PHYSICIAN TOOLKIT AND CURRICULUM

Resources to Implement Cross-Cultural Clinical Practice Guidelines For Medicaid Practitioners

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USING THE TOOLKIT

What is the Purpose of this Toolkit?

The objective of this toolkit is to aid providers in practical application of the Cross-Cultural Clinical Practice Guidelines. It introduces the basic fundamentals of cross-cultural practice and offers steps and processes essential to delivering quality care to culturally diverse populations.

Who is the Toolkit Designed for?

This toolkit is tailored for physicians or clinicians who:

- Work in primary-care practice settings that serve culturally diverse Medicaid populations.
- Have participated in some basic cross-cultural training workshop or program.
- Seek to enhance delivery of quality of care across all populations served by their practice.

The Cross-Cultural Clinical Practice Guidelines offer guiding principles that serve as standards for improving the patient-physician interaction during the clinical encounter. The information contained is intended to be adapted over time.

What Does the Content of the Toolkit Contain?

This resource is organized into sections that address information relevant to implementing the clinical guidelines as follows:

- Section I introduces the rationale and the guiding principles underlying cross-cultural practice.
- Section II presents an overview of health disparities, and the link between quality and the clinical encounter.
- Section III presents an overview of cultural dynamics influencing the cross-cultural encounter.
- Section IV offers information for applying methods to enhance clinical assessment processes.
- Section V offers information for applying methods to enhance treatment planning and adherence.
- Section VI offers information for applying methods to enhance patient communication.
- Section VII offers information on factors that can affect decision-making during the cross-cultural encounter.
- Section VIII offers information for improving organizational supports and system tools in practice settings.

Sections I-III provide overview information, Sections IV-VII includes basic action steps that offer specific examples of techniques to select from or build upon over the course of the physician-patient relationship. Each section also provides references to access other materials (in the form of bibliographic reference and web-based resources) that support content that providers are encouraged to explore. The Toolkit is accompanied by a Provider Curriculum that identifies basic session goals, learning objectives and topic focus areas relevant to each section of the Toolkit.

What Does this Toolkit Not Cover?

The toolkit is not intended to be a comprehensive reference on cross-cultural medical practice. It does not cover in-depth discussion of cultural competence or diversity issues. Providers are encouraged to seek additional resources to complement the contents of the Toolkit and Curriculum.

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SECTION I: INTRODUCTION AND RATIONALE

While the United States continues to become a more culturally diverse society, so too, has the demand increased for medical care delivery that is responsive to multicultural populations. It is expected that by the year 2030, approximately 40 percent of the American population will be comprised of racial and ethnic minority groups. Despite significant medical advances made over the past century to improve health outcomes among the overall population, ethnic minority populations have not benefited from such improvements, as evidenced by their dramatically shorter life spans, higher morbidity rates and continued lack of access to quality care.

Cross-Cultural Clinical Guidelines: The Quality Imperative

The Institute of Medicine (IOM) report "*Crossing the Quality Chasm*" identifies patient-centered and equitable care as two of the six core dimensions of quality. These two dimensions emphasize providing care that is respectful of, and responsive to, individual patient values/preferences, and does not vary in quality based on ethnicity, socioeconomic status or geographic location. A more recent IOM report "*Unequal Treatment*," however, highlights that minorities receive lower quality of care even when controlling for insurance, co-morbidity, education and socioeconomic status. This report notes that the nature of disparities are complex and involve several levels including health system processes, health care professionals and patients.

Current trends point to the use of clinical practice guidelines as one means to improve the quality of patient-care delivery and health outcomes. Yet many guidelines have not focused on issues of patient-centeredness and equity. Consequently, the cross-cultural clinical practice guidelines were developed to assist practitioners in improving the quality of care they deliver to diverse populations.

A key goal of the cross-cultural clinical practice guidelines is to provide guiding principles for improving patient-centered care as a means of reducing disparities in access and health outcomes among diverse populations. The primary objectives are to:

- Improve skills for gathering information related to those factors that influence a patient's health values, beliefs, behaviors and expectations for care.
- Develop clinically effective treatment plans that are compatible with a patient's values, preferences and needs.
- Increase awareness of individual and institutional factors influencing clinical decision-making processes that affect outcomes of care.
- Improve communication that promotes a doctor-patient relationship based on mutual respect and trust.

The guidelines have been written for primary care practitioners serving racial, ethnic and linguistically diverse Medicaid populations through a variety of outpatient settings. The guidelines are comprised of a set of statements designed to enhance existing physician skill sets for meeting the above stated objectives. The statements were developed through extensive review of the medical literature and in consultation with a team of primary care physicians representing a variety of practice specialties and experienced in delivering care to diverse Medicaid populations. The guidelines place emphasis on directives aimed at influencing practitioner behavior to refine current processes that result in better patient outcomes.

Guiding Principles for Cross-Cultural Clinical Practice Guidelines

The clinical guidelines are comprised of 10 statements that highlight the processes and skill sets necessary for physicians to effectively obtain an adequate medical history, ensure an accurate diagnosis and develop a mutually agreeable treatment plan during the cross-cultural encounter.

The statements are intended to be used as a package to affect the entire spectrum of care including the individual, interpersonal and institutional aspects of patient care. They are as follows:

The 10 Guiding Principles

1. **Elicit the patient's views on illness and treatment practices to understand his or her health values, particular concerns and expectations for care.**
2. **Assess the cultural norms, values and customs that influence the patient's health seeking behaviors, practices and expectations for the physician-patient relationship.**
3. **Assess the patient's environmental context to determine what social experiences and resources may be affecting illness behaviors or health-seeking practices.**
4. **Identify a range of treatment goals for a given medical condition that can be mutually satisfactory and take into account the patient's cultural health beliefs, practices, norms, customs and traditions.**
5. **Identify the social and environmental factors that may potentially interfere with adherence to treatment goals.**
6. **Work collaboratively with the patient to negotiate treatment plans that incorporate aspects of the biomedical model while integrating cultural concepts for treating illness familiar and important to the patient.**
7. **Develop communication skills that are respectful of the patient's cultural norms, values and language to facilitate empathy in the clinical encounter.**
8. **Utilize patient education strategies during the clinical encounter that take into consideration literacy, cultural appropriateness and language concordance.**
9. **Acknowledge that personal, professional and institutional factors can affect aspects of clinical decision-making which, in turn, may lead to disparities in care.**
10. **Take proactive steps to adapt institutional and system processes that support clinical practice aimed at delivering clinically appropriate and culturally responsive care.**

The guidelines emphasize promoting skill sets for establishing a doctor-patient relationship based on respect and empathy for cultural and racial diversity as the basis for exchange and engendering trust. In addition, they offer a framework to avoid the pitfalls of stereotyping and generalizing about subgroup beliefs, practices and behaviors. Practitioners must recognize that developing knowledge and skills to deliver patient-centered care to culturally diverse populations is an ongoing developmental process that requires gaining a certain level of awareness, reflecting on current practice and taking actions to continually modify care delivery processes.

The statements are intended to serve as standards to strive towards and are best adapted over time.

Practitioners may choose to customize the guidelines depending on the predominant cultural characteristics of patients served by their practice settings.

An important component of these guidelines require that practitioners have organizational and system supports consistent with national standards for Cultural and Linguistically Appropriate Services (CLAS) in health care settings. The successful adoption of Cross-Cultural Clinical Practice Guidelines not only depends on the knowledge, attitudes, behaviors and resources of the physicians within the organization, but also on creating a practice environment that is committed to reducing barriers to guideline use.

It is recommended that each practice setting provide training and establish interdisciplinary teams to share responsibility in adopting the use of the guidelines. Training can be tailored to the type of patient practice, level of knowledge and experience of physicians within a given setting. Strategies for practical application of these guidelines are addressed throughout the content of this Toolkit. A Provider Curriculum to orient practitioners in implementing these guidelines is included as a companion guide to this Toolkit.

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SECTION II: OVERVIEW OF HEALTH DISPARITIES

Significant disparities in health status, delivery of health services and outcomes of care continue to persist among racial and ethnic minority populations despite scientific advances in medical technology, health promotion and disease prevention efforts. The nature of disparities is quite complex and has long been embedded in historical, social, political and institutional factors that have evolved over time. This section provides a brief overview of some factors that have bearing on health disparities.

The Link between Disparities and the Clinical Encounter

Ethnic minorities experience a higher incidence and prevalence of chronic health conditions, preventable hospitalizations, and morbidity and mortality rates compared to Whites. Although approaches to addressing disparities has been aimed at changing patient behaviors, emerging studies suggest that disparities may also be linked to physician and institutional behaviors.

- *Heart disease* is known to be higher among Black males that White males and 65% higher for Black females than White females; High blood pressure is nearly 40% higher in Blacks than in Whites. A patient's race and gender have been shown to influence a physician's decision to refer for cardiac catheterization after controlling for socioeconomic status, insurance and clinical symptoms (Schulman et al, 1999).

- *Diabetes* in Black, Hispanic and American Indian communities is 2 to 4 times greater than in White communities. Diabetic nephropathy, kidney failure and liver failure are 3-7 times higher among Blacks, Mexican Americans and American Indians than Whites. Yet Blacks are less likely to be referred for renal transplants and offered optimal treatment less frequently than Whites (Cummings et al, 1995).

- *Cancer* mortality rates are not only higher among Black, Hispanic and Vietnamese Americans but these groups have lower survival rates for specific types of cancers than Whites. Evidence-based studies suggest that differences in how physicians manage cancer based on a patient's race contributes to lapses in optimal cancer care that result in lower survival rates among Blacks (Bach et al, 1999; King and Brunetta, 1999).

- Hispanics are twice as likely as non-Hispanic Whites to receive no pain medication for long bone fractures. Studies suggest that differences in pain management and analgesic use relates to failure on the part of physicians to recognize presence of pain in patients who are culturally different from themselves (Todd et al, 1993).

- Black and Hispanic patients are less likely to receive major therapeutic hospital procedures for a number of conditions Differential use of diagnostic and therapeutic hospital procedures for Blacks and Hispanics may be due to physician bias of patient race or gender (VanRyn and Burke, 2000).

- Physicians tend to perceive patients of other races more negatively than they perceive White patients. Physicians also tend to perceive patients of low socio-economic status (SES) more negatively than those of upper SES. These socio-demographic characteristics are associated with a physician's assessment of a patient's intelligence, likelihood of risk behaviors and ability to adhere to medical advice (VanRyn and Burke, 2000).

- Ethnic minorities are more likely to use emergency rooms (ER) as their regular or primary source of care. Approximately 6.6% of visits among Whites occurred in the ER compared to 7.8% for African American and 9.6% for Latinos (Harris, Andrews and Elixhauser, 1997).

While these disparities can be explained by various social, cultural, economic and environmental determinants, the IOM Report on “Unequal Treatment” highlights that delivery of quality care remains a product of the relationship between physician, institutional and health care system behaviors.

Patient Experiences with Clinical Encounter Medical Care System

According to national surveys, ethnic minority patients also face difficulties in accessing quality care and communicating with physicians, and report negative experiences with the medical care system (Kaiser Family Foundation, 1999; Collins et al, 2002).

- Blacks (16%) and Hispanics (18%) were most likely to feel they had *been treated with disrespect* (spoken to rudely, talked down to or ignored) during a health care visit and felt this was related to aspects of communication.

- Asians were least likely to feel that their doctor *understood their background and values* and were more likely to report that their doctor looked down on them because of their culture.

- Black, Hispanic and Asian patients reported having more *communication problems* during doctors visits compared to Whites such as not fully understanding their doctor, feeling that their doctor did not listen to them, or having questions but not asking them during the visit.

- One in three Blacks (30%) and 41% of Hispanics report that *complying with treatment plans* would cost too much compared to 24% of Whites and 27% of Asians. Among those who visited a doctor or hospital, 1 in 4 reported ignoring medical advice because they disagreed with the doctor.

As a result of these experiences, ethnic minority groups feel less involved in their health care decisions, report ignoring medical advice because they disagreed with their doctor and are less likely to comply with treatment plans.

Factors Contributing to Disparate Outcomes

Several factors are viewed as contributing to these disparate outcome:

1) *Patient level factors* that include differences in cultural health beliefs and practices that may lead to lack of agreement in treatment or care regimens; language barriers; familiarity with U.S. medical system, education or literacy levels; lifestyle behaviors related to dieting, obesity, smoking, physical activity, alcohol intake; and lower socioeconomic status that impose constraints for adapting lifestyle changes, accessing preventive services and in turn seeking care at a chronic stage of disease.

2) *Physician level factors* may also include lack of training in cultural competency, stereotyping, prejudice and bias about patient groups that influence decision-making processes about diagnostic procedures or referrals that can affect access to optimal care or patient care management.

3) *Organizational systems* deficient in the tools and resources needed to support clinical care processes to diverse populations.

Additional Resources

Disparities in health status and outcomes of care vary greatly across and within racial and ethnic minority subgroups. Familiarity with the prevalence or incidence of diseases/chronic health conditions of particular subgroups served by your practice will help avoid the pitfalls of making generalizations and better prepare you to tailor strategies for adopting changes in patient care management processes.

To access the most updated information on health disparities or to learn more about quality of care issues impacting culturally diverse populations, refer to the following sources:

- Center for Disease Control: http://www.cdc.gov/nccdphp/aag/aag_reach.htm
- Center for Studying Health System Change: http://www.hschange.org/
- Commonwealth Fund: http://www.cmwf.org
- Kaiser Family Foundation: http://www.kff.org
- Knowledge Path on Racial/Ethnic Disparities in Health: ttp://www.mchlibrary.info/KnowledgePaths/kp_race.html
- National Center on Minority Health and Health Disparities: http://ncmhd.nih.gov
- National Institute of Environmental Health Studies: http://www.niehs.nih.gov/external/resinits/ri-2.htm
- Race and Health Care: http://www.udayton.edu

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SECTION III: CULTURAL CONSIDERATIONS IN HEALTH CARE

Culture is a crucial component in both how the clinician delivers medical care and how the patient responds to medical interventions. Delivering culturally appropriate medical care requires becoming familiar with the many aspects of culture that influence patients' health values, beliefs, behaviors and expectations for treatment. This section of the Toolkit provides summary information on cultural factors that can affect the clinical encounter.

Impact of Culture on Health Behaviors

While data on disparities provide tangible facts on outcomes of care, the dimension of culture lends insight on the complex behaviors that may influence those outcomes. Culture provides the system of information that dictates beliefs and patterns of behavior within any given environment. Some fundamental differences that influence health values, communication and interaction styles between American/Western and Non-Western cultures are summarized in Table 1 below.

Table 1:
Cultural Dynamics Influencing the Clinical Encounter

American/Western Cultures	Concepts	Non-Western Cultures
•Health is absence of disease. •Seeks medical system to prevent disease & treat illness. •Seeks specialty practitioners (e.g., physicians, nurses, psychiatrists, surgeons, etc.). •Prevention is practiced to avoid disease in future. •Foods used to affect biological functioning.	**Core Health Beliefs and Practices**	•Health is a state of harmony within body, mind, spirit. •Seeks medical system when in acute stage of illness. •Seeks herbalists, midwives, santiguadoras, curanderos, priests, shamans, espiritistas, voodoo priests, etc. •Prevention of disease is not a recognized concept. •Foods used to restore imbalances (hot/cold; ying/yang).
•Values individualism: focus on self-reliance & autonomy. •Values independence and freedom. •Values youth over elderly status. •Personal control over environment & destiny. •Future oriented. •Efficiency: time is important; tardiness viewed as impolite.	**Cultural Values, Norms, Customs**	•Values collectivism: reliance on other & group acceptance. •Values interdependence with family and community. •Values respect for authority and elderly status. •Fate controls environment & destiny. •Present oriented: here and now. •Efficiency: time is flexible; viewed as impolite/insulting.
•Greeting on first name basis denotes informality to build rapport. •Being direct avoids miscommunication. •Eye contact signifies respect and attentiveness. •Personal distance denotes professionalism & objectivity. •Gestures have universal meaning.	**Communication Styles**	•Greeting on first-name basis denotes disrespect. •Being direct denotes conflict. •Eye contact is considered disrespectful. •Close personal space valued to building rapport. •Gestures have taboo meanings depending on cultural subgroups.
•Individual interests are valued and encouraged. •Individual is the focus of health care decision-making. •Reliance on nuclear family bonds.	**Family Dynamics**	•Individual interests are subordinate to family needs. •Family is the focus of health care decision-making. •Reliance on nuclear & extended family networks.

