



Population-Specific

Transcultural Competencies for Healthcare



Baptist Health South Florida

Instructions

- 1. Review Population Specific Transcultural Competencies for Healthcare.**
- 2. Review appropriate addendum for your practice area.**
- 3. Complete online Post Test.**

ONGOING COMPETENCY/POPULATION SPECIFIC VALIDATION

(Observed Performance/Competency in Clinical Area)

Must be completed annually

Program Description

This self-study is designed to provide staff with an overview of the population specific factors that play a major role in the delivery of health care. A “universal skills” approach to cultural sensitivity is presented to assist staff with general questioning and assessment techniques for use with an individual from any ethnic background. The avoidance of stereotyping is emphasized, and a self-assessment tool is included for staff to determine their current understanding of cultural issues.

The Joint Commission standards require that healthcare organizations include cultural diversity and sensitivity training as part of employee orientation and on an on-going basis to meet the needs of their patient populations served *this self-study provides* information for staff as they care for patients from multicultural backgrounds.

Ongoing cultural competency is validated in the clinical area and must be completed annually.

Program Objectives

1. Define the term ‘population specific’ as it relates to culture.
2. Articulate how cultural competence translates into improved health outcomes.
3. Describe two activities that result in improved communication with patients of a different culture.
4. Learn how to avoid the trap of stereotyping.
5. Identify the cultural significance of hand gestures.
6. Demonstrate two interviewing techniques that enhance culturally competent care.
7. Learn the behaviors and attitudes that foster safety and trust in patients of a different culture.
8. Learn the three components of effective communication using an interpreter.
9. Identify at least two behaviors that demonstrate the lack of cultural competence.

Content Outline

Population Specific Care

- What Healthcare Staff Need To Know
- Population-Specific Care Defined
- Health Care Disparities

Cultural Differences In Communication

- Credibility, Empathy, Interest & Concern
- What To Ask

Culturally Competent Care

- Avoidance of Stereotyping

Cultural Communication Facts

- Obtaining A Medical History
- The Role of Interpreter
- Body Language & Gestures
- Family Members & Decision-Making

Competency Self-Assessment

- Health Literacy Issues
- Personal Beliefs & Values
- Acceptance & Respect of Diversity

Population Specific Care

What Health Care Providers Need To Know

South Florida contains people with many different cultures, each with its own cultural traits and health profiles, which present a challenge to our hospitals. Both our patient care staff and the patient bring their individual learned patterns of language and culture to the health care experience. This means we must be able to provide care beyond our own limited set of values to achieve quality.

Brian Keeley CEO Baptist Health South Florida

Population Specific Care Defined

Population specific care is care that is given in the most appropriate manner at the most appropriate time. This means that it is appropriate to the culture of that individual patient. Our patients are often part of specific populations such as the young, the elderly, and patients with a reduced ability to speak, understand, and/or read English. This is beyond the scope of what we traditionally think of as culture, which is usually race, country of origin, native language, social class, religion, heritage, and acculturation. Culture actually includes the not so obvious, such as age, gender, sexual orientation, and mental or physical abilities.

Cultural variations include the following:

- Race
- Country of origin
- Native language
- Social class
- Religion
- Mental or physical abilities
- Heritage
- Acculturation
- Age
- Gender

These specific types of patient populations often require that we use customized education and communication techniques so that they can become active participants in their own care.

This is especially important because language barriers and differences in values, beliefs, expectations of care, and thresholds for seeking care can all greatly influence our interactions with patients, and worse, can sometimes lead to disparities in the care provided. By learning how to provide care in a manner that is sensitive to our diverse cultural needs, we can minimize the care discrepancies between specific groups and ensure that every patient receives the care, treatment, and services they deserve.

Health Care Disparities

Every year millions of adults encounter language barriers when they receive health care. This is one factor that contributes to what has been termed 'health disparity'. Health disparity, as defined by the Health Resources and Service Administration, is a population-specific difference in the presence of disease, health outcomes, or access to care. Language barriers between patients and health care providers may affect health outcomes or access to care.

