters to advance their professional knowledge by participating in workshops, taking advanced degrees as needed, and continually strengthening their vocabulary and knowledge of the various fields for which they interpret. Social workers can assist by providing interpreters with information, terminology and orientation to the profession.

Conclusion

The continuing rise in non-English or limited English speaking migrants to the United States is proving to be a major challenge to the safe delivery of health care services. While the field of medical interpreting is relatively new, it is also expanding rapidly in response to care needs.

By offering comprehensive training in foreign language interpreting, including a thorough overview of the interpreters' code of ethics, paired with training in cultural competency, advocates can make a major contribution in raising the standard of care for limited-English proficient people, and instilling a culture of welcome for all newcomers.

The model developed by the Jewish Vocational Services of Kansas City Kansas represents one important resource for training new interpreters and social workers involved with limited English speaking populations. Its adoption is encouraged by those organizations needing additional interpretative expertise in health care and/.or social service settings.

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THE LATINO HEALTH PROJECT: AN APPROACH TO CARING FOR A NEW IMMIGRANT POPULATION

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Abstract

Latinos are the fastest growing ethnic group in North Carolina. Between 1990 and 2000 their number grew by almost 400%, giving North Carolina the fastest growing Latino population in the country. In Durham County, where Duke University Hospital (DUH) is located, the growth has been even more dramatic. Health care facilities have been struggling to meet the challenges of providing health care to a non-English speaking population in a state that has historically been composed only of whites, blacks, and a very small group of Native Americans. This chapter describes the response of one hospital implementing an innovative, centralized, one-person project to assist these new immigrants in accessing healthcare in a strange land.

Introduction

Latinos are the fastest growing ethnic group in North Carolina (*NC Latino Health 2003*). Between 1990 and 2000 their number grew by almost 400%, giving North Carolina the fastest growing Latino population in the country. In Durham County, where Duke University Hospital (DUH) is located, the growth was even more dramatic; in that same time period, the increase in the Latino population was a striking 730%, and going back an additional ten years, between 1980 and 2000, the overall increase has been 1,180%. Historically, whites, blacks, and Native Americans have constituted the majority of North Carolinians. Thus, the influx of Latinos has transformed the sights and sounds of the neighborhoods in this state in a relatively short period of time.

Background

The impact of the Latino migration into North Carolina was soon felt in the community and at DUH. Prior to the Latino migration, NC's minority groups were few, thus the experience of the Latino immigrants was different from those moving into large urban areas where many cultures amd ethnicities had decades of experience in living together. Durham itself was the center of long standing racial tension between primarily two groups: whites and blacks. Duke is still called “the plantation” by many blacks, reflecting a longstanding belief that the powerbase of the hospital and university is white, yet the people who actually make the institution function – those who drive the trucks, clean the floors, and cook the food - are black. It is only in the recent past, the 1960s, that the water fountains, the dining rooms, the employee break rooms, and the waiting rooms of the outpatient clinics in DUH were integrated. These are bitter memories for those patients and staff old enough to remember, or young enough to have heard.

With the appointment in 1993 of Nannerl O. Keohane, the first female ever appointed president at Duke University, an office that oversees both the university and the health system, strong leadership around a variety of diversity initiatives resulted in a concerted effort to recruit, develop and promote minority and women leaders. An office for institutional equity was established, as was a strong harassment policy. Attitudes and behaviors, however, do not change easily. It was this set of suspicious and often hostile attitudes that the newly arrived immigrants first encountered (*Johnson, Johnson-Webb, and Farrell, 1999*), and it was this history that the DUH leadership did not want to repeat.

