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Little Mekong Health Care Center

Prepared in partnership with
Hmong American Partnership (HAP)

Prepared by
Joo H. Kim
Research Assistant
University of Minnesota

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Center for Urban and Regional Affairs (CURA)
University of Minnesota 330 HHH Center
301—19th Avenue South
Minneapolis, Minnesota 55455
Phone: (612) 625-1551
E-mail: cura@umn.edu
Web site: http://www.cura.umn.edu

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Executive Summary

Little Mekong Health Care Center (LMHCC)

The Hmong American Partnership (HAP) is an existing social service agency seeking to open a new community health center serving the a four-zip code area of Saint Paul, Minnesota collectively called Frogtown. The health center is named the Little Mekong Health Care Center (LMHCC) due to its central location within the "Little Mekong" business and culture district. The district's name is derived from the Mekong River, which flows from China through Burma, Laos, Thailand, Cambodia, and Vietnam, and connects the cultures of Southeast Asia. Demographic data for LMHCC reveals a wide diversity of residents; primarily, the residents are Southeast Asian of Hmong, Karen, Bhutanese, Vietnamese and Laotian origins. 68.5% of the Asian residents are Hmong. With such a richly diverse population to service, HAP has endeavored to address the questions of how to provide the best quality of culturally competent care to the local population. It is thus that HAP has partnered with the University of Minnesota Center for Urban and Regional (CURA) to research the best practices for implementing and practicing a cultural competent health care clinic.

Research Objectives

The questions that initiated and guided this research project are: 1) What do culturally inclusive patient services look like within a community health clinic setting? 2) What do culturally inclusive health settings look like?

Research plan

The original five-month plan (January through May) for this research project included the following step-by-step process: literature review, identification of community clinics to interview, designing interview questions, designing focus group questions, conduct focus groups,

conduct interviews, identify an analysis tool, finalize analysis tool, analyze the data gathered, format a report, finalize a report and present to HAP and CURA.

Adjustment to Plan

While researching the original questions, refining the parameters and summarizing the data, it became apparent that the readily available research was sufficient and vast. Summary notes on the research can be found in the next section titled *Key Findings*. It was thusly determined that it would be unnecessary to perform interviews as it would yield similar data. Instead, efforts were focused on the development of an assessment tool from the research data. This data was then distributed to four practitioners in community health centers to assess and evaluate.

Incorporation of Feedback

Responses from the medical providers clarified the need simplify, separate and quantify different aspects of the tool. This has led to organization of the assessment tool into phases of the healthcare clinic's life and for use by varying levels of the clinic's leadership. The final product is thus an assessment tool for infusing cultural competence into the phases of: development, management, practice and review of community health centers. Users of the tool would include: the board of directors, the director of the clinic, the clinical practitioners and the clients.

Project Goals

It is the hope of this project that the assessment tool created will aid in the development, management and reformation of this and other community health clinics towards cultural competence. Ultimately, cultural competence is a goal that assumes the decrease of health disparities in represented populations and increases access.

Key Findings

Best practices for the provision of culturally competent care in health care settings include:

- An advisory Committee that partners with local community leaders and organizations
- Locally hired, language proficient, diverse, culturally competent staff
- Regular survey of clients for satisfaction, quality of interpretation and met needs
- Provision of client education
- Regular trainings for staff (self-awareness, other awareness & interaction)
    - Include basic information on refugee populations
    - Backgrounder sheets and talks on specific population groups
        - Beliefs/ understanding of medicine, diseases
        - Specific issues of adherence
        - Common tests that should be run
        - Interaction habits
        - Stigma, shame, & embarrassment
    - Cultural competency that explores awareness of self, power and privilege (microaggressions)
    - Weekly staff meetings to foster cultural competence amongst staff, updates on cultural competence & cultural competency trainings
    - Communication tools
        - How to convey respect
        - Ask-Learn approach
        - Shared Decision Making (SDM)
        - ETHNIC- explanation, treatment, negotiate, intervention, collaboration
    - Trauma informed
    - How to use a medical interpreter (or interpreter in general)
    - Issues of disparity including poverty, employment, social supports
    - Ethical dilemmas between cultural competency and perceived best medical treatment
- Organizational accommodations
    - Each session could take longer to explain why things are done and Western medical ways and may require more sessions
    - Space for privacy and sharing of stigmatizing information
    - Religious/ Cultural accommodations, for example:
        - Work with a shaman
        - Prayer rooms
    - Professional medical interpreters recommended
        - Reduce misdiagnosis
        - Assist in cultural exchange
    - Operation hours- to include evenings & weekends, 24 hour call line, voice message system, same-day or 48 hour appointment slots
    - Sliding Fee Scale & insurance acceptance
    - Alternative method for tracking patient identities

    - Balance of male and female practitioners for cultural preferences
    - Translated signage, materials & videos
    - Representative artwork
- Organizational Models
    - Culturally responsive Care Model
        - Culhane-Pera, K. (2003). Healing by heart : clinical and ethical case stories of Hmong families and Western providers: Chapter 16: A model for culturally responsive health care (pp. 13-53). Nashville: Vanderbilt University Press.
    - Shared Decision Making Model
        - DeMeester, R., Lopez, F., Moore, J. Cook, S. & Chin, M. (2016). A Model of Organizational Context and Shared Decision Making: Application to LGBT Racial and Ethnic Minority Patients. Journal of General Internal Medicine, Vol.31(6), 651-662. doi: 10.1007/s11606-016-3608-3
    - Model for integrating cultural competence
        - Renzaho, A. (May 2008). Re-visioning cultural competence in community health services in Victoria. Australian Health Review, Vol 32 No 2, 223-235.

Resources for Cultural competency training include:

- *Healing by Heart Model for Culturally Responsive Care*
- Pratt, H. D. & Apple, R. W. (2007). Cross-Cultural Assessment and Management in PrimaryCare. *Primary Care: Clinics in Office Practice, 34(2), 227-242*. doi: 10.1016/j.pop.2007.04.006
- Anderson, N. L. R., Andrews, M., Bent, K. N., Douglas, M. K., Elhammoumi, C. V., Keenan, C., . . . Mattson, S. (2010). Chapter 5: Culturally based health and illness beliefs and practices across the life span. Journal of Transcultural Nursing, 21(4_suppl), 152S-235S. doi: 10.1177/1043659610381094
- empathy skills, emotional regulation skills and quality improvement initiatives such as decision aid lists
    - Van Ryn, M., Burgess, D. J., Dovidio, J. F., Phelan, S. M., Saha, S., Malat, J., . . . Perry, S.(2011). The impact of racism on clinician cognition, behavior, and clinical decision making. Du Bois Review: Social Science Research on Race, 8(1), 199-218. doi: 10.1017/S1742058X11000191
- identifying microaggresive statements
    - Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A. M. B., Nadal, K. L. & Esquilin, M. (2007). Racial Microaggressions in Everyday Life: Implications for Clinical Practice. American Psychologist, Vol.62(4), 271-286. ISSN: 0003-066X
- Issues from practitioner perspectives
    - Jensen, N. K., Norredam, M., Priebe, S. & Krasnik, A. (2013). How do general practitioners experience providing care to refugees with mental health problems? A qualitative study from Denmark. BMC Family Practice, Vol.14, 1-9. doi: 10.1186/1471-2296-14-17

