Minnesota Senior Health Options
Clinical Integration and
Care Management Forum

Fifth in a Series

Serving the MSHO Client at Home: Fostering Culturally Competent Care

May 18, 1998

Developed by the National Chronic Care Consortium in cooperation with
the Department of Human Services, Minnesota Senior Health Options Project
under a grant from The Robert Wood Johnson Foundation.

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Welcome and Introductions

Speakers

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Director of the Minnesota Senior Health Options (MSHO) Project

Vickie Wright, PHN
Hennepin County
Coordinated Home Services

Margaret Jumbe, PHN
Hennepin County
Coordinated Home Services

Stella Kwong-Wirth
Asian Health Specialist
Visiting Nurse Service of New York

Pam Parker, Director of the Minnesota Senior Health Options (MSHO) Project, welcomed all attendees to the program, which is the fifth in a series designed to address clinical integration and care management issues for health plans, counties, care systems and providers participating in MSHO.

The National Chronic Care Consortium (NCCC) develops these forums as part of its role in providing the MSHO Technical and Educational Assistance Program (TEAP). Supported by a grant from The Robert Wood Johnson Foundation, TEAP activities include clinical integration/ care management sessions, such as today's educational forum; an annual one-day educational forum; a series of resource documents on issues that arise from the MSHO project; and informational resources on topics of interest to key MSHO contacts.

Pam Parker explained that combining the Medicare and Medical Assistance funding streams provides MSHO health plans and care systems with the necessary flexibility and the right incentives to better integrate care for the dually eligible enrollees. However, it is up to the plans and providers to take action to improve care management and clinical integration. These forums present an opportunity to "keep an eye on the ball" and to share insights and lessons learned in the process of serving MSHO clients under this innovative demonstration.

The topic of today's clinical forum, "Serving the MSHO Client at Home: Fostering Culturally Competent Care," was recommended by MSHO health plans in response to the unexpected cultural and ethnic diversity of MSHO enrollment. African-Americans, Southeast Asians, Russian Jews, and other groups are represented among the 2400 dually-eligible individuals served by MSHO. Participating health plans have historically served a diverse population enrolled in the Prepaid Medical Assistance Program. However, the health plans' contractual responsibility for arranging and paying for long-term care as well as home and community-based services has presented challenges in light of cultural and language differences found among MSHO enrollees. Case managers who are employed or contracted by the health plans to

What is Cultural Competence?

Cultural Competence in healthcare is defined as the ability of individuals and systems to respond respectfully and effectively to people of all cultures, in a manner that affirms the worth and preserves the dignity of individuals, families, and communities. Cultural competence is important in every aspect of our public lives, but it is a critical skill for healthcare providers, who deal daily with diverse people in life-and-death situations.

The culturally competent provider:

- has the knowledge to make an accurate health assessment, one which takes into consideration a patient's background and culture;
- has the ability to convey that assessment to the patient, to recognize culture-based beliefs about health, and to devise treatment plans which respect those beliefs; and
- is willing to incorporate models of health and healthcare delivery from a variety of cultures into the biomedical framework.

To be culturally competent, a provider should acknowledge culture's profound effect on health outcomes and should be willing to learn more about this powerful interaction.

Recommendations from *Six Steps Toward Cultural Competence: How to Meet the Health Care Needs of Immigrants and Refugees*, edited by Patricia Ohmens, Health Advocates, August 1996. This report contains recommendations from the Minnesota Public Health Association's Immigrant Health Task Force chaired by Carol Berg. Free copies are available from the Minnesota Department of Health/ Refugee Health Program (612-623-5693). A packet of supplementary resources may be ordered for $7.50 from the Center for Cross-Cultural Health, Minneapolis (612-624-4668).

conduct in-home screenings, develop appropriate care plans, and monitor needed services must be able to understand different cultural backgrounds, work effectively with interpreters, and ascertain client and family preferences as well as locate and evaluate culturally competent services that are delivered in the privacy and intimacy of the home.

Today's program includes several MSHO client case study presentations, which illustrate the challenges associated with serving a culturally diverse, low-income, frail elderly population and which highlight practical approaches and lessons learned.

Ms. Parker briefly introduced the two case study presenters, Vickie Wright and Margaret Jumbe, and the keynote speaker, Stella Kwong-Wirth.

Vickie Wright, PHN

Ms. Wright graduated from the University of Minnesota School of Nursing in 1974 with a Bachelor of Science in nursing and a public health nursing certification. In 1995 she received her certification in gerontology. Ms. Wright has worked as a charge nurse in neurology at the University of Minnesota Hospital and in public health nursing at Ramsey County and the Minneapolis Public Health Department. She also has served as a nurse manager at two Twin Cities nursing homes. At the Wilder Foundation Ms. Wright directed the Dementia Specific Adult Day Care Program. She is currently a case manager with Hennepin County Coordinated Home Services.

Margaret Jumbe, PHN

Ms. Jumbe earned a Bachelor of Science degree in nursing from the University of Minnesota and a Master's degree from the University of Wisconsin, Madison. Her professional experience in the field of nursing is broad and reflects her interest in cross cultural health. Earlier in her career, Ms. Jumbe worked in medical-surgical nursing, rehabilitation nursing, and orthopedics, where she was a supervisor. As a Peace Corps volunteer, Ms. Jumbe served as a public health nurse for several years in the African country of Malawi and, following her marriage there, she taught nursing students. In 1991, she returned to Minnesota with her family and joined the nursing faculty at a local community college. For the past six years, Ms. Jumbe has worked as a public health nurse and case manager for Hennepin County Coordinated Home Services.