Some examples of health care disparities can be the following:

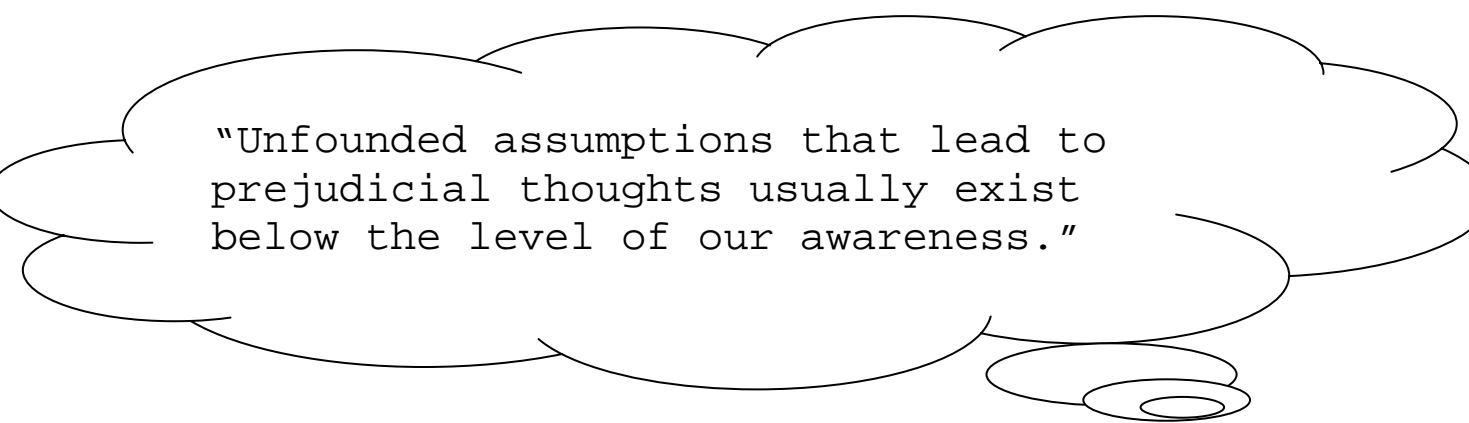
1. *Physicians* may order fewer diagnostic tests for patients of different cultural backgrounds because they may not understand or believe the patient's description of symptoms. On the other hand, providers may order more diagnostic tests to compensate for not understanding what their patients are saying.
2. *Patients* may not adhere to medical advice because they do not understand or do not trust the provider.

Trust is an important part of each relationship with the health care provider. For trust to develop, each person in the relationship needs to understand what is expected of the others. When the patient and health care staff come from completely different backgrounds and life experiences, the expectations may also completely differ. When expectations are not met, distrust is often the result.

The quality of the interaction between the health care staff and the patient has a profound impact on the ability of patients to report symptoms and to adhere to recommended treatment. It also has an impact on the patient's feelings about being respected (or disrespected) as an individual, a member of a family, and a member of a cultural group.

Cultural competence begins with an honest desire not to allow biases to keep us from treating every individual with respect. It requires an honest assessment of our positive and negative assumptions about others. For most people, cultural competence takes consistent and committed individual practice over time.

This is why we have to consciously examine our personal biases and beliefs about cultures other than our own: Unfounded assumptions that lead to prejudicial thoughts usually exist below the level of our awareness. They are often untested and unexamined; yet they shape our behavior profoundly. One way to deal with these assumptions and prejudices is to bring them to the surface and examine them. Practicing this skill helps providers to understand the impact of our unconscious, automatic thinking on ourselves and others. Practicing this skill also helps us to create new mental models of their patients that will, in turn, contribute to the quality of health care for all patients.



"Unfounded assumptions that lead to prejudicial thoughts usually exist below the level of our awareness."