- commonalities and recommendations for new to country refugees
  - Eckstein, B. (February 15 2011). Primary care for refugees. American family physician, Vol.83(4), 429-436. E-ISSN: 1532-0650
- Hmong backgrounder
  - February 2016). Engaging in Culturally Informed Nursing Care With Hmong Children and Their Families. Journal of Pediatric Nursing, Vol.31(1), 102-106. doi: 10.1016/j.pedn.2015.08.008

Translated materials and resources

- Hmong
  - www.nlm.nih.gov/medlineplus/languages/hmong.html,
  - immunization education handouts at www.immunize.org/handouts/hmong.asp
  - illustrations and health information at hmonghealth.org
  - health videos at ECHO, Bridging the Communications Gap for Immigrants and Refugees in Minnesota
    - text available at www.echominnesota.org/hmn/tools/echo-tv/view-all-shows.

Assessment tools found in:

- Anderson, N. L. R., Andrews, M., Bent, K. N., Douglas, M. K., Elhammoumi, C. V., Keenan, C.,. . . Mattson, S. (2010). Chapter 5: Culturally based health and illness beliefs and practices across the life span. Journal of Transcultural Nursing, 21(4_suppl), 152S-235S. doi: 10.1177/1043659610381094
- Pratt, H. D. & Apple, R. W. (2007). Cross-Cultural Assessment and Management in Primary Care. Primary Care: Clinics in Office Practice, 34(2), 227-242. doi: 10.1016/j.pop.2007.04.006
- ETHNIC
  - Annamalai, A. (2014). Refugee health care : an essential medical guide, New York : Springer Science + Business Media. doi: 10.1007/978-1-4939-0271-2_1

Assessment Tool for Evaluating Cultural Competence in a Health Care Clinic (using The McKinsey 7-S Framework)

Tool for Development and Management Phase:
(for executive board)

		Strategy Assessment Tool	Score	1-Not in Place, 2-Sometimes, 3-Always
Strategy	**1**	Does the organizational strategy ensure inclusion of cultural competency?		
	2	When considering reaching objectives, is cultural competency a part of the discussion?		
	3	Does financial or scheduling constraints tend to relegate cultural competency to a lesser consideration?		(-)
	4	Is the organization ready to address or make changes based on client complaints/demands?		
	5	Is the organizational strategy willing to adjust for changes in the community?		
	6	Does the facility have a clearly defined vision?		
		Total Strategy Raw Score	0	
		Strategy Percentile Score	**0.00%**	

Tool for Development and Management Phase:
(for executive board)

		Structure Assessment Tool	Score	1-Not in Place, 2-Sometimes, 3-Always
Structure	1	Are practitioners able to work in a collaborative manner?		
	2	Does the hierarchy allow doctors to disregard cultural competency?		(-)
	3	Are all staff who interact with the client easily able to collaborate and share information?		
	4	Is there a sense of teamwork and mutual respect amongst staff?		
	5	Is the decision-making structure effective for receiving and addressing minority opinions regarding cultural competency?		
	6	Are avenues for communication clear and effective?		
	7	Do employees have avenues of participation in decision-making?		
	8	Do paths exist for employee success and development?		
	9	Are staff goals made, and are staff evaluated based on those goals?		
	10	Are staff kept well-informed?		
	11	Are staff organized into teams (i.e.-front desk, nurse assistants, providers, specialists and referral staff) or have the ability to operate as a team?		
	12	Does the director exhibit cultural humility?		
	13	Is a culturally relevant advisory board utilized?		
	14	Is collaboration with community leaders and organizations implemented?		
	15	Do staff have the ability to involve family and community members at the request of the client?		
	16	Is the community engaged and educated (pamphlets, flyers, posters, classes)?		
	17	Does the organization support addressing of other needs, as they arise, that affect the client (housing, transportation, food, legal, immigration,..)?		
Physical Structure	18	Are other relevant services (mental health, dental, violence, addiction…) located in close proximity or easily connected to?		
	19	Structurally, are there many different sections, locations or hallways?		

	#	Question	Score
	20	Are there culturally sensitive religious outlets (ie- a prayer room with mats)?	
	21	Are there decorations on the building exterior that are reflective of the cultural community?	
	22	Are there interior colors, decorations, pamphlets and photographs representative of clientele?	
	23	Is there private space available whenever the client is asked to divulge information (consider when written material must be translated out loud)?	
		Total Structure Raw Score	0
		Structure Percetile Score	**0.00%**

Tool for Development and Management Phase:
(for executive board & clinic director)

		Systems Assessment Tool	Score	1-Not in Place, 2-Sometimes, 3-Always
Systems	1	Are there primary systems that could override or diminish the implementation of cultural competency (such as finance and HR systems)?		(-)
	2	Do the controls monitor and evaluate towards cultural competency?		
	3	Do rules and processes in place effectively keep the team on track with cultural competency?		
	4	Does the budget adequately cover costs for staff training in cultural competence?		
	5	Is there adequate time allotted for the provision of culturally competent care for the patient?		
	6	Do files and charts efficiently highlight language barriers and cultural orientations?		
	7	Are there mechanisms by which client loads are monitored and kept at a reasonably effective level?		
	8	Are there mechanisms to set goals for improving services?		
	9	Is effective record keeping employed?		
	10	Are effective financial/ accounting procedures used?		
	11	Are client needs (which language, disability, hearing, literacy…) efficiently identified and addressed in the welcoming area?		
	12	Is there an efficient and secure method of sharing patient data upon legally sufficient release/approval?		
	13	Is there an adequate resource where staff can obtain cultural backgrounders and relevant materials regarding interactions of culture and health care?		
	14	Is the use of a telephone interpreter available?		
	15	Are multiple communication systems (telephone, email, meetings) between providers available?		
	16	Are patient transportation needs addressed?		
	17	Do all parties that interact with clients (including front desk) have an area on the client's file to make notations?		
	18	Does the technology and data systems allow for efficient and effective data retrieval and notation?		
	19	Is the volume of work (patient load) too high?		(-)

	#	Question	Score	
	20	Do staff understand or have access to the pre-migration medical systems refugees and immigrants had access to?		
	21	Does the level of care differ between insurance carrying and other individuals?		(-)
	22	Are wait times long for clients?		(-)
	23	Is the time spent with a physician rushed or abbreviated?		(-)
	24	Are there provisions for intersectionality of blindness, hearing impaired and/or disabled?		
	25	Are materials translated for clientele in their common vernacular?		
	26	Are there tools that are implemented to routinely gauge the satisfaction, met needs and quality received by clients?		
	27	Do clients have the ability to connect and develop trusting relationships with a primary care physician?		
	28	Are operating hours of the clinic available to clients outside of regular business hours (evenings, weekends, 24 hour call line, voice message system,...)?		
	29	Are there same-day and/or 48 hour appointment slots?		
	30	Does the clinic accept a sliding-fee scale of payment?		
	31	Does the clinic accept Medical Assistance?		
	32	Are there alternative methods of recording patient identities (not dependent on immigration status)?		
	33	Is gender taken into consideration for culturally competent matching of client and practitioner(s)?		
	34	Is health education provided for clients?		
	35	Does the staff know who to contact and refer the client to for non-medical crises?		
	36	Are there mechanisms by which practitioners are provided with general information background sheets on population groups?		
	37	Are there mechanisms by which cultural colors, symbols and language for clients are identified and incorporated inside the clinic and in recruitment materials?		
		Total Systems Raw Score	0	
		Systems Percentile Score	**0.00%**	

