The Basics of Cultural Competence

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Disclosure

- I have no financial information to disclose relevant to this presentation
Objectives

• Facilitate cultural awareness relative to medical care providers

• Enhance practice interventions to optimize patient satisfaction / outcomes

• Stimulate interest in furthering competence
Significance

- Currently 29% of US population is minority with projection of 50% by 2050\(^1\)

- 2012 US had 116.2 million minorities which is projected to increase to 241.3 million by 2060

- It is predicted that by\(^4\)
  - 2043 the US will be a “majority-minority nation”
  - 2060 minority population will increase 108%

- Some studies indicate that medical providers who are culturally competent have greater patient satisfaction which is linked to Medicare/Medicaid “pay for performance model”\(^4\)

- Latino’s is the fastest growing population in the US; Arizona population is 25% Latino\(^8\)
Culture Is

- Dynamic and ever evolving/changing
- Symbolic (language, dress, music, and behavior)
- Learned and passed on
- Integrated into all aspects of an individuals life
Culture Is Influenced By

- Ethnicity
- Religion
- Community
What is Cultural Competence?

• **Cultural competence** (improve quality of care by understanding how differences among cultures affect behavior and attitudes toward emotional events / medical conditions)₂

• Behaviors, attitudes, and policies that are congruent among professionals in order to cork effectively in cross-cultural situations₁

• A process by which one adapts attitudes, behaviors, knowledge, and skills as needed versus having a PRE-SET protocol (prevents stereotyping)₁
Terminology Related to Cultural Competence

- **Cultural sensitivity** (sensitive to the others values and perceptions)$_2$
- **Cultural awareness** (awareness, appreciation, and sensitivity to the values, beliefs, life ways, practices, and problem-solving strategies of other cultures while keeping in mind your own biases)$_3$
- **Transcultural nursing** (realizing the cultural context to which patient builds their understanding of information to avoid a one-size-fits-all treatment approach)$_2$
- **Cultural knowledge** (education regarding other cultures/world views including values, beliefs, and practices)$_3$
- **Cultural skill** (performing cultural assessments)$_3$
- **Cultural encounter** (participating in cultural events)$_3$
Process of Cultural Competence

- Sensitivity
- Awareness
- Knowledge
- Skills
- Competence
Importance of Cultural Competence

- Reduce disparities in services
- Increase detection of culture-specific diseases
- Ensure equal access to care
- Increase ability to respond to diverse populations and changing demographics
- Improve health status
Elements of Cultural Competence

1. Examine your values, behaviors, beliefs, and assumptions
2. Recognize racism or behaviors that breed racism
3. Allow yourself to understand other world views/perspectives
4. Learn core cultural elements
5. Ask patients about the similarities and differences of what you know
6. Ask patients to share how they define and understand the condition and treatment
7. Foster a relationship of trust
8. Be welcoming to diverse communities
Culturally Sensitive Topics

- Death
- Sexuality
- Women’s Health
- Childbirth
Key to Cultural Competence

- Cultural competence training

- Increases knowledge, awareness, and sensitivity

- Systematic review loosely concluded that patient satisfaction improved
Cultural Sensitivity & Awareness Checklist

<table>
<thead>
<tr>
<th>Focus</th>
<th>Instruction</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Communication method</td>
<td>Identify preferred method of communication. Obtain translators.</td>
</tr>
<tr>
<td>2 Language barriers</td>
<td>Identify verbal and non-verbal language barriers. List possible compensations.</td>
</tr>
<tr>
<td>3 Cultural identification</td>
<td>Identify the culture. Contact the culturally specific support team for assistance.</td>
</tr>
<tr>
<td>4 Comprehension</td>
<td>Double-check patient/family comprehension of the situation.</td>
</tr>
<tr>
<td>5 Beliefs</td>
<td>Identify religious/spiritual beliefs. Make support contacts.</td>
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## Cultural Sensitivity & Awareness Checklist

