

Cultural Competency in Practice

Jennie McLaurin, MD, FAAP

Editor's Note: This is the first in a two-part series on cultural competency. In the second article of this series, Dr. McLaurin will discuss issues of assimilation and acculturation.

Introduction

Clinicians working in migrant health recognize that the farmworker population has unique needs and characteristics that must be addressed in order to optimize health outcomes. Central to this understanding is the role of cultural factors in determining wellness, illness, adherence, and health status improvement. While clinicians are trained in many skill sets, developing competencies in such areas as newborn resuscitation, x-ray interpretation, pharmaceutical dosing, and chronic disease guidelines, most have not received formal education in the area that may profoundly impact their success in all other areas: cultural competency.

The need for cultural competency pertains to both individual clinicians and staff as well as to the health care organization as a whole. This need is not new, but it has received greater emphasis recently as a result of several factors. The latest US Census data shows that America is becoming more culturally diverse. Rural areas as well as urban areas are increasingly composed of people for whom English is not their first language, and who hold to behaviors, practices, and beliefs that differ from the majority.

Disparities in health have been documented along racial and ethnic lines, underscoring the urgent need to develop care that competently reaches all people. Legally, the health care community is expected to communicate with patients in their preferred language (Title VI, Civil Rights Act). Accrediting

bodies such as JCAHCO have added cultural competency to review criteria. Finally, there is an increasing recognition that "compliance" on the part of the patient is related to cultural competence on the part of the clinician.

Clarification of terms is necessary. For the purposes of this article, culture will be defined as: "A specific set of social, educational, religious, and professional behaviors, practices, and values that individuals learn and adhere to while participating in or out of groups they usually interact with." (Durham et al, 1997) In order to effectively partner with farmworkers to optimize health, clinicians must develop cultural competency, defined here as:

The knowledge and interpersonal skills that allow providers to understand, appreciate, and work with individuals from cultures other than their own. It involves an awareness and acceptance of cultural differences; self-awareness; knowledge of the patient's culture; and adaptation of skills. (Culturally Competent Health Care for Adolescents, AMA, 1994)

Cultural competence then involves both understanding and skill development. Methods for obtaining these are discussed below.

Cultural Diversity

There is danger in oversimplification and stereotyping when referencing different cultures or groups of people. Just as it is incorrect to equate "Hispanic" and "migrant farmworker", so it is incorrect to assume that all Hispanics share the same

set of cultural distinctions or that all farmworkers have the same approach to health care. There is diversity within cultures as well as between cultures. Cultural diversity can be thought of as primary or secondary. Primary diversity sets us apart in large groupings based on such things as nationality, race, gender, age, and religion. Secondary diversity further separates due to such factors as socioeconomic status, education, occupation, marital status, sexual orientation, parental status, geographic locale, etc. Many times, the biggest cultural difference between a provider and a patient may be the level of education or the socioeconomic status, rather than the more external difference of race or nationality. The first step in cultural competency is for the clinician to recognize the factors that shape his or her cultural identity. The following is a simple exercise to do as an individual or with center staff:

Pie Chart Inventory

List at least 8 of the above primary and secondary diversity factors on a piece of paper. Draw a circle. Divide the circle into "pie wedges" that reflect the strength of the cultural factor in determining your self-identity. (Some factors may not be used.) You may want to reflect how your pie would have looked ten years ago compared to today. How is your pie similar to and different from that of your clinician colleagues?

Explanatory Model

It can be daunting to attempt to ascertain all these cultural components in the con-

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text of a fifteen-minute office visit. A practical approach to understanding is the Explanatory Model. It can be as brief or complex as the clinician determines, and it treats each encounter uniquely, helping to avoid stereotyping and the impossibility of ever fully knowing a patient's culture. The Explanatory Model simply involves asking good questions. The clinician asks the patient such questions as:

- What do you think caused this problem?
- What have you done to treat this?
- Have you asked anyone else to help you?
- What are some of the ways your parents might have treated this? Traditional ways of treating this?
- What do you want the medicine to do? What medicine do you believe works best for you? Why?
- How does your faith/religion help you to be well?
- Are there any foods or drinks that you know of that will help you with ___?