Tool for Management Phase:
(for clinic director)

		Staff Assessment Tool	Score	1-Not in Place, 2-Sometimes, 3-Always
Staff	1	Are interpreters, who are trained in medical interpretation, readily available for use?		
	2	Are positions purposed for ensuring client-centered care regularly staffed?		
	3	Do hiring practices include criteria of cultural competency, cultural relevance or ability to engage clients in a culturally competent manner?		
	4	Is the leadership culturally representative of the population served?		
	5	Are staff reflective, at every level, of the cultural diversity found in the clientele?		
	6	Does senior leadership propose new projects that are feasible?		
	7	Does leadership provide clear goals for improving patient care?		
	8	Is leadership experienced in working with the culturally diverse population?		
	9	Are there bi-lingual/bi-cultural staff on the team?		
	10	Do the interpreters (or other cultural partners) help address medically relevant issues including: avoiding medical errors, covey respect, talking to the culturally correct person(s), avoid taboos, fulfill legal requirements for interpretation and navigate cultural expectations such as modesty?		
		Total Staff Raw Score	0	
		Staff Percentile Score	**0.00%**	

Tool for Management Phase:
(for clinic director)

		Skills Assessment Tool	Score	1-Not in Place, 2-Sometimes, 3-Always
Skills	1	Does cultural competence rank as a strong skill throughout the company?		
	2	Are there gaps in cultural competence skills in the staff?		(-)
	3	Does the organization have a good reputation in the community for providing relevant services?		
	4	Are practitioners skilled enough to provide client-centered care?		
	5	Are practitioner skills of cultural competence regularly monitored and assessed?		
	6	Are practitioners aware of immigration information (history and trends)?		
	7	Are practitioners aware of psychosocial integration processes for immigrants?		
	8	Are practitioners aware of and comfortable with client use of alternative measures alongside Western prescriptions?		
	9	Do practitioners understand the source of patient resistance and do they have the skills to navigate challenging patient interactions?		
	10	Are practitioners capable of observing nonverbal cues?		
	11	Do practitioners know or have easy access to the medical disparities prevalent in each population they serve?		
	12	Are staff trained in how to engage ELL clients for the first time (relevant language greeting, self-identification, client's name, conveyance of intention...)?		
	13	Are staff cognizant of their biases and potential microaggressions?		
	14	Are staff aware of the effects their microaggressions can have on client outcomes?		
	15	Are staff comfortable working with more than just the individual such as the family or community system?		
	16	Are staff skilled in conveying information in a clear, slow and repeated manner?		
	17	Are practitioners trained in the use of a client-centered approach? (like ETHIC (explanation, treatment, healers, negotiate, intervention & collaboration)		

	#	Question	Score	
	18	Do providers understand essential differences in communication for their client's specific culture (ie- nodding in some cultures means hearing and not affirming)?		
	19	Do providers tend to exhibit ownership of their clients?		(-)
	20	Do providers neglect follow-through in communications with behavioral health?		(-)
	21	Do staff understand or have access to the pre-migration history of refugees and immigrants?		
	22	Can providers teach basic steps to clients such as refilling medicine?		
	23	Can examiners overcome the resistance to admitting problems and pains?		
	24	Are practitioners aware of or utilizing tools to navigate the balance between provider integrity and family's wishes (CHP)		
	25	Are specific population group related screens (Pap screens, breast cancer, stomach cancer, parasites, malaria…) considered and culturally administered?		
	26	Do practitioners understand immigrant issues related around trauma enough to provide gentle, trauma-informed examinations?		
	27	Do practitioners have the ability to recognize trauma related issues as mental health issues?		
	28	For refugees, are all the following common issues considered: psychological issues, nutritional deficiencies, infectious diseases, under-immunization, poor dental and optical health, poorly managed chronic diseases, delayed growth and development of children and physical consequences of torture?		
	29	Do practitioners have the tools to offset personal biases and ensure fair, comprehensive and appropriate examinations?		
		Total Skills Raw Score	0	
		Skills Percentile Score	**0.00%**	

Tool for Practice Phase:

(for clinic director & practitioners)

		Shared-Values Assessment Tool	Score	1-Not in Place, 2-Sometimes, 3-Always
Shared Values	1	Do the core values reflect cultural competence and client centered care?		
	2	Does the clinic culture reflect an openness to diversity and new ideas?		
	3	Are the values that are inclusive to diversity strong in presence?		
	4	Do the fundamental values of the company reflect a commitment to client-centered care in its multitude of forms?		
	5	Is there an atmosphere of cultural learning amongst staff?		
	6	Does the clinic have a learning environment?		
	7	Has the clinic been able to identify core guiding values? (for example- respectful, ethical, inspirational, innovative, patient and family focused)		
	8	Are different kinds of providers located in close proximity to each other?		
	9	Is the vision strong?		
	10	Are there identifiable shared goals?		
	11	Is the team atmosphere positive?		
	12	Is there identifiable homogeneity amongst the clients?		
		Total Shared Values Raw Score	0	
		Shared Values Percentile Score	**0.00%**	

Tool for Evaluation Phase:
(for clients)

		Client-Perspective Assessment Tool	Score	1-Not in Place, 2-Sometimes, 3-Always
Client Perspective	**1**	Does the client feel respected by the staff?		
	2	Does the practitioner(s) display cultural humility?		
	3	Does the client feel listened to?		
	4	Does the client have to repeat their story many times to different staff members?		(-)
	5	Do practitioner(s) have the ability to comfort and connect with the patients?		
	6	Was the clinic easy to find and get to?		
	7	Was the clinic easy to navigate?		
	8	Did the lobby have adequate space for you and your family?		
		Total Client Perspective Raw Score	0	
		Client Perspective Percentile Score	**0.00%**	

Tool for Evaluation Phase:

(for practitioners and clinic director)

		Style Assessment Tool	Score	1-Not in Place, 2-Sometimes, 3-Always
Style	1	Does the management/leadership participate enough to understand challenges for practitioners in delivering culturally competent care?		
	2	Is the leadership effective at addressing and solving challenges to cultural competent care?		
	3	Do employees at the clinic display cooperation and mutual respect?		
	4	Do doctors employ team-informed diagnoses?		
	5	Is the leadership capable of providing supervision and relevant materials to equip practitioners with information in providing culturally competent care?		
	6	Is the leadership able to demonstrate self-awareness and understand power and privilege?		
	7	Does the leadership establish project schedules and deliverables?		
	8	Does the leadership designate a champion for new projects?		
	9	Is leadership capable of providing avenues for raising and reconciling staff-to-staff microaggressions (racial, gender, class)?		
	10	Does leadership use tools (PEDQ, COBRAS, IRRS, SRE...) or otherwise have methods of measuring discrimination amongst staff?		
	11	Does an open atmosphere to discuss issues exist?		
	12	Do staff feel free to ask questions?		
	13	Do staff experienced in cultural navigation serve as role-models for other staff?		
	14	Do staff feel they are learning from the clients?		
	15	Are staff trained in empathy skills?		
	16	Are staff trained in emotion regulation skills?		
	17	Is there a system to assess the need for and acquire visual aids for communication with clients?		
	18	Are there regular weekly meetings that address cultural navigation as one of the topics?		
	19	Is self-care emphasized?		
	20	Are new projects constantly being added?		(-)
	21	Are there annual trainings in cultural competence?		