Communicating With A Patient of A Different Culture

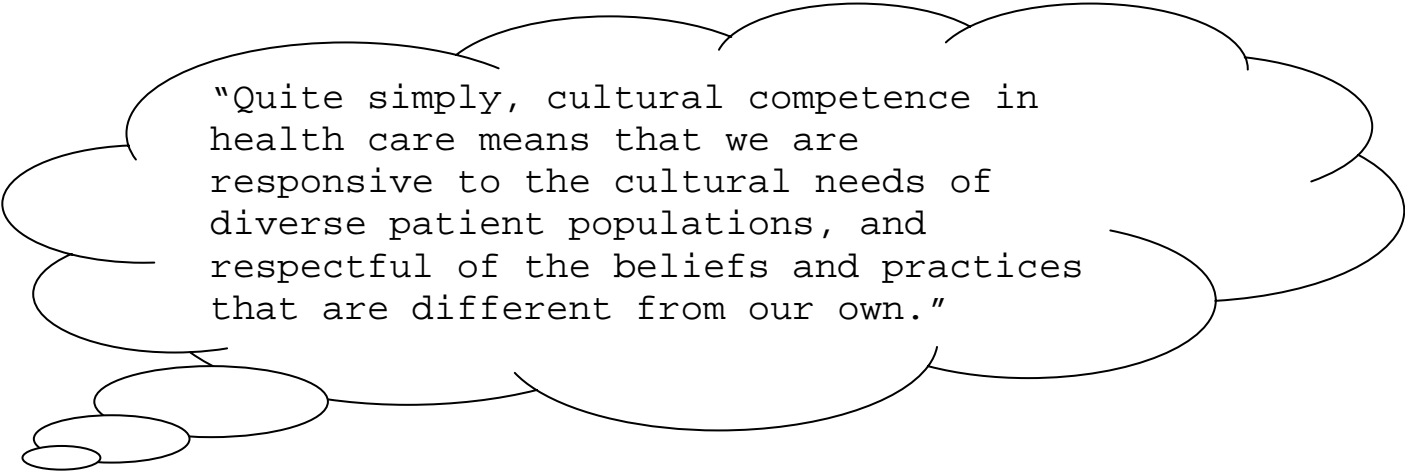
How can a provider convey "credibility, empathy, interest, and concern" to a patient from a different culture? The key to adherence is effective communication between provider and patient.

There are four activities that can contribute greatly to this communication:

1. Asking nonjudgmental questions that help us understand the patient's perspective on the illness, its causes, and its possible treatments;
2. Listening carefully to the patient's replies, trying to pick up clues to the patient's understanding as well as his or her ability to adhere to a recommended treatment;
3. Working with the patient and family members (as appropriate) to set realistic goals for behavior change, if needed.
4. Involving the patient in active problem-solving.

Here Are Some Examples of What To Ask:

- ❖ Tell me about your family.
- ❖ Tell me about your traditions & rituals
- ❖ When a person is sick do you think that person can make themselves well?
- ❖ What do you think makes a person sick?
- ❖ Do you know anyone who has been to a folk healer or used folk medicine?
- ❖ What does being healthy mean to you?
- ❖ How do you keep yourself healthy?
- ❖ What do you do differently from your ancestors to stay healthy?
- ❖ What do you do when you are sick?
- ❖ Where do you get your health information?



"Quite simply, cultural competence in health care means that we are responsive to the cultural needs of diverse patient populations, and respectful of the beliefs and practices that are different from our own."

What Is Culturally Competent Care?

Cultural competence is a matching set of behaviors, attitudes, and policies that come together in a healthcare system and among professionals that allows effective work in cross-cultural situations. 'Culture' refers to 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.

Culture impacts

- How health care information is received
- How rights and protections are exercised
- What is considered to be a health problem
- How symptoms and concerns about the problem are expressed
- Who should provide treatment for the problem
- What type of treatment should be given

Please keep in mind that while culture is an essential factor in people's health status, culture is not the only factor that shapes us. Other factors include environment, economics, genetics, previous and current health status, and psychosocial factors. All of these elements exert considerable influence on our well-being. Just remember that we all need to take care in order to avoid stereotyping!

How Can We Avoid Stereotyping?

While recognizing that there are many similarities among people from the same culture, it is important for health care providers to remember that each individual has a unique personal history, belief system, communication style, and health status. What may be true about some or most individuals from a particular region or country may not be true of all individuals from that region or country.