Stella Kwong-Wirth

Ms. Kwong-Wirth's professional experience includes multicultural health, social services, patient advocacy, and healthcare administration in acute care, ambulatory care, and home care settings. Since 1996, she has served as the Asian Health Specialist for the Visiting Nurse Service (VNS) of New York, the nation's largest home care agency, located in New York City. Prior to joining VNSNY, she worked as the Assistant Executive Director of the Chinatown Health Clinic where she managed the day-to-day operations of a community health center in the heart of New York's Chinatown. Ms. Kwong-Wirth served as a Senior Patient Representative and then the Assistant Director of the Admitting Department at Beth Israel Medical Center. She spent her early career at New York Infirmary/Beekman Downtown Hospital where she provided social services and later directed the Patient Advocate Program. Ms. Kwong-Wirth earned a Masters of Public Administration and a Bachelor of Arts in Sociology at New York University where she has also done graduate work in the School of Social Work.

MSHO Client Case Studies

Vickie Wright, PHN, Hennepin County Coordinated Home Care, described the course of events, decisions, and health outcomes of a frail, community-dwelling MSHO client.

Case Study #1

My client is an 86 year-old African-American woman from a large family who recently moved to the Twin Cities from the south. Following a hysterectomy, she was admitted to a local nursing home for recuperation. However, she left the nursing facility prematurely against medical advice and moved in with her daughter and son-in-law who worked different shifts. My client lived in an upstairs bedroom. Her family expected her to cook, to care for herself, and to pay rent. Weakness, congestive heart failure, hypertension, poor vision, and edema were among the health conditions that I noted. My client failed to make over half of her medical appointments, and she did not receive the help she needed from her family to take her medicine on a regular basis. She used home remedies to treat her skin problems. She did not care for the food served by Meals on Wheels. I tried to set up home care but, over time, two different agencies withdrew from the case. It was evident that my client, her daughter, and her son-in-law had difficulty trusting people outside their family, especially professionals. Communication was a problem.

At her six-month Alternative Care Grant evaluation, my client was determined to be eligible for Medical Assistance, and she and her family decided that MSHO would be the most appropriate option for her. My client selected her son-in-law to be her personal care attendant (PCA), and he completed the necessary training for this role. At the following six-month evaluation, I found that her edema had decreased, her medications were being properly set up by her son-in-law, and she had met over half of her doctor appointments. Clearly her care management situation had improved, resulting in some improvements in her health condition and quality of life.

Issues Discussed

- MSHO clients from communities of color and refugee groups generally prefer to have family caregivers take care of them. In turn, family caregivers require the knowledge and training to effectively take care of frail, at-risk elderly relatives. Unfortunately, this training is not readily available from home health agencies. This is a critical unmet need in our community.

- Many MSHO clients from communities of color and refugee populations are not accustomed to interacting with professionals, particularly in their home environment, and may feel uncomfortable stating their preferences or declining services. Case managers can be instrumental in building a trust relationship in which clients feel safe enough to share their preferences for care and to reject services they do not want.

- The presence of multiple case managers is confusing to our clients, particularly those with cultural and language differences. Specifically, it is difficult for MSHO clients and their families to understand the respective roles of the county case manager and the MSHO case manager. There may be a home care case manager assigned to the case as well. While there are "system" reasons for this layered responsibility, it leads to confusion and greater communication demands on the part of the client and family caregivers.

Margaret Jumbe presented two MSHO case studies featuring Vietnamese clients and shared her insights and lessons learned relative to meeting the needs of clients with cultural and language differences.

Prior to leaving my office for a home visit to a Southeast Asian client, I always find out what language the client speaks. It is important to note that this may be a different language than the family member who answers the telephone speaks. I arrange for a family member to be present during the home visit. I also determine whether an interpreter may be needed and who is the most appropriate interpreter. As an example, it is not appropriate to bring a Chinese-American interpreter to the home of a Vietnamese client.

In order to serve a diverse client base effectively, it is critically important for us first to understand ourselves and to recognize our own values, belief systems, and biases. We healthcare professionals tend to bring our own middle class expectations, assumptions, and frame of reference to our work. When we begin to work with low-income, culturally diverse clients, these attitudes may distort what we see.

When it comes to screening instruments, I have found that the best tools are my own eyes and ears. I learn more from skilled observation and attentive listening than from any standardized questionnaire. I begin by asking my clients to tell me their stories—their histories up through their present life. I ask them to tell me about their health problems, their diet, and the healers and traditional therapies they may be using. As they share their personal histories, I am able to note the answers to the questions that appear in our preadmission screening form.

Case Studies #2 and #3

I would like to tell you about two of my clients, both Vietnamese women. One client, in her eighties, resided in a northern suburb with her son and did not speak English. She could neither manage her medications nor navigate stairs. The other woman, in her seventies, lived alone in a high-rise ten blocks from her family. She could neither speak English nor read or write in her own language. Her husband had died three months ago and she had been recently hospitalized for a myocardial infarction.

Accompanied by an interpreter arranged for by the health plan, I visited the first client and her son. It became readily apparent that the client understood English because she would reply in Vietnamese before the interpreter translated my comment and questions. The son and the interpreter then became competing interpreters for her, and each added his own stories to the interview. I had to attempt to keep track of and sort out the different interpretations and personal accounts.

I discovered that the client could not read her medication labels. However, if you expect and help your clients to be independent, they often can be. We worked together on a care plan. The son and his wife wanted to provide all of the client's care, without any pay. However, do not expect families to serve as unpaid caregivers in all cases.

The client who lived alone was diagnosed with dementia. A closer examination of the incidents which gave rise to this diagnosis led to a different and more accurate assessment. In reality, she was situationally confused. For example, she could not use her EBS card issued by the county to purchase groceries in the store because she was illiterate. She could not find her way home from the store because she left by a different exit and became temporarily disoriented.