	22	Are practitioners utilizing tools to gauge their own ethno-centrism? (*Healing by Heart*)	
	23	Does the organization support the time and resources it takes to explain bill payment, prescriptions and treatment adherence?	
		Total Style Raw Score	0
		Style Percentile Score	**0.00%**

Annotated Bibliography

Anderson, L. M., Scrimshaw, S. C., Fullilove, M. T., Fielding, J. E., & Normand, J. (2003). Culturally competent healthcare systems: A systematic review. *American Journal of Preventive Medicine, 24(3), 68-79.* doi: 10.1016/S0749-3797(02)00657-8.

This literature review investigates a case for culturally competent health care to reduce disparities; it states the federal goals put forth by the DHHS publication of Healthy People 2010. Based on these goals, the researchers studied five areas for improving cultural competence: recruitment and retention of culturally competent staff, interpreter/bilingual staff use, training for providers, education materials and healthcare settings. For recruitment and retention of culturally competent staff, workforce diversity should include hiring practices, employee participation and employee success. For interpreter/bilingual staff use, the goal is for the client to understand the nature and purpose of the health care provided. Interpreters that can understand and convey medical terminology across language and culture is important. Family and friends are sometimes utilized. For training for providers, Cultural competency training is designed to 1) enhance self-awareness of attitudes towards diverse people, 2) improve knowledge of cultural beliefs and practices, attitudes towards health care, healthcare-seeking behaviors and burden of various diseases in different population groups, and 3) improve skills such as communication. For education materials and healthcare settings, no review is given and no comparative studies were found.

The article does well to introduce some critical levels of cultural competence in healthcare; however, it acknowledges that it does little to supply sufficient data or outcomes.

Anderson, N. L. R., Andrews, M., Bent, K. N., Douglas, M. K., Elhammoumi, C. V., Keenan, C., . . . Mattson, S. (2010). Chapter 5: Culturally based health and illness beliefs and practices across the life span. *Journal of Transcultural Nursing, 21(4_suppl), 152S-235S.* doi: 10.1177/1043659610381094

This is the fifth chapter from a core curriculum for nursing and health care in a transcultural setting; it is thorough as it covers many areas of culturally based health beliefs and practices. It provides culturally specific information for many specific ethnic groups including: Chinese, Hmong, Islamic, Asian Indians and Asian/Pacific Islanders. As such, it is excellent for training including with the navigation of ethical responsibilities. Culturally understood origins for disease, culturally specific beliefs, views on disabilities and stigmas are covered, and tools for engaging clients are provided. Some tools are provided and include: Kleinman's patient assessment model, a chart of select genetic traits and disorders by ethnic group, a backgrounder for clients of Islamic faith, 35 cultural views on disability, chronic illness and culturally high risk groups are listed and provider guidance for caring for older adults.

Annamalai, A. (2014). *Refugee health care : an essential medical guide*, New York : Springer Science + Business Media. doi: 10.1007/978-1-4939-0271-2_1

Chapters 1 and 2 are part of a larger book that would serve as good training for practitioners who would work with refugees. Chapter 1 gives an overview of who the modern refugee is. It gives the historical context, the global burden, long term

solutions, the US resettlement process and explains how refugees access and do not access the health care system. This basic overview is to create better understanding, empathy and involvement with refugees. Chapter 2 gives an overview of culturally appropriate care for refugees. Disparities for refugees are broken into the operation of health care systems and factors during clinical encounters. Operational barriers include language, fragmentation of the health care system and location of services. Clinical barriers include provider bias, stereotypes and interaction uncertainty. Culturally competent ways of working with refugees are broken down into self-awareness, clinical practice and nonverbal communication. The pros and cons of using an in-person interpreter and a telephone interpreter are discussed as well as how to work with an interpreter. The tool of ETHNIC (explanation, treatment, healers, negotiate, intervention & collaboration) is described as an appropriate form of communication between practitioner and client.

Bruner, P., Davey, M. P., Waite, R. & Blount, A., editor. (2011). Culturally Sensitive Collaborative Care Models: Exploration of a Community-Based Health Center. *Families, Systems, & Health, 29(3), 155-170*. doi: 10.1037/a0025025

This qualitative focus group study of 6 provider groups researched the issues in collaboration between providers and patients from the perspective of different provider groups. Five findings emerged: "(1) facilitators of collaboration, (2) barriers to collaboration", (3) "provider characteristics and collaboration", (4) patient characteristics and collaboration", and (5) family and community involvement." Facilitators of collaboration included: communication systems, provider interactions, patient factors, and physical structural/building issues. Barriers to collaboration included: patient factors, provider interactions, volume of work, and building structural issues. Provider characteristics and collaboration included: patient treatment, demographics, provider overload and provider roles. Patient's Characteristics and Collaboration included: cultural factors and underprivileged status. Family and community involvement included: patient centered, referrals and family as a tool. This study provides significant findings that can help shape the layout, the vision, the training, expected client loads and coordination needs of a health clinic. These aspects can affect the collaboration between providers and between providers and patients in an ultimate effort to provide the best health care to clients and working environment.

Cheng, I., Wahidi, S., Vasi, S. & Samuel, S. (2015). Importance of community engagement in primary health care: the case of Afghan refugees. *Australian Journal of Primary Health, 21, 262-267*.

This article is an expert paper that connects the pre-migration health care experiences of Afghan refugees and their effect on accessing health care in Australia. The study shows specific differences in the two health care systems (pre- and post-migration), and explains some of the challenges Afghan refugees have in accessing health care. Health care delivery in Australia through health clinics differs from the use of community health workers in Afghanistan, and this difference can lead to considerable Afghan disengagement. Disengagement has led to multiple issues: problems engaging with general practice services, lower antenatal care attendance, lower childhood immunization rates, disengagement

from formal mental health services, inappropriate dental presentations, over-reliance on hospital emergency departments and difficulties obtaining and using medications. One proposed solution is community engagement. Primary health care clinics are encouraged to invite key Afghan individuals to participate in existing advisory groups or planning committees. One step further for consideration of diversity within the group would be to establish a separate Afghan community advisory group.

