Our Nation's Multiculturalism and Challenges to Case Managers

The need for culturally competent health care in the United States is great. Racial and ethnic minorities are burdened with higher rates of disease, disability, and death and tend to receive a lower quality of health care than nonminorities, even when access-related factors (e.g., insurance, income) are considered. Providing culturally competent services certainly has the potential to improve outcomes, increase the efficiency of staff, and result in a greater level of satisfaction from our clients. In this chapter we will define cultural competence, explore the characteristics of a culturally competent healthcare system, examine the role that culture plays in health care, discuss the implications that all of this has for case management, and provide some guidance and recommendations toward achieving culturally competent care for our patients.

Based on the latest census figures, our nation's melting pot is increasingly more multicultural. If you are a case manager in one of the country's more homogeneous and rural settings, you may not have noticed the changes that have been occurring over time, especially in the past 10 years. Suffice it to say, the world is changing along with our nation's demographics. Patients caught in the convolutions of our healthcare delivery system certainly have enough stress as they try to navigate it. For patients from cultures different from mainstream America, or perhaps representing America as it used to be, the experience can be particularly stressful and challenging.

The increasing multiculturalism is not confined to just patients and families. Our healthcare colleagues and those with whom we interact are more diverse as well. Although we hear about the increase in medication errors, lack of adherence to treatment plans, fragmentation and disconnects in care, and a plethora of other problems that directly affect patient outcomes, we have to shine a larger spotlight on the particular challenges of cultural diversity.

CHANGING DEMOGRAPHICS

The United States has 150 different ethnic cultures (estimated in 2008) among 308.7 million people; because immigration is likely to increase, so too will the number of ethnic groups. The population of our country, according to the 2010 census, grew 9.7 percent over the past decade. This was the slowest rate of growth since the Great Depression.[1]

According to the latest statistics from the U.S. Census Bureau American Community Survey, conducted between 2009 and 2013, 350 languages are spoken in the United States; 162

are indigenous to various regions of the country, and another 149 are immigrant languages.[2] From 2010 to 2013, the number of people aged 5 years and older who spoke a language other than English at home reached an all-time high of 61.8 million, up 2.2 million since 2010, with the largest increases for speakers of Spanish, Chinese, and Arabic. This number has grown by nearly 15 million (32 percent) since 2000 and by almost 30 million since 1990 (94 percent).[3] Languages with more than 1 million speakers in 2013 were Spanish (which accounted for the largest increase from 2010 to 2013, with 38.4 million), followed by Chinese (3 million), Tagalog (1.6 million), Vietnamese (1.4 million), French (1.3 million), and Korean and Arabic (1.1 million each).[4] Of the 281 million people aged 5 years or older in 2013, 62 million individuals (21 percent) reported speaking a language other than English at home.[5] There are more than 14 million households today in which a language other than English is spoken.[6] Interestingly, many of those who speak a foreign language at home are not immigrants. Of the 62 million previously mentioned, 44 percent (27.2 million) were born in the United States.[7] Even within these many languages, there are dialects that further increase the nuances. Each of these variations exacerbates the challenges we all face as we endeavor to improve communication among us.

The Census Bureau also found the following, as of 2013:

- After English and Spanish (34.5 million speakers), Chinese was the most common language spoken at home. Five other languages had at least 1 million speakers: Tagalog, the national language of the Philippines (1.6 million); French (1.2 million); Vietnamese (1.4 million); Korean (1.1 million); and Arabic (1 million).
- Not all languages have grown in use over the years. Italian, Yiddish, German, Polish, and Greek were spoken by fewer individuals in 2013 than in 1980.
- There were also 134 American Indian categories, 19 African categories, and 8 Chinese categories.[8]

A report in October 2015 from the U.S. Census Bureau projects that by 2065, non-Hispanic whites will no longer represent the nation's majority. This projection is further confirmed by a report from the Pew Research Center, which projects that by 2065 there will be 117 million more people than today and that non-Hispanic whites will make up 46 percent of the population, a decrease from 67 percent in 2005. The Pew Research Center's report also projects that the Hispanic population will increase from 18 percent to 24 percent by 2065 and that 14 percent of the population will be Asian American (currently 6 percent) and 13 percent of the population will be black (12 percent now) by 2065.[9]

Nationwide, one in five children enters school speaking a language other than English.[10] Unfortunately, the youngsters lose most of their native language in the process of learning English, and typically the heritage language virtually disappears within three generations. This process, in fact, is encouraged in our schools and becomes a part of natural assimilation. When we as case managers look to family members to assist with interpreting on behalf of some of our non-English-speaking patients, we may not be able to utilize these abilities and will have to rely on other resources.

In another look toward the future, the AHRQ determined that racial or ethnic minority Americans are expected to make up almost half of the U.S. population by 2050.[11] Because

racial and ethnic minorities have higher morbidity and mortality rates from chronic conditions, a greater financial burden from direct and indirect costs can be expected.

ACCULTURATION AND ASSIMILATION

It is important to discuss acculturation and assimilation because they directly affect an individual's ability to access the best that our healthcare delivery system has to offer. Some ethnic groups acculturate or adopt the culture, values, and norms of the dominant population. This was very typical of immigrants who came to the United States in the late 1800s. These immigrants felt that to succeed in their new home they needed to learn the language and immerse themselves and their families in all things American. This is the process referred to as assimilation. Individuals abandon their native culture, beliefs, norms, and traditions and replace them with those of the dominant group. That is not to say that they forget or abandon their homeland, but early immigrants believed that holding on to their past traditions and values would somehow impede their ability to be successful in their new country, which was usually, after all, their primary reason for coming to the United States.

In the past, it was assumed that immigrants either acculturated or did not. It is more likely that individuals fluctuate between one or the other extreme, and in other circumstances they land somewhere in between. In more recent years, we have witnessed somewhat of a departure from this. We now see generations of immigrants come to the United States and steadfastly retain their language, customs, lifestyles, and beliefs. An example in my own town is a woman from Korea. She has been here for more than 15 years, owns and operates a very busy and successful nail salon, hires members of her extended family and others from the community of Korean immigrants, and yet has extreme difficulty speaking English and conducting some of the more simple business transactions required of her. I have assisted her in communicating with a credit card company. She would use hand gestures and very limited English to explain her plight to me, and I would assist her in getting it resolved. Frequently, I wondered how she had managed so many transactions over these years to open and expand her successful business. One day I saw a business-to-business yellow page directory that was written all in Korean. She was able to conduct nearly all of her business with other Korean-owned businesses. I then saw the community where she lived. Thirty years ago, there were perhaps several blocks of businesses in this small Asian community. Today the area spans several miles! She and other members of the Korean community operate within a well-planned network of businesses—auto dealers, insurance brokers, banks, clothing and furniture stores, churches, attorneys, physicians, and other entities—that serve the needs of this continually expanding community. As with so many other things in our society, there is an unending number of ethnic diversity variations. It is important for us to recognize this as we strive to obtain appropriate care for diverse populations.

Obviously, individuals who come to the United States and immerse themselves in American culture, language, and so forth soon become comfortable and, in fact, deliberately make a decision to embrace what the country has to offer, including health care. Of course, there are also those who, for a variety of reasons, cannot or do not develop this comfort level, yet they still need to use that same healthcare system. We as case managers need to be prepared to meet the needs of all patients and their families, not just those who look like us, speak like us, and share our values and customs.

IMPLICATIONS AND OPPORTUNITIES FOR CASE MANAGERS

As case management continues to expand into more and more practice settings—from corporate health and managed care, hospitals, home care, and workers' compensation and disability management, to newer models in physician practices and direct-to-consumer community-based practices—opportunities will present themselves for us to improve both the access to and the quality of care. We certainly can ensure that our patient assessments go beyond the essential elements of medical, behavioral, and so forth and include cultural, religious, and language needs. As patient advocates and professionals who, more times than not, have ongoing relationships across the continuum of care, we can bring to the forefront the more specific cultural issues and concerns and ensure that they are incorporated into treatment plans. Excellent illustrations of an effective initial assessment form and plan of care form (**Figures 29-1** and **29-2**) incorporate cultural information, not only about the patient, but also about the case manager. It is advisable for case managers and others involved in the creation of software and case management tools to ensure that cultural issues are integrated into the system, which moves us closer to providing culturally competent care.

