2009 WEST COAST HEALTHCARE MISSIONS AND MINISTRY CONFERENCE

Pasadena, California, United States of America

COURSE PACKET

Workshop (one contact hour)

Cross-Cultural Contextualization of Healthcare Concepts: Is It Possible??

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Learning Objectives:

By participation and completion of this one-hour workshop, the participant should be able to:

1. Define culture, cultural competency, culture care and contextualization.
2. Identify 3 key components in culturally competent health care delivery.
3. Identify the impact of the Culturally and Linguistically Appropriate Service (CLAS) standards upon international healthcare missions.
4. Discuss self-awareness, humility and relationship as the basis for individual cultural competency effective cross-cultural work.
5. Discuss Bloom's Taxonomy, healthcare workers and implications in cross-cultural/contextualized healthcare communications, education and practice.
6. Identify strengths and weaknesses to the concept of contextualization in healthcare missions.
7. Identify 4 process steps to culturally and linguistically appropriate and effective cross-cultural healthcare communications and education.

Workshop Content Plan:

I. Group Exercise: Arrow Exercise

II. Video: Encounter I

III. Group Exercise: Temperature Check

IV. Role Play: Patient Education in the Toggol Village

V. Group Exercise: Evaluation of Role-Play and Report

VI. Verb: Concepts, Constructs, Models and Processes in Cross-Cultural Healthcare Delivery and Healthcare Education (Chris, Powerpoint)

VII. Group Exercise: Application as a Long-term Missionary, Short-term Outreach Worker?

VIII. Video: Encounter II

IX. Verb: Individual Exercise: Self-evaluation

Seminar/ Workshop Content Break-Out

Group Exercise*: Arrow Exercise*

Please take your place in the seminar room based on the designations you received when you entered the room. We apologize if couples or friendships are separated for a time due to the exercise, *but you'll find this enlightening!*

Video*: Encounter I*

Please watch the video scene presented, and at the end be prepared to answer the question in your group exercise; "How did the scene make me *feel*?"

***Group Exercise**: Temperature Check*

Please break into groups of 3 or 4 people and share your answer to the question about the video encounter and the arrow exercise.

***Role Play**: Patient Education in the Toggol Village*

Please watch the 5-minute role-play between two people, and be prepared to answer the two following questions: [1] "How did the scene make me *feel*?" and [2] "In that situation, what I would do *differently* would be…?"

***Group Exercise**: Evaluation of Role-Play and Report*

Please break into the same groups of 3 or 4 people and share your answers to the 2 question about the role play.

***Verb:** Concepts, Constructs, Models and Processes in Cross-Cultural Healthcare Delivery and Healthcare Education (Chris, Powerpoint)*

At the end of the verb, and based on your current role as a healthcare worker, be prepared to answer the question; "How would I apply (or not apply) what was presented in the verb?"

***Group Exercise**: Application (Long-term Missionary, Short-term Outreach Worker)*

Please break into the same groups of 3 or 4 people and share your answers to the question; "How would I apply (or not apply) what was presented in the verb?"

***Individual Exercise**: Self-evaluation*

At the end of the verb, answer the question; "how *will I apply* what was presented in the verb?"

***Video**: Encounter II*

Please watch the video scene presented, and answer the question for yourself; "how well did the caregiver in the video render culturally competent care to the patient who came into his house?"

Post-Conference Assignment:

Please email me with your response to this short, one-hour seminar on cross-culture care. What was helpful? What was not helpful or needs refinement in this seminar?

Your feedback is very important to me, and helps me improve. Thank you so much for coming!!

chris@bajmission.com

Key reference article: Bajkiewicz (1999) Embracing a people: The joy of incarnational ministry. *Journal of Christian Nursing, 16*(4), 4-8

To view, visit www.bajmission.com/teachingEmbrace1.html

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Verb Notes

<><><> from Bajkiewicz, C. (2008). *Cultural competency and culture care education in the patient-centered Intensive Care Unit: An integrative review of the evidence*. Unpublished Master's Thesis, San Diego, CA: Point Loma Nazarene University.

Cultural competency

The Culturally Competent Care (CCC) conceptual framework and practice skill-set in healthcare has grown increasingly complex. Previously thought as mere language translation and key health-care practice *cultural do's and don'ts,* this oversimplification is now known to stereotype minority clients and directly interfere with effective, patient-centered care (Betancourt, 2004).