Latino Migration

The primary reason for the Latino migration is a combination of the dismal state of the economy in Mexico and in Central America and advantageous employment opportunities in the United States *(Kochar, Suro, Tafoya, 2005; NC Latino Health, 2003)*. Latinos are often employed in the state's most hazardous industries or in low paying jobs that are unappealing to native North Carolinians. Some US businesses actively recruit Latinos from Mexico and Central America. Most of the state's immigrants are newly arrived; one unpublished survey conducted by a local grassroots community-based organization, El Centro Hispano, documented that the average Latino residing in Durham, North Carolina had lived in the area for less than three years. Most Latinos have completed only elementary school and literacy rates are low. At least half Latinos have limited English proficiency and over half are uninsured. They are disproportionately more likely to live in poverty and more unlikely to have health care. With the exception of migrant and seasonal farm workers, recent immigrants are in relatively good health compared to whites or blacks, although their health tends to worsen the longer they reside in the United States. This phenomenon is termed "the Mexican paradox" when it refers to positive birth outcomes in recent Latina immigrants from Mexico. Behavioral risk factors such as high rates of smoking and quick adaptation to an American life style of fast food and less physical exercise may, however, increase their risk for developing chronic diseases such as hypertension and diabetes. (*NC Latino Health, 2003*).

Because the first wave of migrating Hispanics was made up of primarily young, relatively healthy males with no health insurance who spoke little English, they were unlikely to present in primary care clinics or use preventative health care services. Language barriers, '*machismo*' (an attitude that men need to be strong and in charge) and '*fatalismo*' (a fatalistic view towards health and illness) contributed to the use of health care only for urgent or emergent situations. These cultural and linguistic factors, combined with unsafe working conditions, living in an all male household, the lack of traditional family structure, few recreational resources, reliance on alcohol for relaxation and celebration, and unfamiliarity with American driving habits and laws, frequently made Latinos' first contact with the American health care system in the emergency room where they were treated as victims of motor vehicle accidents or occupational injuries.

Lucky individuals survived the trauma with relatively few physical sequelae while unlucky ones survived with major injuries, e.g., paraplegia or quadriplegia, needing lifetime highly specialized care. If the individual was an undocumented immigrant, they were ineligible for state or federal medical assistance, regardless of the degree of disability or poverty, resulting in a complete breakdown in the usual provision of post-hospital care. Unless family members or others in the community were willing to take on the highly challenging burden of caring for these men in their homes, they stayed in the hospital for extended periods of time. Repatriation was nearly impossible.

Impact at DUH: The Inception of the Latino Health Project

Numerous challenges soon became apparent in providing health care services to this new group of immigrants. Section 601 of Title VI of the Civil Rights Act of 1964, 42 U.S.C. Section 2000d *et. seq* declares that: "No person in the United States shall, on ground of race, color or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."

Guidance issued by the Office of Civil Rights (*2001*) further clarified Title VI as it relates to persons with limited English proficiency around access to interpreters and translation services as well as the use of family members for interpretation (refer also to *Perkins, 1999*). Because Federal funding of health care is so pervasive, nearly every health care provider is bound by the requirements of Title VI. Based on observations and anecdotal discussions, as well as the number of urgent requests for interpreter services, it appeared few of the Duke employees were fluent in Spanish.

While more than half of the Latinos in North Carolina come from Mexico, Duke health care providers also found themselves treating large numbers of Spanish speaking patients who came from many different countries in Central and Latin America. Each of these groups had differing views, history, values and cultural issues. Often the groups used slightly different Spanish vocabularies and dialects. This posed immediate problems for the hospital as the staff on the inpatient units and clinics struggled to learn about and provide the appropriate level of care and culturally sensitive services to these fast growing minority groups.

In 1999, a taskforce initiated by representatives from the Departments of Social Work and Case Management at DUH began to explore strategies for transition of hospitalized trauma patient ready for discharge. The taskforce reviewed the data on projected population trends and came to the alarming conclusion that DUH could expect to provide more than $30 million of non-reimbursed care to Hispanic trauma patients alone by the year 2005 *(unpublished Indigent International Patient Baseline Impact Report, 1999)*. Not surprisingly, these figures received a great deal of attention from hospital administration. A decision was made to create an actual department that could pursue funding and come up with cost effective strategies. In fact, the increase in Latino trauma patients has not materialized at the projected pace.

Before the intended department was created, cost pressures intervened, and the department became the Latino Health Project (LHP), ultimately placed in the Department of Social Work with one additional budgeted position. Even before the events of 9/11 and their catastrophic impact on the attitudes towards and treatment of immigrant populations, it was soon clear that funding resources for uninsured, undocumented patients were few, but that other important work needed to be done for and with our new Latino patients that was entirely consistent with the overall mission and values of social work.