There are obviously many such questions that can be asked. It is patient centered and allows communication to go beyond the traditional interrogational style of clinical medicine. Importantly, this approach recognizes individuality and allows cultural humility on the part of the clinician. Collaboration and negotiation are possible as a result.

Culture Bound Illnesses and Causation

Too often the idea of cultural competency gets reduced to talks on folk illnesses or keys to using interpreters. Both of these issues are of course important, but not exhaustive. It is not possible to detail all the aspects of common culture-bound illnesses here. Use of the explanatory model will help to draw out those important to the patient. All cultures have ways of describing maladies that are uniquely caused and remedied within that culture. In American culture, many parents believe that otitis media is caused by too much exposure to bad weather: the remedy is a hat and restriction of activity. Another example of a condition recognized in

Components of Culture

There are a number of methods for cultural assessment. One mnemonic helps to categorize cultural factors:

C O N F H E R

Communication Style—oral vs. written, eye contact and facial expressiveness, direct vs. indirect, questioning vs. accepting, group vs. individual, fotonovella vs. video vs. brochure etc.

Orientation—present focused vs. future focused, ownership of time vs. low priority on scheduling, oriented to needs of group vs. those of self

Nutrition—role of food in health and illness, perception of body size and health, availability of traditional foods and connection of food to cultural identity.

Family relationships—traditional family units, marks of childhood, adolescence (if it exists), adulthood, and old age. Decision making in family roles, childbirth practices, sexual practices, child-rearing customs, role of harmony vs. individual expression.

Health Beliefs—causation of wellness and illness, level of self-determination, use of traditional healers, lay advisors, Western medicine, complementary and alternative medicine, priority of health care

Education—formal and informal, gender differences, literacy level

Religion—interface between religion and health, separation of mind-body vs. unity, role of religious community in health provision, fatalism vs. personal power.

American medicine, but not in all modern states, is Pre-Menstrual Syndrome. Culture bound illnesses typically describe symptoms of a syndrome, and often contain components of acceptable remedies. Clinicians need not dismiss these, but learn to recognize if a patient attributes his or her condition to one, and collaborate with the patient to offer a remedy that will heal and also address the cultural needs of the patient. Common culture bound illnesses in subgroups of farmworkers include:

- Susto—illness due to fright (US clinicians recognize Post Traumatic Stress Disorder)
- Mal de ojo—"evil eye"—the ill will of others can cause sickness, especially in children. Remedies include ritual use with prayer and an egg.
- Caida de la mollera—"sunken fontanel"—a serious illness in infants, descriptive of dehydration or sepsis. Treatments can include holding baby upside down or pushing on the palate. Clinicians should verify concern over this syndrome and address as needed.
- Empacho—describes blocked intestines.

Again, coincides often with abdominal disease or constipation in young children.

- Punishment, evil spirits, dreams—there is not the mind-body-spirit trichotomy found in dominant US culture. Mental health and physical health are intertwined, and life events are connected to spiritual forces.
- Hot and cold theory—just as chicken soup is a cultural remedy for many, so there are specific foods and drinks thought to assist or hurt in illness treatment. Sicknesses are classified as "hot" or "cold" and then treatment understood. Remedies themselves are not necessarily temperature-based.

By necessity, these are just brief general statements. Ask your patients what they, or people they've known, understand about these ideas!

Translation and Interpretation

There are many good resources available to clinicians detailing the appropriate use

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of translation and interpretation in the office setting. Several helpful sources are found in the resource section of this article. Translation involves the transfer of written language from one idiom to another. Interpretation is the transfer of verbal communication from one language to another. The need for high quality interpretation is one of the most frequently cited barriers to care in migrant health. Clinicians can always be in process improvement when communicating in a secondary language. The video listed in the resource section is an excellent tool for staff training. Some key points:

- Plan ahead—discuss with the interpreter your interview needs and plan time
- Avoid jargon or technical terms
- Ask one question at a time
- Think of several ways to restate
- Maintain the clinician-patient relationship, using the interpreter as an intermediary but not as clinician
- Do not use family, especially children!