FIGURE 29-1 Initial Assessment Form

Date: _____

Client Name: First: _____ Middle: _____ Last: _____

How to Address Client: _____

How Client's Family Members Address Client: _____

DOB: _____ Sex: ❑ Male ❑ Female

Ethnicity/Race: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Numbers: Home: ( ) _____ Cell: ( ) _____

Live Alone: ❑ Yes ❑ No Marital Status: _____

Client needs assistance in:

ADL
- ❑ Eating
- ❑ Dressing
- ❑ Bathing
- ❑ Toileting
- ❑ Getting in/out of bed
- ❑ Walking

IADL
- ❑ Preparing meals
- ❑ Shopping
- ❑ Managing medications
- ❑ Managing money
- ❑ Using telephone
- ❑ Doing heavy housework
- ❑ Doing light housework
- ❑ Transportation ability

Primary Language: _____ Secondary Language: _____

Language Proficiency:

English:	❑ Good	❑ Fair	❑ Not good
Primary Language:	❑ Good	❑ Fair	❑ Not good
Secondary Language:	❑ Good	❑ Fair	❑ Not good

FIGURE 29-1 Initial Assessment Form (*Continued*)

Educational Level: Home Country: _____ Years In the U.S.: _____ Years

Interpreter Need: ❑ Yes ❑ No

Interpreter Availability: ❑ Yes If yes, who would it be? _____
❑ No

Place (Country) of Birth: ❑ U.S.A. ❑ Other If other, which country? _____
Year when client moved to the U.S.: _____
Age when client immigrated to the U.S.: _____ years old
Reasons of immigration: _____

Cultural Needs: _____

Food Preferences (including ethnic food): _____

Dietary Needs: _____

Religious Preferences: _____

Emergency Contact Name: _____ Relationship: _____
Address: _____ Phone: ( ) _____
City: _____ State: _____ Zip: _____

Emergency Contact Name: _____ Relationship: _____
Address: _____ Phone: ( ) _____
City: _____ State: _____ Zip: _____

Caregiver Name: _____ Relationship: _____
Address: _____ Phone: ( ) _____
City: _____ State: _____ Zip: _____

Financial Resources: ❑ Social security ❑ Supplementary security income (SSI)
❑ Pension ❑ Help from family members
❑ Other

Insurance:
❑ Medicare Policy #: _____
❑ Private Health Insurance Policy #: _____
❑ Private Dental Insurance Policy #: _____
❑ Long-term Care Insurance Policy #: _____
❑ Other Policy #: _____

Hobbies: Currently enjoy doing: _____
Used to enjoy doing: _____
Family activities: _____

Reasons for the initial contact:
_____
_____
_____
_____
_____

FIGURE 29-2 Plan of Care Form

Date: _____

Name of Client: _____

Name of Care Manager: _____

Name of Agency: _____

Address: _____

Phone Number: ( ) _____ Cell Number: ( ) _____

Fax Number: ( ) _____ E-mail: _____

Ethnicity/Race of Care Manager: _____

Linguistic competency besides English: _____
(Name of Language)

❑ Speak ❑ Read ❑ Write

Name of Social Worker: _____

Name of Agency: _____

Address: _____

Phone Number: ( ) _____ Cell Number: ( ) _____

Fax Number: ( ) _____ E-mail: _____

Ethnicity/Race of Social Worker: _____

Linguistic competency besides English: _____
(Name of Language)

❑ Speak ❑ Read ❑ Write

Client - Personal Information

Client Name: First: _____ Middle: _____ Last: _____

How does the client prefer to be addressed? _____

How does the client's family address him/her? _____

DOB: _____ Sex: ❑ Male ❑ Female

Ethnicity/Race: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Numbers: Home: ( ) _____ Cell: ( ) _____

Former Occupation: U.S.A. _____ Other than U.S.A. _____

Live Alone: ❑ Yes ❑ No Marital Status: _____

Other Living Arrangement: _____

FIGURE 29-2 Plan of Care Form (*Continued*)

Has the client had any change in residence in the past year? ❑ Yes ❑ No

If yes, how and why? _____

_____

Does the client wish to remain at home? ❑ Yes ❑ No

Has the client had any life event or traumatic experience in the past year (hospitalization, move, etc.)? ❑ Yes ❑ No

If yes, what, when and why? _____

_____

Names, Addresses, and Phone Numbers of Children:

Name: _____ Relationship: _____
Address: _____ Phone: ( ) _____
City: _____ State: _____ Zip: _____

Name: _____ Relationship: _____
Address: _____ Phone: ( ) _____
City: _____ State: _____ Zip: _____

Name: _____ Relationship: _____
Address: _____ Phone: ( ) _____
City: _____ State: _____ Zip: _____

Current Care Arrangements among Family Members: _____

_____

_____

_____

Preferable Language: _____

Interpreter needed: ❑ Yes ❑ No

Names of Interpreters: _____

Cultural Needs: _____

Food Preferences (including ethnic food): _____

Dietary Needs: _____

Religious Preferences: _____

Emergency Contact Name: _____ Relationship: _____
Address: _____ Phone: ( ) _____
City: _____ State: _____ Zip: _____

Emergency Contact Name: _____ Relationship: _____
Address: _____ Phone: ( ) _____
City: _____ State: _____ Zip: _____

Caregiver Name: _____ Relationship: _____
Address: _____ Phone: ( ) _____
City: _____ State: _____ Zip: _____

(*continues*)

FIGURE 29-2 Plan of Care Form (*Continued*)

Medical Information

Primary Physician: _____ Phone: ( ) _____

Hospital: _____ Phone: ( ) _____

Interpreter Available: ❑ Yes ❑ No

Dentist: _____ Phone: ( ) _____

Interpreter Available: ❑ Yes ❑ No

Pharmacy: _____ Phone: ( ) _____

Interpreter Available: ❑ Yes ❑ No

Name of Health Insurance: _____
Address: _____
Phone Number: ( ) _____ Fax Number: ( ) _____
Policy #: _____

Name of Dental Insurance: _____
Address: _____
Phone Number: ( ) _____ Fax Number: ( ) _____
Policy #: _____

Name of Long-term Care Insurance: _____
Address: _____
Phone Number: ( ) _____ Fax Number: ( ) _____
Policy #: _____

Physical Health Symptoms: _____
_____
_____

Mental/Cognitive Symptoms: _____
_____
_____

Scheduled Medication

Name of Medication	Dosage	Time of Day	Instruction

FIGURE 29-2 Plan of Care Form (*Continued*)

Does the client have a Durable Power of Attorney for Health Care? ❑ Yes ❑ No

Name of the person/agent: _____ Relationship: _____
Address: _____
Phone Number: ( ) _____ Fax Number: ( ) _____

If no, who will make the client's health care decisions?

Name of the person: _____ Relationship: _____
Address: _____
Phone Number: ( ) _____
Name of the person: _____ Relationship: _____
Address: _____
Phone Number: ( ) _____

Does the client have a Do-Not-Resuscitate Order (DNR)? ❑ Yes ❑ No

If no, who will make decisions on behalf of the client?

Name of the person: _____ Relationship: _____
Address: _____
Phone Number: ( ) _____
Name of the person: _____ Relationship: _____
Address: _____
Phone Number: ( ) _____

Personal Care

	Needs Assist	Devices
Ambulation		
Bathing		
Dressing		
Feeding		
Foot Care		
Grooming		
Medication		
Oral Care		
Skin Care		
Toileting		
Transfers		
Vision Care		
Other Care		

(*continues*)

FIGURE 29-2 Plan of Care Form (*Continued*)

Meal Preparation

Food Preferences (including ethnic food): _____

_____

Dietary Needs: _____

_____

Breakfast: _____

Time: _____

Eating Arrangements: _____

Lunch: _____

Time: _____

Eating Arrangements: _____

Dinner: _____

Time: _____

Eating Arrangements: _____

Snacks: _____

Time: _____

Eating Arrangements: _____

Meals-on-Wheels (MOW) requested? ❑ Yes ❑ No

MOW: ❑ Yes ❑ No Which days? _____

Ethnic MOW: ❑ Yes ❑ No Which days? _____

Is the client able to receive MOW without assistance? ❑ Yes ❑ No

Time of MOW delivery: MOW: _____ Ethnic MOW: _____

Additional Meal Instructions: _____

_____

Housework

	Need Assist	Frequency/Instructions
Dishwashing		
Dusting		
Kitchen cleaning		
Bathroom cleaning		
Floor cleaning		
Laundry		
Vacuuming		
Other Housework		

FIGURE 29-2 Plan of Care Form (*Continued*)

Schedule of Activities

Daily Activities:

Morning: _____

Afternoon: _____

Hobbies: _____

_____

Outside Group Activities: _____

_____

Religious Activities: _____

_____

Exercises: _____

_____

Additional Arrangements (such as ethnic video, mobile book programs, etc.):

_____

_____

_____

Finances

Is the client able to manage his/her finances without assistance? ❑ Yes ❑ No

Does the client have agents (representative payee, conservator, power of attorney for finances, etc.)

Finances? ❑ Yes ❑ No

Name of the person/agent: _____ Relationship: _____

Address: _____

Phone Number: ( ) _____ Fax Number: ( ) _____

If no, who makes financial decisions for the client?