The Rationale for Writing a Business Plan

The first step in developing the business plan was the creation of the project coordinator's job description. A master's degree in a health related field was required in order to make the position competitive and attract a skilled applicant pool, as well as written and oral fluency in Spanish and English. Because the project only had one dedicated position, it was also important that the position not be described as a direct caregiver and other professionals such as nurses, discharge planners, and social workers, conduct initial patient assessments. The coordinator was envisioned as available for consultation and intervention as warranted only with the most difficult cases.

Banks lend money to small businesses based in large part on the strength of proposed business plans. As a consequence, immediately after being hired, the coordinator joined the Social Work Director in preparing a business plan designed to both focus project work and promote the project as an outcome driven service for a population that, while initially perceived as a liability, was in fact substantially contributing to the economic, social and cultural enrichment of our state.

Health care system social work departments are often viewed as nice but not necessary and therefore are at great risk during budget cuts and times of shrinking reimbursements. We not only sought to avoid that perception but to align ourselves with critical Duke initiatives. Because we had a business plan with clear outcomes aligned with institutional priorities, we were able to apply for assistance from a hospital administrative fellow. This individual proved to be an invaluable "free" source of help in constructing and administering a needs assessment, (described below), that was used to survey all thirty of our inpatient units as well as our outpatient clinic nursing leadership - a crucial business plan goal.

Eight separate goals were established, each with its own set of strategies and desired outcomes. Many of the goals were ongoing and consequently had open timelines. By pursuing these goals, the project would:

1. *Become the central clearing house for all issues involving Latino patients*. We were aware that there were already multiple initiatives underway throughout the hospital, and as typical in a large institution, the "left hand" often was unaware of the activities of the "right hand." Given the scarcity of bilingual resources, we wanted to maintain awareness of what providers were doing in various clinics or units and to

assist whenever possible, in relaying information, linking individuals and programs and coordinating with the separate office that housed medical interpreters.

2. *Establish and maintain positive linkages with the community*. The LHP coordinator was already familiar with most of the relevant community agencies and had good connections with community Latino leaders. We did not, however, have any relationship with the recently established Mexican consulate in North Carolina nor did we have any data about the Latino community's perceptions of DUH nor were we involved in any recruitment efforts of bilingual employees.

3. *Obtain accurate demographic data on Latino patients*. In reviewing demographic data on known Spanish speaking Latino patients, we were aware that many of them were incorrectly classified within our information systems as English speaking US citizens. We knew we would first have to identify the barriers in obtaining more accurate information by working with our front line registration staff. Accurate demographic information, e.g., the numbers of Latino patients treated inpatient, outpatient, and in the Emergency Department, are critical for many purposes, including grant applications, Title VI compliance, and budget planning.

4. *Complete an assessment of services to Latino patients in the hospital and clinics*. Based on informal discussions, we obtained anecdotal data to support the need for more interpreters, but a more systematic needs assessment of each inpatient unit and clinic was necessary to determine providers' perceptions of health care prioritized needs of this population and availability of bilingual staff in each area.

5. *Ensure compliance with governmental and legal statutes (e.g., Title VI).* To accomplish this goal, an ongoing assessment was needed of patient access to interpreters, bilingual signs and translation of important medical information and forms. It would also mean a close working relationship with the various offices in the medical system responsible for interpreter services, staff education, regulatory and legal affairs including risk management, and our office of institutional equity.

6. *Contribute to the cultural competence of health care providers*. All educational classes in DUH are provided by the Hospital Education Department. We defined our intended contributions in this area as individual health care provider consultations regarding select patients and families, formal presentations and orientations to interested departments and inclusion in formal cultural competence classes provided through Hospital Education. Although it was not part of our formal business plan, we were aware of increasing tensions in the community between these new immigrants and the large African-American population in North Carolina. An openly voiced negative attitude existed regarding "illegal immigrants." Daily articles and frequent letters to local and national newspaper editors suggested this issue might be polarizing our community as well as the rest of the nation. We intended to provide relevant data countering some of the most misleading stereotypes or prejudices.