Encounters in Context

There is much truth to the phrase “medical practice”. We have the opportunity to learn embedded in each encounter.

Cultural competence is a long-term investment in understanding and becoming equipped to offer the highest quality of care to the populations we serve. Struggles with a patient encounter can often be used to facilitate our cultural competency:

- Impatience and annoyance may be your signal of an intercultural misunderstanding
- Personal questions asked of you by a patient may reflect a cultural need for trust and reassurance
- If patients repeat your instructions in exact form, there is a likelihood they do not understand. Rephrase and ask for recapitulation
- Hesitation may indicate you’ve hit a cultural wall
- Try to treat the way the patient likes to be treated rather than the way you like to be treated—be flexible

Adapted from Groppe, 1996

Practice Adaptations

There are many ways that health centers

can adapt to the needs of the patients they serve. Some adaptations for migrant farmworkers might include:

- Walk-in versus appointments
- Group visits versus individual
- Family visits
- Fotonovellas, videos, and promotoras rather than literature based education
- Resources for language enhancement
- Promote health access to family members
- Focus on proven essentials

- Advocacy, partnership, and collaboration

Culturally Competent Organizations

For cultural competency to fully influence health improvement, it must go beyond the individual level to include the organizational level. Culturally competent organizations:

- Are reflected in policies, structures, attitudes, and practices
- Are committed to ongoing professional

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NEWS FLASHES

The Breast and Cervical Cancer Educational Toolbox

The Breast and Cervical Cancer Educational Toolbox (Spanish language) is available free of charge while supplies last at no charge. The toolbox contains teaching sheets (facilitator’s guide), a videotape, a flipchart and brochures. The educational toolbox is intended for health and service organizations to enhance outreach efforts in cancer education and early detection. It is an ideal tool for your health educator and/or community health outreach worker.

If you would like a free Breast and Cervical Cancer Educational Toolbox please send a letter or e-mail with your name, organization, address, phone, and fax number to: H. Lee Moffitt Cancer Center and Research Institute, Project Toolbox, Education Department, 12902 Magnolia Drive, MRC, Tampa, FL 33612-9497, Fax: (813) 903-4976 (Attn: Project Toolbox), riveram@moffitt.usf.edu

Washington Supreme Court Rules Farmworkers Who Handle Toxic pesticides are Entitled to Medical Protection

On February 7th, the Washington State Supreme Court ordered the State Department of Labor and Industries (L&I) to develop mandatory rules for medical monitoring of farm workers who handle neurotoxic pesticides. The ruling came in *Rios v. Department of Labor and Industries*, a suit filed in 1997 by farm workers who suffered repeated illness from handling these pesticides. The Supreme Court found that L&I’s own team of technical experts had reviewed the most current research and found that the monitoring program requested by the farm workers was “both necessary and doable.” It therefore ruled that L&I’s refusal to adopt a monitoring program violated the Washington Industrial Safety and Health Act (WISHA).

The Court noted that overexposure to neurotoxic pesticides can be fatal and can result in symptoms such as respiratory distress, repetitive muscle contractions, blurred vision, cognitive difficulties, and seizures. Monitoring of the blood enzyme cholinesterase, which the farm workers sought, enables employers to identify workers who have been overexposed to these widely-used pesticides, known as organophosphates and carbamates, and remove workers from exposure before they become ill. Monitoring also helps to identify unsafe work practices. A 1995 L&I technical report cited by the Court noted that, “The National Institute of Occupational Safety and Health (NIOSH) and the World Health Organization (WHO) recognize routine blood cholinesterase monitoring as an important tool in the prevention of poisoning among workers who regularly handle these [neurotoxic] pesticides.”