Commission on the Public's Health System. (2010). Culturally competent care: Some examples of what works. Available at: http://www.bronxhealthlink.org/tbhl/education/ culturally_competent_care_some_examp:en-us.pdf. Accessed February 27, 2017.

This Community Based Participatory Research study includes both a survey of client perceptions of problems and solutions in accessing healthcare and a summary of culturally competent best practices from nine culturally competent healthcare clinics in the New York area. The study researched effective cultural and language components in provider settings in a three-part process: survey of community participants, presentation and review with policy committees and development of a checklist from the first two parts to review facilities and interview health care providers. Clients perceived the following barriers: language and socioeconomic, lack of respect for all races, private insurance carriers receiving better care, people treated as a number and not as a person, long wait times and rushed time with doctor and undocumented people only receive care in the Emergency Room. The best practices of nine culturally and linguistically competent health care providers were gathered through qualitative interviews of each site. The study reports aspects of each health center including: knowing the community, language and cultural competence, best practices, weaknesses and access issues.

Culhane-Pera, K. (2003). *Healing by heart : clinical and ethical case stories of Hmong families and Western providers: Chapter 16: A model for culturally responsive health care* (pp. 13-53). Nashville: Vanderbilt University Press.

Chapter 16 of this book provides a comprehensive model for culturally responsive health care. It provides a flow chart for the model, an outline and detailed instructions for application. The Healing by Heart Model includes: "I) awareness of the influence of culture on health status, beliefs, practices, and values, II) increasing self-awareness, III) learning prevailing health beliefs, practices and values of the cultural groups you serve, IV) identifying potential areas of congruity and difference between provider and client, V) increasing self-awareness about your own cross-cultural health care ethics, VI) learning skills to identify, evaluate and respond to cross-cultural ethical conflicts, with special attention to challenges to professional integrity, VII) developing attitudes culturally responsive to the groups served, VIII) learning communication skills culturally responsive to the groups served, and IX) developing skills in applying culturally responsive knowledge, skills, and attitudes to particular clinical relationships." Provided tools include: a comparison of US Health Practitioner and Tradition Hmong Patients, a scale measuring relationships on the continuum from ethno-relative to ethnocentric, a list of possible practitioner objections to patients' or families' treatment wishes, navigating principles to understand

provider integrity vs. families' wishes, specific forms of US vs. Hmong nonverbal communication, instructions on how to work with an interpreter, guidance on how to listen to the patient's responses and perspective and four charts for navigating practitioner integrity vs. patient wish. Chapter 16 is a thorough and thoughtful consideration of the training and tools a practitioner needs to provide culturally competent health care.

De Maesschalck, S., Deveugele, M. & Willems, S. (2011). Language, culture and emotions: Exploring ethnic minority patients' emotional expressions in primary healthcare consultations. *Patient Education and Counseling, Vol.84(3), 406-412*. doi: 10.1016/j.pec.2011.04.021

This study revealed that the reluctance of sharing negative emotions by the patient are more related to lack of language proficiency than culture. When language is a problem, patients will express fewer hints of negative emotions. It describes cues as ways of expression that clients will use. It is thus important to quickly asses the language capacity of a patient. The recommendation is use an interpreter.

DeMeester, R., Lopez, F., Moore, J. Cook, S. & Chin, M. (2016). A Model of Organizational Context and Shared Decision Making: Application to LGBT Racial and Ethnic Minority Patients. *Journal of General Internal Medicine, Vol.31(6), 651-662*. doi: 10.1007/s11606-016-3608-3

This is an article is from a symposium that describes Shared Decision Making (SDM) as a preferred method for delivery care for LGBT racial-ethnic populations. SDM is divided into three steps: discuss, debate and decide. The merits of SDM are discussed, and a model for implementing SBM is clearly laid out through organizational charts, descriptors and examples. Organizational factors like a culture of inclusion and private space throughout the visit can improve SDM and help with those who have faced stigma and discrimination. The SDM model contains six drivers: workflows, health information technology, organizational structure and culture, resources and clinic environment, training and education, and incentives and disincentives. These drivers work through four mechanisms to impact care: continuity and coordination, the ease of SDM, knowledge and skills, and attitudes and beliefs. SDM might benefit populations, like racial/ethnic LGBT patients, in creating a safe environment, increasing trust, and decreasing stigma.

Eckstein, B. (February 15 2011). Primary care for refugees. *American family physician, Vol.83(4), 429-436*. E-ISSN: 1532-0650

Eckstein reviews the commonalities in medical issues that arise across newly arrived refugee populations. In several helpful charts, Eckstein describes the medical information that comes with a refugee client from their overseas medical exam that include: the components of initial overseas exams for refugees, common presenting health problems and conditions found among refugee patients, recommended infectious disease screenings and tests and CDC-mandatory immunizations by age. Eckstein makes a few recommendations for practice: address resettlement challenges for clients, refugees presenting with abdominal symptoms, hematuria or failure to thrive, should be assessed for parasites and refugees from malaria-endemic areas with symptoms, should be evaluated for malaria and federal dollars requires the provision of language

translation services. This article generalizes refugee health care needs and challenges and hopes to help practitioners with a guide to common issues when caring for refugees.

Guruge, S., Hunter, J., Barker, K., Mcnally, M. J. & Magalhães, L. (February 2010). Immigrant women's experiences of receiving care in a mobile health clinic. *Journal of Advanced Nursing, 66(2), 350-359*. doi: 10.1111/j.1365-2648.2009.05182.x

This study focuses on barriers to health care for immigrant women who used a mobile health clinic for their reproductive health care. The mobile health clinic is studied as an alternative way to address disparities for immigrant women; it was perceived as helping to overcome post migration barriers by providing accessible, holistic, and linguistically and culturally appropriate care. Reasons for lower rates of Pap screens and breast cancer screening are given. Factors cited for reduced Pap screening among immigrant women include embarrassment, fear of pain and lack of time, lack of employment benefits, lack of knowledge and understanding of the procedure, lack of social support for screening, and self-perceived lack of need. Barriers to breast cancer screening cited include language differences, cultural belief differences, low socio-economic status, lack of referral from a doctor, modesty or embarrassment on the part of the clients, and modesty or embarrassment on the part of the physicians. Screening for cervical and breast cancer and early detection can lead to a decrease in morbidity and mortality rates. Client participants defined health broadly including physical, mental, social, and spiritual components, and perceived health to be a life priority. Based on such an understanding, they expected holistic care from their providers. Alternative care delivery models, such as mobile health clinics, must be considered to improve access to reproductive health care to immigrant women who may be at a disadvantage because of their socio-economic, cultural, and racialized statuses in post-migration contexts. Health-care professionals interested in improving care to immigrant women must attend to the women's individual care needs, which are shaped by their individual pre- and post-migration situations and experiences, and the meanings assigned to them by the individual woman and her family.