7. Support Latino employees. The number of non-English speaking Latino employees was (and continues to be) relatively small, with most being contract employees hired by construction crews. Our efforts were to be aimed at Human Resources in order to improve systems of identification and recruitment of bilingual employees and to facilitate communication with any non-English speaking employees.

8. *Continue to assess unmet needs identified during global assessment of services.* Our intent was to utilize existing linkages and relationships to explore cost effective strategies, programs, and initiatives for unmet needs that were identified in the earlier survey. By serving as a clearing-house, we would be able to minimize the possibility that services might be duplicated.

Project Outcomes

Having one person whose entire position is dedicated to the Latino patient population and having strong administrative and institutional backing has allowed us to meet all or at least part of seven of our eight goals. We successfully established ourselves as a central clearinghouse and have been used by multiple parts of our large, complicated system to address both complex patient concerns and broader systems issues. The project was a catalyst for initiation of a Spanish channel on the closed circuit, in-house patient education television system, introduction of a bilingual billing letter and a large increase in the number of Spanish interpreters. The project has provided simultaneous interpretation equipment, consulted on sensitive and emotional patient issues, partnered with several clinical departments and community agencies regarding grant opportunities for the Latino community and established a close relationship with the newly established Mexican consulate in North Carolina.

Project relationships with Latino leaders and agencies serving Latino residents are particularly strong and have been instrumental in helping us manage a series of difficult crises involving Latino patients. In December 2002, a catastrophic ice storm downed power lines for more than a week and contributed to large numbers of carbon monoxide poisoning victims requiring care by the DUH Emergency Department. Two-thirds of the patients treated by the Emergency Department were Latino. With all communication systems inoperative, there was no effective way to alert the Latino community about the potentially lethal danger of using charcoal grills inside the home for heat. Fortunately, because of their previously established personal relationships, the LHP coordinator was able to make contact with key Latino leaders and implement a communication tree that eventually resulted in the Governor directing the National Guard to go from house to house in Latino neighborhoods alerting residents to the carbon monoxide threat. The following year, the entire nation became aware of Duke University Hospital after the news reported on ‘Jesica’, a Latina teenager, who ultimately died after receiving an incompatible heart/lung transplant. While her family’s anguish and the negative publicity were overwhelming and agonizing for all involved, the work of the LHP eased some of the tensions with the community and staff.

Our work has been made easier when we could demonstrate the project's relevance not only to the often hard to understand concepts of "cultural competence" and "diversity" but also its alignment with institutional and JCAHO priorities, such as patient safety. As traumatic as the crises of the 2002 ice storm and 'Jesica' have been, they also allowed us to contribute, be present, and do what we could to ease the suffering.

Our project's work with individuals has been particularly rewarding. We have assisted both individual health care providers and patients in better understanding each other and aided patients in navigating through our complicated health care systems. In one instance, project staff successfully assisted an indigenous woman from the mountains of Mexico who presented to the hospital alone but for her critically ill newborn. This individual spoke and understood only an Indian dialect, had never crossed a road that had a stop light and had never used a key card to open up a hotel room. The caring involvement of project staff benefited her as she stood in a tertiary care pediatric intensive care unit looking at a baby hooked up to a heart lung machine.

We have not always been successful. Effecting change in a large, highly complex institution proceeds slowly. There are 7,200 employees in the medical center and more than 24,000 in the entire health and university system. We are still trying to optimize the use of information systems to gather accurate data about our new patients as well as the exact numbers of monolingual Spanish speaking patients, non-USA citizen patients and bilingual (English and Spanish) speaking employees. The absence of such data limits our ability to submit grant requests, enlarge the program or know whether our efforts to increase the number of bilingual staff have been successful.