The workers were represented by Earthjustice Legal Defense Fund, Heller Ehrman White & McAuliffe LLP, and Columbia Legal Services. The Court’s opinion can be found at:

<http://www.courts.wa.gov/opinions/recent.cfm>

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To PPD or Not to PPD, That is the Question

Jeanne Laswell, RN,BSN, TBNet Program Manager

I often hear concerns from seasonal migrant health clinics about starting farm workers who have had positive PPD's on LTBI (latent TB infection) treatment late in the season. The concern is that oftentimes the only information the clinician has for follow-up when the patient has left is that the farm worker migrates from his present location to Florida or Texas for the winter, but the specific location is unknown. Follow-up is virtually impossible without at least the name of a city or town. Or the farm worker returns to Mexico for the winter where LTBI treatment may not be available. If that farm worker returns to the clinic the next year, there will be a gap in treatment and he will need to commence treatment again. Some of the migrant clinics wait until the next season with the hope that the farm worker will visit the clinic early in the season and complete at least six months' of treatment before moving on. Only a small percentage of those farm workers return for treatment, leaving the clinician with a feeling of "missed opportunity".

Another concern is for those farm workers who have had positive PPD's and were referred to the local health department because the migrant health clinic doesn't offer TB services. More often than not, those people never show up at the health

department for follow-up.

MCN has long held that large scale screening for TB is not recommended for migrant and seasonal farm workers. In situations where PPDs have been done it is important to ask the following questions:

- Was it necessary to do PPD testing on the farm workers?
- Were they randomly screened or were they high risk or recent contacts to a case?
- Would reading the PPD's within the recommended timeframe be possible?
- Was there a plan in place for referral and treatment of positive PPD's?

In CDC's publication of *TB Notes*, 2001, No.1, Wendy Mills, MPH wrote:

"A decision to conduct TB screening is a decision to treat LTBI, if identified. Targeted screening of persons at high risk for LTBI or TB disease must be accompanied by a plan for providing necessary follow-up. This plan must include resources for providing a follow-up chest x-ray, medical evaluation, treatment for LTBI or TB disease, and clinical monitoring during such treatment, as indicated. A plan to address each of these criteria should be developed before screening is initiated."?*

Coordinated and cooperative care between

the migrant clinics and health departments is essential to the success of care for this population. Clinicians and Health Centers should be aware that TB Net is available is a tool which can be incorporated into the overall LTBI or TB treatment plan.

Designed to providing tracking, referral and follow-up for mobile TB patients, TB Net can serve an important role in ensuring treatment regimns are completed.

In the May/June 2000 edition of *Streamline*, Charles Nolan, MD wrote an in-depth article on the recommendations for PPD testing and treatment. To obtain a copy of the article, you may contact Jeanne Laswell at 1-800-825-8205. For additional information, you may go to the ATS website at <http://www.thoracic.org> or the CDC website at <http://www.cdc.gov/nchstp/tb/>.

For more information about the TBNet program for continuity of care for mobile patients with tuberculosis or LTBI see the following article or contact Jeanne Laswell at MCN.

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* Wendy Mills, MPH. Highlights from State and Local Programs: *Recommendations on TB Screening of Students in Minnesota*. CDC TB Notes. 2001, No.1. p.6.

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- and staff training
- Are composed of a workforce that reflects the client cultural mix
- Allocate resources for translation and interpretation
- Provide services and programs adaptable to diverse needs of populations
- Evaluate treatment outcomes by racial, ethnic, and language groups

Impact of Cultural Competence

The development of cultural competency is essential to the quality of practice. Among the many measured impacts of improved cultural competency in the provision of health care are:

- More appropriate testing and screening

- Fewer diagnostic errors
- Avoidance of drug complications
- Greater adherence to medical advice
- Increase in health seeking behavior
- Successful patient education
- Expanded choices of clinicians
- Reduced practice liability
- Reduced disparities in health outcomes