Issues Discussed

- Show respect. For example, if you notice a row of shoes by the front door, remove your shoes before entering the home. Observe the order in which family members sit down and speak.

- Recognize the many stresses on immigrant families and understand how they affect your clients' health. Examples include tragic personal histories, citizenship demands, and loss of the next generation to cultural assimilation. Grief, fear, mourning, depression, and post-traumatic stress are prevalent among Southeast Asian elderly.

- We need resources for training family members to be competent caregivers, and we need to find methods of culturally appropriate care supervision.

- Interpreters must accurately translate the client's comments. In the context of their role as interpreters, it is not appropriate for them to modify the client's response, inject their own opinions, or relay their own experiences.

- Each of us has our own story which shapes our identity, colors our perceptions of others, and affects our comfort level in dealing with differences. A starting point to cultural sensitivity is to first understand our own culture and to examine our attitudes and assumptions about other cultures.

- I believe that the "culture of poverty" is a greater barrier than multiculturism per se in the lives of our clients. Unlike middle-income healthcare consumers, our clients do not have the financial resources to buy the services or products that they may need. For example, if we notice that our client wears the same dress every time we visit, let us not automatically view this pattern as a symptom of dementia or attribute it to cultural differences related to appearance or hygiene. This dress may simply be the only one our client owns.

Six Steps Toward Cultural Competence

How to Meet the Healthcare Needs of Immigrants and Refugees

1. Involve immigrants in their own healthcare.
2. Learn more about culture, starting with our own.
3. Speak the language, or use a trained interpreter.
4. Ask the right questions and look for answers.
5. Pay attention to financial issues.
6. Find resources and form partnerships.

Recommendations from *Six Steps Toward Cultural Competence: How to Meet the Health Care Needs of Immigrants and Refugees*, edited by Patricia Ohmens, Health Advocates (612-489-4238), August 1996. This report contains recommendations from the Minnesota Public Health Association's Immigrant Health Task Force chaired by Carol Berg. Free copies are available from the Minnesota Department of Health/ Refugee Health Program at (612) 623-5693. A packet of supplementary resources may be ordered for $7.50 from the Center for Cross-Cultural Health, Minneapolis, (612) 624-4668.

Experiences and Lessons Learned by the Visiting Nurse Service of New York

Stella Kwong-Wirth, Asian Health Specialist with the Visiting Nurse Service of New York, described the systematic approach that the agency has taken to better serve and expand its diverse client base and their Asian Home Care Program.

I am pleased to be with you this morning to share our experiences and lessons learned in developing multicultural home care programs in New York City. To date, we have launched two major multicultural initiatives: the La-Bre-oot ("To Your Health") Program directed to Orthodox Jewish clients (November 1995) and the Asian Home Care Program (June 1996).

VNSNY is a comprehensive home healthcare agency that provides a wide array of home healthcare and community-based services. With over 2, 200 caregivers, VNSNY Home Care—the agency's principal subsidiary—is the largest not-for-profit certified home healthcare agency in the United States. We provide services to over 100,000 patients annually throughout the New York City metropolitan area. With a daily census of 22,000 patients, our agency effectively serves as a 22,000-bed community hospital.

Recognized for its quality and clinical excellence, VNSNY has established centers of excellence in diabetes, cardiac care, wound management, and HIV/AIDS. We provide the most up-to-date nursing care and high-tech medical equipment backed up with a state-of-the art information system. One of our newest, most innovative programs is VNS CHOICE, a Medicaid managed long-term care demonstration program for nursing home certifiable dually eligible clients. The program provides and/or arranges for all capitated Medicaid long-term care services and coordinates all medical services paid for by Medicare. After five months of operation, the program is now serving 105 clients who are similar to your frail elderly community-based MSHO enrollees.

Our multicultural program initiative has three major goals: to improve quality service, to increase referrals, and to build patient loyalty and VNS brand recognition. I advise you to establish explicit, measurable goals for your program so that you can define and evaluate your success.

Services and Products Offered by VNS of New York

Skilled Nursing Care
Home Health Aide Services
Physical, Speech, and Occupational Therapy
Social Work Services
Home Infusion Therapy
Mental Health Services
Elder Care—Consultation and Care Management
Hospice Care
Long-term care
Clinical Triage
Home Care for People with HIV/AIDS
Nursing Home Assessments
Nutrition Counseling
Meals on Wheels

Ten Steps to Success

I would like to outline the ten steps that VNSNY has followed in the development of each of our multicultural home care programs. We have found this comprehensive model is essential to successful program design and implementation.

1. Establish the rationale for developing the program.
This involves understanding the cultural composition of the service area, organizing focus group discussions to identify the current barriers to service delivery, and specifying the reasons to establish a program, such as improving quality and attracting new business.

2. Conduct market research.
Drawing on primary and secondary research, this critical piece of the planning effort includes:

- studying local demographics and trends.
- identifying specific populations to target.
- determining the current and future market size.
- gathering information on the culture, values, and religious practices of potential target populations.
- compiling data on the healthcare and community services currently available to the population.
- identifying healthcare services, needs, and access to care.

3. Analyze the competition.
VNSNY operates in the dynamic NYC healthcare marketplace, characterized by growing managed care penetration, hospital consolidations, physician reorganizations, and shifting demographics, which project an older and increasingly diverse population. Improving and expanding our services to clients with cultural and language differences reflects deep organizational values and also represents a significant business opportunity in a highly competitive operating environment. This step in our development process entails gathering information on current healthcare programs catering to this population, gaining knowledge on their strengths and weaknesses, and defining competitive advantage or niche market.