Future Directions: the Latino Nursing Initiative-Lograremos el Ejercer Enfermeria (LEE)

Two years ago we were approached by a bilingual nursing colleague who was meeting informally with several Latina nurses in the community. These nurses, all trained in their home countries, were working in menial, poorly paid jobs because of language and credentialing barriers, but were anxious to return to their chosen profession. With the documented nursing shortage in the United States and the growing need for bilingual health care providers, the LHP began collaborating with other interested colleagues in the Duke system, including the School of Nursing. A working group has now been formed to implement a pilot project (LEE), funded by Robert Wood Johnson, to provide specialized, individual assistance to a carefully chosen group of 16 qualified individuals residing in North Carolina with the goal of helping them enter the work force as nurses. Key activities accomplished in collaboration with a community college and Latino organizations, include: (a) translation/validation of all educational transcripts and other documents for state nursing licensure, (b) medical English classes, (c) nursing refresher classes, (d) periodic assessment of English language skills and nursing skills, (e) mentoring by bilingual nursing staff, (f) linkages with the nursing recruitment office, (g) guidance through the licensure process, and (h) evaluation of the LEE program

Conclusion

Duke University Hospital responded to a dramatic shift in the demographics of its patient population by creating a specialized project to serve a new wave of immigrants coming from Mexico, Central, and Latin America. Centralizing the project with a dedicated person who has no other responsibilities and no direct clinical responsibilities has allowed us to (a) become easily identifiable in the institution, and (b) delve into a wide variety of individual and systemic issues. We believe this is a viable model when a new immigrant population presents new challenges to the delivery of health care by provider institutions.

Although the project has not yet accomplished one of its original intents, that of discovering ample post-hospital resources for undocumented immigrants, it has provided an excellent opportunity for social work leadership in the health system and community. Most importantly, however, the project has assisted our newest immigrants in their journey through this new land. With very few exceptions, all of our own families once made this journey themselves.

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ISSUES IN PROVIDING CULTURALLY SENSITIVE COMMUNITY CARE: THE EXAMPLE OF A SETTLEMENT HOUSE

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Abstract

The increasingly diverse population of the United States presents a challenge to the health care delivery system. Settlement houses have long demonstrated their role in providing culturally competent services to ethnically and linguistically diverse populations. The strong family and community focus of settlement house based social workers makes them particularly invaluable in addressing immigrant needs. This article discusses successful service delivery strategies of New York City community based organizations, including the Union Settlement Association, and offers specific steps in identifying and bridging service gaps.

Introduction

The increasing diversity of the population in the United States presents a series of challenges to health care organizations, as institutions throughout the country find themselves struggling to serve consumers who represent multiple languages and cultures. No longer are these issues confined to a few large cities with histories of significant immigration, as was the case in the past. In fact, until twenty years ago, the issues of multiple languages and cultures in the health arena largely affected only public hospitals and academic medical centers in those large portal cities, such as New York, Boston and New Orleans, that had been home to immigrants since the turn of the 20th century.

Today cultural and language issues affect hospitals, homecare agencies and community-based organizations in most areas of the country. Health care institutions now struggle to provide a culturally competent workforce and equal access to quality care for racial and ethnic minorities, while meeting standards for culturally and linguistically appropriate services (CLAS). In New York City, that can mean serving residents who come from more than twenty different countries (*The Center for New York City Affairs, 2004*). As the trend toward globalization in business has increased, the effects this change has had on health care have become more apparent. Immigration has changed the demographics of many countries including the United States; with ethnic pride leading the call for culturally appropriate services (*Hanley, 2001*). Although CLAS represents a beginning effort to address issues of diversity, a huge gap exists between its standards and truly culturally sensitive care. Social work is a natural resource in bridging that gap.

Because of their strong family and community focus, social workers are invaluable in helping inform institutional leadership about the specific cultural backgrounds of consumer populations. In turn, social workers presented with issues of diversity and cultural mores with which they are unfamiliar, will seek out trusted community resources to help bridge the gap between CLAS and culturally sensitive care. Reaching out to community organizations is a shrewd strategy. Community-based agencies have long addressed diversity by valuing cultural difference and using an inclusive model of practice.

Perhaps more than other type of community based agency, the settlement house, with its long tradition of serving immigrant populations, can serve as a resource in formulating culturally competent care. Since the days of Toynbee Hall and Hull House, the settlement house movement has been an exemplar of a community-based agency that serves as a forum for community voices to be heard and addressed.