Culture and cultural competency acquisition

Leininger defines *culture* as the "learned and shared beliefs, values, and lifeways of a designated or particular group that are generally transmitted inter-generationally and influence one's thinking and actions modes" (2002a, p. 9). Language, communication styles, customs and role understanding are included, conceptually reaching past the demography of race, ethnic background and country of origin (Betancourt, 2004).

Cultural Competency

Exactly what is *cultural competency*? Authors have noted that cultural competency lacks any clear consensus of definition or defining characteristics (Kehoe, 2003; Betancourt, Green 2003). It has been suggested to be more an operational construct (Capell, Dean Veenstra, 2008). Multiple descriptors in the literature, such as diversity, competence, awareness and sensitivity has added to general confusion and possibly creating actual resistance in provider-learners to overall cultural competence (Schim, et al, 2007). The Joint Commission has listed cultural

competence as a provider requirement since 1994 (Schim, Doorenbos, Benkert & Miller, 2007), framed in individual-provider terms.

Foundational transcultural nursing theorist Leininger has noted that the nursing goal is clearly to provide "culturally congruent nursing care" that includes, "culture care values, beliefs and lifeways to provide meaningful, beneficial and satisfying care" that is patient-focused (Leininger, 2002, p. 58).

Campinha-Bacote, considered an expert alongside Leininger in the area of transcultural nursing (Braithwaite, 2005), defines cultural competence in individual provider terms as well, namely, "a process in which the healthcare provider continuously strives to achieve the ability to effectively work within the cultural context of a client/individual, or family, or community" (Campinha-Bacote, 1999, p. 203). This *cultural competence model* has five components; cultural awareness, cultural knowledge, cultural skill, cultural encounter and cultural desire. All five components must be passed through and integrated into the individual provider for cultural

Core Definitions

Culture (noun) will refer to the "learned and shared beliefs, values, and lifeways of a designated or particular group that are generally transmitted intergenerationally and influence one's thinking and actions modes" (Leininger, 2002a, p. 9). *Cultural* is the adjective referring of, or pertaining to culture.

Also of note is the concepts that culture is the sum of the distinctive characteristics of a peoples way of life, including socially defined contexts of a people, and includes the conceptual design, the definitions by which people will order their lives, interpret their experience and evaluate the behaviors of others. These values are common, held as a priority and standard for application in social contexts. Discordance occurs when the behavior is at variance with the

pattern of the whole (Lingenfelter & Mayers, 1986). Note how this functions within boundaries, allowing for the distinction of *inside* and *outside* the group norm (Leininger, 2002).

Care will refer to "assistive, supportive, enabling, and facilitative culturally based ways to help people in a compassionate, respectful, and appropriate way to improve a human condition or lifeway or to help people face illness, death or disability" (Leininger, 2002, p. 11). Important to note is Leininger's placement of *culture* in the fundamental definition of care, hence *culture care*.

Cultural competency, for purposes of this study and with knowledge of the previous discussion from the literature, will embrace the Campinha-Bacote definition, "a process in which the healthcare provider continuously strives to achieve the ability to effectively work within the cultural context of a client/individual, or family, or community" (Campinha-Bacote, 1999, p. 203). This cultural competence has five components; cultural awareness, cultural knowledge, cultural skill, cultural encounter and cultural desire. All five components must be integrated into the individual provider for the quality of cultural competency (Braithwaite, 2005).

Culturally competent care (CCC) is the operation of a provider delivering care in a culturally competent manner, involving the cognitive/knowledge, affective/awareness and psychomotor/skill domains (Callister, 2005).

Culturally Competent Care Education (CCCE) will be considered a composite of *culturally competent care* and *education*, and generally meant to signify any purposeful intervention involving a *teacher-learner-learning paradigm* for the communication and acquisition of cultural competency (as previously described). In this study, it will primarily signify the intervention for healthcare providers-professionals (Campinha-Bacote, 1999; Leininger, 2002).