4. Select the target population—an underserved group or one of significant size.
For example, the fact that Asians comprise 7 percent of the total population of NYC was a major factor in the decision by VNSNY to target this group. This step involves determining current unmet needs and identifying both current and future market potential.

5. Form a work team.
Key activities include:

- Identifying internal staff and external resources that mirror cultural groups. Solicit participation from community groups if your staff does not contain representation from the groups you wish to serve.
- Organizing work team members.
- Recruiting a project manager to lead and facilitate the work team.
- Establishing the role and function of the team.
- Setting team goals and objectives.

6. Set program goals and objectives.
Define the program features and benefits, identify marketing targets, and determine internal resource needs.

7. Establish the building blocks.
There are five core elements that we consider essential to every multicultural program that we develop:

- Cultural sensitivity training for the staff.
- Availability of multilingual staff members.
- Development of nutritional diet plans which revolve around ethnic foods and eating behavior and the customized design and translation of patient education materials.
- Linkage with community resources in order to better understand client needs and to create a source of future referrals.
- Quality management program which includes patient satisfaction surveys conducted in client languages. Look at new ways to promote and measure client satisfaction. For example, VNS of NY taught all staff how to say "hello" in Chinese, Korean, and Japanese.

8. Develop the work plan
This plan should address operations, recruitment, training, and marketing as well as identify the key tasks, timeframes, and assigned staff.

9. Implement the program.
Important tasks include:

- Hiring the program manager and recruiting staff.
- Implementing the training program and introducing new procedures and work flows.
- Marketing, public relations, and community outreach.

10. Track and evaluate the program.
VNSNY has developed program tracking mechanisms (e.g. referrals by source, geography, and payer), processes for measuring employee cultural sensitivity awareness, and client satisfaction measures.

Case Study: Asian Home Care Program

Our Asian Home Care Program is the outcome of the ten planning steps I just described. Ten months in development, the Asian Home Care Program provides a broad spectrum of services such as:

- staff trained on cultural sensitivity to Asian values and customs of many different Asian groups including Chinese, Korean, Filipino, Japanese, Vietnamese, Cambodian, Thai, Laotian.
- availability of Asian-speaking home care staff for Asian clients who do not speak English.
- placement of home health aides who speak Chinese dialects, Korean, Tagalog and other Asian languages for Asian clients who do not speak English.
- availability of Asian escort translators.
- nutritional diet plans specifically designed for Asians.
- patient materials, especially diets, translated into various Asian languages.
- linkages with Asian community resources.
- quality management program.

Program referrals rose by 35 percent between 1996 and 1997. We project nearly 2000 cases in 1998.

Understanding the Asian Client

- polite
- courteous
- practices self-control
- respect for authority
- privacy
- respect for elderly
- discomfort with strangers
- strong family bonds
- tied to tradition

Source: VNSNY

Staff training is a critical, ongoing program activity. A review of the topics that are covered in our Asian Home Care Program Training Manual will help you understand the depth and breadth of our commitment to and investment in preparing our staff to deliver culturally competent care:

- importance of understanding cultural differences
- demographic profile
- map of Asia
- history and culture
- Asian values: politeness, self-control, privacy, respect
- communication
- nutrition
- common health problems
- maternal/child healthcare
- beliefs about sources of illness
- use of traditional medicine
- use of healthcare services
- cultural barriers to healthcare: belief in pain and suffering
- death and dying
- Asian religion
- key Asian holidays.

When our staff visit an Asian client at home, they remove their shoes and sit down to converse with the family. They graciously accept the food and drink that are customarily offered to guests. Refusing hospitality is considered an insult. They see the client following this family visit. They speak quietly because raising one's voice is considered rude. They realize that smiling and nodding by the Asian client and family connotes respect, not affirmation. They also recognize that female clients may allow male relatives to make healthcare decisions for them. They understand that Asian clients may delay seeking help for pain and discomfort, relying instead on traditional remedies, such as herbal soup. Our staff recognizes that certain diagnoses such as mental illness or AIDS are considered shameful by many in the Asian community and

that clients will seek services far from their own neighborhoods to avoid embarrassment to self and family.

In summary, the staff are sensitized to individual differences in cultural practice related to language, values, manner of dress, dietary customs, and manner of religious observance. They are taught to balance cultural sensitivity, knowledge, and practice; to take direction from the client and the client's family concerning cultural issues; and, above all, to respect the client's right to his or her beliefs.

Marketing the Asian Home Care Program has involved identifying target customers, planning and launching a high-impact kickoff campaign, organizing special events, and managing ongoing public relations and media coverage. We participate in community health fairs, advertise on Asian cable television, and help celebrate the Chinese New Year. We find opportunities to continue to educate our own employees through special events and activities. For example, we sponsored an Asian cultural fair for VNSNY staff featuring ethnic food and entertainment.

Lessons Learned and Next Steps

Our major challenges pertain to:

- recruitment, training, staffing.
- translating patient education materials.
- maintaining competitive advantage.

We continue to learn in the process of designing and implementing programs to address the healthcare needs of our ethnically diverse client population. Our next multicultural program geared to address the needs of Hispanic clients is scheduled to be introduced this September.

A Global Village: It's a small world after all...

If we could shrink the earth's population to a village of 100 people, would you recognize it?