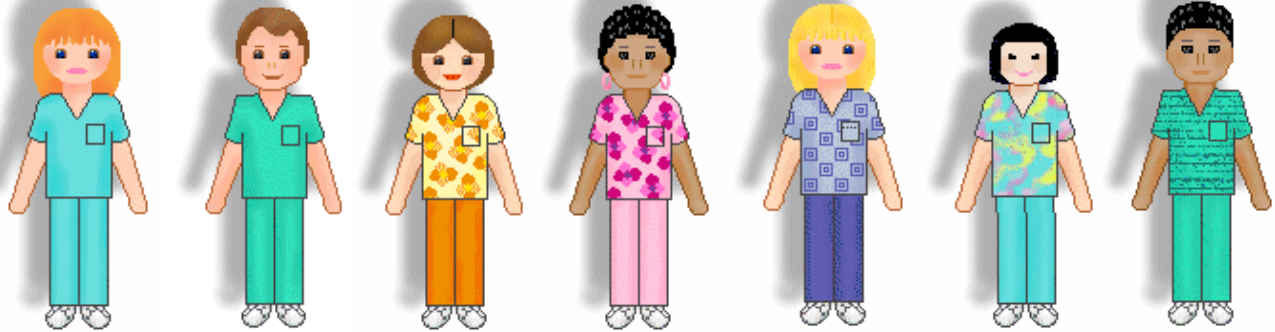
Some differences to look for include:

- People from rural areas may have been living a more traditional lifestyle than people who have emigrated to the U.S. from urban areas.
- Economic status and education can vary greatly among people from the same country.
- People from the same country may have migrated to the U.S. for very different reasons, including seeking economic opportunity, escaping religious or ethnic persecution, fleeing civil strife, or joining relatives in America.
- There are important intra-region and intra-group variations among people from the same country, and cultural variations may be marked among generations.



Reduced Ability to Speak, Understand, or Read English

With more than 46 million people in the United States who do not speak English as their primary language, and more than 21 million people who speak English less than “very well,” language is recognized as a significant barrier to quality health care. If your patient is illiterate or speaks a foreign language, giving them written materials will only increase their confusion. *Asking someone who has reduced literacy whether they understand what you just gave them to read may make them too embarrassed to admit their difficulty.* Another issue is the problem experienced by clinicians for whom English is a second language. Another staff member in the unit should help them communicate more clearly. Patients should be encouraged to say, “I don’t understand what you’re saying, Doctor. Can you explain?” Because providing an adequate understanding of a patient’s illness can often be invaluable in reducing a patient’s fear and anxiety and is instrumental in bringing about a more positive outcome for the patient, it is important that health care workers understand how to adjust their styles of educating and training patients depending on the specific population they are a part of.



Culturally Competent Communication Facts

- ✓ Low levels of **cultural competence** can impede the process of making an accurate diagnosis, cause the provider to order contraindicated medication, and reduce patient adherence to recommended treatment.
- ✓ When the patient and provider come from different cultural backgrounds, the medical history obtained may not be accurate. This is because the patient may not understand the questions or may be reluctant to report symptoms; in turn, the provider may **misunderstand** the patient's description of symptoms.
- ✓ Most of us harbor some **assumptions** about patients, based on race, ethnicity, culture, age, social and language skills, educational and economic status, gender, sexual orientation, disability/ability, and a host of other characteristics. These assumptions are often unconscious and so deeply rooted that even when an individual patient behaves contrary to the assumptions, the provider views this as the exception to the rule. A conscientious provider will not allow prejudices to interfere with making an accurate diagnosis with an appropriate treatment plan.
- ✓ When taking a **medical history** from a patient with a limited ability to speak English, asking questions that require the patient to give a simple "yes" or "no" answer, such as "Do you have trouble breathing?" or "Does your knee hurt?" is not helpful. While it may seem easier to ask questions that require a simple "yes" or "no" answer, this technique seriously limits the ability of the patient to communicate information that may be essential for an accurate history and diagnosis. The most effective way to put the patient at ease and to ensure that the patient provides essential information about his or her symptoms is to combine two types of questions: 1) open-ended questions such as "Tell me about the pain in your knee" and 2) more directed questions, such as "What makes the pain get better or worse?" Always get a qualified interpreter when possible.