Addendum

Contextualization, a word not found in healthcare culture care literature but occasionally used by some corporate, anthropologic and Biblical studies references, will refer to the dictionary definition, "to place (a word or activity) in a particular context"

(found at www.merriam-webster.com)

Worldview and the Three Zones of Cross-Cultural Interaction

Worldview: "a set of assumptions through which the important issues of life are perceived… not the same as world religions, but worldviews underpin every religion" (Kumar, 2004)

Worldview deals with what people believe about God, the Universe/Creation/Reality, Themselves and Others (Bajkiewicz, 1999)

Religious Worldviews / Beliefs: Paradigm

Theism (one God)

Atheism (no God)

Deism (a God who does not interact with us/the Creation)

Agnosticism (cannot know IF there is a God)

Polytheism (many gods)

Pantheism (everything is God… different manifestations)

Animism (that gods inhabit objects)

Monism (Buddhism – everything that is, is One)

(Piippo, 2009, personal communication)

Three Zones: Interactional Psycho-Social Phenomenon/Process

1) You (your sphere, culture, socio-economic-cultural-linguistic worldview)
2) Them (their sphere, culture, socio-economic-cultural-linguistic worldview)
3) The You + Them Intersect

Individualistic versus Collective Societies

West = individualistic

Non-Western = collective

New Millennium = patch-work (exposure, socio-cultural network, economic level, education)

Some individualistic in Non-Western locations/contexts

Some collectives in Western locations/contexts

Worldview Interaction

Similar: Harmony (God, Material, Societal, Others, Cultural, Self)

Little in Common (God, Material, Societal, Others, Cultural, Self)

Disparate (God, Material, Societal, Others, Cultural, Self)

Remember: Personal Worldview of Health-Wellness-Illness not shared across cultures (Nash, 1992)

Process Steps in Effective Cross-Cultural (Contextualization) Patient Health Education Materials

Arch: Treat new cross-cultural education interventions like a new medication for prescribing…

1. Define and draft the material to be presented across cultures

<>What is to be taught, displayed or given? (Write all content, graphics, diagrams, pictures in the language of origin)

<>Who is the target audience? (Identify/study worldview, language/dialect, level of literacy, socio-economic levels of those who will receive the intervention. One-on-one? Group learning?)

<>Where it will be taught? (What setting or settings? Classroom, clinic, public meeting, street-corner, village. Anticipate implications of settings. Consider technology and access of electricity).

<>When it is to be taught? (during clinic, before/after, individual patient education).

<>Assessment of draft by development team for reading level, grade level of concepts and material (Flesch-Kincaid assessment, SMOG Readability Formula, Fry Graph, Bloom's Taxonomy, Percentile of page graphics-to-text. Use rules of research audit: 2-3 reviewers, independent, trained, ? masking of reviews, common evaluation criteria and tools).

<>Have accurate data (government reports, on-the-ground healthcare workers) on the literacy, grade level and conceptual abilities of the target group. Consider a Gardner Multiple Intelligences survey, Cultural Values assessment (Lingerfelter).

2. Engage 2 'emic' culture members from specific group and region (fully bi-lingual/bi-cultural interpreters, certified/trained in USA). [Note: difference between general versus specific culture]

<>Full translation and idiomatic interpretation

<>Assessment of graphics, figures, gestures, pictures

<>Full 'veto' power, able to offer appropriate bridging/re-interpretation

3. Time-process

<>allow 90 days if working group in same region, 3-6 months if materials being written, transmitted (mail, electronically), interpreted/translated, then re-transmitted.

<>possibility of major revisions of work based on cultural-worldview differences

<>reverse translation for trustworthiness (take work in second culture-language and back-translate by independent source to first culture-language)

<>Reliability, validity reporting

4. Emic culture member to teach/present (or fully participate) material to target audience while in country. Short-term worker, regardless of level of healthcare training is culture-outsider and presence may hinder or alter health education receptivity or learning by nationals.

Overview/Important Points: Cross-Cultural Health Education

<>Contextualization of health information requires commitment to a long-term, rigorous process incorporating multiple experts in language, culture and context. It must be able to stand the ultimate litmus test of approval by a panel of regional nationals who belong to the target ethno-cultural group in the target region of the world.

<>Cultures cognate information and educational materials differently. Contextualized health information methodologies cannot be transferred from one culture to another with the assumption that the reliability and validity in the first culture will transfer to the second and new

cultural context. This is particularly true between Western and Non-Western cultures and their respective models of health, wellness, illness and disease etiology.

<> Health worldviews, health beliefs, health assumptions, health delivery systems and trust-authority healthcare relationships are culturally locked and significantly between culture-ethnic groups. Euro-western assumptions and systems are completely different outside those regions.

<>The Western medical model, based in assumptions related to the biologic sciences and individual rights does not readily translate to non-Western cultures that believe in wholistic models and collective society. This holds true for the Western Health Belief Model, which is the basis of much of the Health Education literature and patient educational materials written in the United States.