Table 1 on the previous page summarizes the common views on health beliefs/practices, norms for interpersonal interaction, communication styles and family dynamics across various ethnic minority group cultures. These beliefs and concepts inform the actions for seeking health care, a proper relationship between physician-patient, decision-making processes and expectations for care.

While the information in Table 1 can be helpful, caution must be exercised in making generalizations during a cross-cultural encounter as this risks stereotyping.

Instead, this information can be viewed in the context of a continuum where each end represents the extreme on the spectrum of beliefs/values while being aware that many patients may fall in the middle or somewhere between both ends.

Core Cultural Concepts

The core beliefs and concepts highlighted in Table 1 inform the actions for seeking health care, a proper relationship between physician-patient, decision making processes and expectations for care.

- ***Core Health Beliefs/Practices***: Culture influences core health values. Many ethnic minority groups may share a holistic view of health, illness and treatment that integrates body, mind and spirit, whereas American/Western approaches treat these dimensions separately. For example: illness is defined as being out of balance with body, mind and spirit rather than as a disease. These beliefs often dictate health- seeking behaviors and the types of practitioners sought to treat illness or condition.

- ***Cultural Norms, Values, Customs***: Some ethnic minority groups may also share approaches to health/illness behaviors that rely on group support and interdependence (collectivism), whereas American/Western approaches focus on patient autonomy and independence (individualism). Cultural values about respect, deference to authority, control over fate or environment and time orientation will often dictate proper physician-patient interaction during the encounter.

- ***Communication Styles*:** The nature of the physician-patient interaction relies on recognizing and understanding the basic norms, mannerisms and tools for communication that are acceptable to both parties (Yu, 1999). Differences in values for direct (verbal) and indirect (non-verbal) communication can also influence physician-patient relationship and outcomes of care. For example, eye contact with physicians is viewed as disrespectful and consistent with norms for deference to authority figures among African American, Hispanic, Asian and some immigrant cultural groups. Physicians who expect ethnic minority patients to speak up or be direct about their concerns may miss the essence of what is being communicated.

- ***Family Dynamics***: Culture also influences the family structure and interaction dynamics. A shared value across many ethnic minority groups is the strong identification and reliance on immediate and extended family members for emotional and material support. Family members become active participants in making all medical decisions, which differs from American/Western values where cultural norms of individualism and patient autonomy are central to the decision-making process. Physicians should be aware that patients may delay crucial medical treatment decisions to permit consideration and input of the family.

Delivering patient care that does not take into consideration how culture influences health beliefs, health seeking practices, norms for communication and interaction or family role dynamics can limit the efficacy of therapeutic interventions and treatment adherence**.** Physicians are encouraged to reflect on how culture influences their own core beliefs, professional behaviors and their practice environment, as well as to learn about the particular subgroups served by their practices.

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SECTION IV: CLINICAL ASSESSMENT PROCESSES

Obtaining an accurate diagnosis not only relies on having a clear understanding of the patient's medical history and symptoms but also of the cultural meaning and values being expressed about his or her experience with illness. The accuracy and quality of the diagnosis can be greatly enhanced through a patient-cultural assessment process compatible with clinical-diagnostic activity.

This section offers information on how to put into practice guiding principle statements 1- 3, which are outlined in Section I of this Toolkit.

Cross-Cultural Views on Diagnostic and Treatment Concepts

Culture tends to magnify differences in views about how one experiences health and well-being, communicates about illness and seeks treatment. Acknowledging and understanding the basic differences in worldviews between Western Biomedical and non-biomedical techniques that inform concepts about diagnosis and treatment can be useful during the cross-cultural encounter. These views often dictate how the patient communicates about his or her illness or expectations for treatment and are summarized in Table 2 below.

Table 2:

Techniques Influencing Diagnosis and Treatment Practices Across Cultures

CONCEPTS	WESTERN BIOMEDICAL TECHNIQUES	NON-BIOMEDICAL TECHNIQUES Physiological	 Spiritual/Mental
Focus of Diagnosis:	• To identify pathogen or biochemical change responsible for disease. • Diagnostic procedure relies on physical exam and laboratory tests.	• To identify forces affecting imbalances of bodily humors. • Diagnostic procedures may use taking of pulse, examining tongue or eyes to determine state of internal organs, hot-cold or ying-yang imbalances.	• To identify agent behind the cause and render it harmless. • Diagnosis of physical symptoms is of secondary concern since condition will not improve without addressing primary belief for cause of disease.
Focus of Treatment:	• Destroy or remove entity causing disease or control symptoms affecting physical/mental functions.	• To restore equilibrium of physiological function. • Treatment may include herbs, food combinations, dietary restrictions, enemas, massage, poultices, coining, cupping, acupuncture and discontinuing biomedical treatments.	• Primary treatment involves a curing ritual to remove object of intrusion (lifting spell, reversing technique). • Secondary treatment is to address physical symptoms and implement cure through use of herbalist.

Table 2 shows that non-biomedical techniques focus on an integrated (body, mind, spirit) approach to diagnostic and treatment practices compatible across various cultures. This information must also be viewed in the context of a continuum where the approaches represent the extreme on the spectrum of beliefs/values about diagnostic and treatment practices. This will depend on the extent of the patient's familiarity and experiences with the U.S. medical care system.

Caution must also be used in generalizing the information in Table 2, as this risks stereotyping.

One approach to avoiding such generalizations is to adapt interviewing techniques that obtain information on the extent of patients' adherence to their health beliefs/practices as a way of improving the accuracy of diagnosis.

Eliciting Patient Views

Physicians can adopt a framework that gets at the patient's explanation about the origin of his or her illness, onset and severity of symptoms, cultural meaning of symptoms and expectations for treatment using a patient explanatory model during the clinical diagnostic process. (See Figure 1 below.)

Figure 1:
Eliciting Patient's Views on Illness

1. What do you call your problem? What name does it have?
2. What do you think caused your problem?
3. Why do you think it started when it did?
4. What is your sickness doing to you? How does it work?
5. What problems has it caused you?
6. Will it last a short or long time?
7. What kind of treatment do you think you should get?
8. What results do you hope to get from the treatment?

Source: Klienman, et al, 1978.

The Patient Explanatory Model

The explanatory model uses a process that is compatible with the clinician's diagnostic activity to get a patient's views of illness and treatment.

The questions in Figure 1 serve as a basic script to elicit information on how the patient perceives the problem, how it affects his or her day-to-day functioning and what treatment expectations he or she may have for the visit.

Views about common western diagnostic procedures (ex: physical exams, laboratory tests, surgical procedures, etc.) can also be elicited to determine if these may conflict with cultural health beliefs/practices.

For example: physical exams may be taboo among some cultural subgroups, blood tests may also interfere with balances in bodily humors and transplants may go against some religious beliefs.

Physicians that elicit patient views of illness/treatment in this manner are at an advantage for:

- Identifying discrepancies among physician-patient health beliefs and practices.
- Generating a common language to anchor physician-patient communication about illness.
- Building trust to involve the patient in negotiation and making decisions about treatment goals.

Refer to the case study example at the end of this section for an illustration on how to elicit information on views of illness during a cross-cultural clinical encounter.

Patient Cultural Assessment

The purpose of the cultural assessment process is to clarify the nature of the problem, modify interventions and define treatment goals. It can facilitate getting a more complete picture of what influences patient health values, behaviors and the quality of the physician-patient relationship.

The cultural assessment process can use a systematic approach to aid the clinician in distinguishing which factors (cultural, social or environmental) may be predominant influences on patient health values, behaviors, and norms for physician-patient interaction. An added feature of this process is that it can serve to establish rapport, which can lead to building relationships with the patient and his or her family.

Not all patient encounters will require the need for a cultural assessment. Gathering data on culture is an ongoing process and will occur as the physician-patient relationship develops over time.

Focus of a Cultural Assessment

A patient cultural assessment can focus on getting data in key areas (noted on Figure 2 on this page) to supplement information elicited on views of illness such as:

- *Cultural Context:* The elements listed provide insight about the patient's cultural identity, family dynamics, communication patterns, time/space orientation or religious beliefs influencing decision-making behaviors and physician-patient interaction.
- *Social Context:* The elements listed in this area provide insight on the type of social support networks and resources available to the patient and his or her family for health care or during illness.
- *Environmental Context:* The elements listed can provide information on surroundings influencing health-seeking behaviors, access to regular sources of care and treatment adherence. Length of time in the U.S. or frequency of returns to country of origin can also influence treatment practices and use of medications.

Figure 2 lists some of the many elements under the key areas that can serve as useful information on behaviors and norms for physician-patient communication, interaction and health-seeking practices.

Figure 2:
Elements of a Cultural Assessment

Cultural Context: Values, Norms, Customs

- Racial/Ethnic identity
- Family structure
- Communication patterns & styles
  - Verbal vs. Non-Verbal
  - Language preferences
- Gender roles
- Sexuality
- Authority figures
- Religion & spirituality
- Food and dietary habits
- Time/space orientation

Social Context:

- Social support networks
- Social structures (extended family)
- Socioeconomic status
- Community resources (churches, etc.)
- Education level
- Literacy level
- Lifestyle behaviors (smoking, exercise, etc.)

Environmental Context:

- Familiarity with U.S. health care system
- Acculturation
  - Example: Length of time in U.S. (3 yrs)
- Frequency of returns to country of origin
- Political history and experience in U.S.
- Racism and discrimination
- Geographic access

The information from the Patient Explanatory Model (Figure 1) and the Cultural Assessment (Figure 2) together will provide a comprehensive picture of the cultural, social and environmental factors that may be influencing patient behaviors or outcomes of treatment. Appendix A of this Toolkit offers examples of some questions to consider when designing a cultural assessment for use in your practice setting.

Sample Case Study 1:
Hispanic Female Presenting with Type 2 Diabetes*

The following case study provides an illustration of how the Patient Explanatory Model and Cultural Assessment process can be applied to elicit information during a cross-cultural clinical encounter.

BACKGROUND:

A 68-year-old Puerto Rican female who was born and raised in Puerto Rico moved in with her oldest daughter two years ago and depends upon family members to take her shopping, do errands and bring her to doctor's appointments. She is independent in her abilities to cook, clean and take care of her daily needs but is unable to read or write. She speaks only Spanish. She was diagnosed with Type II diabetes several years ago and is taking Glipizide and Metformin. This is her first visit with a primary care physician in the United States.

SAMPLE QUESTIONS FOR CLINICIAN	PATIENT RESPONSE (TRANSLATED)
What symptoms are you having?	I'm very thirsty and urinate a lot, but don't know why.
What do you think may be the reason you have these symptoms?	I think it's because I'm old and these things happen as you get older.
What do friends, family, others say about these symptoms?	Some say it could be diabetes and that I should get checked.
Have you heard about, read, or seen anything on TV, radio or newspaper about diabetes?	Sometimes on TV I've seen something about diabetes. But I don't read and listen to music during family events.
What kinds of medicines, home remedies or other treatments have you tried for this illness?	*Agua con Sabila* (aloe) and sometimes water with eggplant. I saw this on TV and currently I'm taking orange juice with Aloe to help clean my insides and blood. It is considered a miracle plant.
Is there anything you eat, drink or do (or avoid)?	I don't eat chicken and stopped eating most other meat, except for a pork chop I eat once or twice a month. I always drink lots of water, I eat rice and beans, mixed salads, a lot of root vegetables (*verdura*) with *bacalao* (cod fish). I believe in taking care of myself but will not starve myself from eating things I like.
Have you sought any advice from friends, alternative/folk healers or other people (non-doctors) for help with your health problems? Tell me about it.	No, but I take natural herbal pills like *VenoFlash* which helps my circulation, and Aloe pills to help me with bowel movements. I learned about these two pills from television (Spanish channel). I feel they help me and the herbal medicine doesn't contain drugs. I also pray every morning and know that God will hear my prayers.
What kind of treatment are you seeking from me?	Well I want you to cure me, but because I'm old, I know these things happen when you are old. So I just want you to give me medicine to help me feel better.
What results do you hope to achieve from this treatment?	I want to feel better, enjoy the years I have left, don't want to have pain, and I want to keep my sugar and cholesterol in control.

** Adapted from: Institute Health Improvement Health Disparities Collaborative Series 2001 (www.healthdisparities.net).*

An evaluation of how this case study addresses the application of clinical practice guiding principles 1 – 3 (presented in Section I of the Toolkit) is provided in Appendix B.

Summary Action Points

The summary action points highlight select tips contained in this section on how clinical practice guiding principles 1–3 can be adopted to enhance clinical diagnostic activity during the cross-cultural encounter.

The action steps offer specific examples of techniques to select from or build upon as the physician-patient relationship develops over time. Clinicians are encouraged to review the tools provided in the Appendix and references listed at the end of each section of the Toolkit or Provider Curriculum for other ideas on tailoring techniques to the populations served by your practice.

Clinical Practice Guiding Principles	**Action Steps**
1. Eliciting patient views on illness and treatment …..	☐ Use the explanatory model to get at the patient's cultural meaning of disease and expectations of care. ☐ Be flexible in the way you structure questions when applying the explanatory model to fit to the nature of the visit and situation. ☐ Use alternatives to direct questioning (close-ended yes/no) during history taking and apply conversational styles or open-ended questions. ☐ Get the patient's views about common biomedical diagnostic procedure to determine if these may conflict with cultural health beliefs and practices. ☐ Acknowledge differences and similarities in physician-patient views about the nature of the problem or illness.
2. Assessing cultural norms, values and customs ……	☐ Assess extent of use for folk remedies and practitioners. ☐ Determine the patient's language preference for communication during visits. ☐ Be open to learning about cultural norms/customs from a variety of sources (family, social workers, cultural informants, interpreters, etc.). ☐ Work with clinical staff in your practice to determine the most appropriate method for doing a cultural assessment (e.g., initial or follow-up visits). ☐ Use the cultural assessment process to establish rapport with the patient and his or her family.
3. Assessing social and environmental context …..	☐ Document social context in medical records (e.g., years in U.S., English fluency, family support systems, community resources, education, literacy, etc.). ☐ Assess access to transportation and working or income status to determine constraints related to medical care. ☐ Ask about country of origin and frequency of return to country of origin. ☐ Ask patient and his or her family about experiences with medical care in this country and their country of origin.

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SECTION V: TREATMENT PLANNING AND ADHERENCE

A key goal of patient-centered care is to develop treatment plans that are not only clinically effective but also compatible with the patient's cultural values, preferences and needs. This section offers information on how to put into action the clinical practice guiding principle statements 4 - 6 outlined in Section I of this Toolkit.

Considerations in Treatment Planning

Working with patients from other cultures requires becoming familiar with their health practices and health-seeking behaviors, and learning to distinguish when choices made about treatment plans and adherence are based on cultural, social, environmental or other forces. Some of the areas that can be considered during the clinical encounter include the following:

> *"A full 30% of Blacks and 41% of Hispanics report that complying with treatment plans would cost too much compared to 24% of Whites and 27% of Asians. Among those who visited a doctor or hospital, 1 in 4 reported ignoring medical advice because they disagreed with the doctor." ----Kaiser Foundation Study*

a) *Cultural Health Practices:*	Treatment planning must not only consider incorporating the patient's views about how to treat the condition but also a willingness to accept his or her views unless it poses serious harm to the patient. Physicians are encouraged to consider treatment practices such as: o Types of traditional/folk medicine practitioners sought to diagnose or treat symptoms/illness. o Type and frequency of traditional/folk remedies used to treat symptoms/illness. o Religious practices or spiritual beliefs that may affect or interfere with treatment regimens. o Patient's health beliefs and views about medications. o Patient's expectation of your role during treatment.
b) *Role of Family:*	Treatment planning also requires acknowledging and understanding that cultural norms and customs across many cultural groups dictate that medical decisions about care goals be made as part of a group process. Physicians are encouraged to learn about family dynamics such as: o Which family member is designated as the key decision-maker on health issues. o Which members of the family would help implement and monitor treatment. o Which extended family members need to be consulted or included in the process.
c) *Socioeconomic Factors:*	Limited economic resources may also influence patient treatment adherence in the following manner: o Ability to pay for treatment (medications, medical supplies, etc.) over time. o Can lead to seeking alternative less expensive remedies as substitutes for treatment. o Can lead to cutting back or skipping dosages to make medicines last longer. o Can lead to sharing medications with immediate or extended family members.
d) *Environmental Factors:*	Treatment adherence may also be impacted by the patient's surroundings in a variety of ways: o Patient or family caregiver work status can affect the ability to take time off to keep follow-up appointments to monitor treatment. o Lack of access to transportation can present barriers to keeping medical appointments. o Exposure to toxins (e.g., pollution, allergens, roaches, etc.) that may decrease the efficacy of treatment. o Length of time in U.S. may affect familiarity with American biomedical treatment practices and processes.