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<tr>
<td><strong>6</strong> Trust</td>
<td>Double-check: does the patient/family trust the provider. Look for verbal and non-verbal cues. Seek advice from culturally specific support team.</td>
</tr>
<tr>
<td><strong>7</strong> Recovery</td>
<td>Double-check: does patient/family have misconceptions or unrealistic views about the providers, treatment, or recovery process? Make adjustments.</td>
</tr>
<tr>
<td><strong>8</strong> Diet</td>
<td>Address culture-specific dietary considerations.</td>
</tr>
<tr>
<td><strong>9</strong> Assessments</td>
<td>Conduct assessments with cultural sensitivity in mind. Watch for inaccuracies.</td>
</tr>
<tr>
<td><strong>10</strong> Health care provider bias</td>
<td>Always remember we all have biases and prejudices. Examine and recognize your own.</td>
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QUESTIONS TO ASK DURING A PATIENT ASSESSMENT:

- What do you think caused your problem?
- Why do you think it started when it did?
- How severe is your illness? Will it have a long or short course?
- What kind of treatment do you think you should receive?
- What are the most important results you hope to receive from treatment?
- What are main problems this illness has caused for you?
- What do you fear most about your illness?
How Strong Is The Cultural Belief

- How recently did they immigrate
- Was the immigration voluntary or involuntary
- Did they live in intermediate countries prior to US
- Who does the patient associate with
- What type of neighborhood does the patient live in
- Does the patient follow traditional dietary habits
- Does the patient wear native dress
- Does the patient use folk medicine or healers
- Did the patient live in rural or urban area in native country
Keep In Mind

1. “When we treat people **EQUALLY** we ignore differences”

2. “When we treat people **EQUITABLY** we recognize and respect differences”

![Image showing a balance scale and two hands shaking, one white and one black, symbolizing equality and respect.](image_url)
Provider Awareness

• 2 key assumptions
  • Everyone who looks / sounds the same are the same
  • Everyone who looks / sounds like us are like us

• Pay attention to how you think / feel about other people and how that influences your interactions toward them

• Our own cultural backgrounds can create our biases
Tips for Providers

• Avoid using family members as interpreters
• Be familiar with signs of distress
• Get to know that patient, ask questions, avoid making assumptions
• Learn about and avoid religious and/or social taboos
• Offer options for treatment
Culture Considerations

• **Before the consultation**
  - Preference for *male or female provider*
  - Interpreter

• **Before/during the consultation**
  - Others to be included with diagnosis / treatment decision making

• **During the consultation**
  - How patient is managing condition
    (medicines, *herbal remedies*, alternative treatments)
  - How is patient feeling
  - Treatment preferences
  - Ask to examine patient
  - Tell me what you heard me say
  - Special diet
  - *Ask how or what caused their condition / illness*

• **During / after the consultation**
  - Time to make decision
  - Ask if they’d like explanation of next step
Comparisons

**Western Medicine**

- Disease is scientific in nature
- Treatment is with medicine and technology

**NON-WESTERN MEDICINE**

- Disease is supernatural
- Treatment with prayer or spiritual interventions

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Conformity to Western Medicine

- Barriers to care occur when we expect patient conformity to Western Medicine
- Be willing to negotiate culture
14% of US population **DO NOT** speak English at home (54% Spanish and second most common language is Chinese)

- Use simple words but do not speak childish or overly simplistic; avoid slang; avoid long explanations; avoid jokes/humor

- Speak full sentence then pause allowing interpreter to finish
Seven Cultural Competence Assessment Tools

- Standardized patient scenarios
- Nonverbal communication (facial expression / vocal tones)
- Inventory to assess the process of cultural competence among healthcare professionals
- Patient reported physician cultural competency scale
- Self-assessment of cultural awareness questionnaire
- Spanish proficiency clinical scenarios and questionnaires
- Healthcare provider questionnaire on cultural competence training module
Take the Survey

- Cultural Competence Assessment Survey (CCAI)\textsuperscript{12}

- Self-Assessment Checklist for Personnel Providing Services and Supports to Children and Youth with Special Health Needs and Their Families\textsuperscript{13}
AOTA-Resources

• AOTA: “How Can Occupational Therapy Strive Towards Culturally Sensitive Practices?” 14

• Culture can shape the identity, roles, and perception of a patient’s independence.