Jensen, N. K., Norredam, M., Priebe, S. & Krasnik, A. (2013). How do general practitioners experience providing care to refugees with mental health problems? A qualitative study from Denmark. *BMC Family Practice, Vol.14, 1-9*. doi**:** 10.1186/1471-2296-14-17

This is a qualitative study of practitioners regarding their work with and provision of quality care for refugees with mental health issues. The main findings were in the areas of communication, quality of care, referral pathways and expectations and understanding of disease. In communication, general practitioners (GP) prefer to use professional interpreters and communication involves more than sharing a common language. For quality of care, the GP showed limited awareness of past trauma among refugee patients, may feel reluctant to initiate certain types of treatment due to language barriers in refugee patients, and may feel powerless in the treatment of refugee patients. In referral pathways, the GP may refer refugee patients to specialized treatment centers for traumatized refugees. In expectations and understanding of disease, the refugee patients may lack an understanding of the connection between psychological problems and physical symptoms, and the refugee patient may exhibit different expectations of

treatment. This study revealed that general practitioners use very different strategies in providing care for refugee patients. The findings suggest that there is an increased need for the GP to be aware of potential traumas experienced by refugee patients, but also leave room for taking individual differences into account in the consultation. This study was part of a larger EU project on Best Practices in Access, Quality and Appropriateness of Health Services for Immigrants in Europe (EUGATE).

Johnson, D. R., Ziersch, A. M. & Burgess, T. (2008). I don't think general practice should be the front line: Experiences of general practitioners working with refugees in South Australia. *Australia and New Zealand Health Policy, 5:20, 1-11*. Doi: 10.1186/1743-8462-5-20

This is an informative qualitative study with semi-structured interviews of twelve General Practitioners (GPs) providing care to refugees. Challenges for GPs include: knowledge of previous health history, cultural conditions, experience to manage cultural conditions, burden of additional guidelines and time consumption of extra practices including explaining Western medical practices. GPs reported some helpful aides would include background information sheets about refugee groups or talks explaining the group and their medical conditions and beliefs. This study is helpful for understanding the challenges to a GP for implementing cultural competency and quality health care for refugee patients.

Kue, J., Thorburn, S., & Keon, K. L. (2015). Research challenges and lessons learned from conducting community-based research with the Hmong community. *Health Promotion Practice*, *16(3), 411-418*. doi: 10.1177/1524839914561515.

This study is primarily about the challenges related to Community Based Participatory Research (CBPR) in the Hmong community and recommends using a cultural insider for navigating the investigative work. The study's review of literature revealed health disparities in the Hmong population included the lowest rates of survival from liver cancer compared to any other Asian group and possibly stemmed from Hmong women not having autonomy to make their own cancer screening decisions and Hmong beliefs of the spiritual etiology of cancer and a fatalistic attitude towards cancer. Effective research in the community was vitally linked to having a member of the community involved, partnering with an existing local community based center, using an interpreter and establishing training protocols for interviewers. Cultural sensitivity was attempted by utilizing Hmong text in recruitment materials, cultural colors and symbols and bilingual staff.

Milosevic, D., Cheng, I.-H. & Smith, M. M. (March 2012). The NSW Refugee Health Service – improving refugee access to primary care. *Australian family physician, 41(3), 147-9*. ISSN: 0300-8495.

The article addresses issues encountered with refugees in primary care. It lists commonly identified health needs refugees face including: "psychological issues, nutritional deficiencies, infectious diseases, under-immunization, poor dental and optical health, poorly managed chronic diseases, delayed growth and development of children and physical consequences of torture." Patient barriers for addressing health needs include: "lack of familiarity with how the health system operates, language barriers, mistrust or anxiety and financial constraints." For providers, trauma informed practice is emphasized as is the caution to not over-medicalize.

This means having a sensitive and gentle physical examination and the understanding that psychological distress often presents as physical symptoms. Other recommendations include: how to work with medical interpreters, understanding what codes apply for insurance reimbursement and working with social service workers. Providing primary care services to refugees requires that providers understand the common issues involved with care for that population.

Noe, T. D., Kaufman, C. E., Kaufmann, L. J., Brooks, E. & Shore, J. H. (September 2014). Providing culturally competent services for American Indian and Alaska Native veterans to reduce health care disparities. *American journal of public health, 104 Suppl 4, S548-54.* doi: 10.2105/AJPH.2014.302140.

This article focuses on cultural competent services for American Indian and Alaska Native veterans and has generalizable application. It recommends tailoring health care towards each specific cultural population. Key components to delivering culturally competent care includes: "respect for the patient, clear communication, shared decision-making, and building strong doctor-patient relationships." In patient-centered care, key considerations may include: "incorporation of traditional healing practices", culturally specific medication and attention to mind, body and spirit in the treatment of trauma disorders.

VA facilities that were perceived by clients to meet needs implemented organizational change models that focused on mission defined needs, feasible staff goals and robust communication with staff. This article is helpful for management of a health care facility as it describes best practices that contributed towards organizational change and effectiveness in cultural competence.

Peterson, P., Sackey, D., Kay, M., Nicholson, C. & Correa-Velez, I. (May 2016). Innovations in connecting with vulnerable communities around health. *16th International Conference on Integrated Care, Barcelona, 23-25*

This article is only available as a conference abstract. It thusly does not provide much for the project.

Pratt, H. D. & Apple, R. W. (2007). Cross-Cultural Assessment and Management in Primary Care. *Primary Care: Clinics in Office Practice, 34(2), 227-242*. doi: 10.1016/j.pop.2007.04.006

This article provides a good overview of cultural competence. It provides definitions and explanation of words and concepts relevant to cross-cultural assessment and management including: ethnicity, ethnocentric, Eurocentric, culture, culture of the patient, culture of the patient, role of physician bias and stereotype, multicultural, cross-cultural, awareness, knowledge, skills, techniques and culturally specific techniques. Provided tools for cross-cultural assessment include: "Additional resources for increasing cross-cultural competence", a generalized Western vs. Non-Western beliefs chart, "Factors that influence care-seeking behavior", biomedical techniques compared with non-biomedical techniques and a list of potential items to consider in a cross-cultural collaboration between provider and patient.

The article is a bit too generalized and dated, but it can be a good introductory session and some basic training to providers.

Purnell, L. D., *Guide to culturally competent health care: Third edition* (2014). Philadelphia: F.A. Davis Company. ISBN: 0803641184

This book provides a guide to providing culturally competent health care. Chapter 1 discusses cultural competency and lists some areas where cultures can have characteristic variations, and cultural competence is defined. Chapter 2 describes the Purnell Model; this model lists some medically relevant categories and lists variations people could have in their beliefs and assumptions in such areas. Questionnaire tools derived from this model are provided. Chapter 3 describes barriers to culturally competent health care. The rest of the chapters provide historical and cultural backgrounder information as well as clearly labeled suggestions of interaction for providers. In addition, specific high-risk categories and culturally specific health practices are described. Chapters giving backgrounder and suggestions include the following heritages: African American, American Indian, Amish, Appalachian, Chinese, Cuban, European, Filipino, German, Guatemalan, Haitian, Hindu, Hmong, Iranian, Japanese, Jewish, Korean, Mexican, Polish, Puerto Rican, Russian, Somali, Thai, Turkish and Vietnamese. Chapter 17 gives an overview of Hmong Heritage, common communication assumptions and differences, description of family roles and organization, workforce issues, biocultural ecology including common health conditions, high-risk health behaviors, nutrition, pregnancy and childbearing practices, death rituals, spirituality, health-care practices and traditional health-care providers. Purnell's book is helpful for preparing to work with and navigating interactions with culturally diverse clients.