Negotiating Treatment

Negotiating treatment goals and adherence involves an acknowledgment by both the patient and clinician that there may be a lack of congruence about the treatment plan, methods and how treatment is to be provided. The goal of negotiation is to come to a mutually-agreeable care plan that ultimately improves the patient's health.

The negotiation process can emphasize acknowledging and addressing the patient's cultural context, collaborating and problem solving on the conditions for treatment, and cultivating the physician-patient relationship. Basic steps can be taken to enhance each of these components.

Cultural Context:	The clinician can begin the negotiation process by presenting the problem using terms and concepts that reflect the patient's views/beliefs by taking the following steps: o Identify discrepancies in physician-patient views on how to treat symptoms/illness for the condition based on the explanatory model (EM). o Review the patient's view/beliefs about the symptoms, illness and treatment for the condition. o Determine how the patient's view differs from yours. o Explain the views of the biomedical model using concepts and terms familiar with their EM. o Identify disagreements related to cultural or religious practices. o Clarify and discuss ethical disagreements related to cultural or religious practices.
Negotiating Treatment Options:	Negotiating treatment options can incorporate some of the following: o Involve immediate or extended family members to discuss care goals. o Determine patient/family priorities about treatment preferences. o Clarify and discuss ethical disagreements related to cultural or religious practices. o Consider consulting spiritual or traditional healers in treatment planning. o Set realistic treatment regimens based on resources available to the patient and his or her family. For example: diet restrictions may be difficult to adhere to during family gatherings or special events that have strong cultural meaning. Also be aware that outdoor exercise regimens may be difficult to adapt for environmental safety reason so offer other alternatives. o Be willing to compromise. For example, the patient can continue cultural practices as long as it does not contraindicate prescribed medications or jeopardize health. Invite the patient to bring examples of remedies to the next follow-up visit. o Negotiations may also include culture specific interventions (*e.g.*, special foods, herbal remedies, medicinal teas, etc.) believed by the patient to be helpful as long as these interventions are clinically safe.
Enhancing the Physician-Patient Relationship:	The process of negotiation requires good listening and cross-cultural communication skills. Be sure to: o Convey empathy, interest and concern for patient views on treatment and practices sought. o Listen carefully to patient/family responses about their concerns/fears. A way of showing that you are listening is to rephrase patient comments or probe on specific issues. o Be aware that cultural norms about deference to authority may interfere with the negotiation process in that patients expect to get guidance from authority figures, agree out of respect and not question your judgment or recommendations. o Be aware that when a patient feels that the provider has violated respect, he or she may seek alternative care or terminate treatment.

Communicating Treatment Options

When the physician sets out to communicate treatment options, he or she can focus on explaining:

- Why a specific medication regimen is recommended.
- The importance of taking and monitoring medication use.
- How the treatment will affect daily functions.
- How the family will be impacted.
- How culture-specific practices (diet, herbal remedies, etc.) can be modified to enhance the effects of medication.
- Why follow-up appointments are important to monitor treatment.

Patient Adherence

Clinicians can also be attentive to differences in medication response as it can provide important information on other factors (besides cultural, social) that may influence treatment plans. Physicians can learn about responses to medication by asking about the patient’s experience and/or sensitivity with dosage of medication. The Physician can also become familiar with traditional herb and medication interactions that might pose a danger to the patient’s health.

The consequence of not factoring cultural, social and environmental factors into the treatment planning and negotiation process will present a variety of barriers that can affect the physician-patient relationship.

- Treatment regimens that are not consistent with the patient’s concepts of treatment or practices for a given medical condition will result in his or her failure to adhere to medication regimens.

- The patient reverting to the use of traditional folk medicines that may have adverse reactions with prescribed medication regimens.

- An unwillingness to negotiate differences between the physician and patient’s view of treatment for a given illness may also suggest to the patient that the physician is not flexible and does not value the patient’s views, which will further justify patient non-adherence to treatment, not returning for routine care or not keeping follow-up appointments to monitor outcomes of treatment.

Summary Action Points

The summary action points highlight select tips contained in this section on how clinical practice guiding principles 4 – 6 can be adopted to enhance treatment planning, negotiation and care management during the cross-cultural encounter.

The action steps offer specific examples of techniques to select from or build upon as the physician-patient relationship develops over time. Clinicians are encouraged to review the tools provided in the Appendix and references listed at the end of each section of the Toolkit or Provider Curriculum for other ideas on tailoring techniques to the populations served by your practice.

Clinical Practice Guiding Principles	Action Steps
4. Identify treatment goals compatible with patient's cultural health beliefs, practices …	☐ Identify discrepancies in views on the kind of treatment expected and what it will address based on the patient explanatory model on illness and treatment. ☐ Plan care based on patient preferences and values (views on illness, treatment). ☐ Attend to the patient's fear and confusion about treatment goals and plan. ☐ Interpret your views of treatment using words and concepts that are consistent with the patient's explanatory model. ☐ Clarify and discuss important ethical disagreements about treatment
5. Identify the social and environmental factors that may interfere with treatment adherence….	☐ Realize that the family may be more important than individual rights. ☐ Determine who are the most appropriate persons within the family to make decisions on treatment and care management. ☐ Consider social and material supports available to the patient when designing treatment goals/plans. ☐ Ask about social support networks. ☐ Work with the patient to identify what is the least expensive treatment and find out what other resources are available to support treatment goals.
6. Negotiate treatment plans that integrate cultural concepts familiar and …...	☐ Be prepared to negotiate with the patient using words or concepts familiar to the patient. ☐ Identify sources of discrepancy between physician-patient views for treating the medical condition or symptoms described. ☐ Check for acceptance of recommendations and be patient and understanding. ☐ Be willing to compromise about treatment goals, such as incorporating folk remedies or treatment practices unless they are harmful. ☐ Consider involving spiritual or religious advisors as part of treatment when appropriate. ☐ Validate resolution of the patient's concerns about illness at the end of the encounter. ☐ Promote positive cultural practices and encourage changing harmful ones.

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SECTION VI: PATIENT COMMUNICATION AND EDUCATION

Patient communication is the cornerstone to building relationships and engendering trust. The inability to communicate effectively with patients presents an obstacle to obtaining or deciphering facts about what brings the patient to your office. Without an accurate understanding of facts, the clinician cannot arrive at the correct clinical diagnosis or profile. This may, in turn, lead to inappropriate clinical decisions that may result in under or over-prescribing of diagnostic tests or procedures and prescribing inappropriate treatment.

This section offers information on how to put into practice clinical guiding principle statements 1- 3 outlined in Section I of this Toolkit.

Interpersonal Communication Styles

Effective communication requires developing approaches and skills that can enhance physician-patient interaction and rapport. Several factors that can get in the way of effective communication during the clinical encounter include cultural norms/customs for interpersonal communication, language barriers, devaluing patient/family views of diagnosis or treatment practices, patients feeling rushed and physician biases.

> ***"Black, Hispanic and Asian patients reported having more communication problems during doctors visits compared to Whites, such as not fully understanding their doctor, feeling that their doctor did not listen to them, or having questions but not asking them during the visit.***
> ***--- Kaiser Foundation***

Rules for interpersonal communication and the proper physician-patient relationship are guided by concepts of respect required to establish rapport. This interaction is driven by cultural norms with authority figures, as well as verbal (direct) and non-verbal (indirect) communication styles as outlined below.

Verbal Communication

> ***"Blacks and Hispanics were most likely to feel they had been treated with disrespect (spoken to rudely, talked down to or ignored) during a health care visit and felt this was related to aspects of communication.***
> ***--Commonwealth Fund***

Physicians are trained to use a list of close-ended questions that make up the crux of good medical history taking. This style of questioning can be counter-productive to getting at cultural issues and can also lead patients to perceive the physician is not listening to them.

Slight modifications in verbal communication styles can be taken to select speech and style that demonstrate respect during the cross-cultural encounter such as:

- Use open-ended questions in several ways to get more information.
- Gather information via conversation rather than intensive questioning.
- Avoid interrupting patient.
- Communicate in unhurried manner.
- Allow time for patient to ask questions.
- Speak in normal tone and refrain from raising voice.
- Explain medical terms in simple language.
- Use validating techniques to let patient know you are listening.
- Return to an issue if you don't get clear information or patient is unsatisfied.

These recommendations can be viewed as guidelines that can be adapted over time.

Non-Verbal Communication

Physicians can also be attentive to mannerisms and styles for non-verbal communication and assess how these might be interpreted by patients from different cultures. Non-verbal (indirect) communication, such as facial expressions (smile, eye contact, etc.), personal space orientation, use of gestures and touching or body postures, have different meanings depending on the culture one is from.

Simple steps can be taken to ensure that unspoken communication does not detract from building rapport with the patient and his or her family:

- Speak directly to the patient and do not interpret lack of eye contact to mean the patient is uninterested.
- Limit the use of gestures such as the OK sign, thumbs up, etc., as these have different meanings across cultural groups.
- Become aware of the patient's cultural norms for appropriate personal distance.
- Touching in the form of handshakes, patting head or hugging varies by cultural group and should be used with caution. Patting a child's head in Asian cultures is considered offensive. Handshakes may not be acceptable in some cultures.
- Body postures such as slouching or leg crossing that exposes the sole of foot can be viewed as disrespectful.
- When communicating with non-English speaking patients, use interpreters to help in deciphering meaning of non-verbal cues.

Being aware of and modifying one's own verbal and non-verbal communication styles during the cross-cultural encounter not only serves as another way to demonstrate respect but also enhances rapport and builds a stronger physician-patient relationship.

Working with Language Barriers

Language barriers have been associated with non-English speaking patients having more diagnostic testing, fewer physician visits, poor treatment adherence and infrequent use of primary care/preventive services. The use of trained medical interpreters are key to diminishing errors in diagnosis and prescribing treatment.

The **use of an interpreter** (or third person) during the medical interview poses unique challenges to communication. The addition of a third person during the clinical encounter can change the dynamics of physician-patient interaction and affect the sharing of sensitive information. Physicians can take steps to minimize the threat to the patient and maximize the use of a medical interpreter during the clinical encounter by keeping the following in mind:

- Meet with the interpreter prior to the patient encounter to brief him or her on the goal of the visit.
- Allow extra time for an interpreter-dependent visit.
- Arrange seating so that the physician and patient are facing each other directly.
- Address patient directly during questioning – not the interpreter.
- Ask only one question at a time..
- Avoid complex sentences and medical jargon during explanations or response to questions.
- Ask the interpreter for a literal translation of what the patient says, to ensure the interpreter does not add, delete or coach the patient on how to respond.
- Use the same interpreter with your patient whenever possible to maintain consistency of care.
- Select an interpreter whose cultural background is similar to the patient's whenever possible.
- Debrief with the interpreter at the end of the visit to ensure that no gaps in communication remain.

Family, friends, relatives or minors should be not be used as medical interpreters as this poses a liability and risk to the practice.

While family/friends are important sources of social support, these individuals may have limited knowledge and skill in translating medical terminology or procedures. If you must communicate through these individuals, make sure they understand their role before you begin.

Patient Education During the Medical Encounter

Patient education during the clinical visit usually involves helping the patients to understand, accept and manage their illness, change risky behaviors and make informed treatment decisions.

Patient education during the cross-cultural encounter must not only factor in differences in views about treatment and care management processes but also depends upon the patient's comprehension of what is being communicated. Factors that can affect patient comprehension include:

- *Conceptual Equivalence:* Patient education must incorporate concepts that are familiar to the patient's views and understanding of health values, beliefs and practices.

- *Education Level:* Health materials used to re-enforce messages about managing the patient's medical condition, related medication regimens or treatment plans should take into account a fourth grade reading level.

- *Literacy Level*: Patients with low health literacy are more likely to have problems with medication adherence, understanding health care information on chronic diseases or negotiating within the health care system. Use visual aids when possible and involve the family, case worker or other health professionals to reinforce messages.

- *Language Barriers*: Arrange to have medical interpreters present during the clinical visit to ensure accurate communication about physician-patient views on illness, treatment and expectations for care. Translation of patient education materials should reflect education and literacy levels of the specific populations being served by your practice.

Patient education should also apply the pointers listed under verbal and non-verbal communication along with the areas listed above. Whenever possible, use the patient education process to familiarize the patient with how the health care system works, how to navigate the system and how to advocate for himself or her self.

Summary Action Points

The summary action points highlight select tips contained in this section on how clinical practice guiding principles 7 – 8 can be adopted to enhance patient communication and education during the cross-cultural clinical encounter.

The action steps offer specific examples of techniques to select from or build upon as the physician-patient relationship develops over time. Clinicians are encouraged to review the tools provided in the Appendix and references listed at the end of each section of the Toolkit or Provider Curriculum for other ideas on tailoring techniques to the populations served by your practice.

Clinical Practice Guiding Principles	**Action Steps**
7. Develop communication skills congruent with cultural values and norms….	☐ Understand that respect is central to building relationship and rapport with the patient and family. ☐ Use open-ended questions and a conversation style of questioning to facilitate communication. ☐ Communicate in an unhurried manner and allow time for the patient to ask questions. ☐ Minimize interrupting the patient during the medical interview. ☐ Avoid technical terms and jargon, as well as ambiguous, complex explanations or sentences. ☐ Be aware that making eye contact is a form of disrespect with an authority figure. Do not force eye contact or interpret this to mean the patient is not interested. ☐ Make arrangements to have a trained medical interpreter present during the clinical visit to ensure accurate diagnosis and treatment planning. ☐ Allot additional time for appointments that require the use of medical interpreters. Work with interpreters to facilitate scheduling processes. ☐ Avoid the use of family, relatives or friends as medical interpreters whenever possible.
8. Apply patient education strategies that match literacy, cultural appropriateness and language concordance ….	☐ Patient education should incorporate vocabulary and concepts that are familiar to the patient's view of illness, treatment and care management. ☐ Identify and document the patient's literacy level in both his or her native language and in English. ☐ Determine whether the patient prefers to receive written materials in English or in his or her native language. ☐ Translated health-related materials should be reviewed by knowledgeable people to ensure they contain the appropriate reading level and are free of linguistic and cultural gaffes. ☐ Teach and offer a bicultural approach to health care. ☐ Teach the patient how to navigate the health care system.

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SECTION VII: CLINICAL DECISION-MAKING

Research suggests that health disparities among racial and ethnic minority groups may be attributed to aspects of clinical reasoning. Factors such as physician worldviews, personal and professional experiences, societal norms and conscious or unconscious biases are said to influence clinical reasoning and decision-making processes. The consequences of not factoring in conscious or conscious biases will result in a lack of trust and poor communication that affects the physician-patient relationship.

This section offers information on how to put into practice guiding principle statement 9 outlined in Section I of this Toolkit.

Areas for Consideration

- *Individual Level Factors*: Clinicians enter the medical encounter with a particular worldview and set of experiences that are a product of ongoing interaction among the social, cultural, economic and political determinants all of which influence interpreting the appearance, actions and ways of thinking about different patient groups. Clinicians should examine their assumptions about who the patient is and how he or she became ill, as well as taking a look at his or her own attitudes about experiences with patients from different races, cultures or social classes.

- *Professional Level Factors*: The clinician's professional training, experience and norms for professional behaviors can also influence clinical reasoning and the decision-making processes. The type of professional training and experience in working with ethnic and linguistic populations can also affect clinical reasoning. Professional norms that define social distancing from patients and biomedical vs. holistic models of care must be re-evaluated when providing care to culturally diverse populations.

- *System Level Factors*: The health care system and institutions operate under complex arrangements that promote administrative policies and procedures to control costs, clinical productivity, quality and workforce competence and also affect the extent to which they adapt structures and processes to meet compliance with regulations and laws. Such arrangements like time constraints tend to influence clinical reasoning and decision-making processes by limiting information gathering and fostering cognitive shortcuts, as well as leading to stereotyping based on a lack of information relevant to the patient's individual needs and preferences.

The ability to transcend biases about race and class relies on the establishment of human contact between the doctor and patient, as well as transcending the conditioning of the system. The consequence of not factoring the impact of conscious/unconscious biases or stereotyping will result in a lack of trust and poor communication that affects the physician-patient relationship.

Summary Action Points

The summary action points highlight select tips on how clinical practice guiding principle 9 might be adapted to enhance the decision-making processes that are mutually beneficial to the physician-patient relationship.