<>Translation of the language is only one aspect of health information.

<>Language is only one aspect of communication and culture.

<>Language translation requires multiple validity/reliability testing by emic cultural members.

<>Language translation must include local/regional review.

<>Literacy levels are frequently over-reported in governmental data, and local emic nationals will know the overall literacy and reading-comprehension level of the local population. The less written words, the better!

<>It cannot be assumed that persons who have learned English as a second language have the same worldviews and cognitive processes regarding health as those who are primary white, non-Latino, English-speaking Westerners.

<>Success in one region or locale does not insure even marginal effectiveness in another region. (George, 2001; Monsivais & Reynolds, 2003; Rudd, 2005; Williamson, Stecchi, Allen & Coppens, 1997)

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26GG.

Appendix A

Culture Care / Competency Educational Frameworks and Models Encountered

Study/Source used	**Culture Care Frameworks Used / Cited / Referenced**
Hagman (2006), Hart (1999)	Leininger and McFarland (2002)
Joseph (2004)	Bandura (1977)
Smith (2001)	Giger and Davidhizer (1999)
Schim (2006)	Schim and Miller Cultural Competency Model (1999)
Marrone (2008)	Ajzen (2001)
Brathwaite (2005)	Campinha-Bacote (1994, 1999)
Jirwe, Gerrish &Emami (2006)	Suh (2004), Gerrish and Papadopoulos (1999)
Carol (2007)	Andrews and Boyle (2007), Purnell (2005)

Appendix B

United Sates Department of Health and Human Services Office of Minority Health (OMH)

National Standards on Culturally and Linguistically Appropriate Services (CLAS)

Culturally Competent Care

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

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

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

Language Access Services

Standard 4
Health care organizations must offer and provide language assistance services, including

bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

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

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

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

Organizational Supports for Cultural Competence

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

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

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

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

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

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

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

Available from the OMH Resource Center (OMHRC) at **http://www.omhrc.gov**

Appendix C

EVALUATION OF PATIENT EDUCATION MATERIALS (PEMs) (Bajkiewicz, 2007)

Use this guide as the form for observational evaluation of PEMs (Mexican-American specific)

1. DESCRIPTION OF PEMs

2. OVERALL APPEARANCE

3. % WORDS TO GRAPHICS

4. GRAPHICS: USE, TYPE

5. COLOR USE

6. LAYOUT, PRINT SIZE

7. TARGET GROUP (states or inferred)

8. PEMs ADDRESS TARGET GROUP?

9. GENERALIZED OR SPECIFIC?

10. READING LEVEL OF PEMs (calculated):

Flesch Reading Ease Formula Score calculation:

$$206.835 - 1.015\left(\frac{\text{total words}}{\text{total sentences}}\right) - 84.6\left(\frac{\text{total syllables}}{\text{total words}}\right) =$$

Flesch-Kincaid Grade Level Formula

$$0.39 \left(\frac{\text{total words}}{\text{total sentences}} \right) + 11.8 \left(\frac{\text{total syllables}}{\text{total words}} \right) - 15.59 =$$

11. LANGUAGE OF PEM

12. HEALTH BELIEF MODEL USED??

13. CONCEPTS CULTURALLY RELEVANT?

14. ANY ASSUMPTIONS THAT COULD AFFECT PEMs?

15. ANY EVIDENCE OF POST-DEVELOPMENT EFFECTIVENESS RESEARCH?

16. ANY HISTORICAL USAGE AND FOUND EFFECTIVENESS?

17. MEXICAN-AMERICAN SPECIFIC: (skip if material not for Mex-Am clients)

Meaningful message to Mex-Ams?	[ ] YES	[ ] NO
Dynamic visuals?	[ ] YES	[ ] NO
Repeatable?	[ ] YES	[ ] NO
Simplicity in presentation?	[ ] YES	[ ] NO
Relational approach?	[ ] YES	[ ] NO
Personal stories/testimonials?	[ ] YES	[ ] NO
Family approach to care?	[ ] YES	[ ] NO

FINAL ANALYSIS:

Pending focus group results and Quantitative/RCT results, these PEMs should be deemed:

[ ] Highly appropriate for target group and target message

[ ] Moderately/acceptably appropriate for target group and target message, possible barriers, requires careful analysis, possible revisions indicated

[ ] Not appropriate for target group and target message. Requires significant revisions