- 52 villagers would be female; 48 would be male
- 33 would be children
- 6 would be over the age of 65
- 58 would be Asian
- 70 would be persons of color
- 6 would own half of the village's wealth; all 6 would be U.S. citizens
- 9 would speak English
- 50 would suffer from malnutrition
- 80 would live in substandard housing
- 66 would not have access to clean, safe drinking water
- 10 would be lesbian, gay, or bisexual
- 1 would have a college education

From Harvard Pilgrim Health Care's *Diversity Journal, Our Third Checkup, 1997.* For more information or to order, contact: Felicita Alvarado, Office of Diversity, (617) 730-7710. www.employer.harvardpilgrim.org (click "resource center")

Panel and Audience Question and Answer Session

Panelists:

Joan Barnett, GNP, Assistant Clinical Director, Optage, St. Paul
Ms. Barnett is a certified nurse practitioner with extensive experience with geriatric populations in primary medical care, case management, and health education. She has a Bachelor of Science degree in nursing education and has completed a Master's degree in Public Health as well as the geriatric nurse practitioner (GNP) program from the University of Minnesota. She has practiced as a GNP in a variety of settings, including clinic, nursing homes, and a geriatric managed care organization.

Wanda Breyer, PHN, St. Paul-Ramsey County Public Health, St. Paul
Ms. Breyer is a graduate of the University of Minnesota with a bachelor of science degree in nursing. Her career in nursing has included practice in multiple settings. She has ten years of experience in the acute care setting, six years of experience as a staff nurse and head nurse in long-term care, and ten years in public health nursing with the St. Paul-Ramsey County Department of Public Health where she is currently employed. For the past seven years, Ms. Breyer has served as a case manager for home services for the elderly and disabled of all ages who are eligible for the state's alternative care and waiver programs.

Vinodh Kutty, Executive Director, Center for Cross Cultural Health, Minneapolis
Vinodh Kutty is the Executive Director of the The Center for Cross Cultural Health, Minneapolis. He grew up in Malaysia and Singapore. He has lived in Minnesota for approximately ten years. He has certifications in education, English, and anthropology. His work experience includes the military, teaching, research and analysis, designing and facilitating seminars, administration and management. He has also worked in both the private and public sectors in Singapore and the United States.

Stella Kwong-Wirth, Asian Health Specialist, Visiting Nurse Service of New York
Ms. Kwong-Wirth's professional experience includes multi-cultural health, social services, patient advocacy, and healthcare administration in the acute care, ambulatory care, and home care settings. Since 1996, she has served as the Asian Health Specialist for the Visiting Nurse Service (VNS) of New York, the nation's largest home care agency, located in New York City. Prior to joining VNS of NY, she worked as the Assistant Executive Director of the Chinatown Health Clinic where she managed the day-to-day operations of a community health center in the heart of the New York's Chinatown. Ms. Kwong-Wirth earned a Masters of Public Administration and a Bachelor of Arts in Sociology at New York University, where she has also done graduate work in the School of Social Work.

Q: **Vinodh Kutty:** In what ways does VNSNY recognize and integrate cultural healers and culturally specific alternative therapies into the care plans of clients?

A: **Stella Kwong-Wirth:** We ask our clients if they use any alternative therapies and encourage them to let their physicians know. We find that there is extensive use of herbal medicines among our Asian clients.

Q: **Vinodh Kutty:** What local or national resources have you found helpful in the development of your multicultural home care programs? For example, do you tap the expertise of local ethnic centers and mutual assistance associations?

A: **Stella Kwong-Wirth:** Yes, we have close ties with many organizations in the Asian community. I encourage the MSHO health plans and care systems to work with mutual assistance associations and other organizations in the ethnic communities that you serve in order to learn more about their needs, traditions, and beliefs. This is a way to build trust and relationships.

Q: **Joan Barnett:** Mental status screening instruments in wide use (and in Minnesota's Preadmission Screening "PAS" tool) are culturally appropriate for only the dominant culture with basic education. When using a one-tool-fits-all approach, the results may not be accurate or meaningful. Persons may be presumed more incapacitated than they really are. How does one assess mental status when using such tools with immigrants, individuals who are illiterate, or people who do not speak English?

A: **Stella Kwong-Wirth:** We do stick to the basic tools. It definitely helps for the case manager to know the language and culture in order to be able to interpret client responses. We do modify certain obvious questions. For example, many Asian clients may not know today's date or the name of the current president of the United States. However, failure to answer these standard questions correctly is not a sign of memory loss in Asian clients. They may follow the Chinese calendar; they may not vote in U.S. elections or understand our political system. So these questions are not meaningful.

Q: **Wanda Breyer:** We often observe a reluctance to talk about hospice and living wills, especially among our clients of Asian and African-American descent. Is this the experience of VNSNY as well, and if so, how have you dealt with it?

A: **Stella Kwong-Wirth:** Yes, we face this challenge daily at VNSNY. We find that it is not advisable to raise these sensitive topics, particularly with Asian and African-American clients, until we have established a long-standing trust relationship with them.

Note: Those who are particularly interested in this topic may wish to refer to a recent PACE study reported in the following article: Eleazer, G. Paul et al. "The Relationship Between Ethnicity and Advance Directives in a Frail Older Population," *Journal of the American Geriatric Society* 44: 938-943, 1996.

Q: **Forum Attendee:** Do you teach clients skills that could be helpful to them in navigating the "mainstream culture" such as how to speak English or how to take the bus?

A: **Stella Kwong-Wirth:** No, we do not. Our emphasis is to help our staff learn how to be respectful of and knowledgable about the cultural backgrounds of our clients. We do go to where our clients are—we do not expect them to adapt to Western ways.

Translating Lessons Learned From VNSNY to MSHO

There is much to learn from multicultural models of care that have been developed across the country. These approaches are worth examining and offer useful strategies and lessons learned. While the principles of culturally competent healthcare are universal, the development of culturally competent healthcare services is a local activity which reflects the community's own unique set of needs, strengths, barriers, and opportunities. For example, one major difference between the Twin Cities and New York City or the West Coast is a much smaller representation of ethnic groups in the workforce to serve as native speakers and culturally knowledgable healthcare workers.