Clinical Practice Guiding Principles	Action Steps
9. Acknowledge personal, professional and institutional factors…….	☐ Recognize that ethnic variation exists within each cultural subgroup. ☐ Be interested and non-judgmental when eliciting the patient's explanatory model of illness. ☐ Be respectful of, interested in, and understanding of others views without judgment. ☐ Avoid stereotyping.

Sample Case Study 2:
African American Patient with Cancer*

Mr. Jones is a 77-year-old African American male born in Macon County, Georgia who came to Boston in 1945. He is a widow with three sons and many grandchildren. He was a cigar smoker with a remote history of alcohol excess. He went to a neighborhood health center a year ago with a cough, was treated for "bronchitis" and told to go to a nearby medical center for a chest x-ray (CXR) if his symptoms persisted. Three months later he came to the ED for a bad chest cold, and was told he had mild pneumonia and that his CXR was abnormal. He was given antibiotics and a number to call for a clinic appointment with a new PCP. When he called, he was told that the new intern schedule was not ready yet and was offered an appointment to be seen in the Pulmonary Clinic instead, but he declined. Six weeks later, he returned to the ED with hemoptysis and he was admitted.

Imaging studies revealed an infiltrate with a possible associated mass and mediastinal nodes. Bleeding stopped when ASA and ibuprofen were held. Sputa were sent for cytology. The patient was seen by the new Pulmonary Fellow who suggested a bronchoscopy. The patient said he wanted to discuss this with his sons, so he was discharged with a follow-up appointment to see the Pulmonary Clinic. The patient missed the appointment, citing problems with transportation. The Pulmonary Fellow called the patient to tell him that his sputum cytology had revealed "squamous cell carcinoma of the lung." An appointment was made for three weeks later to see Oncology.

The Oncology Fellow told the patient that he had an incurable cancer, and asked if the patient was interested in an experimental therapy protocol that might help. When informed consent forms were produced, the patient said he needed time to discuss things with his family. When he returned to the clinic with two of his sons a month later, he was told that his abnormal lung function made him ineligible for the protocol. The Fellow told him "there is nothing more we can do for you." His sons were angered by this response and one threatened to sue the hospital for delayed diagnosis. The Fellow arranged an appointment with Radiation Therapy but the patient did not show up.

Over the next two months, the patient returned to the ED for symptoms of cough, hiccoughs and chest pain. He was treated with Tylenol and Robitussin. Eventually, a pleural effusion and liver metastases appeared. Narcotic analgesics were prescribed in the ED, but the drug selected was not available at the local pharmacy used by the family. Eventually, the patient was readmitted to the hospital with fever and pneumonia. The Ward Attending told the patient that the pneumonia would be difficult to clear as it was located distal to the obstructing lesion. The patient was wary of radiation treatments. The inpatient team asked the patient to pick a Health Care Proxy and to clarify his code status.

The Ward Attending asked if he would be interested in a hospice referral. The patient said he would need time to think about these things. After three days, the patient was transferred to a skilled nursing facility for continued antibiotics and rehabilitation. There he spent two months with progressive weakness, poorly controlled pain and recurrent fevers. His sons asked if it would be possible for their father to return home. The nursing home social worker said that she was having difficulty finding an agency that would take the case. The local hospice cited difficulties in recruiting staff to work in what was considered a dangerous neighborhood and their intake worker said that hospice care wasn't very popular in the black community.

The patient was ultimately readmitted to the hospital with impending respiratory failure, still a full code despite extensive spread of his tumor. His sons wanted full support including ICU care, but the inpatient team reported to them that the request had been denied because of his poor prognosis. The team consulted the Ethics Committee to get guidance on how to deal with the family. That night, the patient was found in bed in full cardiac arrest. Attempts to resuscitate him were not successful.

**© Developed by Eric Hardt, MD, Linda Clayton, MD, W. Michael Byrd, MD (2003).*

Questions for Case Discussion

- What does this case tell us about the patient's health values, cultural norms and customs?
- What social and environmental context may be affecting the patient's health behaviors?
- How might the patient's cultural, social or environmental context be affecting treatment or adherence?
- How could a more accurate diagnosis have been obtained?
- At what point in this case should medical care staff have developed a care management plan?
- What conscious/ unconscious bias may be affecting the professional decision-making behaviors in this case?
- How are some of the institutional and system factors affecting the patient-care processes?

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SECTION VIII: ORGANIZATIONAL SUPPORTS AND SYSTEM TOOLS

A key component to successful implementation of the cross-cultural clinical practice guidelines hinges on having the organizational resources necessary to support physicians or clinical teams in practice settings. The national standards for Cultural and Linguistically Appropriate Services (CLAS) provide guidance on organizational changes that contribute to delivering quality health care to culturally diverse populations (see Appendix D). This section offers information on how to put into practice guiding principle statement 10 outlined in Section I of the Toolkit.

Impacting System Change

Adopting a practice that is responsive to the needs of culturally diverse populations requires fundamental changes in the care delivery system. Yet many practice settings face budget constraints, staffing shortages, and time pressures that emphasize clinical productivity, making it a challenge to tackle system change.

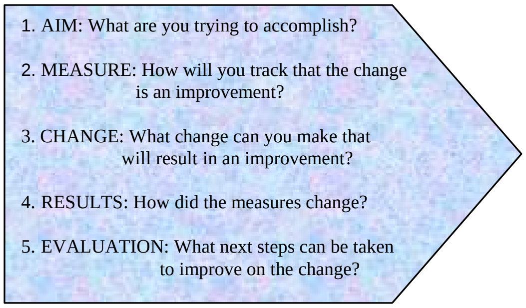
System changes require new structures and processes that are purposely defined and thoughtfully carried out. ***Approaches to system change need not be a monumental task but rather can be tailored to the size/scope of practice and can be carried out over time.*** Strategies can focus on promoting system change consistent with the CLAS standards (see Appendix D). Priorities can be set to adapt standards that improve structure/processes to address areas of quality that seek to reduce disparities in access, patient care coordination and health outcomes.

Quality Improvement Planning

Quality improvement models use trial and learning approaches that systematically build knowledge to make decisions about improving a problem at hand. They provide an opportunity to test an idea for a change and learn what leads to improving a process or outcome. These models, also referred to as Plan-Do-Study-Act (PDSA) cycles, apply small-scale efforts in short-term consecutive cycles to determine if change can be implemented at a larger scale.

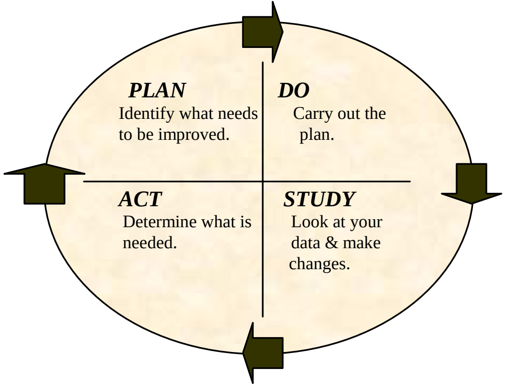
This PDSA cycle provides a framework that is preceded by a set of questions to guide the learning process and is followed by the use of the consecutive cycles to plan and test changes in systems and processes.

"Guiding Questions"



1. AIM: What are you trying to accomplish?
2. MEASURE: How will you track that the change is an improvement?
3. CHANGE: What change can you make that will result in an improvement?
4. RESULTS: How did the measures change?
5. EVALUATION: What next steps can be taken to improve on the change?

"PDSA Cycle Process"



Designing Cultural Competence QIP's

Quality is culturally defined and depends on the rules that are valued within a particular group. What is considered quality in one cultural group may not be applicable in another.

Designing Quality Improvement Plans (QIP's) that are responsive to the needs of culturally diverse groups requires basic knowledge of the populations being served in your practice. Practice settings can begin by focusing on areas to reduce disparities in the following:

- Access to care.
- Patient care coordination or care management.
- Health outcomes.

Quality Improvement Plans require identifying the following components:

- QIP team.
- Target goal/aim that is specific, measurable, attainable.
- Baseline measures.
- Change or intervention to be tested.
- Examining results to analyze measures.
- Evaluating the effect of changes made and refining the process through additional test cycles.

The following illustrates an example of a QIP plan that improves health outcomes:

CASE BACKGROUND:
African Americans are twice as likely to develop diabetes compared to Caucasians and also experience vascular and macro-vascular complications. Hospital admissions data over the past six months shows a steady increase in African American patients being admitted. The Diabetes Self-Management Program (DM) is responding with efforts to target programs for this population.

QIP Case Example 1

IMPROVING DIABETIC OUTCOMES AMONG AFRICAN AMERICANS

AIM: To reduce potential diabetes-related complications among African American patients that attend a three month Diabetes Self-Management Program.

MEASURES: An improvement is identified as changes in hemoglobin A1c levels, weight reduction and lipid levels after program completion. The numeric improvement goal for HgA1C levels is less than 7.0 from more than 10.0; weight reduction (pounds) and a decrease in lipid levels by 5% will be tracked three months after program completion.

CHANGE: The proposed change is to provide patient education on nutrition, exercise, glucose monitoring and risk reduction practices to 20 patients participating in the program during April – June. The program will recruit an African American physician to work with the nursing staff, and will provide educational materials developed by national associations.

ANALYSIS: The QIP team will track changes in hemoglobin A1C levels, weight reduction and lipid levels pre and post intervention during the three-month period to determine if any improvement has occurred.

EVALUATION:

- If the target goal for cycle 1 is not met, the numeric goal will be rest to reduce HgA1C levels 100%.
- If the target goal for cycle 2 is met, cycle 3 will implement the same process for Spanish-speaking patients.

Quality Improvement Teams. A targeted QIP requires bringing together expertise and skills in working with cross-cultural populations to oversee the development, implementation and monitoring quality activities. Team effectiveness can be enhanced when the workgroups are guided by a clear purpose, process, multi-disciplinary skill base and work plan with timelines for accomplishing its goals.

Additional QIP case examples are provided in Appendix C of this Toolkit

Interpreter Service Arrangements

Title VI requires that all providers make language services available to improve access and ensure proper communication during the clinical encounter with non-English speaking patients. A quality language service is characterized by the following criteria:

- ❑ *Interpreter Qualifications*: All persons serving as medical interpreters must have minimum training in the translation of medical terminology, interpreter code of ethics and cross-cultural communication and must be proficient in the language of translation. These qualifications are key to diminishing errors in communication, decreasing liability and reducing risk for the practice.

- ❑ *Method of Service*: Language services can be provided in a variety of ways including face-to-face or telephone interpreters, use of bilingual staff or a combination of these. Selecting a method will depend on the volume of linguistic subgroups served by the practice and resources in your geographic area.

- ❑ *Alternative Arrangements*: Other options for accessing language services can include making arrangements with local area hospitals, community-based organizations or community language banks in your service area. Many private commercial or state managed-care plans may offer interpreter services to their physician network. Check with your local health organizations or managed care plans.

Additional Supports

Additional supports can focus on strategies to adapt organizational processes consistent with the national CLAS standards. The following highlight how guiding principle 10 can be adopted to enhance clinical practice:

- ❑ *Clinician Training*: Training can serve as an important tool for engaging clinical staff in implementing the guidelines. Practice settings can expand clinician education by adapting competency training aimed at building core knowledge/skills relevant to clinical diagnostic activity and patient care management. A variety of incentives (e.g., CME credits, etc.) can be used to ensure participation. Refer to the provider orientation curriculum for ideas on how to get started (see companion Provider Education Curriculum).

- ❑ *Quality Improvement Teams*: A targeted QIP requires bringing together organizational resources, expertise and skills in working with cross-cultural populations to oversee the development, implementation and monitoring quality activities. Team effectiveness can be enhanced when the workgroups are guided by a clear purpose, process, multidisciplinary skill base and a systematic process for accomplishing its goals.

- ❑ *Workforce Diversity:* A key component central to cross-cultural practice requires recruitment and retention of bicultural and bilingual clinical, office staff and interpreters that can serve on care management teams or quality improvement projects.

- ❑ *Community Collaboration:* Identify and establish partnerships with community-based organizations to access training resources and cultural informants, and to learn more about issues and concerns of importance to the racial and ethnic subgroups in your service area.

- ❑ *Medical Intake Forms*: Modify medical history intake or patient/family education forms to include information on race, ethnicity, language, use of interpreter, cultural health beliefs/practices and social/environmental issues affecting health behaviors in medical records.

- ❑ *Patient Educational Materials*: Identify and select patient materials that reflect the language preferences of cultural subgroups being served by the practice. Assure that translated materials are reviewed by professionals familiar with cultural concepts and linguistic nuances relevant to the subgroups served.

Resources

To get information on best practices for organizational supports and system tools refer to the following sources:

- ✓ http://www.omhrc.gov/omh/programs/2pgprograms/finalreport to obtain the full report of the CLAS standards.
- ✓ http://www.healthdisparities.net offers quality improvement training tools developed by the Institute of Healthcare Improvement collaborative series.
- ✓ http://www.hhs.gov/ocr provides information on Title VI regulations for interpreter services to limited English speaking populations.

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APPENDIX A:
Sample Questions for the Patient Cultural Assessment Tool

I. Cultural Context: Values, Norms, Customs

Racial/Cultural Identity:

- ☐ What country were you born in? What country are you from?
- ☐ What country did you grow up in?
- ☐ What is your nationality?
- ☐ With what racial group do you identify?

Family Structure:

- ☐ Who makes important [health care] decisions for the family?
- ☐ Who else is considered part of your extended family? Are any of them involved in the decision-making process?
- ☐ Would you prefer to discuss your treatment options with family for help in making a decision about your health care?

Communication Patterns/ Styles:

- ☐ How do you prefer to be addressed … Mr. or Mrs.?
- ☐ What language do you speak at home, with family, at work, at school, etc.?
- ☐ What language do you prefer to speak at the doctor's office or during this visit?

Religion and Spirituality:

- ☐ Do you use prayer or meditation during illness or in general?
- ☐ Are there any rituals or ceremonies used in your family or used for people who are sick?
- ☐ Does your faith or religion have views on acceptance of blood transfusions, organ donation or transplants?

Food and Dietary Habits:

- ☐ What are the typical foods eaten in your home? What about during special occasions or holidays?
- ☐ Who usually prepares meals for you or the family?
- ☐ Do you change your diet during certain times (menstruation, pregnancy, postpartum, religious holidays)?
- ☐ What foods, herbs or remedies are used to promote health or to treat your medical condition/illness?

Time/Space Orientation:

- ☐ Are you more concerned about how your health affects you right now or about how it might affect you in the future?
- ☐ Would you be able to take your medicines for the next month at the same time each day?
- ☐ Are you able to make appointments on time? How do you keep track of appointments?
- ☐ Will you be comfortable with my touching you during the physical exam?

II. Social Context:

- ☐ What is the primary source of income in your household? Who is the primary wage earner for your family?
- ☐ How many years of schooling have you completed?
- ☐ Are you involved in any religious organizations or community agencies in your neighborhood?
- ☐ What is causing difficulty or stress in your life? How are you dealing with that stress?
- ☐ Do you have any friends or relatives you can call for help? Do they live close to you?
- ☐ Do you have trouble reading your medication or appointment slips?
- ☐ Are you more comfortable reading health information in your native language or in English? Or do you prefer pictures to explain what is happening in your body?

III. Environmental Context:

- ☐ How long have you been in the United States?
- ☐ How frequently do you return to your country of origin?
- ☐ Have you ever been treated differently because of your background when getting health care?
- ☐ What is your regular means of transportation to get to medical or follow-up appointments?

Sources: Carillo, et al (1999), Kleinman, et al (1978); American Psychiatry Association (2000), Spector (2000), Oncology Nursing Society (2000), Leininger and McFarland (2002).

APPENDIX B:

Case Study 1*: Summary Evaluation

BACKGROUND: A 68-year-old Puerto Rican female who was born and raised in Puerto Rico moved in with her oldest daughter a year ago and depends upon family members to take her shopping, do errands and go to doctor's appointments. She is independent in her abilities to cook, clean and take care of her daily needs but is unable to read or write and speaks only Spanish**.** She was diagnosed with Type II diabetes several years ago and is taking Glipizide and Metformin. This is her first visit with a primary care physician in the United States.