- ✓ When conducting a **medical interview** with a patient from a different cultural background, you may be tempted to correct the patient's different beliefs about illness. This may lead the patient to simply withhold his/her thoughts in the future and interfere with building a trusting relationship. It is more effective to be nonjudgmental about differences in beliefs. You want the patient to honestly answer your questions and develop trust in the information and interventions you render. To accomplish these goals, it is essential to treat the patient with respect, openly discussing differences in health beliefs without specifying "correctness" or "incorrectness."
- ✓ In the US, some individuals from minority and immigrant groups use traditional **folk treatments** before turning to conventional Western medicine, or use both concurrently.
- ✓ When a patient who has not adhered to a treatment regimen states that s/he cannot afford the medications prescribed, do not assume that financial factors are indeed the real reasons. In addition to exploring **payment options** with the patient, it is important for the provider to inquire about cultural and psychological factors that may impede adherence to the prescribed treatment regimen.
- ✓ Although it may seem natural to look at the **interpreter** when you are speaking, you want the patient to feel that you are speaking to her/him, so you should look directly at her/him, just as you would if you were able to speak her/his language. It is best to speak in a normal tone of voice, at a normal pace, rather than pausing between words. Because of differences in grammar and syntax, the interpreter may have to wait until the end of your sentence before beginning to interpret. Do pause after one or two sentences to allow the interpreter to speak. When you need further information, or need to clarify what the patient has said, clearly tell the interpreter what you want asked of the patient. Although you may ask the interpreter to add his or her opinion of what the patient really meant, try to get as close as possible to the patient's actual words and intent.
- ✓ It is an inappropriate responsibility for families to take on the **role of interpreter** and may actually place the provider in violation of the Civil Rights Act of 1964 and the August 30, 2000 Office for Civil Rights (OCR) Policy Guidance. The rationale for using professional interpreters is clear. Professional interpreters have been trained to provide accurate, sensitive two-way communication and uncover areas of uncertainty or discomfort. Family members are often too emotionally involved to tell the patient's story fully and objectively, or lack the technical knowledge to convey the provider's message accurately.

- Cultural background, diet, religious, and health practices, as well as language, can differ widely within a given country or part of a country. The only assured similarity among people from around the world who come to you for care is the fact that they are your patients and they hope to be treated with respect and with concern for their individual health needs. As a health care provider, it is important to have a basic understanding of your patients' cultures—and to recognize the **similarities and differences** among people from the same region of the world and the same country. Differences in cultures within a region can be pronounced. Each patient is the product of many cultural forces. People from the same continent, the same country, the same part of the country, and even the same city, may have major differences in cultural heritage, traditions, and language, as well as differences in socioeconomic status, education, religion, and sexual orientation. It is the combination of all of these factors that make up a person's "culture."
- In many cultures, men are not involved in the activities surrounding pregnancy or childbirth. Yet they maintain the responsibility for **making decisions** and giving permission for treatment, medication, and hospital stays. A female relative may have to intervene between the provider and the husband.
- When a patient is **not adhering** to a prescribed treatment after several visits or hospitalizations, family members can provide valuable support. It may also be necessary to set small, realistic goals in order to achieve long-term behavioral change. Finally, an understanding of the patient's beliefs about other remedies may offer valuable clues to her/his reluctance to adhere to treatment. Simply repeating the instructions may not address the real issues that are keeping the patient from adhering to the regimen. In fact, repetition of instructions may be inappropriate and quite offensive if the patient has a communication disability.
- Recognize that a **smile** might express unhappiness or dissatisfaction in some cultures. Although smiling is an expression of happiness in most cultures, it can also signify other emotions. Some Chinese, for example, may smile when they are discussing something sad or uncomfortable. The use and interpretation of body language depends entirely on the patient's culture and personal preferences. What is appropriate in one culture may be embarrassing or offensive in another culture. Interpersonal greeting behaviors, for example, vary widely from one culture to another. Beliefs about touching are also highly variable, with some cultures placing a high value on physical contact, and others believing that physical contact of any kind are too intimate. Similarly, some cultures perceive direct eye contact as a sign of respect, but in other cultures, eye contact with elders and authority figures is to be avoided.
- Hand gestures** in particular can lead to serious misunderstandings. For example, the "ok" sign, widely used in the US, is the symbol for coins or money in Japan. In several other cultures, the gesture represents a bodily orifice and is highly offensive. Even "universal" symbols—a positive nod of the head, a pointing finger, a "thumbs-up" sign—have very different meanings in different cultures, and may be offensive.