Name of the person: _____ Relationship: _____

Address: _____

Phone Number: ( ) _____

Name of the person: _____ Relationship: _____

Address: _____

Phone Number: ( ) _____

LANGUAGE AND COMMUNICATION BARRIERS ARE PROBLEMATIC

With each culture comes different beliefs and sensitivities relating to how members of a particular ethnic group view and respond to illness, medical treatment, medical technologies, and medical professionals. Healthcare consumption patterns also vary among ethnic groups. In its 2012 Survey of Health Care Consumers, the Deloitte Center for Health Solutions, part of Deloitte LLP, found that the 4,000 survey respondents, ages 18 to 75, clearly fell into six segments of healthcare consumers: "Content & Compliant" (22 percent), "Sick & Savvy" (14 percent), "Online & Onboard" (17 percent), "Shop & Save" (4 percent), "Out & About" (9 percent), and "Casual & Cautious" (34 percent). Many interesting findings of this survey reveal the differences in how consumers regard health care and related aspects of care (e.g., health insurance, healthcare providers, pharmaceuticals, and treatment modalities). For example, based on the survey, only 52 percent of consumers say they understand their insurance coverage; 84 percent prefer generics to name-brand drugs; 1 in 3 want more holistic and alternative therapies; 3 in 4 want expanded use of in-home monitoring devices and online tools that would reduce the need for visits and allow individuals to be more active in their care; 60 percent want physicians to provide online access to medical records, test results, and online appointment scheduling; and 1 in 4 say they would pay more for this service.[12] When these healthcare consumption traits are added to culturally driven attitudes, it is evident that case managers must begin to drill down into their patients' (and their patients' families') total psyches regarding medical care.

THE DIFFERENCES MATTER

Let's look at some of the cultural nuances that influence the way individuals consider health care. Culture and ethnicity create a unique pattern of beliefs and perceptions as to what *health* and *illness* actually mean. In turn, this influences how symptoms are recognized, to what they are attributed, and how, where, and when services are sought. According to a report commissioned by the National Hispanic Medical Association (NHMA) titled *Model Hispanic Health Programs: Prevention, Treatment, Training, and Research*, and presented at the NHMA's seventh annual conference in 2003, Hispanic men's health was being negatively affected by their poor health literacy and machismo. The report found that many Hispanic men do not go to a doctor because of their machismo attitude, even when care is readily accessible. It also found that this attitude contributed to their higher percentages of illness in certain areas. For instance, 37 percent of Hispanic men versus 21 percent of non-Hispanic whites die prematurely of diabetes. Among Hispanic males, 4 percent of Mexican American men versus 2.5 percent of non-Hispanic whites die prematurely of this disease.[13]

Mexican American men and women share a common belief that health is derived from one's spiritually; a belief they share with older, rural African Americans as well as older Filipinos. Different ethnic groups also view end-of-life care and directives differently. African Americans seek out all possible life-sustaining measures and tend to distrust advance directives as giving license to provide inferior care based on their race or socioeconomic position.

Korean Americans may lean toward having a natural death absent of any life-prolonging technology, but they do want their children to request lifesaving measures.[14]

The influence of spirituality on health care can also be demonstrated within other culturally driven traditions, such as the following:

- Within Latino cultures, religious healing, praying to certain saints, and the use of religious symbols to maintain health
- Within Asian cultures, the need for a balance between yin and yang to preserve health, achieved by using certain foods and herbs, and unblocking the free flow of qi (chi) or energy through the use of acupuncture
- Within African cultures, the belief that harmony with nature provides power and energy, and belief in the healing power of religion[15]

In the "Vietnamese and Armenian Health Attitudes Survey" by Jamin, Yoo, Modoveanu, and Tran, published in the *Journal of Multicultural Nursing and Health*, the authors found that individuals of Vietnamese descent most often seek out health care from physicians of their own ethnicity, but one-third visit Western doctors. Compare this to Armenians who typically receive health care from a Western doctor, but 50 percent also visit physicians of their own ethnic background. The health problems for which medical care was frequently sought also varied among these two groups. Whereas the Vietnamese survey respondents most frequently sought help in the areas of dentistry, medications, eye care, pediatric care, stomach and intestinal problems (for infections), and blood pressure, the Armenian respondents most frequently used health services for dental care, medications, and eye care. These two groups also varied in their attitudes regarding waiting in various healthcare settings. The Armenians were found to be more tolerant of county health facilities and the bureaucracy associated with them, whereas the Vietnamese held that it was degrading to be seen waiting in a county facility, and they would rather pay more for courteous and prompt treatment in a physician's office.[16]

The groups' perceptions regarding the safety of various treatments and screening devices also differed. Of the Vietnamese respondents, 60 percent were willing to take pills, 30 percent were willing to take injections (24 percent were not), 46 percent thought that surgery was generally safe (24 percent believed surgery was unsafe), and 46 percent thought X-rays were safe (18 percent believed they were unsafe). Of the Armenian respondents, 75 percent were willing to take pills, more than 60 percent were willing to receive injections, 75 percent believed that surgery was safe, and 35 percent believed that X-rays were safe (35 percent also believed they were unsafe).[17]

FAMILY VALUES

Each family, whether born in this country or from a different ethnic culture, has values unique to their background. Americans are encouraged and raised to be independent, assertive, autonomous, and in control of our lives from birth to death. Of course, that does not mean we each are successful in these areas, but it is the culture of our country. We are encouraged to communicate and even question authority figures, including physicians, and to demand individual rights. Interestingly, over the past several years, consumers have had more direction to take charge of their own health care.

The U.S. healthcare system places a great deal of emphasis on patient autonomy and the patient's right to know. We have legislation, the Patient's Bill of Rights, that ensures it. This belief, however, is not shared by all cultures. The custom in many cultures, including Mexican, Filipino, Chinese, and Iranian cultures, is for a patient's family to be the first to hear about a poor prognosis, after which the family decides whether the patient should be told and, if so, what should be told. These families may believe that full information takes hope away and possibly hastens the death of their loved one.

The study titled "Ethnicity and Attitudes toward Patient Autonomy," published in *JAMA*, found that "Korean-American and Mexican-American subjects were more likely to hold a family-centered model of medical decision making than the patient autonomy model favored by most of the African-American and European-American subjects."[18] The survey involved 200 subjects aged 65 years and older representing four ethnic groups (i.e., European American, African American, Korean American, and Mexican American). The study also revealed cultural preferences regarding whether patients should be informed of a terminal illness; for example, 88 percent of African Americans and 87 percent of European Americans agreed, whereas 65 percent of Mexican Americans and 47 percent of Korean Americans agreed.
Other families may have stronger religious beliefs. They may believe that only God really knows when an individual will die and that telling the patient anything related to the possibility of death is of little consequence.

In other cultures, the focus may not be as much on the individual; instead, greater emphasis may be placed on the immediate or extended family, the village, or the tribe. Children are warned not to bring shame on their families, and some cultures stress nonconfrontational behaviors and encourage deference to authority.

COMMUNICATION CONSIDERATIONS

The ways that individuals communicate their feelings, concerns, symptoms, and pain are as different as individuals themselves. Even when the language is the same, gender, age, religion, and ethnicity may obscure some of the important considerations surrounding the elements of a patient's medical condition. For example, in some cultures, direct eye contact is perceived as threatening; for the healthcare professional who is trying to communicate with an individual from such an ethnic culture, the patient's avoidance of eye contact may be mistakenly interpreted as resistance to the information being given, embarrassment, or even depression. If the patient is Chinese, he may be showing respect; if the patient is a female from a Muslim country and the physician is male, she may be trying to avoid sexual impropriety.

Many healthcare professionals, especially nurses, who are the largest group of professionals in case management, are taught the importance of touch and instinctively offer comfort or reassurance to a patient with a physical gesture. If that patient is of the opposite sex and is an Orthodox Jew, it is important to know that for the Orthodox religion, contact outside of hands-on care is prohibited.

From these few illustrations, one can readily appreciate that gaining knowledge of the customs and beliefs of particular cultures can be an additional challenge for case managers. We need to distinguish between generalizations and stereotypes. Certain cultures may

indeed have beliefs and even fears; however, this is not to be deemed as factual for all within the culture. Knowledge about a particular ethnic group should serve as a beginning, not a conclusion, advises Geri-Ann Galanti, PhD, in her article titled "An Introduction to Cultural Differences."[19] In another article, "The Challenge of Serving and Working with Diverse Populations in American Hospitals," Galanti discusses this further, noting that although we do look for similarities among groups, we then need to see whether a particular individual fits the pattern. She sees that the generalization is the starting point and that "making the appropriate generalization in healthcare situations can be a useful tool that narrows the field of thinking and sometimes can help save a life or prevent complications."[20(p21)] On the other hand, Galanti cautions that a stereotype as an end point can be dangerous. In this form of thinking, Galanti notes that "we develop conventional, formulaic, and oversimplified conceptions and opinions . . . It then becomes easy to categorize a patient as being a certain way and make no further effort to learn whether the individual in question fits the conception."[21(p21)]

Galanti offers more than 200 case studies that underscore the challenges that case managers and our colleagues in health care may face; however, the core issues of generalizing and stereotyping are wonderfully illustrated by the following example.