Clinical Practice Guideline Principles	OBSERVATIONS
1. Elicit patient views on illness and treatment … and expectations for care.	**Views of Illness:** • Uses alternative remedies to control diabetes. • Patient believes prayer is a vital component of her life. • Unable to associate symptoms of thirst and urination with diabetes. • Refers to concepts about body cleansing, improving circulation. **Treatment Practices:** • Does not seek alternative healers. • Treatment practices include herbs (pill form) and foods. • Food is important to staying well (will not starve herself). • Expects a cure from doctor. • Expects treatment to control sugar, cholesterol and pain.
2. Assessing cultural norms, values and customs….	• Patient believes her medical condition is part of aging (no control over environment). • Cultural specific foods (rice, beans, root vegetables, bacalao/salted cod fish, etc.) are part of her staple diet. • Diet is high in complex carbohydrates (rice, beans, root vegetables, orange juice) and low in protein (she dislikes meat).
3. Assessing social and environmental context…..	• Unable to read and may not relate to the idea of diabetic exchange concepts or portion size. • Relies on family members to help her with shopping (food, etc.), errands (filling prescriptions, etc.). • Relies on family for transportation to keep doctor's appointments. • Relies on television as a source of health information.

** Adapted from: Institute Health Improvement Health Disparities Collaborative Series 2001 (www.healthdisparities.net).*

Questions for Discussion

- ☐ What are the differences in physician-patient views on illness?
- ☐ What are the similarities in physician-patient views on illness?
- ☐ What are the differences in physician-patient views on treatment practices?
- ☐ What are the similarities in physician-patient views on treatment practices?
- ☐ What aspects of environmental and social context can be used to support patient-care plan?

APPENDIX C:
Examples of Cultural Competence Quality Improvement Plans

The following case examples can be adapted by a variety of primary care practice settings with different populations.

Case Example 2:
Improving Access to Care for Asian Populations

AIM:
To reduce delays in access to care for Cambodian-speaking patients by 50%. The hospital is experiencing delays in accessing care for Cambodian-speaking patients after hours. These patients are waiting on average 4 hours before being seen by a doctor at the emergency room.

MEASURES:
A change in an improvement is identified as a decrease in wait time to 2 hours (numeric goal is 50% decrease). The measure identified is the time between when the request was made and when the interpreter in the target language arrived in the emergency department and the patient is seen by the doctor. The previous year quarter data (three months) will be used as the baseline measure.

CHANGE:
The QIP team examined the process and found the root cause of delays occurred because volunteer interpreters were not consistently available after hours for Cambodian languages to return calls. The proposed change/intervention is to hire a per-diem Cambodian interpreter to be on call after hours rather then to rely on a volunteer. The timeline for implementation is to hire a Cambodian interpreter by the end of March. In the interim, on-call per-diem interpreters will retrieve messages. The project timeline is three months.

ANALYSIS:
The QIP team will look at changes in wait times from the interpreter phone logs for the pre and post intervention three-month period. The team will examine differences between the time the patient checked in and the time when the interpreter arrived, to determine if the average time to return calls has improved.

EVALUATION:
- If the target goal for cycle 1 is met, in cycle 2, the team will reset the QIP goal to 100% and the numeric measure of wait time to 1 hour (or 75%).
- If the target goal for cycle 2 is met, in cycle 3 team, the team will implement the same process for Cantonese and Arabic- speaking patients.

Case Example 3:
Improving Asthma Care Coordination Among Hispanics

AIM:
The aim in cycle 1 is to improve the coordination of care for Hispanic asthma patients seen in the emergency room by 75%. The hospital has noted an increase in Hispanics using the E.R. as a primary source of care for treatment of asthma attacks. This will reduce inappropriate utilization of the E.R and promote a continuum of care for this population.

MEASURES:
A change in an improvement is identified as a decrease in E.R. use as primary source of care for asthma-related conditions. Baseline data from patient education logs shows that limited English-speaking Hispanic patients are presenting problems with asthma treatment self-management. The measure identified is the PEF (peak expiratory flow) indicator. The baseline numeric goal is to decrease variability of PEF by x%. Previous year quarter data (three months) will be used as the baseline data.

CHANGE:
The QIP team examined the process and found the root cause of increased use of the E.R. to be patients not contacting their primary clinician due to language barriers. This also impacted a clear understanding of all aspects of the self-management treatment plan. The proposed change/intervention is to do patient education that emphasizes the use of peak flow meters to prevent asthma attacks, provide materials in their own language and schedule a follow-up visit to determine progress. Primary care clinician linkage will also be tracked to assure that a continuum of care is established. The project timeline is six to nine months.

ANALYSIS:
The QIP team will look at changes in PEF indicators from patient education logs in three-month intervals. The team will examine differences between patient monitoring before and after the intervention to determine how PEF indicator rates have changed.

EVALUATION:
- If the target goal for cycle 1 is met, in cycle 2, the team will reset the QIP goal to 100% and the baseline measure to 25%.
- If the target goal for cycle 2 is met, in cycle 3, the team will implement the same process for Haitian subgroups.

APPENDIX C

APPENDIX D:

National Standards for Culturally and Linguistically Appropriate Services (CLAS)

1. Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable and respectful care that is provided in a manner compatible with their cultural beliefs, practices and preferred language.

2. Health care organizations should implement strategies to recruit, retain and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

3. Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in cultural and linguistically-appropriate service delivery.

4. Health care organizations must offer and provide language assistance services including bilingual staff and interpreter services, at no cost to each patient with limited English speaking proficiency at all points of contact, in a timely manner during all hours of operation.

5. Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

6. Health care organizations must assure competence of language assistance provided to limited English-speaking proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

7. Health care organizations must make available easily understood patient-related materials and post signage in the language of the commonly encountered groups and/or groups represented in the service area.

8. Health care organizations should develop, implement and promote a written strategic plan that outlines clear goals, policies, operational plans and management accountability or oversight mechanisms to provide culturally and linguistically appropriate services.

9. Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments and outcomes-based evaluations.

10. Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, spoken and written language are collected in health records, integrated into the organization's management information systems and periodically updated.

11. Health care organizations should maintain a current demographic, cultural and epidemiological profile of the community, as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

12. Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in design and implementing CLAS related activities.

13. Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing and resolving cross-cultural conflicts or complaints by patients/consumers.

14. Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

Sou*rce: Department of Health and Human Services. National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Healthcare. Final Report. Washington, DC: DHHS, Office of Minority Health, 2001.*

PROVIDER CURRICULUM SUPPLEMENT

A TRAINING GUIDE
TO THE PHYSICIAN TOOLKIT ON
CROSS-CULTURAL CLINICAL PRACTICE
GUIDELINES FOR MEDICAID PROVIDERS

Prepared by:
University of Massachusetts Medical School
Office of Community Programs

For the:
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USING THE PROVIDER EDUCATION CURRICULUM

What is the Purpose of the Provider Education Curriculum?

The purpose of the Provider Education Curriculum is to orient practitioners on practical application of the Cross-Cultural Clinical Practice Guidelines (CPG) and the contents of the Provider Toolkit.

For Whom is the Curriculum Designed?

The curriculum was designed to guide the user through content specifically aimed at addressing the Cross-Cultural CPG template and each section of the Provider Toolkit. It is also designed to factor in flexibility that will allow tailoring and/or expanding the content to use in practice settings as needed. This design feature, therefore, limits its use as a stand-alone product and it should not be used without the Cross-Cultural CPG and Provider Toolkit.

What Does the Content of this Curriculum Contain?

The curriculum content closely parallels the topics contained in the Provider Toolkit but also expands upon the information. Each module provides a framework to guide practice settings in identifying the basic session goals, learning objectives and topic focus areas most relevant to implementing the Cross-Cultural CPG. The modules are formatted to address an introductory overview, an outline that orients the trainer to the topics in the Toolkit, resources and an Appendix that contains various learning tools to facilitate discussion.

What Does This Curriculum Not Cover?

This curriculum is not intended to serve as a comprehensive learning device but rather offers suggestions for minimum areas of knowledge and competency-building activities recommended by experts in the field. It is strongly recommended that users access additional information during the various planning and implementation aspects of training to complement and tailor contents to meet their staff's experience and the populations being served by their practice

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MODULE 1: CROSS-CULTURAL CLINICAL PRACTICE GUIDELINES

Session Goal:	*Learning Objectives:*	**Topic Areas:**
Introduce Cross-Cultural Clinical Practice Guidelines (CPG)	• ***Introduce CPG Statements*** • ***Introduce Toolkit Sections I & II***	• CPG Goal, Objectives and Statements • Changing Demographics • Health Disparities by Race and Ethnicity • Factors Contributing to Disparities

Overview

Changing demographics point to an increased demand for medical care delivery that is responsive to multicultural populations. Census data predicts that by the year 2030, approximately 40 percent of the American population will be comprised of racial and ethnic minority groups. Yet despite improved health outcomes among the overall population, ethnic minority populations continue to experience dramatically shorter life spans, higher morbidity rates and lack of access to quality health care (Lillie-Blanton & Correa, 1995; Waidmann & Ragins, 2000).

Problems with access and the delivery of health care for racial and ethnic minority populations have long been influenced by historical, sociocultural, political and institutional factors. Race and class have long contributed to the unequal distribution of health care, thereby further widening the gap in health disparities (Byrd & Clayton, 2000 & 2002). Numerous studies continue to point to health disparities among ethnic minority populations. For example, several studies have shown that minorities suffer heart disease, cancer, stroke and HIV/AIDS at disproportionately higher rates than whites (Cunningham et al, 2002; Collins et al, 2002; Keppel et al, 2002). Moreover, ethnic minorities are the least likely to have medical insurance, are disproportionately represented in the Medicaid population and are more likely to be underinsured, thereby limiting their access to medical care (Collins et al, 2002; Kaiser, 2003; Rosenbaum & Shin, 1998). Medicaid programs have historically served populations who have been disproportionately burdened by poverty, poor health status, disabilities and language barriers and who are likely to contend with problems that further affect their ability to access care, such as transportation, lack of child care, limited or no leave from work to keep medical appointments and language and literacy difficulties (Kaiser, 2003; Lonner, 2000; Rosenbaum & Shin, 1998).

According to the Census 2000 data, racial and ethnic minority groups make up approximately a third of the United States population. Yet ethnic minorities are more likely to have lower rates of employment-based insurance and rely more on Medicaid and other public insurance sources compared to Whites as shown in the table below.

Table 1.
Census Population and Medicaid Status

Race/Ethnicity	Census 2000	Medicaid Enrollees
African American	12.1 %	24.1%
American Indian/Alaska Native	0.7 %	2.2 %
Asian/Pacific Islander	3.7 %	3.9 %
Hispanic/Latino	12.5 %	22.5 %
Other	1.8 %	N/A
Whites	69.1 %	47.4 %
Totals	281.4 million	31 million

Source: Kaiser, 2003.

Table 1 also shows that over half of all Medicaid enrollees are represented by ethnic minorities, reflecting a disproportionate enrollment in public as opposed to private health insurance programs.

Consequently, the last decade has prompted numerous public, private, federal and state partnerships to establish targeted policies, standards and regulations that address multi-prong approaches to improving system structures, as well as process and outcomes-monitoring as a means towards reducing health disparities. One area that has not been given much attention, however, is the development of clear standards or clinical practice guidelines to support physician skill sets in delivering culturally and linguistically appropriate clinical care.

I. Guiding Principles for Cross-Cultural Practice

Part 1 of this session introduces the rationale for the cross-cultural clinical practice guidelines as a means to improve delivery of quality health care to diverse populations. The minimum topic areas for meeting this learning objective can address:

a) CPG Goal: To provide guiding principles that improve patient-centered care as a means to reducing disparities in access, quality and health outcomes among diverse populations.

b) CPG Objectives:

- **Improve skills for gathering information related to those factors that influence a patient's health values, beliefs, behaviors and expectations for care.**
- **Develop clinically effective treatment plans that are compatible with a patient's values, preferences and needs.**
- **Increase awareness of individual and institutional factors influencing clinical decision-making processes that affect outcomes of care.**
- **Improve communication that promotes doctor-patient relationship based on mutual respect and trust.**

C) CPG GUIDING PRINCIPLES:

- Review CPG statements (guiding principles).
- Practice domains: statements focus on influencing behaviors to refine processes and practice in the area of:
    - Clinical assessment process.
    - Treatment planning and negotiating adherence.
    - Patient communication and education.
    - Organizational supports and system tools.

Resources to Facilitate Discussion

- ☐ Refer to Section I of the Provider Toolkit.
- ☐ Refer to Curriculum Appendix A: Module 1 Handout (CPG statements).
- ☐ Refer to Institute of Medicine Report on Unequal Treatment (2003).
- ☐ Refer to data sources on websites listed in Section II of the Toolkit.

II. Disparities in Outcomes of Care

Part 2 of this session aims to expand knowledge of health disparities, factors contributing to disparate outcomes and the link between quality and outcomes of care. The minimum topic areas for meeting this learning objective can address:

A) CHANGING DEMOGRAPHICS:

- Demographics by race, ethnicity and immigrant influx for your state and service area.
- Health insurance status by race and ethnicity.
- Medicaid enrollment by race and ethnicity.
- Socio-demographic characteristics by race and ethnicity (education, SES, etc.).

B) HEALTH DISPARITIES BY RACE AND ETHNICITY:

- Healthy People 2010 indicators.
- Morbidity and mortality rates.
- Top chronic conditions affecting racial and ethnic minority populations.
- Minority experiences with accessing quality care.

C) FACTORS CONTRIBUTING TO HEALTH DISPARITIES:

- Patient level factors.
- Physician level factors.
- Institutional level factors.

Resources to Facilitate Discussion

- ☐ Refer to Section II of the Provider Toolkit.
- ☐ Refer to websites listed in Section II of the Toolkit to address Topics 1a and 1b above.
- ☐ Refer to the Institute of Medicine Report on Unequal Treatment (2003) and websites to address Topic 1c above.

Module 2: Basic Concepts

Session Goal:	*Learning Objectives:*	**Topic Areas:**
Examine Cultural Considerations in Health Care	• Introduce Core Cultural Concepts • Introduce Toolkit Section III	• Basic Concepts • Biomedical vs. Non-Biomedical Systems • Cultural Dynamics Affecting Clinical Encounters

OVERVIEW OF CULTURAL CONCEPTS

Culture represents an integrated system of information that includes shared values, beliefs, norms, customs, traditions, symbols, religion and language that informs the internalized pattern of human behaviors within a given environment. Culture shapes our world views, values and experiences about health beliefs, views of diagnosis and treatment practice and teaches us how to behave during illness, what to expect from caring processes and what is expected from experts in healing (physicians, healers, nurses, etc.) during times of illness.

Cultural factors are situations or behaviors grounded in information and experience that have potential for shaping and impacting physician-patient communication, interaction and the nature of the relationship. Failure to take these factors into account can compromise care management during the cross-cultural encounter. Clinicians can focus on learning to identify and deal with cultural occurrences, and understand how they impact patient behavior and interaction rather than attempting to learn all culture- specific nuances for each group (Carillo, et al, 1999).

Cultural competence is a developmental process involving a series of changes that include increasing awareness and knowledge, changes in attitudes and behaviors, and gaining skills to engage with culturally diverse groups in a manner that results in positive outcomes. Cultural competence is a multi-dimensional occurrence that is expressed and measured at various levels that include:

- Individual level: Focuses on the clinician's cultural frame of reference (e.g., one's own perceptions, attitudes, behaviors, etc.).

- Institutional level: Focuses on the ability of the system components (e.g., administrative, governance, clinical services, information systems, etc.) to work together towards creating a culturally responsive practice environment.

A culturally competent system of care consists of a set of policies, attitudes and behaviors that come together at the individual, group or system level, enabling it to deliver medical care that addresses the cultural needs of diverse groups.

Western biomedicine is a term used often to describe the American health care system since it originated in -- and remains the dominant health-belief model of -- the United States and other European countries, whereas non-Western medicine is associated with non-European countries (Jackson, 1993).

Differences between Western and non-Western views on medical care models are frequently cited as a major factor influencing the cross-cultural clinical encounter. The predominant medical care models co-existing among many societies fall primarily into three categories: *Western Biomedicine*, *naturalistic* and *personalistic* models—each relying on distinct conceptual logics regarding origins of disease, approaches to diagnosis and treatment, types of practitioners used and practice among specific countries. These medical care models share distinct differences and similarities. While *Western biomedicine* emphasizes the origin of disease as a function of biochemical changes, *naturalistic* models explain illness based on the concept of maintaining equilibrium of physiological functions, and *personalistic* models explain illness as originating from purposeful intervention of supernatural forces. The fundamental differences among these models are embedded within their etiology of disease/illness. While *Western biomedicine* emphasizes a reductionist approach in defining disease and treatment of illness based primarily on physical determinants, *naturalistic* and *personalistic* models incorporate physical, mental and spiritual components as well.