In many of the world's cultures, an individual's health problems are also considered the family's problems, and it is considered threatening to exclude **family members** from any medical interaction. The provider should ask the patient whether she/he would prefer to be seen alone or with the family. It should be the provider's goal to help the patient to express her/his true preference about this - without offending any family members. The provider might ease any tension around this issue by assuring family members that they will be asked to return to the examining room in a short time.

Promoting Cultural Competency Self-Assessment Checklist

A = Things I do frequently **B** = Things I do occasionally **C** = Things I do rarely or never

When interacting with individuals and families who have limited English proficiency, I always keep in mind that:

1. ___ Limitations in English proficiency are in no way a reflection of their level of intellectual functioning.
2. ___ Their limited ability to speak the language of the dominant culture has no bearing on their ability to communicate effectively in their language of origin.
3. ___ They may or may not be literate in their language of origin or in English.
4. ___ I understand that it may be necessary to use alternatives to written communications for some individuals and families, as word of mouth may be a preferred method of receiving information.
5. ___ I understand the implications of health literacy within the context of my roles and responsibilities.
6. ___ I use alternative formats and varied approaches to communicate and share information with individuals and/or their family members who experience disability.
7. ___ I avoid imposing values that may conflict with or be inconsistent with those of cultures or ethnic groups other than my own.
8. ___ I intervene in an appropriate manner when I observe other staff or clients within my unit engaging in behaviors that show cultural insensitivity, racial biases, and prejudice.
9. ___ I recognize and accept that individuals from culturally diverse backgrounds may desire varying degrees of acculturation into the dominant culture.
10. ___ I understand and accept that family is defined differently by different cultures (e.g., extended family members, godparents, etc.).
11. ___ I accept and respect that male-female role may vary significantly among different cultures.
12. ___ I understand that age and life cycle factors must be considered in interactions with individuals and families (e.g., high value placed on the decisions of elders, the role of the eldest male or female in the family, or on the roles and expectations of children within the family).
13. ___ Even though my professional or moral viewpoints may differ, I accept individuals and families as the ultimate decision makers for services and supports impacting their lives.
14. ___ I accept that religion and other beliefs may influence how individuals and families respond to illnesses, disease, and death.
15. ___ I understand that grief and bereavement are influenced by culture.
16. ___ I accept and respect that customs and beliefs about food, its value, preparation, and use are different from culture to culture.
17. ___ I keep abreast of the major health and mental health concerns and issues for ethnically and racially diverse client populations residing in the geographic locale.

This checklist is intended to heighten the awareness and sensitivity of staff. There is no answer key with correct responses. However, if you frequently responded "C," you may not necessarily demonstrate beliefs, attitudes, values, and practices that promote cultural and linguistic competence within health and mental health care delivery programs.

Source: Goode T.D.: "Self-assessment checklist for personnel providing primary health care services," from Promoting Cultural Competence and Cultural Diversity for Personnel Providing Services and Support to Children with Special Health Care Needs and Their Families. Georgetown University Center for Child and Human Development (revised 2004).

Addendums Available In Baptist Health University:

1. Arab Cultures
2. Asian Cultures
3. Caribbean Cultures
4. Latino & Hispanic Cultures
5. Native American Cultures
6. Polynesian Cultures
7. South Asia- India Cultures

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