For more than a century and a half, settlement houses have provided services to culturally and linguistically diverse populations. Settlements are open to all neighborhood residents and provide a forum for learning about difference and for reducing community tensions that result from that difference (*Brown and Barnes, p.79*). Historically, they also have offered an inclusive and holistic view of service delivery with the goal of improving the life of the neighborhood as a whole. Early settlement leaders shared a common intention to imbed their agency in the life of the surrounding community. They encouraged their staff to live in the houses where they worked (*Frabricant and Fisher, p. 241*). Settlement houses are by their very nature and philosophy, community building institutions that use programs to build, strengthen and enhance a community across racial, ethnic and class divisions (*Hirota, Brown and Martin, p. 2*). These neighborhood institutions were and are warm, welcoming places where people from diverse cultures, heritages and of all ages have joined together to receive services, enjoy celebrations and address community issues (*Brown and Barnes, p.4*).

Today, most settlement houses continue to draw many of their staff from the communities they serve and rely on community residents' goals and needs to define their service agendas. This reliance on community voices and the settlement's long history in responding to the needs of ever-changing community groups can be instructive in informing healthcare institutions in ways to best recognize and respond to community needs.

In the standards of the National Association of Social Workers (NASW), Standard #10 for Cultural Competence in Social Work Practice (*2001*) unequivocally states that social work must take a leadership role in disseminating knowledge about diverse client groups and create proactive processes within their institutions that empower individuals, families, groups and communities. Social workers can begin to meet that standard by reaching out to trusted neighborhood institutions such as settlement houses that promote relationships across generations and across racial, ethnic and socioeconomic groups. Such outreach serves to reduce community tensions resulting from indifference and lack of awareness of cultural preferences and practices. It is unrealistic to expect a social worker to know every culture's traditions and practices and how these traditions influence selecting the best approach toward a family experiencing a health crisis. As an alternative, social workers can turn to settlement houses where immigrants receive services such as Headstart and English as a Second Language classes (ESL), delivered by individuals speaking their own language and where they can find assistance in navigating the health care and entitlement bureaucracies safely without fear.

As leaders in health care, we need to ensure staff is culturally competent, aware of individual difference, able to advocate for the needs of diverse client populations and sensitive to the history, traditions and values of a diverse clientele. Reaching out to agencies traditionally rooted in the dual values of bridging the gap between communities of privilege and new immigrant groups and advocating for those in need, can help facilitate this process.

The Settlement House Today

Union Settlement Association has served the largely immigrant community of East Harlem, New York for 110 years with childcare, after school programs, youth services, college preparation, adult education, senior services, home care, mental health and financial/economic development. Today, the agency runs 22 programs from seventeen locations in the community. Through its services and advocacy, settlement house participants are assisted in accomplishing their own life goals.

Union Settlement currently operates two health related programs - a full-service community mental health clinic and a home care agency. The agency additionally initiated a medical clinic during the 1970s that now functions as an independent program serving community residents. Union Settlement is surrounded by a public hospital, a large teaching hospital, several community based clinics and a small community hospital. In theory, the presence of these institutions should contribute to unencumbered health care access by neighborhood residents. In practice however, many residents have no primary care physician and use emergency rooms as their primary source of health care.

Poor access to consistent and quality health care can be attributed to both area economics and a combination of language and cultural barriers. The 13,000+ clients served by the Settlement arrive from Mexico and a myriad of other Central and South American countries. More recently, increasing numbers of immigrants from China and countries in West Africa or the Indian sub-continent have located in East Harlem to be in easy reach of attending the largest mosque in North America. The majority of these immigrants have little or no experience with modern health systems. Initially approaching the Settlement to take free adult classes in English, new immigrants are assisted by teachers and counselors to access other available services such as Headstart or after school programs for their children. These services require that the children have medical examinations in order to enter classes. For a recent immigrant from Senegal, for example, with no knowledge of Western medicine, such a requirement may prove to be an overwhelming obstacle.