Ramsey County, Statewide Health Improvement Program. Culturally informed clinical practices for healthy Hmong lifestyles. (2015). Available at: https://www.ramseycounty.us /sites/default/files/Health%20and%20Medical/Public%20Health%20Initiatives/Culturally %20Informed%20Clinical%20Practices.pdf. Accessed February 27, 2017.

This publication presents culturally appropriate best practices for clinical staff to promote health lifestyles for Hmong in Minnesota. It provides data, historical and cultural context, information about existing programs and recommendations for clinicians around the topic of Hmong health specifically for: healthy weight, nutrition, physical activity and tobacco use. The nature of the research behind the publication is not disclosed, but it does provide helpful advice for clinicians and recommendations relevant for staff training and organizational considerations. Helpful recommendations include: the use of multi-disciplinary teams from front desk to specialist, use of health education materials for the community, use of Healing by Heart Model and many online resources, videos, handouts and books for Hmong cultural background. Ramsey County provides a good resource for understanding Hmong culture, how to increase cultural competency in working with Hmong people and practical suggestions for clinicians and organizations engaging Hmong clientele.

Renzaho, A. (May 2008). Re-visioning cultural competence in community health services in Victoria. *Australian Health Review, Vol 32 No 2, 223-235*.

This study is part of a larger Victoria-wide study, and it outlines a model focusing on cultural consultation and the needs of Culturally and Linguistically Diverse (CALD) patients. The study posits that "one approach fits all" models have led to little collaboration, duplication of services, poor referrals, incomplete assessment of needs, poor compliance with medical treatment, underutilization of available

services and poor continuity of care. Understanding the needs of CALD patients can be aided by various informational tools including: migrant needs from provider perspectives, pressing needs from migrant perspectives, major reasons of health service underutilization, levels of barriers to interpreter usage and a conceptual organizational framework for working with CALD communities. The hope of this study is to maximize service delivery and reduce duplication for CALD communities by outlining a culturally consultative model and emphasizing a needs-led rather than service-led set of programs.

Rorie, S. (February 2015). Using medical interpreters to provide culturally competent care. *AORN Journal, 101(2), P7-P9*. doi**:** 10.1016/S0001-2092(14)01420-3.

This article emphasizes the need for using culturally competent medically trained interpreters to avoid misdiagnosis and cultural mistakes. The National Board of Certification for Medical Interpreters certifies interpreters. When communicating with limited English proficiency (LEP) individuals, medical interpreters help offset the high rates of misdiagnosis and help patients understand the risks and make informed decisions. For health centers and practitioners, the interpreters help avoid medical errors, convey respect, talk to the culturally correct person(s), avoid taboos, fulfill certain legal requirements for interpretation, and navigate cultural expectations such as modesty.

Shapiro, J., Hollingshead, J. & Morrison, E. H. (August 2002). Primary care resident, faculty, and patient views of barriers to cultural competence, and the skills needed to overcome them. *Medical Education, Vol.36(8), 749-759*. doi: 10.1046/j.1365-2923.2002.01270.x

This focus group study explores resident, faculty and patient attitudes and beliefs about barriers to cultural competent communication and the skills needed to achieve cultural competence. Providers (separated into residents and faculty) believe that 3 barriers are primary: time constraints, interpretation, and patient shortcomings (passivity, demanding, expecting doctor to know all, non-compliance). Provider skepticism is also listed among some of the perceived barriers from all groups (providers and patients). Regarding communication, residents were skeptical about cross-cultural curricula and especially self-awareness exercises. Instead, residents and faculty mentioned role-modeling, perhaps from bi-cultural staff, as the best way to convey cross-cultural skills. Residents also thought videotaping interactions with patients and providing feedback would be useful (this would require client consent). Faculty were more enthusiastic about lectures and coursework format. Regarding organizational culture, person-blame models were common. Residents often criticized and blamed interpreters and client attitudes, patients blamed doctors and faculty held both residents and patients accountable. A consolidation of approaches for overcoming communication barriers include: language and interpreters, experience and time with the patient, cultural knowledge, communication skills, treating patient as person, conveying global attitudes of decency and continuity of care.

Smalkoski, K., Herther, N., Xiong, Z., Ritsema, K., Vang, R. & Zheng, R. (2012). Health Disparities Research in the Hmong American Community: Implications for Practice and Policy. *Hmong Studies Journal, Vol.13(2), 1-31*. ISSN: 15533972

This is a comprehensive literature review of the disparities surrounding Hmong American access to health care. Three monographs of Hmong health cultural practices and beliefs are highlighted: *Hmong American concepts of health, healing, and conventional medicine* by Dia Cha (2003), *Healing by heart: Clinical and ethical case stories of Hmong families and Western providers* edited by Kathleen A. Culhane-Pera et al. (2003) and *Bamboo among the oaks* by Mai Neng Moua (2002). This research on the health disparities within the Hmong population is critical for understanding issues and addressing disparities. Included is a chart summarizing studies regarding health disparities, from 1990 to 2012, and it exposes a void in data that is problematic and requires more attention.

Sobel, L. L & Metzler Sawin, E. (2016). Guiding the Process of Culturally Competent Care With Hispanic Patients. *Journal of Transcultural Nursing, Vol.27(3), 226-232*. doi: 10.1177/1043659614558452

This is a qualitative focus group study that describes connectedness between nurse and Hispanic client as the determiner of cultural competent care. Under the category of "up to you", patients felt empowered and a stronger sense of connectedness. Under the category "at the mercy of the system", patients felt vulnerable and powerless with negative influences on connectedness. Core themes to connectedness included the power of language, cultural awareness and kindness and good treatment. Included in the study are nursing actions that establish connectedness as identified by participants. Culturally well-informed nurse-patient interactions help create an environment in which nurses can work collaboratively with patients to best meet their needs.

This study is useful for providing training material and a reference list on the provider-client interaction.

Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A. M. B., Nadal, K. L. & Esquilin, M. (2007). Racial Microaggressions in Everyday Life: Implications for Clinical Practice. *American Psychologist, Vol.62(4), 271-286*. ISSN: 0003-066X

This article focuses on the modern forms of racism known as microaggressions and their cumulative effect on potential patients. Foundational to cultural competency is the self-awareness of a practitioner and subsequent awareness of worldviews of culturally diverse clients. Consequences of offending the client can result in less self-disclosure and failure to return for schedules. Racial microaggressions are the modern form of racism, and the practitioner can display various forms of these microaggressions to the detriment of the client. Forms of microaggression include microassault and microinvalidation. Nine categories of microaggressions include: alien in one's own land, ascription of intelligence, color blindness, criminality/ assumption of criminal status, denial of individual racism, myth of meritocracy, pathologizing cultural values/communication styles, second-class status and environmental invalidation. Because microaggressions are often unintentional, White American perceptions and minority perceptions regarding the same incident, personal complicity and degree of harm differ widely. Research shows the effects can be devastating, create greater harm than overt forms of racism and result in diminished mortality, increased morbidity and reduced confidence. Asian Americans are prone to be victims of microinvalidations with themes that revolve around 'alien in one's own land.'