Consider the statement, "Mexican women often express their pain loudly." If there is a Mexican female patient who is moaning about her pain and she is ignored because the provider thinks, "Don't worry, Mexican women express their pain loudly," this is stereotyping and is not constructive. If, on the other hand, knowing that female Mexican patients often express their pain loudly, the case manager checks with a family member to see whether this particular woman is vocal when in pain, then follows up by assessing the woman's complaint, this is a generalization that is a first step in the resolution of this woman's discomfort.[22]

WHERE YOU ARE FROM DOES MATTER

There are significant differences among racial and ethnic groups in our country and throughout the world. The underlying reasons for this vary but certainly are influenced by the complex factors that affect health for all: socioeconomic status, family history, behavioral risk factors (e.g., smoking, alcohol, lack of exercise), stress, and so forth. When individuals are from minority or disadvantaged groups, or groups of a different ethnic culture, and/or who speak another language, other factors influence their health. Some of these factors include the cost and availability of health care, lack of culturally competent care, cumulative prejudice, and discrimination.

Culture and language may influence health, healing, and wellness belief systems; how illness, disease, and their causes are perceived by patients; the behaviors of those seeking health care and the attitudes they may have toward their providers; and the actual delivery of healthcare services by providers who tend to see the world through their own values and experiences. A report from the IOM on unequal medical treatment noted that "the sources of these disparities are complex, are rooted in historic and contemporary inequalities, and involve many participants at several levels, including health systems, their administrative and bureaucratic processes, utilization management, healthcare professionals, and clients."[23]

Each society presents its own challenges in providing healthcare delivery services. According to Nancy Davis, PhD, RN, FACMT, retired director of the Office of Managed Care, Indian Health Services in Aberdeen, South Dakota, privacy and client confidentiality are big concerns for case managers working among American Indian populations. "The entire community knows everything about the patient almost before the door shuts" (personal communication). American Indians conceive of individual wellness as harmony and balance among mind, body, and spirit. The same belief that gives him spiritual strength can present a dilemma for a diabetic patient requiring leg amputation. How can he be whole in his afterlife if he is buried without his leg?

American Indian medicine incorporates consultations with medicine men, a high degree of family involvement, and the American Indian concept of individual wellness as harmony and balance among mind, body, and spirit. These elements of care are acknowledged, supported, and initiated by patients and their families. The beautiful spiritual rooms at the Pine Ridge and Rosebud hospitals are used often.

Profiled by Jane Gross in *The New York Times*, Dr. Iffath Abbasi Hoskins, Chief of Obstetrics and Gynecology at New York University Downtown Hospital, has created a welcoming atmosphere to serve the 65 percent of obstetrics patients in the hospital who are Chinese. The staff is bilingual, and there are Chinese-language videos for expectant mothers. Sensitivity training for staff members teaches that the cultural resistance to breastfeeding stems from new immigrants' belief that using formula indicates assimilation into American culture. The suggestion to soothe a sore bottom with an ice pack is often rejected because it goes against the rules of yin and yang.

During a visit to China, Kathleen Moreo, cofounder of Professional Resources in Management Education, shared with me that the Chinese do not say no because it is associated with disrespect. When they disagree, they are silent. When an American is greeted with silence, he usually assumes there is a misunderstanding and reiterates the question, position, or statement. Moreo cautions that this is the worst thing a case manager can do when speaking with a Chinese American. The case manager immediately breaks any developing trust because the patient has made a decision and believes the case manager is trying to force her to change her mind.

Michael J. Demoratz, COO of CareMedical Systems, cites a number of ways in which cultural diversity affects pain management. He notes that patients from Hispanic, Middle Eastern, or Mediterranean backgrounds generally express pain openly, whereas those from Asian or northern European cultures tend to underreport pain. In certain cultures, including Asian and Christian African American populations, pain and suffering are believed to redeem or purify. Individuals may present a stoic front or refuse medication.[24] For such reasons, a patient might not be able to give the case manager an accurate assessment of pain.

Honoring one's elders is integral to Japanese, Chinese, and Korean cultures. Turning over a loved one's care to a professional, rather than to family members, can be unthinkable to the family. Italian, Greek, French, South and Central American, Middle Eastern, and some Asian societies consider it inhumane to reveal a terminal diagnosis to a patient. Among the Japanese, discussing gastrointestinal conditions is shunned.[25] Most Americans fear death to the point of refusing to consider end-of-life planning.

GUIDANCE AND STANDARDS

To further illustrate the significance of the differences among cultures, it is helpful to examine some specific concepts and preferences in a few groups. The University of Washington Medical Center (http://depts.washington.edu/pfes/CultureClues.htm) has developed a number of educational tools that address these disparities (**Appendices 29-A through 29-D**) among several ethnic cultures (African American, Albanian, American Indian and Alaska Native, Chinese, Korean, Latino, Russian, Somali, and Vietnamese). These tip sheets, called Culture Clues, are focused on improving communication between patients and healthcare professionals. They examine the perception of illness, patterns of kinship and decision making, and comfort with touch, and provide useful insight and guidance to enhance relationships with diverse cultures.

The Office of Minority Health (OMH) at the U.S. Department of Health and Human Services (www.minorityhealth.hhs.gov) provides assistance and guidance to improve care for those in minority groups. The OMH developed the National Culturally and Linguistically Appropriate Standards (CLAS) in Healthcare tool, which contains training modules for healthcare professionals regarding cultural awareness.[26] In an interview with *Case in Point*, Garth N. Graham, MD, MPH, deputy assistant for Minority Health, specifically mentions CLAS guideline 11 as one that could greatly benefit case managers: "Healthcare 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."[27] He comments: "Case managers get to interact with patients in a unique way . . . right at the nexus point in terms of understanding the full spectrum of the patient . . . they understand not just the clinical scenario, but the social and cultural scenarios too . . . from the provider perspective, there are many times that case managers know more about patients than physicians do."[28]

This branch of the federal government, which was established in 1985, works closely with accrediting bodies and other organizations that are seeking to improve culturally appropriate care. The OMH offers a comprehensive continuing education program, Culturally Competent Nursing Modules (CCNMs), which is based on the CLAS standards and is divided into three categories: culturally competent care, language access services, and organizational support. Because URAC's Case Management Standards strongly urge development and education in cultural diversity, this resource is an important one and can be accessed on their website (www.thinkculturalhealth.org).

CULTURAL COMPETENCY: DEFINING IT, ACHIEVING IT

Culture refers to integrated patterns of human behavior that include language, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. "*Competence* implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities."[29] Cultural and linguistic competency, as noted on the OMH website (www.minorityhealth.hhs.gov), is a set of congruent behaviors, attitudes, and policies that

come together in a system or an agency, or among professionals, that enables effective work in cross-cultural situations.[30] A culturally competent healthcare setting should include some of the following:

- A culturally diverse staff that reflects the communities being served
- Providers or translators who speak the clients' language
- Training for providers about the culture and language of the people they serve
- Signage and patient educational materials in the clients' language
- Culturally specific healthcare settings

THE ROLE OF CULTURE IN HEALTH CARE

Cultural competency is essential to close the widening gaps of disparities in health care. For patients and healthcare providers, including case managers, to come together and explore and resolve healthcare concerns, cultural differences should not be a hindrance to the conversation, but rather something that enhances the discussion. When it is known that providers are knowledgeable, respectful, and responsive to the issues surrounding cultural diversity, positive outcomes are much more likely to occur.

Achieving cultural competency is no easy matter for many organizations as they become filled with diverse patient and provider populations. This most assuredly is the ideal breeding ground for conflict and misunderstandings. By understanding that virtually every organization is concerned about costs, that pressures to achieve more with less are the norm, and that education is among the last resources surrounding patient care to obtain funding, we each need to assume responsibility for our own cultural competence. Case managers and other healthcare professionals cannot always depend on their employer to provide ongoing education. Fortunately, much of this information is just a mouse click away. Some organizations, however, see cultural education as a necessary part of their business, and part of their responsibility in the business community, and have created wonderful programs for staff and patients.