Certain cultures may share a conceptual ideology of health and illness that is rooted in a holistic approach to diagnosis and treatment. This is manifested by patients having different explanatory models (for causes and symptoms) of disease that intertwine *naturalistic* and *personalistic* models or even aspects of western medicine to address the multiple dimensions perceived to be affecting illness and treatment. Conceptual differences about the norms for use of medical care models can lead to problems with accurate diagnosis when medical providers are not aware of, or attentive to, variations in cultural expression, communication, meaning and interpretation of symptoms (Flores et al, 2000; Kleinman et al., 1978; Scott, 1997). The consequence of ignoring differences in health beliefs and practices will result in a patient not adhering to biomedical treatment plans and a delay seeking care at a chronic stage of a disease or illness.

Lastly, while acculturation to American cultural norms can occur over time and may influence behaviors towards utilizing Western biomedical systems, the reality is that cultural minority communities continue to access folk or traditional medicine as a primary source of care because of the low cost and easy accessibility. Practitioners must also exercise caution to not equate folk/traditional medicine to complementary alternative medicine (CAM) being adapted by *Western biomedicine* as the CAM's are primarily grounded in Eastern philosophies and marginally integrate views from Africa and the Caribbean, as well as from indigenous people's practices and those of people in other developing countries.

I. INTRODUCE CORE CULTURAL CONCEPTS

This session aims to introduce core cultural concepts that influence the clinical encounter. The minimum topic areas for meeting this learning objective can address:

a) **Basic Terminology:**

- Review basic terms presented in the overview of this curriculum. Providers are encouraged to seek additional information and learn about other terminology pertinent to the cross-cultural clinical encounter.

b) **Cultural Concepts Influencing the Medical Encounter:**

- Health beliefs and practices.
- Cultural values, norms and customs for interaction.
- Communication styles.
- Family dynamics.

c) **Cultural Differences in Views of Diagnosis and Treatment:**

- Views on origin of illness.
- Views on diagnosis and treatment.
- Practitioner types used.
- Practicing countries.

RESOURCES TO FACILITATE DISCUSSION

- ☐ Refer to Office of Minority Health Website (www.ohmrc.gov) for resources to address Topic 1a above.
- ☐ Refer to Section III of the Toolkit and Appendix A: Module 1 for definitions on Topic 1b above.
- ☐ Refer to Curriculum Appendix B: Module 2 Handout (Cultural Dynamics Influencing the Clinical Encounter) to address Topic 1c above.
- ☐ Refer to the following websites to get information on health beliefs/practices across cultural groups:
  - ▷ Providers' Guide to Quality and Culture at http://erc.msh.org/mainpage.cfm provides links on cultural characteristics for select subgroups.
  - ▷ Understanding Health Culture of Recent Immigrants at http://www.apha.org/ppp/red/Intro.htm provides links to a maternal and child-health information catalog of health beliefs/practices.

MODULE 3: CLINICAL ASSESSMENT PROCESSES

Session Goal:	*Learning Objectives:*	**Topic Areas:**
Enhance Clinical Assessment Processes	• Introduce CPG Statements 1-3 • Introduce Toolkit Section IV	• Eliciting Patient Views of Illness • Patient Cultural Assessment • Focus of Cultural Assessment

Overview

Consensus among medical professionals across a variety of disciplines points to the importance of assessing cultural, social, environmental and socioeconomic factors as part of diagnostic procedures, since these provide insight on how the patient understands, interprets and treats his or her illness.

The physician literature acknowledges and promotes the importance of adapting a modified form of cultural assessment that is compatible with the clinician's diagnostic activity (Flores, 2000; Kleinman et al., 1978; Pachter, 1994; Orr, 1996, Scott, 1997). Kleinman et al., (1978) were among the first to propose the concept of an explanatory model of disease/illness that provided a framework for eliciting patients' views on the etiology, onset of symptoms, cultural meaning of illness and treatment expectations grounded in the clinical diagnostic model. By eliciting the patient's views, the clinician is able to get information on the meaning of the disease/illness, meaning and severity of symptoms in relation to cultural norms and the patient's concept of the sick episode, as well as his or her expectations for treatment (American Psychiatric Association, 2000; Flores, 2000; Johnson, Hardt, Kleinman, 1995; Pachter, 1994; Scott, 1997).

Physicians who elicit information on the cultural health beliefs and practices are also in a better position to identify discrepancies among provider-patient views, generate a common language for anchoring physician-patient communication about illness and involve the patient in negotiation and decisions about treatment goals (Botelho, 1992; Buchwald et al., 1993; Carillo et al., 2002; Kleinman et al., 1978; Pachter, 1994; Scott, 1997; Vermeire, et al., 2001).

Betancourt et al., (1999) proposes an ESFT model to guide physicians on determining a patient's explanatory model, social risks, fears and concerns about medications, and understanding of the treatment regimen. This model serves as a patient-based tool that allows screening for barriers regarding compliance and identifying communication strategies to improve outcomes. Flores (2000) recommends that the physician-patient encounter utilize an assessment framework that incorporates an understanding of normative cultural values (i.e., *respeto, simpatia, familismo, fatalismo*), cultural beliefs, folk illnesses (culturally constructed diagnostic categories recognized among ethnic subgroups), language issues and provider practices. By understanding what cultural health beliefs and practices inform the patient's explanatory models of illness and treatment the physician can identify and accommodate those that improve the patient's condition and recommend alternatives for those practices that are harmful or that contraindicate biomedical therapies (Betancourt et al., 1999; Flores et al, 2000).

Moreover, the mental health literature has also moved toward formal methods to improve the collection of clinical information during the therapeutic encounter with ethnically and culturally diverse populations (American Psychiatric Association, 2000; American Psychological Association, 1993). The Diagnostic and Statistical Manual of Mental Disorders-4th Edition outlines a cultural formulation process to guide psychiatrists and other mental health professionals in a systematic assessment of the patient's cultural background, the role of culture in the expression of symptoms and the identification of culture-bound syndromes, as well as the effect culture may have on the clinician-patient relationship.

Cultural-assessment instruments are designed to collect information on cultural identity (cultural reference group, language preferences, etc.), explanatory models of illness (idioms of distress, culture-bound syndromes, preferences for professional and traditional sources of care), psychosocial stressors (social supports, role of religion, kin networks, etc.), differences between patient-clinician cultural and social status and treatment modalities. Likewise, clinical guidelines for psychological services to culturally diverse populations focus on conceptual frameworks that enable psychologists to accurately assess the role of cultural values, the effectiveness of therapeutic styles, and the impact of the counseling process on utilization outcomes (American Psychological Association, 1993). Their guidelines encourage documenting not only the cultural, but also the socio-political (number of years in country, generation, English fluency, etc.), impact of environmental factors (discrimination, bias, prejudice, etc.) and institutional practices affecting ethnic minority patient care and treatment goals

I. Improve Information Gathering

The aim of this session is to introduce frameworks and techniques useful for gathering information on cultural, social and environmental factors during the cross-cultural clinical encounter. The minimum topic areas for meeting this learning objective can address:

a) Cultural Differences in Diagnostic and Treatment Practices (Review):
  - Views on origin of disease.
  - Views on focus of diagnosis.
  - Views on focus of treatment.

b) Eliciting Patient Views of Illness:
- The Explanatory Model (EM):
  - i. Framework for eliciting a patient’s views on the etiology, onset of symptoms, cultural meaning of illness and treatment expectations grounded in the clinical diagnostic model.
  - ii. Used to identify a patient’s prevalent subgroup beliefs by using basic questions.

- Practicing the Use of the Explanatory Model:
  - iii. Mnemonic devices exist to guide clinicians in eliciting patient views that include:
    1. ETHNIC framework.
    2. LEARN framework.
    3. BATHE framework.
    4. ADHERE framework.

C) PATIENT CULTURAL ASSESSMENT:

- Purpose of cultural assessment.
- Process of cultural assessment.
- Contents of cultural assessment:
  - o Cultural context.
  - o Social context.
  - o Environmental context.

RESOURCES TO FACILITATE DISCUSSION

- ☐ Refer to Curriculum Appendix A: Module 1 Handout (CPG statements 1 - 3).
- ☐ Refer to Section III and IV of the Toolkit to address Topic areas 1a above.
- ☐ Refer to Curriculum Appendix D: Module 3 Handout (Mnemonics) to cover Topic 1b above.
- ☐ Refer to Toolkit Appendix A (Sample Patient Cultural Assessment Tool) to address Topic 1c above
- ☐ Review Summary Action Points in Section IV of the Toolkit.

☐ Refer to Curriculum Appendix E (Case Study Roster) to select a case for discussion.

MODULE 4: TREATMENT PLANNING AND ADHERENCE

Session Goal:	*Learning Objectives:*	**Topic Areas:**
Improve Treatment Planning and Patient Adherence	• Introduce CPG Statements 4 – 6 • Introduce Toolkit Section V	• Considerations in Treatment Planning • Negotiating Treatment Plans • Monitoring Treatment

Overview

A variety of factors are said to influence patient treatment adherence, including patient health beliefs/views about medications, cultural and social factors, constraints of a patient's everyday life, the clinician's ability to provide appropriate information and elicit respect, and the clinician's attitude toward patients and an openness to negotiating differences (Barnard, 1985; Betancourt et al., 1999; Botelho, 1992: Kleinman et al., 1978; Lazare, et al., 1995; Vermeire et al., 2001). The current literature reveals a consensus on the importance of adopting treatment goals compatible with the patient's beliefs/practices and negotiation skills to enhance clinician-patient interaction and relationship during the cross-cultural encounter. Kleinman et al (1978) first proposed the concept of creating a cultural construction of clinical reality using the explanatory model of illness as the basis for revealing discrepancies among cultural belief systems and conflicts in treatment expectations. Botelho (1992) suggests that negotiation is a multifaceted process that examines the context of a patient's disease experience, deals with physician-patient explanations of illness and examines the personal and relationship levels between physician-patient, as well as problem solving on treatment goals, management and completing the clinician-patient relationship.

Considerations in Treatment Planning

Growing support points to the importance of using the patient's explanatory model as a basis for initiating discussion grounded on the concepts, words and metaphors familiar to the patient about treatment goals and expectations (American Psychiatric Association, 2000; Flores, 2000; Johnson et al., 1995; Orr, 1996; Scott, 1997). Clinicians are encouraged to elicit specific information about treatments used for symptoms presented under common folk illnesses, types of folk medicines and healers used to treat illness and, whenever possible, to integrate folk medicine and biomedical therapies as part of treatment planning (Flores, 2000; Pachter, 1994; Putsch, 1985; Yamey, 2000). Clarifying and discussing important ethical disagreements related to particular religious or cultural practices, as well as a willingness to compromise about treatment goals when possible, are equally important during the negotiation process.

Both Betancourt et al., (1999) and Flores (2000) propose models that illustrate the importance of physicians becoming knowledgeable about differences in views of treatment, culturally based treatment practices, and cultural norms relevant to interpersonal dynamics, to assure accurate communication between the physician-patient when negotiating treatment plans. When developing treatment plans, physicians can also determine if patients are utilizing particular folk medicines and suggest alternatives to harmful remedies when necessary. Moreover, the mental health practice guidelines parallels physician literature views on the importance of addressing treatment planning and negotiation processes that are culturally relevant.

The American Psychiatric Association (2000) guidelines suggest incorporating comprehensive approaches that include the medical, religious, psychiatric, community and traditional folk practices to get a broad view regarding specific factors that may affect treatment goals. Similarly, the American Psychological Association (1993) guidelines recommend that clinicians consider the impact of socio-political and environmental factors in designing treatment, and respect the role of the patient's family and culture by including specific religious beliefs and practices as part of treatment planning.

Lastly, a growing body of literature points to the importance of monitoring drug metabolism and response as a feature of treatment planning that may impact treatment outcomes. Studies related to ethno-pharmacy have uncovered significant differences in drug metabolism, dosing adjustment requirements, medication response and side effects among racial and ethnic groups (Kudzma, 1999; Salerno, 1995). Although the topic of ethno-pharmacology remains controversial, clinicians must be attentive to drug metabolism responses, as it can provide some insight on other factors than may be influencing adherence behaviors among racial and ethnic minority populations.

I. Factors Affecting Treatment Planning

The aim of this session is to identify factors affecting treatment planning and strategies to improve negotiation skills during the cross-cultural encounter. The minimum topic areas for meeting this learning objective can address:

A) CONSIDERATIONS IN TREATMENT PLANNING:

- Cultural health beliefs.
- Role of family.
- Socioeconomic factors.
- Environmental factors.

B) NEGOTIATING TREATMENT PLANS:

- Cultural context.
- Identifying cultural discrepancies on treatment modalities.
- Resolving different views on treatment.
- Managing the relationship.
- Process of negotiation involves:
    - Relationship building.
    - Problem clarification.
    - Agenda setting.
    - Assessment.
    - Follow-up care management.

C) FACTORS AFFECTING PATIENT ADHERENCE:

- Components of adherence.
- Culture.
- Socioeconomic status.
- Environment.
- Physiological - medication response.

RESOURCES TO FACILITATE DISCUSSION

- ☐ Refer to Appendix A: Module 1 Handout (CPG Statements 4 - 6)
- ☐ Refer to Section V of the Toolkit to address Topic 1a above.
- ☐ Refer to Summary Action Points in Section V of the Toolkit.
- ☐ Refer to Curriculum Appendix E (Case Study Roster) to select a case for discussion.

MODULE 5: PATIENT COMMUNICATION AND EDUCATION

Session Goal:	*Learning Objectives:*	**Topic Areas:**
Enhance Patient Communication and Education	• Introduce CPG Statements 7 – 8 • Introduce Toolkit Section VI	• Factors Affecting Communication • Cultural Factors Affecting Interaction • Working With Language Barriers • Patient Education Strategies

Factors Affecting Communication

Effective patient communication and education are also considered key to physician functions during the clinical encounter. Several factors are said to thwart effective communication during this interaction, including the physician's awareness of the patient's expectations, devaluing patient and family views on diagnosis or treatment goals, the patient feeling rushed, cultural norms/customs for interpersonal communication, language barriers, socioeconomic status, noncompliance, difficult or sensitive topics and physician biases (Collins et al., 2002; IOM, 2003; Rivadeneyra et al., 2000; Stewart et al., 1999). Successful communication, however, requires an awareness of the cultural (norms, values, language, etc.) or environmental (education level, literacy, etc.) factors that may be influencing physician-patient interpersonal communication styles or preempting learning, as well as the development of approaches and skills that can enhance clinician efforts.

Several authors point to the importance of recognizing differences in the cultural norms, values and customs that dictate verbal and non-verbal communication styles for developing relationships among various cultural minority subgroups (Buchwald et al., 1993; Flores, 2000; Giger & Davidhizer, 1999; Hardt, 1995; Johnson et al., 1995; Orr, 1996; Poss & Rangel, 1995). Physicians need to become aware and understand the norms for verbal greeting among people with different hierarchical status such as authority figures, elder members, or strangers and maintain respect, as these directly influence the quality and maintenance of interpersonal relationships. Current guidelines recommend applying basic principles for verbal communication such as avoiding medical jargon or elaborate explanations about the patient's illness, speaking slowly, avoiding ambiguous statements or idioms not relevant to the patient's conceptual orientation or vocabulary and using clear and specific language (Buchwald et al., 1993; Hardt, 1995). Clinicians should also be aware and understand the norms and role of non-verbal communication such as body language, eye contact, hand gestures, time orientation and personal space, as these also affect interpersonal communication. Many ethnic minority groups share cultural norms in which direct eye contact is considered disrespectful and close personal space is valued for enhancing relationships.

The use of interpreters adds another level of complexity to physician-patient verbal/non-verbal communication. Medical interpreters trained in cross-cultural communication can also be a source of important information in assessing and learning about verbal/non-verbal behaviors characteristic of different linguistic subgroups. Current guidelines also recommend that clinicians consider various factors during interpreter dependent visits such as: arranging patients and interpreters in a position that allows maximum observation of non-verbal cues, addressing patients directly and not the interpreter, learning basic words/phrases in the patient's predominant language to make him or her feel more comfortable, observing patient-interpreter verbal/non-verbal interaction patterns, asking interpreters for the literal translation of what patients are saying and meeting with interpreters prior to patient encounters to discuss goals for visits.