To overcome potential impediments to accessing service, staff paraprofessionals, called family workers, assist families obtain needed medical care through public health stations and clinics. Once enrolled, children are afforded vision, dental and asthma screenings during the school day. The family workers explain each process to families so that parents may give informed consent. At every step, family workers interpret, explain and link families to health systems. They serve as guides to the bewildering maze of health and mental health services in New York City. They look for ways to connect individuals and families with resources outside the neighborhood. By being embedded in the neighborhood, but having staff and board members with strong connections beyond the immediate area, the Settlement serves as a bridge to other networks of service (*Brown and Barnes, p.80*).

By linking residents and institutions, a settlement house would appear to be a logical resource for health care institutions seeking to help diverse populations understand our complex health care system. Unfortunately, contact more frequently flows from settlement houses *to* the health care system. When contacts are initiated with Union Settlement, not infrequently requests are for patients of a particular ethnic group to fill clinical protocols. Screenings may be offered to community residents, but only in the context of meeting specific grant expectations. True partnerships to enhance services to residents of different cultural heritages are rare. While Union Settlement's mental health clinic functions as a discharge planning resource for children leaving psychiatric hospitalizations, it is the only consistent contact flowing from the hospital to the Settlement.

Using Community Based Organizations (CBOs) As Linkages

It is crucial that hospital and health system based social workers reach out to community-based resources, not just to assist with individual patients, but to address larger-scale, institutional issues as well. Failure to reach out contributes to inequity in health care. Recent studies have repeatedly demonstrated that African-American patients are less likely than white patients to be referred for transplant evaluations and that there are far fewer organ donors of color (*Wolfe, p. 75*). The impact of culture is further reflected in research documenting that fewer African-Americans donate their kidneys after death because of a historically rooted distrust of the medical establishment. The effect is to leave most African-American kidney failure patients with excessively long waits for transplant due to genetic incompatibility (*IBID, p. 79*).

Non English-speaking patients must frequently wait for interpreters before receiving care. Studies of consumer satisfaction with health care services often report that speakers of other languages feel less satisfied with services and report they sensed others were given preference treatment (*Thompson, p. 10*). Wait times for translators can leave patients convinced that they are not treated fairly. To address this concern, Union Settlement adjusted operations such that no discernible differences were found among English and Spanish speaking clients recently sampled about satisfaction with agency services (*Union Settlement Association, 2004*).

Feelings of being ignored by the medical establishment or denied access to health care follow patients all the way to the end of life. Payne (*2000*) quoted an African-American clergyman to whom he was trying to demonstrate the need for, and importance of, palliative care as replying, “How can you ask us to trust an institution that one generation ago would not let us in the door?” Health care social workers need to acknowledge and understand the potential for mistrust and fear when dealing with patients of differing ethnic groups and cultures. True cultural competence requires moving beyond simple translation and political correctness to understanding and accepting differences; and moving beyond the current one-sided flow of contacts from CBOs to the health care community. Given the need of health care institutions to initiate increased and bilateral contact, NASW, the Society for Social Work Leadership in Health Care and other local networks of human service organizations can encourage and support the enhanced flow of information, advice and resources between CBOs and hospitals and other health care facilities.

Successful Strategies

An exemplar of an organization with a strong community focus, Mt. Sinai Hospital in New York City, has developed excellent relationships with the surrounding community and CBOs. Staff social workers have provided leadership in these efforts through the organization’s Department of Community Relations and development of a strong community advisory board. Mt. Sinai researchers additionally routinely reach out to CBOs to form partnerships and to link services. Initial efforts may have focused on increasing access to the facility, in order to improve diversity in its patient census or it may have sought to address needs of the surrounding neighborhood. What is significant is that the medical center has actively sought to develop and refine community linkages for more than twenty years.

Joint funding proposals contribute to representatives of CBOs having expanded roles in new service initiatives. In the instance of Mt. Sinai, both preventative and treatment services are offered to agency participants, while in turn the partnering CBO offers English as a Second Language (ESL) classes and other services to Mt. Sinai staff. The CBO may also assist in identifying individuals to serve on advisory councils, with the benefit of staff from both organizations more often engaging in referral and collaboration.