Blue Cross and Blue Shield of Minnesota provides literacy and motivational interviewing for its case management staff. Jane Cavanaugh, RN, CCM, CPHQ, was interviewed for an article in *Case Management Advisor* and commented that traditional approaches that are fine with American-born people will not necessarily work with those from other cultures. She provides an example of managing a Vietnamese woman diagnosed with lung cancer who needed transportation for appointments. Cavanaugh learned that the woman would ride in a car only with her husband, so Cavanaugh had to arrange the woman's appointments around the husband's work schedule—a somewhat more complicated process, to be sure, but it was certainly a meaningful gesture by the case manager that was understood by the woman.

The same article (for which I was also interviewed) described how care coordinators with UCare Minnesota's Senior Health Options visit homes of clients from other cultures with a staff member from the client's culture. This obviously communicates acceptance and a real desire to understand and meet unique needs of diverse cultures.

The National Association of Social Workers identified multiple aspects of cultural competence, which include the following:

- Ethics and values: Cultural competence complements the values of self-determination, individual dignity, and worth, which are inherent in many healthcare professions.
- Self-awareness: Self-awareness is an awareness of one's personal and cultural values. What are they? How do they influence relationships with clients?
- Cross-cultural knowledge: This represents knowledge of various groups while also acknowledging individual differences and avoiding stereotypes.
- Cross-cultural skills: This includes applying self-awareness and knowledge in the development of skills.
- Culturally and linguistically appropriate service delivery: These attributes are reflected not only at the microsystem (point of care) level, but also at the macrosystem (organizational) level.
- Workforce: A multicultural workforce is committed to ongoing education to meet the changing needs of the community being served.
- Advocacy: A commitment to cultural competency demonstrates our role as advocates.[31]

CASE MANAGERS MAKE A DIFFERENCE

As with other challenges we face, case managers are at the forefront and in the middle of the swirling issues surrounding cultural diversity. It is not just because we are caring professionals who want the best for patients, though that certainly is true, but many individuals who come from diverse cultures possess some other characteristics (e.g., chronic illnesses, financial issues) that become red flags that signal a need for case management. Once again, we do not need to look; they are there in our midst, waiting for someone to reach out.

Just as we look within our organizations for assistance in medical, nursing, and therapeutic domains, we must once again step outside of our comfort zone to find solutions to some of these other problems. In well-established cultures, there is often a wealth of information and resources available to assist the members of that particular group.

In its yearly conferences, and in many chapters across the country, CMSA has responded to requests from its members and provides ongoing workshops addressing the broad issues of cultural diversity and, more specifically, the dominant cultures in various regions. Several case management publications have also focused on this subject, and this is likely to continue as our population continues to evolve.

DEVELOPING CULTURAL COMPETENCY

Taking the First Step

Various techniques are used for developing cultural sensitivity. A good place to start is to understand how your own cultural heritage has influenced your attitudes toward illness and health care. Looking back on your own experiences with individuals from different cultural, socioeconomic, and religious backgrounds is also helpful in raising your own awareness.

In its "Techniques to Develop Cultural Sensitivity," the Geriatric Interdisciplinary Team Training Resource Center of New York University recommends the following steps:

> Engage trainees in exercises designed to uncover their cultural heritage . . . engage trainees in exercises to assess their level of cultural competence . . . introduce a framework for understanding the cultural influences brought by another to the caring interaction between provider, patient, and family . . . introduce the explanatory model for understanding illness in the context of culture . . . and apply learning mnemonic to ensure a culturally sensitive response.[32]

In addition to participating in cultural sensitivity training programs such as the aforementioned one, case managers should seek out reading materials to learn about different cultures and their attitudes regarding health care. An online search will uncover enlightening articles on the topic. In addition, some medical schools are beginning to offer cultural sensitivity and competency courses for both matriculated and nonmatriculated students. It is a good idea to contact schools in your area to determine whether they offer these programs.

Local medical societies in states with legislation enacted or pending that mandates requirements related to cultural and/or linguistic competency for physicians, medical professionals, and/or healthcare providers in their jurisdiction also offer educational programs or continuing education courses. Among the states with this legislation are New Jersey, which requires physician cultural competency training as a condition of licensure (Bill S144); California (AB 810 Chapter 510 and AB 1195); Washington (ESB 6194); New Mexico (SB 600); Arizona (SB 1468); Illinois (SB0522); Ohio (SB 160); Maryland (HB 883, HB 1455, HB 1127); and New York (AO3751).[33] Case managers should also continue to take advantage of the programs offered by CMSA.

In addition to these organizations, the AMA offers a Cultural Competence Compendium as a guide to assist physicians and other healthcare professionals in their communications with patients. Sections of the book are accessible on the AMA's website (www.ama-assn.org).

The websites of the EthnoMed (www.ethnomed.org) and DiversityRx (www.diversityrx.org) are also good resources for information that is helpful in guiding individuals, communities, and healthcare providers with culturally sensitive and competent health care. Numerous videos, newsletters, seminars, and tools are available for organizations and healthcare professionals.

Beyond gaining knowledge of the subject, case managers should also strive to know themselves and whether or not they can effectively serve a multicultural population. It is common for people to be more comfortable with the familiar. For case managers who find it difficult or uncomfortable relating to or understanding a patient's cultural differences, it may be best to consider a healthcare setting where there is less exposure to patients of multiple cultures and beliefs. Conversely, for case managers who are excited to become further integrated into our nation's increasingly diverse population, becoming more competent in the beliefs of various ethnic and multicultural patient groups is likely to be a very fulfilling and rewarding experience.

To determine where you might be on the cultural competency learning curve, take a few minutes to respond to the questions in **Table 29-1**.

TABLE 29-1 Cultural Competency Self-Test

1. Name two diseases/conditions that are influenced by racial/ethnic factors. Explain.
2. Describe two cultural values or beliefs that influence how a cultural group, different from your own, responds to being sick.
3. Do you respect differences in health behaviors practiced by your client?
4. Name two ways in which your practice is responsive to the needs of diverse groups.
5. Do you take culture, gender, and race into consideration when examining risk factors faced by your clients?
6. Do you involve your clients in the decision-making process when considering a course of treatment?
7. What is a question you commonly ask to learn about your clients' ethnic or sociocultural background? How is this information relevant to your practice?

Add up your score. Give yourself one point for each item named on questions 1, 2, 4, and 7. Give yourself one point for a yes on questions 3, 5, and 6.

Score 9–10: Good work, keep it up! Cultural competency is a continuous quality improvement process.

Score 2–8: Keep working, you have a way to go.

Score 0–1: It is time to start developing your competency skills.

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A 12-STEP PROGRAM

Thankfully, several outstanding professionals in the field of cultural competency have partnered with case managers and have shared their insight and expertise with us. In addition to those cited earlier in this chapter, Dr. Josepha Campinha-Bacote, president of Transcultural C.A.R.E. Associates (www.transculturalcare.net), created a model to assist healthcare professionals in providing culturally appropriate care and services (**Table 29-2**).

Lessons Learned

Clearly, there is much to learn, and never enough time. The following are some quick lessons about cross-cultural communication adapted from Craig Storti's *Cross-Cultural Dialogues*:

1. Don't assume sameness.
2. What you think of as normal behavior may only be cultural.
3. Familiar behaviors may have different meanings.
4. Don't assume that what you meant was what was understood.
5. Don't assume that what you understood was what was meant.
6. You don't have to like or accept different behavior, but you should try to understand where it comes from.
7. Most people behave rationally; you just have to discover the rationale.[34]

TABLE 29-2 Twelve Steps to Cultural Competency

1. Find out about the family's internal dynamics, as well as family members' beliefs and what those beliefs mean to them and to the patient.
2. Look at the length of time the family has been in the United States.
3. Don't make an assumption based solely on the country of origin.
4. Don't make assumptions about why people act the way they do.
5. Don't be afraid to ask questions in a respectful manner.
6. If you need an interpreter, find someone who is not a family member, if possible.
7. Compile a list of available translators and have it at your fingertips.
8. Go out of your way as a clinician to learn basic language skills for members of the predominant patient groups you are likely to encounter.
9. Develop a "cheat sheet" of cultural issues that affect case management.
10. List the cultures you may be coming in contact with and do some basic research on their beliefs.
11. Find the resources you need to educate yourself.
12. Above all, treat the families with respect and let them know you care.

Courtesy of Providing culturally appropriate care and services. (2001). *Case Management Advisor, 12*(10), 147.[35]

CONCLUSION

Although some of our colleagues in case management may feel uncomfortable among different ethnic groups and may inadvertently convey this discomfort to others, others will see this as yet another adventure, another chapter to be explored. Where will you be?