Here are some possible initiatives and next steps that MSHO health plans and care systems could take.

Sociocultural Barriers to Healthcare

- Cultural Traditions
- Language
- Provider Insensitivities
- Complexities of the Healthcare Systems
- Healthcare Institution/ Community Relations

Source: Sally Kohn, Opening Doors, George Washington University Medical Center, "Creating Culturally Sensitive Systems of Care" NCCC National Conference, September 23, 1997

Develop a Cultural Competence Working Group.

Interested members of MSHO health plans and care systems along with representatives from the Minnesota Department of Human Services could address common issues and concerns related to improving the cultural competence of healthcare for MSHO clients. Potential project ideas for a collaborative effort by plans, counties, the state, and providers (or for a single organization to pursue on its own) include:

1. **A Needs Assessment.**
   A systematic needs assessment would be helpful in identifying the options and setting priorities, given the growing diversity of the state's population across the age spectrum. This could be undertaken as a collaborative project with the assistance of the Center for Cross Cultural Health. It would tie in well with the Minnesota Department of Human Services Project 2030 and the Citizen's League "Wrinkle on Aging" study.

2. **Development of a Screening Tool.**
   Modifying specific questions in the screening tool in order to make it more culturally appropriate for Southeast Asian clients (and/or other groups) would be a project with immediate practical application for MSHO case managers and clients. Guidelines for the modifications would mean that the tool is applied consistently.

3. **Contracting with Ethnic Providers.**
   This project would explore the barriers to and opportunities for expanding the provider networks of MSHO health plans to include providers who are trusted and favored by MSHO clients from refugee populations and communities of color.

4. **Training Family Caregivers and Community Health Workers.**
   In other parts of the country, care systems hire members of refugee communities who have completed a training program to serve as lay public health workers and educators. Maternal and child health is the traditional focus of these programs. It might be worthwhile to explore the benefits and feasibility of this approach for community-dwelling MSHO clients.

5. **Use of Interpreters.**
Examine the qualifications and training requirements for interpreters. Find solutions to problems that case managers have identified in connection with working with some interpreters. Involve interpreters in this project.

Expand recruiting efforts to develop a culturally diverse workforce.

Work with training programs at local community colleges, colleges, and universities and with state agencies. Offer internships, scholarships, or fellowships. Try advertising positions in local ethnic newspapers, on radio stations and cable TV, and at neighborhood centers that serve immigrants and communities of color. Contact mutual assistance associations and resettlement agencies. Help sponsor and be present at local festivals and celebrations. Evaluate your employment application process as well as any pre-employment testing in order to make sure that they are culturally-sensitive. Assess your organizational culture—does it support and celebrate workforce diversity? Examine your governing board—is it representative of the diverse community?

Learn more about the populations you serve.

Subscribe to local ethnic/minority newspapers. Support local ethnic/minority fairs. Form a local community advisory group to provide cultural intelligence and helpful input. Organize focus group discussions to better understand client expectations, concerns, and issues. Assemble a resource library and/or intranet resource folder for your staff. Consult local experts. Prepare a training program for staff who interact with clients with cultural and language differences.

Find resources to move ahead.

Hire a student intern with the language skills and/or community connections to help your organization with specific projects. Consult local and national resources for information. See the resource listing on the next four pages.

Building Healthcare Cultural Competence to Meet Current and Future Needs

By the Year 2025:

- Minnesota's population will be about 5.3 million, compared to 4.6 million in 1995.
- More than half the population will be over age 40.
- For the first time ever, people age 65 and older will outnumber children under 15.
- Roughly 17 percent of Minnesota's population will be African American, Asian, American Indian, or Hispanic.

Source: *Faces of the Future...Minnesota Population Projections 1995-2025*, Minnesota Planning State Demographic Center, 1998.

Resources for Fostering Culturally Competent Care

This is intended to be a compilation of resources related to healthcare cultural comptency. For additional local and national resources, please contact the Center for Cross-Cultural Health at (612) 624-4668.

Local

Center for Cross-Cultural Health
410 Church Street S.E., Suite W227, Minneapolis, MN 55455
Phone: (612) 624-4668
E-Mail: CCCH@TC.UMN.EDU Web site: http://www. umn.edu/ccch
Contact: Vinodh Kutty, Executive Director
The Center is a unique resource designed to help Minnesota healthcare providers in their work with patients of diverse cultures. Designed as a clearinghouse and source of information, training and research on the role of culture in health, the Center is based in Minneapolis with outreach capacity for the entire state of Minnesota.

International Institute of Minnesota
1694 Como Avenue, St. Paul, MN
Phone: (612) 647-0191 Contact: Robbie Hamblen, Project Coordinator
The Institute publishes the *Minnesota Ethnic Resources Directory* and operates a nursing assistant training program that recruits students from the refugee community.

Mixed Blood Theatre/EnterTRaining
1501 South 4th Street, Minneapolis, MN
Phone: (612) 338-0937 Contacts: Jack Reuler and Syl Jones
EnterTRaining, an arm of Mixed Blood Theatre, produces custom-written, live theater to help business and government address workplace issues of race, gender, age, disability, and sexual orientation.

Program in Translation and Interpreting (PTI)
University of Minnesota
Phone: (612) 624-6552 E-mail: bdowning@maroon.tc.umn.edu
Contact: Bruce Downing, PhD, Program Director
PTI offers a series of courses designed to develop translation and interpreting skills for employment in a variety of community settings.