Such partnerships are not a quick fix as the process of building an institutional relationship is as complex and time-consuming as developing a therapeutic relationship. As leaders, we need to assume responsibility for establishing these relationships and becoming as ingrained as possible in the fabric of the communities in which we serve. We need to agree to serve on community advisory boards and participate in collaborative working groups to respond to request for proposals. We need to view ourselves as educators for staff, and assist them in recognizing that working with people who are different from us can be a challenging and complex effort. It is crucial to enhance staff awareness and use of available community resources. Finally, we must demonstrate to staff that the reward of such efforts is improvement of conditions for not only the individual client, but ultimately the community at large.

Steps to Bridging Service Gaps

The first step in bridging service gaps is to identify the problems through some quick and dirty fact-finding:

- Conduct a needs assessment. What cultures and languages are represented among the populations you serve?
- Survey key staff members from other departments to identify issues they perceive as most pressing.
- Analyze your results. What are the emerging trends? Are immigrants from a new country starting to appear? In New York, for instance, the newest Chinese immigrants come from Fukien province and speak no Mandarin or Cantonese.
- Early assessment will benefit your efforts to secure needed services of individuals familiar with these cultures and enhance your program planning
- Survey your staff to assess linguistic and cultural expertise. Strategize with staff about CBOs to determine the quality of any interaction and the factors affecting the CBO services provided to the community.

Seek to develop relationships between the health care institutions and CBOs in your community.

- Be aware that relationships take time to develop. Attend community meetings and introduce yourself to social workers from other venues. Establish relationships on a non-emergency basis so that when discharge resources are needed quickly, you have immediate contact options.

- Enhance resource awareness by encouraging dialogue among community professionals and facility staff. If you are in a CBO, invite health care professionals to speak about their area of expertise to various client groups. If you are in a health care organization that is suddenly experiencing a rise in the number of individuals from a new immigrant group, invite representatives from an organization currently serving that population to speak to your staff about service delivery issues, concerns or evolving needs.

- Be creative in reaching out to nontraditional organizations such as churches or small grass roots organizations. Establish partnerships with neighboring institutions by working together on a grant proposal that would positively impact both the institutions and community.

Conclusion

Cultural and language issues affect hospitals, homecare agencies and community-based organizations in most areas of the country. As a consequence, it is crucial that health care and community-based professionals work together to address the issue of cultural competence. Settlement houses have long addressed diversity by valuing cultural difference and providing examples of inclusive models of practice. Social workers are invaluable in advising institutional leadership about specific cultural backgrounds of consumer populations. By being proactive in seeking resources and solutions, a steady and mutually rewarding flow of information, advice and ideas will be generated in a climate of mutual support that enhances the prospect of positive outcomes for clients, community and agencies.

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WEBSITE RESOURCES
CULTURAL COMPETENCE
IN HEALTH CARE SOCIAL WORK PRACTICE

The following web sites offer information, literature and tools about cultural competency.

At the time of this publication, the sites noted below do not charge for most of their offerings and provide a wide range of usable information.

Readers are encouraged to utilize these resources as they will benefit conceptualizing and planning work on cultural competency.

National Society for Social Work Leadership in Health Care
www.sswlhc.org

The Center for Cross-Cultural Health
www.crosshealth.com

University of Michigan Health System Program for Multicultural Health
www.med.umich.edu/multicultural/ccp/tools.htm

Culturally Sensitive Care for Holocaust Survivors
www.hrsa.gov/OMH/cultural/sectionii.htm

Joint Commission on Health Organizations'-Hospitals, Language and Culture
www.jcaho.org/about+us/hic/links.htm

Cultural Competence Standards in Managed Mental Health Care
www.wiche.edu/MentalHealth/Cultural_Comp/ccslist.htm

National Center for Cultural Competence – Georgetown University
www.gucchd.georgetown.edu/nccc/products.html

The Center for Linguistic and Cultural Competence in Health Care
www.omhrc.gov/cultural/

The Cross Cultural Health Care Program
www.xculture.org

Achieving Cultural Competence: A Guidebook for Providers of Services to Older Americans
http://aoa.gov/prof/adddiv/cultural/addiv_cult.asp

Bridging the Health Care Gap Through Cultural Competency Continuing Education
http://www.thinkculturalhealth.org/