• Occupational Therapy Practice Framework: Domain and Process

• Occupational Therapy Code of Ethics and Ethic Standards (beneficence, nonmaleficence, autonomy/confidentiality, social justice, procedural justice, veracity, and fidelity)

• Use health literacy (functional, interactive/communicative, critical)
Relevance for Occupational Therapists (Law)

- Person-Environment-Occupation Model
- Center 3 = Occupational Performance

Figure 1a
A Person-Environment-Occupation Model of Occupational Performance

Figure 1b
Depiction of the Person-Environment-Occupation Model of Occupational Performance across the lifespan illustrating hypothetical changes in occupational performance at three different points in time
Translation of Culture into OT (Awaad)

**Keep in Mind and Honor Differences**

- OT’s are goal-directed
- Work/leisure and mind/body divides
- Concept of time
- Illness / recovery beliefs
- Religion / spirituality
- Analysis of activities
Culturally Responsive Caring (Munoz)

Consider Culture When Addressing ADL

- Eating
- Bathing
- Dressing /Clothing
- Cooking
- Cleaning
- Toileting
- Grooming

FIGURE 1: The central categories of culturally responsive caring.
Asians/Pacific Islanders

• Extended family has significant influence especially the oldest male who is the decision maker/spokesperson
• Harmony is important therefore avoid conflict and direct confrontation
• Disagreement with healthcare professionals is avoided (lack of disagreement does not indicate compliance with recommendations)
• Chinese families expect appropriate behavior so lack of self control results in shame/guilt
• Chinese patients may avoid discussions related to mental illness or depression

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India / Pakistan

• Reluctant to accept diagnosis of mental illness or mental retardation as it reduces chance of marriage

Vietnamese

- Mystical beliefs explain physical and mental illness
- Harmonious balance between poles of hot and cold that govern the body will produce health
- Western medicine approach to mental health intervention is difficult to accept without trust
View US health care with mistrust
Not used to free exchange of health care as they are used to authoritarian relationship
Hispanic

- View illness as God’s will or divine punishment due to sinful behavior
- Prefer home remedies or folk healer (Curandero)
African American

• Culture centers on family and church
• Extended family play important roles
• Key family members are consulted for medical decision making

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Native Americans

• Oriented to the present and value cooperation
• Strong family and spiritual beliefs
• Health occurs when the individual is in harmony with nature
• Illness occurs with an imbalance between person and natural/supernatural forces
• Use medicine men/women (Shaman)
African

- African Americans
- Africa Immigrants
- Caribbean Immigrants
- Sickle cell anemia
- History of slavery and segregation
- Strong faith

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A Cultural Encounter
My Experience In Africa at WFOT

An amazing place to visit

- Restaurants
- Entertainment
  - Comedy Clubs
  - Dinner Theaters
  - Dance classes
- Beautiful scenery
- Tourism

- Similarities
Medical

- Diagnosis
- Facilities
Water
Schools / Employment
Transportation
Money
Rand
Agriculture
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Image Credit

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Standardized Patient Scenarios

- Study done by *Prescott et.al.* in the United Kingdom
- Vocational Dental Practitioners
- 76 with training (8 modules) compared to
- 15 without training
- Each group rated 4 scenarios
- Objective Structured Clinical Examination (OSCE) used to compared trained versus non on standardized patient scenarios
- Scenarios included: race, religion, gender, sexual orientation, age, disability, and other
- **Themes:** understanding individuals/negative assumptions, language/communication, courtesy/respect, avoiding discrimination, clinical issues, leadership/management, access, and legislation.
- The practionners with training scored better
Nonverbal Communication

Study completed by Coelho, et.al.

N=30 physicians

- (26 males; mean age 46.14; 16 S Asian; >5 years in USA; San Francisco / N Cal., >4 years practicing)
  - Media Lab software on computer for facial expression and voice tones
  - Drawn photographs of Caucasian
  - Recording of vocal expression (both groups)
  - From list selected anger, fear, disgust, happiness, sadness, surprise, neutrality

Physicians

- Both physician groups were more accurate with reading Caucasian face/voice than the Asian population
Continued
Nonverbal Communication

Study completed by Coelho, et.al.
N=60 patients (27 male, mean age 25, 30 S Asian)

• Completed a survey on satisfaction with physician, adherence to medical treatment, and intent to continue care with physician.