Refugee Health Program
Minnesota Department of Health
717 Delaware Street S.E., Minneapolis, MN 55440
Phone: (612) 623-5693 Contact: Kaying Hang, Refugee Health Coordinator
The Refugeee Health Program oversees the administration of the domestic refugee health assessment and follow-up process. It also serves as a clearinghouse for refugee health information and resources. Two program publications of interest include, *Health Resources Serving Diverse Communities, Ramsey County* and *Health Resources Serving Diverse Communities, Hennepin County*; both are being updated this spring. Call Jeannie Watson at (612) 623-5530 to receive a free copy. The Refugee Health Program also maintains a list of local and national organizations that offer health education literature and videotapes in other languages. One local resource is the Minnesota Department of Health Library at (612) 623-5478, which lends multilingual health videotapes.

Six Steps Toward Cultural Competence: How to Meet the Health Care Needs of Immigrants and Refugees, edited by Patricia Ohmens, Health Advocates, August 1996. This report contains recommendations from the Minnesota Public Health Association's Immigrant Health Task Force chaired by Carol Berg. Free copies are available from the Minnesota Department of Health/Refugee Health Program at (612) 623-5693. A packet of supplementary resources may be ordered for $7.50 from the Center for Cross-Cultural Health, Minneapolis, (612) 624-4668. Highly recommended.

National

Agency for Health Care Policy and Research Publications Clearinghouse
US Department of Health and Human Services
P.O. Box 8547 Silver Spring, MD 20907-8547
Phone: (800) 358-9295 Web site: http://www.ahcpr.gov/
AHCPR publishes many publications for healthcare practitioners, researchers, policymakers, and consumers. Some consumer titles are available in languages other than English. Examples of interest to an older patient population:
• *Cataract in Adults. A Patient's Guide.* (Spanish)
• *Depression is a Treatable Illness. A Patient's Guide.* (Spanish)
• *Living with Heart Disease: Is It Heart Failure?* Patient and Family Guide. (Spanish)
• *Quality Mammography Series.* (Spanish, Laotian, Vietnamese, and other languages)
• *Prescription Medicines and You. A Consumer Guide.* (Spanish, Cambodian, Vietnamese, and other languages)

American Association of Retired Persons
Diversity Program
601 E Street, N.W.Washington, DC 20049
Phone: (202) 434-2460 Contact: Gwenda Harrison, Program Director
The mission of AARP Minority Affairs, the precursor to the organization's Diversity Program, is to strive to respond to the concerns of AARP members and today's mid-life and older minority populations, to advocate to improve the quality of life for current and future generations, and to serve as a catalyst for change in order to reduce economic, health, age, ethnic and racial disparities. Helpful reports, resources, and tools are available.

American Society on Aging
833 Market Street, San Francisco, CA 94103-1824
Phone: (415) 974-9630
Contact: Carmelita Tursi, Manager of Diversity Programs, Education & Training
In collaboration with seven other national organizations, ASA is undertaking a two year project funded by the Retirement Research Foundation entitled "Serving Elders of Color: A Training and Networking Initiative." The project addresses the needs of aging services providers in responding to challenges posed by the increasing diversity of the older population, particularly the growth of ethnic minority groups by developing a comprehensive training program and network. ASA will offer a two-day, train-the-trainer workshop in ten cities this fall.

Asian Health Services (AHS)
818 Webster Street, Oakland, CA 94607-4220
Phone: (510) 986-6830 Contact: Linda Okahara
AHS is a federally-funded comprehensive community health center that provides medical care, health education and promotion, and client advocacy to the low-income Asian/Pacific Islander community in Alameda County, California.

Brandeis University/Heller School
National Aging Resource Center
415 South Street, Waltham, MA 02254-9110
Phone: (781) 736-3932
Contact: John A. Capitman, PhD, Director, Diversity & Long Term Care
Dr. Capitman provides consultation and training related to cultural competency and community-based long term care. Developing "cultural humility," learning cross-cultural sensitivity and communication skills, and fostering a greater self-awareness of one's own culture and beliefs/attitudes about other cultures are key components of the his approach to cultural competency training and consultation for home and community-based service providers.

Comunity Health Training and Development Center
Department of Health Education
1600 Holloway Avenue, San Francisco, CA 94132
Phone: (415) 338-3034 E-mail: chw@sfsu.edu
Web site: http://thecity.sfsu.edu/~chtdc
Established in 1992 as a joint project of San Francisco State University and City College of San Francisco, CHTDC is a nationally-recognized center for training, research and development on first-level community health professionals and interdisciplinary community health teams.

Cross Cultural Health Care Project (CCHCP)
PacMed Clinics
1200-12th Avenue S., Seattle, WA
Phone: (206) 326-4161 Contact: Bookda Gheisar, Executive Director
Web site: www.xculture.org E-mail: xculture@ix.netcom.com
CCHCP serves as a bridge between communities and healthcare institutions to ensure full access to quality healthcare that is culturally and linguistically appropriate by providing: cultural competency training, interpreter training, interpreter services, translation services, bilinguial medical glossaries, and community organizing and coalition building. It also publishes the monthly newsletter *Across Cultures.*

Culturally Competent Care
Inter-Face International
3821 East State Street, Suite 197, Rockford, IL 61108
This brief, easy-to-read bi-monthly newsletter is designed to increase the clinicians' effectiveness in providing medical care and services to patients form other cultures. Each issue includes a feature article, practical tips, a question-of-the-month, and announcements, events, and publications. Price: $15.00/year.

Culture and Nursing Care: A Pocket Guide
University of California, San Francisco
School of Nursing/Nursing Press
521 Parnassus Avenue, San Francisco, CA 94143-0608
Phone: (415) 476-4992
This manual offers practicing nurses a snapshot of cultural diversity. Each chapter outlines issues related to health and illness, symptom expression, self-care, birth, death, religion, family participation in care, among other topics. It contains profiles for many groups including: American Indians, African-Americans, Cambodians, Central Americans, Hmong, Mexican-Americans, Russians, and Vietnamese. Price: $18.95 plus shipping and handling.