NOTES

1. Christie, L. (2010). Census: 308.7 million people live here. Retrieved from http://money.cnn.com/2010/12/21/pf/Census_2010/index.htm
2. U.S. Census Bureau. (2015). Census bureau reports at least 350 languages spoken in U.S. homes. Retrieved from http://www.census.gov/newsroom/press-releases/2015/cb15-185.html
3. Zeigler, K., & Camarota, S. A. (2014). One in five U.S. residents speaks foreign language at home, record 61.8 million. Retrieved from http://cis.org/record-one-in-five-us-residents-speaks-language-other-than-english-at-home
4. Ibid.
5. Ibid.
6. Ibid.
7. Ibid.
8. Ibid.
9. Cohn, D. (2015). Future immigration will change the face of America by 2065. Retrieved from http://www.pewresearch.org/fact-tank/2015/10/05/future-immigration-will-change-the-face
10. National Center for Education Statistics. (n.d.). Fast facts: English language learners. Retrieved from https://nces.ed.gov/fastfacts/display.asp?id=96
11. Agency for Healthcare Research and Quality. (2014). Disparities in healthcare among racial and ethnic minority groups. Retrieved from http://archive.ahrq.gov/research/findings/nhqrdr/nhqrdr10/minority.html
12. Deloitte Center for Health Solutions. (2012). *The U.S. health care market: A strategic view of consumer segmentation*. Retrieved from http://www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-lshc-health-care-market-consumer-segmentation.pdf

13. PR Newswire. (2003). Machismo attitudes keep Hispanic men from going to the doctor. Retrieved from http://www.prnewswire.com/news-releases/machismo-attitudes-keep-hispanic-men-from-going-to-the-doctor-74718162.html
14. Kramer, B. J. (2004). Cultural assessment. In M. Mezey, B. J. Berkman, & E. L. Mitty (Eds.), *Encyclopedia of elder care*. New York, NY: Prometheus Books.
15. Roswell Park Cancer Institute. (n.d.). *Caring across cultures and belief systems.* Retrieved from https://www.roswellpark.org/sites/default/files/node-files/page/nid940-21946-caring-across-cultures-web.pdf
16. Jamin, D., Yoo, J. H., Modoveanu, M., & Tran, L. (1999, Winter). Vietnamese and Armenian health attitudes survey. *Journal of Multicultural Nursing and Health,* 6–14.
17. Ibid.
18. Blackhall, L. J., Murphy, S. T., Frank, G., Michel, V., & Azen, S. (1995). Ethnicity and attitudes toward patient autonomy. *JAMA, 274*(10), 820–825. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/7650806
19. Galanti, G. A. (2000). An introduction to cultural differences. *Culture and Medicine, 172*, 335–336.
20. Galanti, G. A. (2001, Spring). The challenge of serving and working with diverse populations in American hospitals. *Diversity Factor,* 21–26.
21. Ibid.
22. Ibid.
23. Institute of Medicine. (2002). Unequal treatment: Confronting racial and ethnic disparity in health care. Retrieved from http://www.nationalacademies.org/hmd/Reports/2002/Unequal-Treatment-Confronting-Racial-and-Ethnic-Disparities-in-Health-Care.aspx
24. Demoratz, M. J. (2003). Managing pain across diverse cultures. *Disease Management Digest, 7*(3), 3.
25. Ibid.
26. U.S. Department of Health and Human Services, Office of Minority Health. (2001). *National standards for culturally and linguistically appropriate services in health care.* Retrieved from http://minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf
27. Hageman, J., & Llewellyn, A. (2008). Working together toward cultural competency. *Case in Point.* Retrieved from http://www.caseinpointmagazine.com
28. Ibid.
29. National Center for Cultural Competence. (n.d.) Definitions of cultural competence. Retrieved from http://www.nccccurricula.info/culturalcompetence.html
30. Ibid.
31. National Association of Social Workers. (2001). *NASW standards for cultural competence in social work practice.* Retrieved from http://www.naswdc.org/practice/standards/NAswculturalstandards.pdf
32. Fasser, C. (1999). *Interdisciplinary team training curriculum resource document*. New York, NY: Geriatric Interdisciplinary Team Training Resource Center of New York University. Retrieved from http://dept-wp.nmsu.edu/geriatriceducation/files/2014/03/GITT_ImplementationManual_Ch4.pdf
33. U.S. Department of Health and Human Services, Office of Minority Health. (2001). *National standards for culturally and linguistically appropriate services in health care*. Retrieved from http://minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf
34. Storti, C. (1994). *Cross-cultural dialogues.* Yarmouth, ME: Intercultural Press.
35. Providing culturally appropriate care and services. (2001). *Case Management Advisor, 12*(10), 147.

APPENDIX 29-A
Communicating with Your Chinese Patient

Culture Clues™ **Patient and Family Education Services**

Communicating with Your Chinese Patient

Perception of Illness • Patterns of Kinship and Decision Making • Comfort with Touch

Culture Clues™ is designed to increase awareness about concepts and preferences of patients from the diverse cultures served by University of Washington Medical Center. **Every person is unique; always consider the individual's beliefs, needs, and concerns.** Use *Culture Clues*™ and information from the patient and family to guide your communication and your patient care.

How does the Chinese culture deal with illness?

Helping Your Patient Feel Comfortable with UWMC

- Remember to find out if this is your patient's first visit to University of Washington Medical Center.
  - **Keep in mind that patients who are new to the system may not be aware of the role of the Primary Care Team or the process for getting a referral to a specialist.**

Explaining the Cause of Illness and Disease

- Your patient may have specific cultural beliefs, for example they may view illness and death as a natural part of life.
- Health may be viewed as finding harmony between complementary energies such as cold and hot, dark and light. These forces are called *yin* and *yang*. Most Chinese actually are very comfortable with duality between western and traditional Chinese health beliefs.

Building Bridges Between Traditional Remedies and Western Health Care

- Your patient may use foods and herbs to restore *yin/yang* balance. In addition to special foods, your patient may use other traditional Chinese remedies as an initial approach for healing, especially during the early stages of illness. Some traditional Chinese therapies, including massage, acupuncture, and moxibuxtion are commonly used as an adjunct to western medicine.
- Your patient may prefer to drink only hot liquids (water or tea) when sick or postpartum.
- Patients may try traditional approaches first, and will seek western medical care if these treatments fail. Patients may occasionally delay seeking care out of concern for communication barriers, costs, etc. As a result, patients may present at the medical center acutely ill.
  - **Ask your patient, "What do you call your problem? When did it start? What do you think caused the problem? Have you taken any medicines or herbs? What results have you had from the medicines or herbs? Do you believe the illness is serious? How can I help you?"**
  - **Build bridges between traditional medicine and western care: when considering traditional practices, determine when the remedies are beneficial, neutral, or harmful. Incorporate beneficial and neutral remedies into the plan of care, such as dietary advice. Consider potential drug interactions.**

Helping Your Patient Understand Medicines

- Your patient may believe that western medicine is too strong and may not take the full dose or complete the course of treatment. Your patient may cut the dose in half or stop taking the medicine whether he/she feels better or not.
  - **Explain that the dose is customized for your patient's height, weight and metabolic needs. Describe the need to take the full dose whether your patient feels better right away or not. Talk about side effects. Share your plan in dealing with side effects. Ask open-ended questions to ensure understanding.**
  - **<u>Alert</u>: Be aware that your patient may have enzyme deficiencies that may require a change in medication or dosage. Contact the pharmacy if the patient does not appear to be responding to medications or if he/she appears to be especially sensitive to medications' effects.**

How are medical decisions made in the Chinese culture?

Understanding Relationships

- The Chinese culture emphasizes loyalty to family and devotion to traditions and puts less emphasis on individual feelings. Assess your patient's kinship relationships and determine which family members are most influential in decision making. When possible, engage the whole family in discussions that involve decisions and education about care.
  - **Be aware of the importance of family members serving in caregiver roles and consider extending visiting hours. Explain the visitation policy before admission or surgery so that the family knows what to expect.**

- Bad medical news is often shielded from the patient by the family in the belief that telling the patient will only make the patient's condition worse.
  - **Ask your patient whom they want included in medical decisions. If patients do not want to make medical decisions for themselves, let them know they need to prepare a Durable Power of Attorney for health care.**

Customs that Influence Decision Making

- In addition to religious beliefs, there are many cultural and traditional beliefs that your patient may subscribe to that will influence decisions about health care treatment. For example, your patient may seem hesitant to make a decision about surgery because of preference to retain full complement of body parts (eg., uterus, gall bladder, etc.).
- Whenever possible, allow time for the patient to gain perspective and make decisions. Schedule a follow-up appointment or set up a scheduled phone call to allow for needed time. Offer time limits that are acceptable to patient and medical necessity. Patients tend to rely heavily on doctor's advice, so they may have trouble deciding between different options.

Understanding Communication About Health Care and Treatments

- Your patient may nod, smile, and/or say "yes" or "ya" to acknowledge he/she heard you, rather than that he/she understands or approves. Your patient may be reluctant to say "no" to a doctor or health care provider because it may be considered disrespectful or cause disharmony.
  - **Ask your patients open-ended questions to verify understanding and encourage them to ask questions.**
  - **Ask them to repeat what they understand in their own words.**

What are the Chinese culture's norms about touch?