Patient Education During the Medical Encounter

Patient education encompasses giving information, instruction and counseling that help patients understand and manage their illnesses or conditions (Grueininger et al., 1995; Lazare, et al., 1995). One of the most important roles of patient education is to change risky behaviors that may be detrimental to the patient's health, well-being and recovery during illness. Several factors are said to impede effective patient education, including the patient's education level, literacy in his or her primary language, language barriers and familiarity with medical care concepts, as well as perceptions about the physician's role and behaviors (Betancourt et al., 1999; Buchwald et al., 1993; Flores, 2000; Grueininger et al., 1995).

Experts point to the importance of considering patient education strategies that apply conceptual cultural equivalence and language differences, and consider literacy and education level when communicating and developing patient materials. Cultural equivalence was echoed as a major theme across the functions discussed in previous sections about the importance of communicating and developing patient materials that use idioms, expressions and semantic terms that are meaningful to the patient's conceptual orientation. Physicians must also be able to adopt patient education methods that are sensitive to their patients' reading, comprehension and literacy levels, and consider using alternatives such as visual aids when possible, simplifying messages and avoiding medical jargon in both verbal and written education strategies.

Moreover, patient education can be further confounded by language barriers even when trained interpreters are present. Current literature documents the perils of language barriers in diagnosis and treatment compliance. When trained medical interpreters are not available during the physician-patient education encounter, problems such as misdiagnoses and poor compliance may result, further eroding the physician-patient relationship (American Institutes for Research, 2002; DHHS, 2001; Flores et al., 2000). Other problems resulting from language barriers include lack of information on informed consent, which may result in malpractice or negligence claims against the physician, medical practice or hospital (Woloshin et al, 1995). Baker et al., (1998) found that the use of interpreters with Spanish-speaking patients tend to provide more positive response in terms of patient satisfaction regarding interpersonal aspects of care.

I. IMPROVING PHYSICIAN-PATIENT COMMUNICATION

The aim of this session is to identify strategies to improve physician-patient communication and education during the clinical encounter. The minimum topic areas for meeting this learning objective can address:

a) Factors Affecting Physician-Patient Communication:

- Cultural norms/customs affecting interaction.
- Guidelines for addressing verbal communication.
- Tips for addressing non-verbal communication.
- Working with language barriers.
    - Tips for using a medical interpreter.

b) Factors Affecting Patient Education During the Medical Encounter:

- Conceptual equivalence of message.
- Education and literacy appropriateness.
- Language barriers.

Resources to Facilitate Discussion

- ☐ Refer to Curriculum Appendix A: Module 1 Handout (CPG Statements 7 - 8).
- ☐ Refer to Section VI of the Toolkit for content focus areas.
- ☐ Refer to Curriculum Appendix B (Cultural Dynamics) to address parts of Topic area 1a above.

☐ Refer to Summary Action Points in Section VI of the Toolkit to address Topics 1a and 1b above.
☐ Refer to Curriculum Appendix E (Case Study Roster) to select a case for discussion.

MODULE 6: CONSIDERATIONS IN CLINICAL DECISION-MAKING

Session Goal:	*Learning Objectives:*	**Topic Areas:**
Increase Awareness of Clinical Decision-Making Processes	• ***Introduce CPG statement 9*** • Introduce Toolkit Section VII	• Personal Level Factors • Professional Level Factors • Institutional Level Factors

Factors Influencing the Clinical Decision-Making Process

Physicians are trained in a scientific rationality that emphasizes objectivity, numerical measurement of physicochemical data and the treatment of all human beings alike, while ignoring dissimilarities to find common features (Giorgianni, 1998; Helman, 1998). Physician practice centers on applying diagnostic and treatment procedures to all individuals in exactly the same manner. However, medical historians have pointed out the persistent inequities in application of procedures among ethnic minority populations (Byrd & Clayton, 2000; 2002). While the main functions of the medical encounter are to diagnose the problem, recommend treatment and provide patient education, the components that go into applying knowledge and arriving at decisions for treatment are fraught with uncertainty. Diagnostic methods depend on a breadth and depth of knowledge, but application of such knowledge is not always straightforward and is often affected by biases (Round, 2000). Studies suggest that health disparities among racial/ethnic minority groups may be attributed to aspects of clinical reasoning (Andrews & Elixhauser, 2000; IOM, 2003; Schulman et al., 1999).

The clinical reasoning process is used as a tool to analyze information and to generate hypotheses and test them if uncertainty exists among a diagnosis or regarding a treatment plan. The reasoning process aims to deduce information from particular facts, and recognize signs/symptoms from previous clinical experiences to make a decision and take a course of action (IOM, 2003; Quill, 1995; Round, 2000; Yamey, 2000). This process, however, must also integrate aspects of knowledge about the clinical condition (technical procedures), about the interaction between practitioner-patient and about the intersection between the patients and their conditions.

Several factors may influence the dynamics of how the physician applies her/his knowledge to derive a diagnosis, interacts with patients and makes decisions regarding treatment during the clinical encounter. These factors essentially fall into themes that address individual, professional and systemic level factors and are briefly discussed below.

a) Individual Level Factors. Physicians enter into the clinical encounter with a particular worldview and set of experiences that are also a product of continuous interaction among various cultural, social, economic and political determinants. This worldview directly informs structural and systematic ways of perceiving and interpreting various realities, views of hierarchical thinking and typecasting of patient populations (Barnard, 1985; IOM, 2003; Yamey, 2000; Saha et al, 1999). Physician bias and prejudice also influence subjective views that are informed by conscious and unconscious processes that are socially conditioned. Evidence in the literature suggests that bias and prejudice regarding perception of the patient's race, class, culture, age and gender may account for stereotypes and therefore contribute to disparities in care and treatment planning (Andrews & Elixhauser, 2000; Barnard, 1985, IOM, 2003; Round, 2000; Schulman et al., 1999). Likewise, physician-patient socioeconomic status (SES) [low SES as compared to middle SES] and explicit versus implicit communication about social status can influence clinical reasoning and decision-making processes. Barnard (1985) further suggests that sociolinguistic differences between physician-patient can result in viewing lower SES patients as being less linguistically competent and less able to communicate during the clinical encounter, thus influencing the physician's clinical reasoning processes (IOM, 2003).

b) Professional Level Factors. The clinician's professional experience, norms, behaviors and training specialty are also said to influence clinical reasoning and decision-making processes. Factors like the type of postgraduate training completed, academic versus private practice experience, number of years in practice and experience in working with medically underserved and culturally diverse populations are some issues that may influence decision-making processes (Davis & Taylor, 1997; Silberman, 1995). Professional norms and behaviors also serve to inform the objective and subjective definition of the physician-patient relationship, social distancing from patients and views on biomedical versus holistic care models (Barnard, 1985; Byrd & Clayton, 2002; IOM, 2003). Aspects of medical training specialty can also influence the clinical decision-making process. For example, primary care clinicians focus on incorporating health-illness profiles, while specialty care physicians focus on specific diseases. Clinicians who are academic or research-based may focus on decisions that relate to improve training or publications, whereas community-based practice may be more pragmatic and less distant/formal in nature (Barnard, 1985; Round, 2000). The clinician's exposure to cultural competence training is needed in order to understand differences among patient-provider worldviews, and social, economic and cultural factors influencing communication, trust and clinical decision-making, among other things (Betancourt et al., 1999; IOM, 2003; Like, Steiner, & Rubel, 1996).

c) Systemic Factors. System factors have also been identified as influencing the clinical reasoning and decision-making process (IOM, 2001a & 2003). Institutional policies represent those aspects of organizational administrative policies and procedures that may target rationing care to control costs, clinical productivity, quality improvement, workforce competence, the degree to which cultural and linguistic appropriate standards are adopted to support structure and processes and meeting compliance for regulations and laws (IOM, 2001a). Time constraints also influence clinical reasoning and decision-making processes in that it limits information gathering and fosters cognitive shortcuts or stereotyping, as well as a lack of attention to information relevant to patient cultural preferences/values and needs.

I. Increase Awarness of Factors Influencing Decision-Making

The aim of this session is to increase awareness of the various factors that influence clinical reasoning and the decision-making process. The minimum topic areas for meeting this learning objective can include:

a. **Individual level factors.**

b. **Professional level factors.**

c. **Institutional level factors.**

RESOURCES TO FACILITATE DISCUSSION

☐ Refer to Appendix A: Module 1 Handout (CPG Statement 9).
☐ Refer to Curriculum Appendix E (Case Study Roster) to select a case for discussion.
☐ Review Summary Action Steps.
☐ Refer to Section VII of the Toolkit for focused case study presentations.
☐ Refer to Curriculum Appendix E (Case Study Roster) to select a case for discussion.

MODULE 7: ORGANIZATIONAL SUPPORTS AND SYSTEM TOOLS

Session Goal:	*Learning Objectives:*	**Topic Areas:**
Improve Organizational Supports and System Tools	• Introduce CPG Statement 10 • Introduce Toolkit Section VIII	• National CLAS Standards • Interpreter Service Arrangements • Quality Improvement Planning and Monitoring • Other Organizational Supports

Overview

While substantial literature focuses on the development of clinical practice guidelines, an area often neglected, yet of critical importance, is adoption of these guidelines into practice settings. Several factors are said to impede the adoption of clinical practice guidelines, including characteristics related to the system environment such as the habits, customs and beliefs of peers, provider background and medical training, legal or financial incentives, regulatory bodies and characteristics of the patient population served (Davis & Taylor-Vaisey, 1997; James, 1995; Weber, 2000). Davis and Taylor-Vaisey (1997) suggest that the creation of clinical practice guidelines without attention to how the system environment or practice setting is going to implement them is an exercise in futility. The successful adoption of clinical practice guidelines not only depends on the culture, knowledge, attitudes, behaviors and resources of the clinicians within the organization, but also requires multi-level strategies that aim to train physicians, change clinician behavior and create an organizational culture that is committed to reducing environmental barriers to guideline use (Davis & Taylor Vaisey, 1997; IOM, 2001a). Adopting cross-cultural clinical practice guidelines requires attention to enhancing system/office features that can support clinicians in modifying practice settings serving culturally diverse populations. The current literature points to specific recommendations in the area of physician training, workforce concordance, interpreter services, patient education materials, data collection and community networking.

I. Improving Organizational Supports

The aim of this session is to identify system factors that can support cross-cultural practice. The minimum topic areas for meeting this learning objective can address:

a) Review of Standards and Policies Related to Reducing Disparities in Healthcare

- National CLAS Standards 1 – 14.
- Additional organizational supports relevant to physician practice (see Section VIII of the Toolkit).

b) Interpreter Service Arrangements

- Title VI Regulations.
- CLAS Standards 4 – 7.

C) QUALITY IMPROVEMENT PLANNING

Quality is culturally defined and rooted in a value system that constitutes a set of cultural rules and expectations. Concepts of quality are first and foremost culturally bound constructs that depend on the rules that are valued within a particular group or society and what is considered quality or competence in one group is not applicable in another (Donabedian, 1988).

Quality improvement models are based on trial and learning approaches to systematically build knowledge and make decisions to improve the problem at hand (Nolan, 1998). They provide an opportunity to test an idea about a change and to learn what actually leads to improving the systems performance in a process or outcome. Trial and learning approaches are best carried out through small-scale efforts in consecutive test cycles to determine whether they can be implemented on a larger scale or into day-to-day operations. Improvement models use a logical sequence of steps to guide participants through the "test and learn" process by using Plan-Do-Study-Act or PDSA cycles.

AIM	What are you trying to accomplish?
MEASURE	How will you know that change is an improvement?
CHANGE	What changes can be made that will result in improvement?
RESULT	How did measures change?
EVALUATION	What are next steps?

The PDSA logic presents the framework to guide the components and steps of the plan to inform that learning process as follows:

1) Project Aim: What are you trying to accomplish?

- ☐ Identify a goal relevant to improving an aspect of quality that contributes to reducing disparate outcomes of care in quantifiable terms.
- ☐ State how this goal will move you towards improving outcomes of clinical care for a targeted subgroup population.
- ☐ Specify what data sources were used to both identify and decide on this QIP goal as a priority.

2) Baseline Measures: How will you know that change is an improvement?

- ☐ Identify existing clinical data stratified by race, ethnicity and language (ex: diabetes, asthma, maternity process indicators, patient satisfaction, interpreter services, etc.) reported to Medicaid or other insurers.
- ☐ Identify the baseline measures that will tell you that improvement is actually taking place.
- ☐ Set numeric goals for improving that baseline measure as (or when) it becomes available.

3) Changes: What intervention can be made that will result in improvement?

- ☐ Identify root causes underlying the problem/area you are trying to improve. (Why is it a problem, what processes are involved, what systems underlie those processes?)
- ☐ Describe proposed change you have chosen to test/implement. Clarify how this intervention will assist in meeting your goal.

4) Results: How did measures change?

- ☐ Describe what data and measures relevant to the aim will be analyzed.
- ☐ How do you plan to communicate your findings (ex: in graphs, charts, tables, etc.)?
- ☐ Describe data relevant to effects of intervention and measures, including intermediate steps influencing the overall measure and what factors prove how well the intervention works.

5) Evaluation: What next steps can be taken to improve on change made?

- ☐ Describe how end results will be used to improve goal attainment.
- ☐ State how end results will be used to modify change in process.
- ☐ Describe follow-up activities that will be planned for continued improvement (ex: number of test cycles, etc.).

RESOURCES TO FACILITATE DISCUSSION

- ☐ Refer to Curriculum Appendix A: Module 1 Handout (CPG Statement 10).
- ☐ Refer to Section VIII of the Toolkit.

- ☐ Refer to Appendix G of Toolkit to review CLAS Standards.
- ☐ Refer to Toolkit Appendix E for sample QIP plans.
- ☐ Refer to Curriculum Appendix E (Case Study Roster) and identify a system process intervention that can enhance clinical care processes for case selected.
- ☐ Refer to http://www.usdoj.gov to track Executive Order no. 13166, Improving Access to Services for Limited English Speaking Persons.

APPENDIX A: MODULE 1 HANDOUT

Cross-Cultural
Clinical Practice Guideline Statements

◆ ◆ ◆ ◆

1. **Elicit the patient's views on illness and treatment practices to understand his or her health values, particular concerns and expectations for care.**

2. **Assess the cultural norms, values and customs that influence the patient's health-seeking behaviors, practices and expectations for the physician-patient relationship.**

3. **Assess the patient's environmental context to determine what social experiences and resources may be affecting illness, behaviors or health-seeking practices.**

4. **Identify a range of treatment goals for a given medical condition that can be mutually satisfactory and take into account the patient's cultural health beliefs, practices, norms, customs and traditions.**

5. **Identify the social and environmental factors that may potentially interfere with adherence to treatment goals.**

6. **Work collaboratively with the patient to negotiate treatment plans that incorporate aspects of the biomedicine while integrating cultural concepts for treating illness familiar and important to the patient.**

7. **Develop communication skills that are respectful of the patient's cultural norms, values and language to facilitate empathy in the clinical encounter.**

8. Utilize patient-education strategies in the clinical encounter that take into consideration literacy, cultural appropriateness and language concordance.

9. Acknowledge that personal, professional and institutional factors can affect aspects of clinical decision-making which, in turn, may lead to disparities in care.

10. **Take proactive steps to adapt institutional and system processes aimed at delivering clinically appropriate and culturally responsive care.**

◆ ◆ ◆ ◆

APPENDIX B: MODULE 2 HANDOUT

Cultural Dynamics Influencing the Clinical Encounter

American/Western Cultures	Concepts	Non-Western Cultures
•Health is the absence of disease. •Disease/illness results from exposure to pathogens, hematological or environmental factors.	**Core Health Beliefs**	•Health is a state of harmony within body, mind, spirit, family, community & outside world. •Illness results from body imbalances (hot/cold; ying/yang). •Illness results from God's will or supernatural forces (spirits, deity, etc.) that affect mental and physical function.
•Seek medical system to prevent disease & treat illness. •Use physicians, nurses, psychiatrists, surgeons, specialists and select bodyworkers (chiropractors, etc.). •Prevention is practiced to avoid future disease. •Foods used to ensure biological functioning.	**Health- Seeking Practices**	•Seek medical system when in acute stage of illness. •Use herbalists, midwives, santiguadoras, curanderos, priests, shamans, espiritistas, voodoo priests, etc. •Prevention of disease is not practiced. •Foods used to restore imbalances (hot/cold; ying/yang).
•Values individualism: focus on self-reliance & autonomy. •Values independence and freedom. •Values youth over elderly status. •Personal control over environment & destiny. **•Future oriented.** •Efficiency: time is important; tardiness viewed as impolite.	**Cultural Values, Norms, Customs**	•Values collectivism: reliance on other & group acceptance. •Values interdependence with family and community. • Values respect for authority and elderly status. •Fate controls environment & destiny. •Present oriented: here and now. •Efficiency: time is flexible; viewed as impolite/insulting.
•Greeting on first name basis denotes informality to building rapport. •Being direct avoids miscommunication. •Eye contact signifies respect and attentiveness. **•Personal distance denotes professionalism & objectivity.** •Gestures have universal meaning.	**Communication Styles**	•Greeting on first-name basis denotes disrespect. •Being direct denotes conflict. •Eye contact is considered disrespectful. •Close personal space valued to building rapport. •Gestures have taboo meanings depending on cultural subgroups.
•Individual interests are valued and encouraged. •Individual is the focus of health care decision-making. **•Reliance on nuclear & immediate family bonds.**	**Family Dynamics**	•Individual interests are subordinate to family needs. •Family is the focus of health care decision-making. •Reliance on extended family networks.