Resources for Cultural Competency

- The Provider's Guide to Quality and Culture: <http://ecu.msh.org> (HRSA)
- Georgetown University Child Development Center – National Center for Cultural Competence: www.dml.georgetown.edu/depts/pediatrics/gucdc/cultural.html CLAS (Culturally &

Linguistically Appropriate Services) Early Childhood Research Institute/Migrant Clinicians Network: www.migrantclinician.org

- Guidelines for the Care of Migrant Farmworkers' Children (AAP & MCN, multiple resources on language and culture)
- *Culture and the Clinical Encounter*, Rena Gropper, 1996 (207-846-5168)
- *Communicating Effectively Through an Interpreter* (video: 206-621-4161) or www.xculture.org
- "A Practical Guide to Culturally Competent Patient Care" by Suzanne Salimbene, available from Diversity Resources at 800-865-5549.

TBNet — A Resource for Mobile Patients

TB Net is a bi-national tuberculosis patient tracking and referral project. The erosion of the American public health infrastructure in the 1980s created a situation that increased the burden of tuberculosis on minorities and the poor. Treatment of these populations is complicated by the fact that many people, given the circumstances of their lives, are unable to remain in a given location long enough to complete the lengthy TB treatment regimen. By the mid-1990s, many clinicians and public health officials recognized the need for a way to track and coordinate the treatment of TB patients who moved between public health jurisdictions. In 1996, the Migrant Clinician's Network, working with a consortium of public health organizations, and funded by a grant from the Texas Department of Health, founded TB Net to address this very problem. Although the program was originally created with migrant farm workers in mind, it is expanding its patient base to include the homeless, prison parolees, or anyone who might be mobile during their treatment.

TB Net helps migrant TB patients complete treatment in three ways. First, TB Net supplies TB clinics with wallet-sized portable treatment records for their patients. These records provide a handy summary of a patient's TB treatment and can easily be carried by the patient wherever they go. The information in this record enables other TB clinics to continue the patient's treatment. Second, TB Net maintains a central storehouse of enrollee medical records. A patient's health care provider, whether they are in the US or Mexico, can call TB Net on a toll free line to request an up-to-date copy of the patient's medical record. Finally, migrant patients can also call TB Net on the toll free line for help locating treatment facilities at their next destination. These three systems work together to coordinate the continuous treatment of migrant TB patients.

And TB Net is successful. Since 1996, TB Net has enrolled over twelve hundred patients in the program. It's greatest success has been working with cases of active TB. TB Net has consistently experienced a high completion rate with those patients. Some patients have moved 4-5 times during treatment. TB Net has facilitated the tracking and transfer of records for those patients. At the conclusion of treatment, TB Net notifies the enrolling clinic that

that patient has completed treatment. Figures 1, 2, and 3 show the most recent figures for TB Net indicating the location of sending clinics as well as receiving sites.

Please consider enrolling your migrant TB patients in TB Net. The program operates free of charge to both your clinic and the patient. If you would like more information about TB Net, please contact:

information about TB Net, please contact:

Jeanne Laswell, RN, BSN
 TB Net Project Manager
 P.O. Box 164285
 Austin, TX 78716
 (800) 825-8205
jlswell@migrantclinician.org