Recommended tools for measuring race-related stress and discrimination include: Perceived Ethnic Discrimination Questionnaire (PEDQ), Color-Blind Racial Attitude Scale (COBRAS), Index of Race Related Stress (IRRS) and Schedule of Racist Events (SRE). Microaggressions should be addressed for the sake of a strong therapeutic alliance, and the willingness to discuss racial matters is of central importance towards creating a strong therapeutic alliance. Also included are helpful charts that show types of microaggresive statements and the effects they might have on a client. Effective tools for assessing racial microaggressions or if it is intentional or unintentional are needed and merit additional research. This would be a helpful addition to foundational level training in cultural competency.

Taylor, S. P., Nicolle, C. & Maguire, M. (April 3, 2013). Cross-cultural communication barriers in health care. (Art & Science) (Report). *Nursing Standard, Vol.27(31), 35-44*. ISSN: 0029-6570

This is a qualitative study of semi-structured interviews of practitioners in the UK. Some of the questions to the practitioners are included (p.36). The barriers to communication with patients include: language barriers, low literacy and anxiety, lack of understanding, general attitudes and beliefs and retention of information. The time involved for working with linguistically and culturally diverse populations affected the workflow, and heavy workloads reduced the level of quality care. Suggestions are scattered throughout the discussion including: understand that practitioner's individualistic approach is sometimes different from the patient's collective stance, utilize a strategy of limiting and repeating information, use visual communication aids, promote English, use efficient electronic patient data that can be shared upon staff approval and patient forms with appointment letters and identify when patients have a language barrier.

Thomas, C. A. & Lee, B. (2010). Language liaisons Language planning leadership in health care. *Language Problems & Language Planning, 34, 2, 95-119*. ISSN: 0272-2690

This case study reviews language planning from a leadership perspective as the Children's Medical Center of Dallas recognizes patient linguistic needs, develops its workforce and creates a language program. Language Management Theory (LMT) is described as a strategy for managing multiple languages in an organization. In Dallas, the board of trustees developed a list of identified values that each represented a complex set of behaviors (respectful, ethical, inspirational, innovative, patient and family focused). The development of a language program that trains staff, not a doctor or nurse or professional interpreter, to gain bilingual skills is described as a language liaison program. Bilingual staff can master a smaller set of medical terminology that includes: culture and medicine, legal and ethical issues related to interpreting, anatomy and physiology, diseases and conditions, tests and treatments, the use of formal language in the culture and still provide safe interpretation. This program alleviated the workload burden of many professionals working in the hospital as interpreters. 150 trained bilingual staff spent 30% of their time providing medical interpreter services saving the hospital $1.6 M. The program additionally created a community of professionals that resourced each other and served as a resource for practitioner trainings. The article also lists the medical and legal risks of using untrained bilingual staff as

opposed to medical interpreters. Quality of services to linguistically diverse populations is enhanced through organizational planning around language. At the time of this article, there were no standards for medical interpreters.

Van Ryn, M., Burgess, D. J., Dovidio, J. F., Phelan, S. M., Saha, S., Malat, J., . . . Perry, S. (2011). The impact of racism on clinician cognition, behavior, and clinical decision making. *Du Bois Review: Social Science Research on Race, 8(1), 199-218*. doi: 10.1017/S1742058X11000191

This is an inter-disciplinary narrative report on previous literature. It describes the effects of biases on the cognitive functioning of the clinician and the potential reactionary implications to conveyed stereotypes for the patient. Clinician biases affect beliefs and expectations of patients, interpretation of signs and symptoms, diagnostic steps, interpretation of findings and referral and treatment recommendations. For clients, the threat of stereotypes diminishes information processing and treatment adherence, impairs communication, increases dismissing clinician recommendations, and clinic avoidance. Testing for explicit biases is reportedly achievable through sociopolitical orientation tools like Social Dominance Orientation (SDO) and Medical Authoritarianism (MA), an offshoot of Right Wing Authoritarianism (RWA). The article makes recommendations with examples of how to create an "Identity Safe" clinical environment. Some management-level recommendations are given including: establish ongoing procedures for monitoring and assessing equity in care, reduce stressors that increase clinician's cognitive load, improve organizational racial climate, ensure racial diversity at all levels of organizational hierarchy and promote intergroup contact, mandate appropriate and effective training programs and hold clinicians and staff accountable for skills and knowledge, carefully implement quality improvement initiatives, decision aids and reminder systems and partner with grant agencies to test creative innovative strategies. Training aspects included in this article are: empathy skills, emotional regulation skills and quality improvement initiatives such as decision aid lists; a list of some recommendations is provided.

Xiong, S., Degroote, N., Byington, H., Harder, J., Kaminski, K. & Haglund, K. (January-February 2016). Engaging in Culturally Informed Nursing Care With Hmong Children and Their Families. *Journal of Pediatric Nursing, Vol.31(1), 102-106*. doi: 10.1016/j.pedn.2015.08.008

This is a very informative article that can serve as a cultural backgrounder for serving Hmong clients. It is useful for training and handing out to nurses and doctors. The article covers Hmong history, Hmong societal structures, cultural influences on provider interactions and strategies to facilitate care. Hmong history includes a brief connection to Southern China, US military relationships and major US cities with Hmong populations. Hmong social structures include basic information on patriarchy, clan structure, shaman roles, decision making, family structure, polygamy, demographic averages, animism, spirits, balance of between body and spirit, Khi tes, herbalists, natural treatments, wholeness of body and absence of sense of chronic illness. Cultural influences on provider interactions touches on the meaning of 'yes' or nodding, systemic skepticism and resistance to treatment for the unseen such as immunizations. Strategies to

facilitate provision of care include routine explanations by nurses, conveyance of respect through nonverbal communication, speaking with children and parents separately, collaboration with the shaman, translation provision, translated materials, tempered emotions and allowing adequate time to achieve thorough culturally competent and medical understanding. Highlights to consider from this article include: the extended time that may be required to be culturally competent, nodding simply means hearing and not affirming, conveying respect is essential, building trust may mean working with the local shaman, and cultural values can affect acceptance of immunizations and adherence to medicine. This article provides resources for translated materials that can be used in the clinical practice including: www.nlm.nih.gov/medlineplus/languages/hmong.html, immunization education handouts at www.immunize.org/handouts/hmong.asp, illustrations and health information at hmonghealth.org, and health videos at ECHO and Bridging the Communications Gap for Immigrants and Refugees in Minnesota with text available at www.echominnesota.org/hmn/tools/echo-tv/view-all-shows.