References: Harwood (1981), Buchwald (1993), Putsch (1985), Flores (2000) Spector (2000), Leininger and McFarland (2002).

NOTE: This table is an expanded version of the one in Section III of the Toolkit. Clinicians must use caution in learning and applying these categorical characteristics as these can potentially result in stereotypic behavior. Instead these should be viewed as a continuum where they represent the extreme end of the spectrum. They can be used as a basis for further exploration rather than making generalizations about certain cultures fitting to a set of specific unifying characteristics.

APPENDIX C: MODULE 2 HANDOUT

Differences Among Biomedical and Non-Biomedical Techniques

BASIC CONCEPTS	**BIOMEDICAL TECHNIQUES**	**NON-BIOMEDICAL TECHNIQUES**	
		Naturalistic (Physical)	**Personalistic (Spiritual/Mental)**
Views on Origin of Disease	• Disease is caused by pathogens, biochemical or hematolologic changes due to environmental factors (e.g., stress, poor nutrition, injury, aging process).	• Illness is caused by impersonal forces (cold, heat, wind, dampness, etc.) or conditions creating imbalances in bodily humors, or disruption of physical function. • Bodily imbalances originate from foods, medicines or changes in physical conditions (pregnancy, menses, childbirth), emotions (anger) or environment.	• Illness is caused by external agent that may be supernatural (God, deity, etc.), non-human (evil spirit, ancestor) or another human being (witch, sorcerer). • The external agent causes disease via theft of soul, or invoking spells that affect mental or physical function.
Focus of Diagnosis	**• To identify pathogen or biochemical process responsible for abnormality.** • Diagnostic procedure relies on physical exam and laboratory tests.	• To identify forces contributing to bodily imbalances. • Diagnostic procedure may use taking of pulse, examining tongue or eyes to determine state of internal organs, hot-cold/ying-yang imbalances.	• To identify agent behind the act and render it harmless. • Diagnosis of physical symptoms is of secondary concern since condition will not improve without addressing primary belief for cause of disease.
Focus of Treatment	• Destroy or remove entity causing disease or modify/control affected body functions.	• Restore equilibrium of physiological function. • Treatment may include herbs, food combinations, dietary restrictions, enemas, massage, poultices, acupuncture, cupping, coining and stopping western medication treatments. • Prevention includes avoiding mental, environmental and emotional factors that affect equilibrium and balance.	• Primary treatment involves a curing ritual to remove object of intrusion (lifting spell, reversing technique). • Secondary treatment to address physical symptoms & implement cure done by herbalist. • Prevention of illness involves making sure social networks with people, deity or ancestors are in good working order.
Practitioner Types Used	Physicians, nurses, psychiatrists, chemists, surgeons, specialists.	Herbalists, body workers, midwives, Santiguadora, Curanderos, etc.	Priests, Shamans, Espiritistas, sorcerers, voodoo priests, etc.
Practicing Countries	U.S. and European societies.	China (traditional), India (Ayurveda) Greece, Latin America, Caribbean, Phillipines, Pakistan, Malaysia, etc.	Indigenous groups of Americas, African tribes, Asian tribes, Latin American, Caribbean groups (Cuban, Puerto Rican, Haitian, etc.).

***References**: Loustaunau and Sobo (1997), Harwood (1981), Jackson (1993), Spector (2000).*

***NOTE**: This table is an expanded version of the one in Section IV of the Toolkit. Clinicians must use caution in learning and applying these categorical characteristics as these can potentially result in stereotypic behavior. Instead these should be viewed as a continuum where they represent the extreme end of the spectrum. They can be used as a basis for further exploration rather than making generalizations about certain cultures fitting to a set of specific unifying characteristics.*

APPENDIX D: MODULE 3 HANDOUT

Mnemonic Devices to Elicit Patient Views

MNEMONIC	**FRAMEWORK**	*SAMPLE QUESTIONS*

APPENIDIX C

ETHNIC E: Explanation T: Treatment H: Healers N: Negotiate I: Intervention C: Collaborate	ELICIT HEALTH VIEWS E: Elicit patient's explanation of the problem. T: Elicit information on treatment practices. H: Elicit information about use of healers. N: Negotiate options. I: Determine Intervention. C: Collaborate with patient.	• What do you think may be the reason you have these symptoms? • What do friends, family, others say about these symptoms? • Do you know anyone else who has had this kind of problem? • Have you heard about/read/seen it on TV/radio/newspaper? What concerns you most about your symptoms? • What kinds of medicines, home remedies or other treatments have you tried for this illness or symptoms? • Is there anything you eat, drink, or do on a regular basis to stay healthy? Tell me about it. • What kinds of treatment are you seeking from me? • Have you sought any advice from traditional/folk healers, friends or other people for help with your problems? Tell me about it. • Negotiate options that will be mutually acceptable to you and your patient that do not contradict but incorporate patient's beliefs. • Ask what are the most important results your patient hopes to achieve from this intervention. • Determine an intervention with your patient. May include incorporation of alternative medical remedies, spirituality and healers as well as other cultural practices. • Collaborate with patient, family members and other health care team members, healers and community resources.
LEARN L: Listen E: Explain A: Acknowledge R: Recommend N: Negotiate	ELICIT HEALTH VIEWS L: Listen with sympathy and understanding to patient's perception of the problem. E: Explain your perceptions of the problem. A: Acknowledge and discuss differences and similarities. R: Recommend treatment. N: Negotiate treatment.	• Listen with sympathy and understanding to patient's perception of the problem. • What worries you the most? Are you afraid that you may have something serious? What do you think has caused this problem? Have you started any treatment on your own or gotten advice from someone else? • How can I be of the most help to you? • Assess potential circumstances and problems in a person's life that may have an impact on his or her health or health behaviors in the areas of a) control over life b) changes in life c) language and literacy d) support network. Ask: Do you have coverage for your medications? Are there times that are bad for you to come to appointments? Is transportation a problem for you? What brought you here to this city? How does medical care differ her? Do you have any trouble reading medicine bottles or appointment cards? Do you have family and friends that you can call on for help? • Recommend a plan of action with an explanation of your rationale, using language that patient is able to understand. To make sure we understand one another, can you tell me what I just told you? Is there any part you do not understand? Do you have any questions? • Negotiate a plan of action with your patient after you have made your recommendations. Now that we understand each other, let's develop a plan that works for you. What do you think the next steps should be?
BATHE B: Background A: Affect T: Trouble H: Handling E: Empathy	ELICIT PSYCHOSOCIAL CONTEXT B: Elicit information on context of patient's visit. A: Allow patient to report/label his or her current feeling/state/mood. T: Help physician and patient focus and bring out symbolic significance of illness or event. H: Get an assessment of functioning and provide direction for an intervention. E: Legitimize patient's feelings and provide psychological support.	• B: What is going on in your life? • A: How do you feel abut what is going on? • T: What about the situation troubles you the most? • H: How are you handling that? • E: That must be very difficult for you. (Legitimize the patient's feelings and provide psychological support.)
ADHERE A: Acknowledge D: Discuss H: Handle E: Evaluate R: Recommend E: Empower patient	TREATMENT ADHERENCE A: Acknowledge the need for treatment. D: Discuss potential treatment strategies. H: Handle any questions or concerns. E: Evaluate patient's understanding. R: Recommend and review treatment regimen. E: Empower by engaging patient.	• A: Ask about previous treatments used and determine mutual goals. • D: Discuss potential treatment strategies as well as consequences of non-treatment with patient. Consider issues such as treatment effectiveness, prognosis, use of complementary medicines (brand name vs. generic, etc.). • H: Handle any questions or concerns the patient may have about treatment (e.g., side effects, fears or worries, costs, dosage, frequency, timing, sequence, duration of treatment, drug or food interactions, proper storage techniques, etc.). • E: Evaluate the patient's functional health literacy and understanding of treatment, and assess barriers and facilitators to adherence (e.g., environmental, economic, occupational, socio-cultural, family situation and supports). • R: Review and recommend the therapeutic treatment regimen with the patient. • E: Empower by eliciting the patient's commitment and willingness to follow through with treatment regimen.

APPENDIX E: CROSS-CULTURAL CASE STUDY ROSTER

Case Study Vignettes	**SOURCE**
Case Study #1: A 58-year-old Dominican women has been diagnosed with hypertension. Despite being seen by several physicians who ordered multiple tests to rule out secondary causes, and having tried various medications over the years, her blood pressure has remained poorly controlled. After completing the medical interview, the physician surmises that the patient may not be complying with her regimen. The physician explores the patient's explanatory model. The patient communicates an episodic problem related to tension and stress that requires treatment only as needed.	Carillo et al, 1999
Case Study #2: A 34-year-old Egyptian women accompanied by her husband presents as a new patient to a male physician. A history of menstrual irregularity is elicited, but this problem has been denied and minimized previously. Her husband dominates the conversation by answering all medical history questions for her. When conversation is shifted back to the patient, he states she does not speak English very well. For the PE the husband leaves the room and it becomes clear that the patient is proficient in English. When the patient is asked to disrobe, she becomes noticeably uncomfortable in the presence of a male physician.	Carillo et al, 1999
Case Study #3: A 53-year-old African American male from North Carolina presents with a severe cough that gradually worsened over the past year. He noticed some blood-streaked sputum four months ago. He came north with family five years ago and holds down two jobs. He cannot afford to take time off work because of illness as he is sole wage earner for his family and mother-in-law. He has avoided medical attention for fear of a secondary diagnosis that would prevent him from supporting his family in the future. He is also concerned about the possibility of the cost of medications, tests or operations.	Carillo et al, 1999
Case Study #4: A 29-year-old Puerto Rican single mother brings her 12-year-old daughter to her (the mother's) first medical appointment. The physician was troubled by the child's interpreting ability and called in a female lab technician who is from Central America. This interpreter summarized the patient's wordy monologue in one brief sentence, saying that patient felt tired and fatigued during sexual intercourse. The physician ordered a complete blood count and thyroid studies and scheduled the patient to return in one month. The patient left the office unrelieved.	Carillo et al, 1999
Case Study #5: A 57-year-old African American male who recently moved from Georgia has a history of HTN. He takes the doctors anti-HTN medication when he gets symptoms (e.g., headaches, feels blood rise, etc.). When he is told his BP is high after the office visit, he experiences emotions (anger, anxiety). In addition, he eats lots of garlic and pickles, rubs his body with Epsom salts and avoids pork and salt. These activities are believed to decrease blood volume and lower blood away from the head so he will not have a stroke. He does this intermittently rather than continuously. He is a devout Christian who turns to faith healing when pressure/stress is extremely high. He is reluctant to tell the doctor of these activities for fear of ridicule. However, he is willing to tell a doctor who seems open to hearing about alternative ways.	Kulhane-Pera, 1999
Case Study #6: A 19-year-old Hmong mother brings her 3-year-old son, who has been sick for two days and has a 103.6 fever. The child is quiet and subdued, but not listless. You examine the child and there appears to be no infection. You recommend a septic work-up, including LP and blood cultures. The parent refuses, wanting to take the child home for traditional Hmong treatment first. You then ask questions to elicit beliefs, concerns and desires. The mother thinks the fever may be caused by germs, so she came to the doctor. But the results indicate no infection apparent, so she thinks there could be other reasons (e.g., soul loss, fright, recent change in weather, spirits, etc.) as he had fallen last week. The mother does not want to have multiple blood tests and LP procedures on the child. She had a sister who died in a refugee camp after a lumbar puncture. She decides to take the child home to the grandparents to have them evaluate and treat him with traditional therapies. She believes there is something important that the grandparents can do for the child, although she is not sure what it is. She is willing to return if this approach does not work and the child does not get better.	Kulhane-Pera, 1999

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Case Study #7: A 30-year-old Mexican women who recently arrived from a rural village in Mexico brings in her 10-month-old girl, who has a fever, vomiting, diarrhea, decreased appetite, abdominal bloating and sunken fontanelle. The mother is concerned about the baby and has been using traditional remedies. She recently changed from breastfeeding to formula. Thinking the child is reacting to formula and has empacho, she tried to find a curandero to treat her but was not able to pay for the cost. As the diarrhea continued and the sunken fontanelle occurred, she tried traditional techniques like pushing up on the palate and turning the child upside down with her hair in water, with some success. Now she comes to the doctor and wants medicine. She is familiar with ORT but is reluctant to admit the baby to the hospital due to concerns with her undocumented status and the doctor's motivations and language. She says she will go home to talk with her family members before consenting.	Kulhane-Pera, 1999
Case Study #8: A 42-year-old Ojibwa women from a reservation comes to you presenting with symptoms of RUQ tenderness. You took a medical history and ordered RUQ- ULS and diagnosed cholecystitis and cholelithias. You recommend surgery. She is reluctant to go to hospital as she knows hospital won't let her perform a traditional healing ritual before/after surgery (burning sage to purify room). She politely declines, avoiding direct eye contact with you and seems hesitant to explain her cultural practices for fear of not being taken seriously. She would like her family members to be present.	Kulhane-Pera, 1999
Case Study #9: A 49-year-old African American male resides in the inner city with his extended family. He lives with his 5 children, 2 grandchildren, elderly mother and a sister-in-law. He completed 11th grade and is working more than 40 hours a week in a steel factory with an income that places him at poverty level and leaves him unable to buy health insurance. He was diagnosed with cancer one year ago, which has been making him tired and unable to eat. He is receiving spiritual healing from his pastor for this illness. He comes to your office presenting fatigue and abnormal lab tests.	Purnell, L., 2002
Case Study #10: A 71-year-old elderly Black woman, Mrs. Washington, was in the recovery room after surgery. To assess her condition, the nurse spoke her name "Mary." The patient slowly opened her eyes but made no further sign of acknowledgement. The nurse became concerned, because most patients responded readily and clearly at this point. Shortly afterwards, the nurse called the woman Mrs. Washington. The patient then became alert and cooperative.	Galanti, G., 1997
Case Study #11: A female Filipino patient with limited English-speaking ability was explained the harmful effects of medication she needed to take prior to being discharged from the hospital. Her husband served as an interpreter in the process. Throughout the nurse's explanation, the couple nodded in agreement of understanding and laughed nervously. When the nurse tested them verbally on the information, it was apparent that they understood very little. What had happened?	Galanti, G., 1997
Case Study #12: A home health care visit to a 65-year-old Vietnamese LESP female refugee reveals she is living in a two-bedroom apt with 8 other members of her extended family. They had all arrived in the U.S. two years ago and still hold to strong traditional customs. The patient was recently discharged from an acute hospital suffering from lung cancer along with tubercular cavitary lesions in the lungs. She does not speak English and her teen granddaughter acts as an interpreter. The teen has to communicate via her 80-year-old uncle [also NESP], as he is the patriarch of the family and an important figure.	Galanti, G., 1997
Case Study #13: A 47-year-old Hispanic male with Dm for two years who is on oral medications comes to the clinic with blurred vision, requesting eye drops. He is an undocumented laborer living with his brother. His wife and children are in Guatemala, caring for sick, aging parents. The patient drinks on weekends to relieve stress. He was hospitalized two years ago with sepsis and Dx with DM, and was given a glucometer and basic DM education. He goes to a local health center periodically to get free samples of Diabeta, but it is difficult for him to go routinely. He knows diabetes is a chronic disease as his mother and aunt also have it, and he is aware of the symptoms of blood sugars. He takes medications when he can, herbal medicines including cactus every morning and goes to church. He feels these treatments help make him feel better. He has had little success controlling his blood sugars and the doctor recommends insulin therapy. The patient is reluctant to try this, as he dislikes needles, is asymptomatic and knows insulin can cause serious problems such as blindness or infection leading to amputation. He refuses the doctor's recommendations, wanting eye drops and more samples.	Kulhane-Pera, 1999

APPENIDIX E

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