Patients

• Caucasian more satisfied with physician regardless of ethnicity
• Caucasian patients more likely to adhere to recommendations
Inventory to Assess the Process of Cultural Competence Among Healthcare Professionals

Study completed by Castro and Ruiz

- 25 items with 4 point Likert scale to measure cultural competence
- Measures 5 constructs of competence: awareness, knowledge, skill, encounter, and desire
- 15 NP: 66% <10 year experience, 73% Caucasian, 47% age 41-50, 53% Spanish speaking, 93% culture training, 80% certified, 73% Master’s degree, 73% practice in Latino area
- Results for NP’s: 2 proficient, 7 competent, 6 aware
- Patients satisfied with NP care primarily due to reduced waiting time
Patient Reported Physician Cultural Competency Scale

Study completed by Thome, et.al.

- 4 sites N. Calif. (all 4 received results of PRPCC); (2 of 4 sites received cultural training; then a follow up PRPCC)
- 53 physicians, mean age 39.2 years, (45%) female, (62%) family physicians, (72%) were White, 8 Latino, 5 Asian-American, 1 African-American; 43 spoke second language (34 Spanish).
- 429 patients completed the first survey and 320 completed the follow up survey
- Patient mean number of visits to their physician prior to the study (3.8 vs 3.7) or during the study (2.7 vs. 2.9), mean age (60.1 vs. 59.4 years) and percent female (54 % vs 60%). Of non-respondents were Asian (40% vs. 18%, p < .001) and not primary English speakers (54% vs 32%).
- Cultural competence model for primary health care was adapted from Dr. Miguel Tirado’s model-Health Services and Research Administration (HSRA) of the U.S. Department of Health and Human Services. (3 separate 1-1.5 hr modules on knowledge, communication, and cultural brokering)
- (4.5 hours) training curriculum aimed at improving physician cross-cultural knowledge and skills did not impact patient outcomes
Patient Reported Physician Cultural Competency Scale

1 = never, 2 = seldom, 3 = sometimes, 4 = usually, 5 = always

1. My doctor asks me why I think I got sick.
2. My doctor talks with me about medications I may use other than the ones he/she prescribes.
3. My doctor talks with me about traditional healing remedies I may use.
4. My doctor asks if I seek advice from other family members and friends in making decisions about my health care.
5. When discussing diagnosis and treatment related to my condition, my doctor asks if I would like to include family members in the discussion.
6. My doctor takes time to help me understand possible side effects of the medications he or she prescribes for me.
7. My doctor informs me of the resources in my local community where I can find help.
8. My doctor asks if I understand his/her instructions and if not repeats them when necessary.
9. My doctor asks if I have other questions or concerns before I leave the office.
10. My doctor helps me to ask questions about my condition and treatment.
11. My doctor helps me answer the questions he or she asks.
12. My doctor encourages me to stop him or her when I am confused.
Self-Assessment of Cultural Awareness Questionnaire

Study completed by Majumdar, et.al.

- Canadian Study
- N=114 providers from two home care and one hospital received cultural sensitivity training
  - Experimental group at start of study completed 2 surveys, at 3 months received 36 hours of cultural sensitivity training
  - Control group received training at 12 months
  - Results: Experimental group showed increased understanding of multiculturalism, cultural awareness, understanding differences, cultural beliefs, adopting health care literature, considering social circumstances, and culture importance.
- Pre and post 3, 6, 12 month assessments completed to determine if training affects provider attitude, patient satisfaction, and accessibility
- N=133 patients completed 6 instruments, one scale, and five questionnaires
- Patient results: NO difference between control and experimental group in client satisfaction, mental health, physical health, or activities of daily living. Difference in social and economic resources.
Study completed by Mazor, et.al.

• My provider is concerned for me as a person
• My provider spends enough time with me
• My provider listens carefully to what I am saying
• My provider explains medication to my satisfaction
• My provider supplies me with the results of my tests in a timely fashion
• My provider supplies information so I can make decisions regarding my own care
• My provider refers to me to specialists as needed
• My provider treats me with respect and courtesy
• My provider returns my telephone calls within a reasonable period of time
• I would recommend my provider to family and friends
Spanish Proficiency Clinical Scenarios and Questionnaires Results

- Patients of general practitioners and internists were mailed satisfaction surveys
- Findings of response bias