Understanding Norms About Eye Contact and Body Language

- Respect is shown to authority figures by giving a gentle bow and avoiding eye contact.
- Nonverbal cues are an important part of communication. For example, smiles when appropriate may be one way to build rapport.
- Your patient may highly value emotional self-control, appearing stoic. Be aware that your patient may not show pain or ask for pain medications.
  - **Instead of asking your patient about pain, ask, "May I get you something for pain?"**
  - **Be respectful of your patient's desire to keep emotions in control when asked about upsetting subject matters.**

Understanding Norms About Modesty

- Consider the modesty of women and girls when giving a pelvic exam. Many young women are modest about having an exam and may prefer a female doctor to do it. In some cases, your patient may refuse a gynecological exam from a provider of either gender.
  - **Before you begin a gynecological exam, it is important to ask your patient, "May I examine you?" Ask your patient if she prefers a female doctor, attendant, or interpreter to remain in the room during the exam.**

What is unique about this patient and family that you will not learn from culture tips or information?

There is a wide range of cultural differences based on age, ethnic group, country of origin, religious beliefs, generation, migration wave, and length of time away from China.

Check Out These Resources to Learn More About Health Care and Chinese Culture

- ✓ ***Culture and Nursing Care, A Pocket Guide,*** J.G. Lipson, S.L. Sibble, P.A. Minarik, 1997, pp. 280-290*.
- ✓ ***Explaining Illness Research, Theory, and Strategies,*** Whaley, Bryan B., Lawrence Erlbaum Associates, 2000, pp. 283-297*. (*Available at UWMC's Learning Resource Center – Room cc420.)
- ✓ **Culture Clues and End-of-Life Care Sheets:** *http://depts.washington.edu/pfes/cultureclues.html*

Culture Clues™ is a project of the Staff Development Workgroup, Patient and Family Education Committee
Contact: 206-598-7498/Box 358126/pfes@u.washington.edu

The Chinese *Culture Clues*™ was developed with thanks to Eddie Brolley, Annie Tu, and Emily Wong.

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APPENDIX 29-B
Communicating with Your American Indian/Alaska Native Patient

Culture Clues™ **Patient and Family Education Services**

Communicating with Your American Indian/Alaska Native Patient

Perception of Illness • Patterns of Kinship and Decision Making • Comfort with Touch

Culture Clues™ *is designed to increase awareness about concepts and preferences of patients from the diverse cultures served by University of Washington Medical Center.* ***Every person is unique; always consider the individual's beliefs, needs, and concerns.*** *Use* Culture Clues™ *and information from the patient and family to guide your communication and your patient care.*

American Indians (AI) and Alaska Natives (AN) are terms identifying the indigenous peoples of North America. In the 2000 Census, four million people identified themselves as American Indian or Alaska Native. About ¾ of this population live near urban areas; about ¼ live in non-urban areas, including reservations. There are more than 500 federally-recognized tribes and over 245 tribes without this federal designation, which may have state recognition. Be aware that there is variability between tribes in their health care seeking and health promotion behaviors. The AI/AN culture varies considerably by age, place, or residence (urban, rural, reservation), education, socioeconomic factors, and awareness and utilization of community resources.

In the AI/AN culture, there is historical mistrust of mainstream institutions due to centuries of abuses such as broken treaties and forced relocations. In addition, only the small percent of American Indians who are affiliated with registered tribes receive treaty-granted health care benefits. Acknowledging this history is an important step in building trust with your patient and their family and understanding that at times this lack of access to health care can lead to frustration.

While it is important to have a basic knowledge and respect for this culture, remember that all, some, or none of these beliefs may be associated with each patient and their family.

How does your AI/AN patient perceive illness?

Cause of Illness

- Your patient may have a holistic view in which people, community, nature, and spirituality are interconnected and interrelated. This perspective views physical, spiritual, mental, and emotional health in unity, instead of in discrete categories. Sickness may be viewed as the result of disharmony between the sources of life.
  - **Consider this holistic view when assessing, diagnosing, and treating an illness.**
- Your patient may seek western medicine for treatment of symptoms of illness. However, patients may also seek traditional healers to address the disharmony that caused the illness. Traditional practices may include different rituals and ceremonies as well as herbal remedies. The sweat lodge is an example of a health practice American Indian patients may apply.
  - **Ask your patient if he/she is using traditional healings or practices. Acknowledge the value of traditional practices and whenever possible incorporate beneficial and neutral remedies into the plan of care. Consider potential drug/herb interactions.**

Understanding Time Orientation

- Time orientation may be perceived as cyclical, present-oriented, and "in-the-moment" as compared to linear, future-oriented, and "time-by-the-clock" in western culture. As a result, patients may be late or miss appointments.
- Transportation issues and unfamiliarity with the city and the medical center neighborhood may also impact your patient's time of arrival for their appointment.
  - **Schedule appointments within a window of time to allow for more flexibility.**
  - **Whenever possible, use natural events such as sunset or meal times to schedule prescribed medications.**

How are medical decisions made in the AI/AN culture?

Concept of Family/Community

- The concept of family may include immediate family, extended family, and community and tribal members.
- Your patient's medical decisions may depend on how the family is affected because of the importance of group orientation. As a result, your patient may include the entire family when making important medical decisions.

- Urban AI/AN may not have family living nearby, and AI/AN who live on reservations may be receiving care far away from home. Lack of family support during medical decision making may be a source of stress for your patient.
  - **Ask your patient about who they would like to have included in their medical decisions. Give your patient time to process and consult with family, community, and tribal members as desired, before making health care decisions. Be aware that a large family contingent may be present.**

Informed Consent

- Due to a history of misuse of signed documents, some patients may be unwilling to sign informed consent, advance directives, and durable power of attorney forms. Your patient may perceive verbal agreement as sufficient.
  - **If it is your patient's first experience with informed consent, explain its purpose. You may want to consider a Social Work consult. Every care area has available the UWMC publication, "Information About Your Health Care" (UH2056) to support this discussion.**

How can I reduce the communication barriers with my AI/AN patient?

Nonverbal Communication

- Direct eye contact may be avoided out of respect or concern for soul loss or theft.
- Traditionally, AI/AN have been taught to resist any expression of pain. Your patient may not express pain directly and instead report feeling uncomfortable or use storytelling.
  - **Ask your patient, "May I get you something for your pain?" Respect their wishes if they decline.**
- Time and silence may be used to maintain harmony, be non-confrontational, and as a way to prepare to listen to your patient.
  - **Listen for at least 2 minutes without saying a word. Let patients talk or let them be silent. Be aware that it may take 3 or 4 encounters before trust and dialogue emerge.**

Verbal Communication

- Storytelling and circular conversation may be used to build trust or describe symptoms. For example, a personal story about an ill neighbor may be a metaphor for the patient having the same symptoms.
  - **Listen for signs of symptoms that your patient may not be expressing directly. Sharing a personal experience may be a way to build trust with your patient.**

Explaining Touch

- Touch may be very personal for your patient. The head and hair may be considered particularly sacred.
  - **Before touching, always explain what will be done and why.**
- Hair, jewelry, ornaments, or other regalia may have a spiritual meaning.
  - **Ask your patient if they have any spiritual objects with them. If it is necessary to remove an object from the patient's body, have the patient or family member remove the item, and if possible keep it close to the patient until it is reattached. The item can be placed in a plastic bag and kept with the chart during surgery. Whenever possible, return the item to the patient in the recovery room.**

Check Out These Resources to Learn More About Health Care and AI/AN Culture

- ✓ ***Culture and Nursing Care, A Pocket Guide,*** J.G. Lipson, S.L. Dibble, P.A. Minarik, 1996, pp. 11-12 (available at the Learning Resource Center cc420).
- ✓ **Urban Indian Health Institute:** *http://www.uihi.org*
- ✓ **NLM American Indian Health:** *http://americanindianhealth.nlm.nih.gov/tribes.html*
- ✓ **Culture Clues and End-of-Life Care Sheets:** *http://depts.washington.edu/pfes/cultureclues.html*

Culture Clues™ is a project of the Staff Development Workgroup, Patient and Family Education Committee. Contact: 206-598-7498/ Box 358126/pfes@u.washington.edu

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APPENDIX 29-C
Communicating with Your Latino Patient

Culture Clues™ **Patient and Family Education Services**

Communicating with Your Latino Patient

Perception of Illness • Patterns of Kinship and Decision Making • Comfort with Touch

Culture Clues™ is designed to increase awareness about concepts and preferences of patients from the diverse cultures served by University of Washington Medical Center. **Every person is unique; always consider the individual's beliefs, needs, and concerns.** Use *Culture Clues*™ and information from the patient and family to guide your communication and your patient care.