Diversity Journal
Harvard Pilgrim Health Care, Office of Diversity
10 Brookline Place West, Brookline, MA 02146-7229
Phone: (617) 730-7710 Contact: Felicita Alvarado
Web site: www.employer.harvardpilgrim.org (click "resource center")
$7.50 per issue. Highly recommended.

EthnoMed
Website: http://www.hslib.washington.edu/clinical/ethnomed
This electronic database with cultural and medical information on Seattle refugee populations was developed by Harborview Medical Center, Seattle in collaboration with the Health Sciences Library, University of Washington. It is designed to be a clinical tool to help providers learn about the culture, language, health and illness, and community resources of refugee groups.

Harvard Pilgrim Health Care
Office of Diversity
10 Brookline Place West, Brookline, MA 02146-7229
Phone: (617) 730-7730 Contact: Marilyn Gellner, Project Manager
Harvard Pilgrim Health Care, the largest HMO in New England, has developed a national reputation for its diversity-related programs and initiatives. It conducts an annual "diversity checkup" of its missions and values, hiring practices, marketing activities, compensation systems, organizational culture, and public image.

Health Literacy Project
311 South Juniper Street, Suite 303, Philadelphia, PA 19107-5803
Phone: (215) 546-1276
E-Mail: hlphpc@libertynet.org Website: http://www.libertynet.org/~hpcpa
Contact: Jane Friedman, Assistant Director
A patient and professional education program spearheaded by the Health Promotion Council in 1988, HLP helps to improve communication between healthcare providers and their low-income African-American, Latino, and Asian patients. It produces and distributes low-cost, easy-to-read pamphlets and videos for patient education.

Healthcare Forum Journal
May/June 1995
This issue explores sociocultural barriers to healthcare and showcases innovative responses across the country.

Office of Minority Health Resource Center
US Department of Health and Human Services
Public Health Service
P.O. Box 37337, Washington, DC 20013-7337
Phone: (800) 444-MHRC Web site: http://www.omhrc.gov
OMH-RC maintains an extensive database on information on minority health topics in various forms including audiotapes, books, community programs, documents, manuals, resources, and reports. Customized literature searches are available upon request. The Center's website includes information on mission and services, minority health publications and organizations, funding sources, and upcoming conferences.

Opening Doors: Reducing Sociocultural Barriers to Health Care
National Program Office
c/o The George Washington University Medical Center
1001 22nd Street, NW #810, Washington, DC 200037
Phone: (202) 467-2200 E-mail: opnaej@gwumc.edu
Contact: Thomas Chapman, Director
A national program of The Robert Wood Johnson Foundation and The Henry J. Kaiser Family Foundation initiated in 1993, Opening Doors funds and supports service and research projects to identify and break down non-financial, culturally based barriers to healthcare, especially maternal & child health as well as reproductive health.

Resources for Cross Cultural Healthcare
8915 Sudbury Road, Silver Spring, MD 20901
Phone: (301) 588-6051
E-mail: RCCHC@aol.com Web site: www.diversityRX.org
Contact: Julia Puebla Fortier, Director
RCCHS is a national network of individuals and organizations in ethnic communities and healthcare organized to offer technical assistance, information, and conferences on linguistic and cultural competence in healthcare. RCCHS also publishes a newsletter called *Cross Currents* and maintains an informative website co-sponsored by the National Conference of State Legislatures and the Henry J. Kaiser Family Foundation.

What Language Does Your Patient Hurt In?
Inter-Face International
3821 East State Street, Suite 197
Rockford, IL 61108
Published in 1995, this series of eight books is intended to serve as a brief, practical guide for physicians, nurses, and healthcare administrators.

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Minnesota Senior Health Options Project

The Minnesota Department of Human Services has developed a program called Minnesota Senior Health Options (MSHO) which combines Medicare and Medicaid Financing and acute and long-term care delivery systems. This demonstration facilitates the integration of primary, acute, and long-term care services for people over age 65 who are eligible for both Medicare and Medicaid. Minnesota has received federal Medicare 222 and Medicaid 115 waivers from the Health Care Financing Administration (HCFA) to put this demonstration into practice. The waivers allow the State of Minnesota to combine the purchase of both Medicare and Medicaid services into one contract managed by the state. Minnesota is the first state ever to be granted such a combination of waivers. This demonstration will be implemented in the seven-country metropolitan area for a five-year period.

The Robert Wood Johnson Foundation (RWJF), which supported the planning stages for this demonstration, has provided a grant to cover the initial administration and implementation of the demonstration.

National Chronic Care Consortium
National Resource Center on Chronic Care Integration

The NCCC National Resource Center (NRC), a subsidiary of the National Chronic Care Consortium, is the nation's premier resource for obtaining best practice information, consultation, and tools on chronic care integration. NRC products and services are designed to help emerging health networks restructure their primary, acute, and long-term care relationships under risk-based Medicare and Medicaid financing. These practice-based resources enable health networks to move beyond the merger of assets and authority toward integrating the ongoing management of governance, programs, information, financing, and care for people with chronic diseases and disabilities. This service is provided in response to the emergence of people with chronic conditions as the fastest-growing and highest-cost user segment in healthcare and the need to restructure how we finance, administer, and deliver care to contain cost accumulation and maintain quality.

The NRC is sponsored by the National Chronic Care Consortium (NCCC), a strategic alliance of 34 leading nonprofit health systems in the United States and Canada who share a vision of integrated care for individuals with chronic health conditions, from the time of earliest condition awareness until problem resolution or death.

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