FIGURE 1. CLINIC SITES ENROLLING PATIENTES IN TB NET, 2001

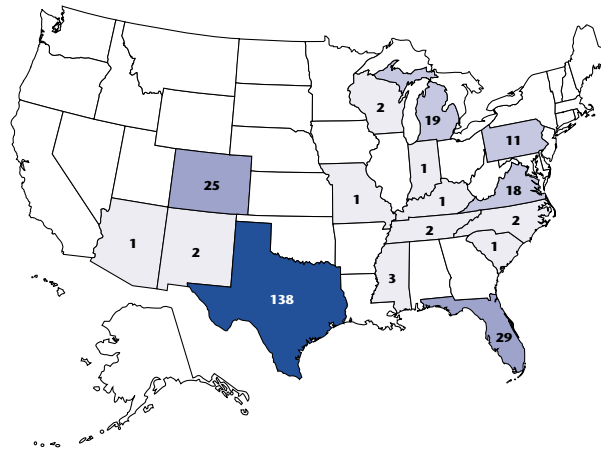


FIGURE 2. PATIENT REFERRALS WITHIN THE UNITED STATES-2001

The majority of TBNet clients were referred to clinics on the East Coast for the continuation of their treatment. The greatest number of patients were referred for continued treatment in either Texas or Florida. In addition to referrals within the United States, TBNet referred 36 clients for tuberculosis treatment in Mexico. TBNet referred 6 clients for continued treatment in Honduras, 3 clients for continued treatment in Guatemala, and 1 client for continued treatment in El Salvador.

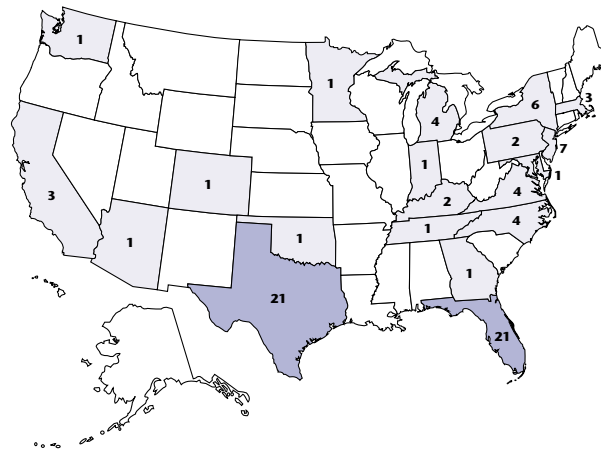


FIGURE 3. TBNET PATIENT REFERRALS TO MEXICAN AND CENTRAL AMERICA, 2001



Changes to Joint Commission Network Manuals go into Effect July 1, 2002

Effective July 1, 2002, new credentialing requirements will go into effect for the Comprehensive Accreditation Manual for Health Care Networks (CAMHCN), Comprehensive Accreditation Manual for Managed Behavioral Health Care Organizations (CAMMBHC), and Accreditation Manual for Preferred Provider Organizations (AMPPPO). The principle revision to the credentialing requirements extends a network's recertification cycle from 2 to 3 years.

Also effective July 1, 2002, three components have been added to the scope of the network survey process for managed care plans and integrated delivery networks. Beginning July 1, unaccredited assisted living, office-based surgery, and preferred provider organization components will be

sampled for survey at the time of survey of the managed care plan or integrated delivery network. Three appendices to the CAMHCN containing standards subsets for each of these components that commonly comprise a health care network are now available on the website.

All new standards are available on the Joint Commission's website <http://www.jcaho.org/> under "Top Spots" on the home page, "Standards Revisions for 2002".

Additional Cultural Competency Resources

The University of Washington Medical Center has developed Culture Clues® — tip sheets for clinicians designed to increase awareness about concepts and preferences of patients from the diverse cultures. Currently there are five cultures represented, Albanian, Korean, Latino, Russian, and

Vietnamese. Additional ones are in progress. The tip sheets are available at <http://www.depts.washington.edu/pfes/cultureclues.html>

CALENDAR

2002 National Farmworker Health Conference

May 2-4, 2002
Indianapolis, IN
National Association of Community Health Centers
202-659-8008
www.nachc.com
<http://www.nachc.com>

16th Annual California Conference on Childhood Injury Control

September 23-25, 2002
Sacramento, CA
California Center for Childhood Injury Prevention
619-594-3691
www.cccip.org

2002 National Conference on Health Care and Domestic Violence

September 26-28, 2002
Atlanta, Georgia
Family Violence Prevention Fund
(415) 252-8900
www.endabuse.org/health/CFA

The National Safety Council Annual Congress and Exposition

October 7-9, 2002
San Diego, California
(630) 285-1121
www.nsc.org



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