How does the Latino culture deal with illness?

Explaining the Causes of Illness and Disease

- Your patient may see illness as an imbalance. The imbalance may be between internal and external sources (for example, hot and cold, natural vs. supernatural, the soul is separate from the body).
  - **Ask your patient, "Can you tell me what caused your illness?"**
- There are folk-defined diseases such as *empacho* (stomach ailment) and standard western medically defined diseases such as measles, asthma, and TB.
- Many patients seek medical care from *curanderos* or other folk healers.
  - **Ask about use of pharmaceuticals or home therapies such as herbal remedies or certain foods. Screen for possible patient use of injectables, especially antibiotics or vitamins. Ask if you can see the home treatment if your patient cannot identify the substance.**

Helping Your Patient Take an Active Role in Care and Recovery

- Your patient may believe that God determines the outcome of illness.
  - **Consider the impact religion will have in your patient's active participation in health care recovery. You can validate your patient's belief by asking, "Will God be served by taking the best care of yourself?"**
- The patient is seen as an innocent victim, and will be expected to be passive when ill.
  - **Help your patient take an active role in his or her recovery.**

Helping Your Patient Feel Comfortable with UWMC

- Remember to find out if this is your patient's first visit to University of Washington Medical Center.
  - **Keep in mind that patients who are new to the system may not be aware of the role of the Primary Care Team or the process for getting a referral to a specialist.**

Understanding Concerns About Depression

- Depression may not be seen as an illness. It is often seen as a weakness and an embarrassment to family.
  - **Treat these issues with respect. You may want to also offer the services of a clergy member.**

How are medical decisions made in the Latino culture?

Making Decisions About Health Care

- The mother determines when a family member requires medical care; the male head of the household gives permission to go to the medical center.
- Head of household, often oldest adult male, is the decision-maker, but important decisions often involve the whole family. The family spokesperson is usually the father or oldest male.
  - **Ask your patient about whom they want to be included in medical decisions. If the patient does not want to make medical decisions for themselves, let them know they need to prepare a Durable Power of Attorney for health care.**
  - **When possible, engage the whole family in discussions that involve decisions about care.**

Managing Medical News

- The family would prefer to hear about bad medical news before the patient is informed. The family spokesperson usually delivers information about the severity of illness. The family may want to shield the patient from the bad news.
  - **If your patient consents, meet with the identified persons to strategize how to communicate medical news.**

Gaining Family Support

- *La familia* – the family – is an important source of emotional support during recovery. Patients like to be able to see and embrace their family members.
  - **Be aware of the importance of this and consider extending visiting hours. Explain the visitation policy at the time the patient is admitted or before a surgery, so that the family knows what to expect.**
- The family may want to allow the patient to remain passive during recovery while they provide complete support for activities of daily living.
  - **Educate family members about the importance of the patient's active participation during recovery.**

What are the Latino culture's norms about touch?

Understanding Relationships

- Your patients value relationships. They prefer a polite and friendly encounter before a therapeutic relation.
  - **Take time to develop relationships. Shake hands and greet your patient by name, or ask the patient what they prefer to be called. An older patient may prefer to be called Señor (Mr.) or Señora (Mrs.).**

Understanding Norms About Eye Contact and Body Language

- Eye contact with health care professionals or people of authority may be avoided as a sign of respect.
- For some patients, eye contact may be related to evil spirits. An illness may be attributed to receiving an "evil eye" or *mal ojo*.
- Another example of evil eye is the belief that if you admire a child by looking without actually touching him or her, the child can become very ill.
- When your patient nods his or her head, it does not necessarily signify agreement, but that he or she is listening to you. Silence is more likely a sign of not understanding or disagreement.
  - **To ensure understanding, ask open-ended questions and encourage the patient to ask questions.**

Understanding Norms About Touch, Modesty, and Body Language

- Consider the modesty of women and girls; having a female provider may be helpful.
  - **Ask your patient about her gender preference for providers. Consider having a female attendant present when a male provider is examining a female patient.**

What is unique about this patient and family that you will not learn from tips or information about their culture?

Country of origin, education, and income level make a difference about how your patient perceives illness and makes health decisions. What are the questions you want to ask to learn more about this patient and their family?

Check Out These Resources to Learn More About Health Care and Latino Culture

- ✓ **Culture and Nursing Care, A Pocket Guide,** J.G. Lipson, S.L. Dibble, P.A. Minarik, 1997, pp. 203-215 (available at the Learning Resource Center cc420).
- ✓ **Culture Clues and End-of-Life Care Sheets:** *http://depts.washington.edu/pfes/cultureclues.html*

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APPENDIX 29-D
Communicating with Your Russian Patient

Culture Clues™ **Patient and Family Education Services**

Communicating with Your Russian Patient

Perception of Illness • Patterns of Kinship and Decision Making • Comfort with Touch

Culture Clues™ is designed to increase awareness about concepts and preferences of patients from the diverse cultures served by University of Washington Medical Center. **Every person is unique; always consider the individual's beliefs, needs, and concerns.** Use *Culture Clues*™ and information from the patient and family to guide your communication and your patient care.

How does the Russian culture deal with illness?

Helping Your Patient Feel Comfortable with UWMC

- Remember to find out if this is your patient's first visit to University of Washington Medical Center.
  - **If it is your patient's first visit to UWMC, take a few moments for orientation.**
  - **Keep in mind that patients who are new to the system may not be aware of the role of the Primary Care Team or the process for getting a referral to a specialist.**

Explaining the Causes of Illness and Disease

- Your patient and his or her family may believe that illness is caused by weather or social experiences, such as stress from the living situation or because of arguing with the family.
  - **Ask your patient if they have experienced stresses or strains recently.**
- Your patient may not like to take excessive medications. When an option, ask your patients if they prefer over-the-counter or homeopathic medicine.
- Spend time with the patient to show that the patient is cared for.

Communicating with the Patient Experiencing Depression

- Mental health does not receive due respect in the former Soviet Union. Even the word "mental" has negative connotations because it is connected with "mental illness."
  - **Use the term depression, not mental health or mental illness.**
  - **The social worker in your clinical area is a resource to help with referrals and other ways of addressing mental health issues.**

How are medical decisions made in the Russian culture?

Making Decisions About Health Care

- Often the extended family – a working-age couple, their children and parents – have immigrated together. They may have other family members who might have immigrated to the United States at other times.
- There are strong kinship bonds and everyone in the family provides support and service during a crisis.
- Decisions are made by the parents or the oldest child.
- The elders are respected.
- There are no major gender issues; decisions could be made by the mother, father, or eldest son or daughter.
  - **Ask your patient about whom they want to be included in medical decisions. Then meet with the identified family members to strategize how to communicate the medical news. If the patients do not want to make medical decisions for themselves, let them know they need to prepare a Durable Power of Attorney for health care.**

Managing Medical News

- Bad medical news is often shielded from the patient by the family in the belief that telling the patient will only make the patient's condition worse.
  - **If the patient consents, meet with the designated persons to strategize how to communicate medical news so that you are sure of the patient's informed consent for treatment.**

What are the Russian culture's norms about touch?

Understanding Norms About Touch and Body Issues

- **Direct eye contact with your patient is acceptable.**
- **A handshake is welcome from the health care provider.**

Explaining Touching

- Before touching your patient, always explain what will be done and why.
- Your gender as the health care provider is not likely to be an issue for your patient when doing peri-care or assessing urinary catheters.
- Your patient may prefer that opposite gender family members leave the room.
  - **Find out if this is the case for your patient.**
- Female patients may prefer a female OB Gyn.
  - **Ask your patient to learn about her preference.**

Understanding Concerns About Hygiene and Health

- When sick, your patient may prefer sponge baths to daily baths or showers.
- Your patient may not wash hair as frequently when sick, especially when in the hospital, for fear of catching a cold or headache.
  - **Your patient may prefer to keep the room warm and the window shut.**
- Hygiene may be performed by the patient, family, or with the help of a nurse or aide.
  - **Maintain modesty and privacy issues with patient's opposite-gender family members present.**

What is unique about this patient and family that you will not learn from tips or information about their culture?

Birth region, education, and income level make a difference about how your patient perceives illness and makes health decisions. What questions do you want to ask to learn more about this patient and their family?

Check Out These Resources to Learn More About Health Care and the Russian Culture

- ✓ **Ethnomed:** *http://ethnomed.org*
- ✓ **Culture and Nursing Care, A Pocket Guide,** J.G. Lipson, S.L. Dibble, P.A. Minarik, 1997, pp. 239-249 (available at the Learning Resource Center cc420).
- ✓ **Culture Clues and End-of-Life Care Sheets:** *http://depts.washington.edu/pfes/cultureclues.html*

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