2012 WEBINAR SERIES PART II: TACKLING THE TOUGH TOPICS IN ETHNOGERIATRICS

Sponsored by Stanford Geriatric Education Center in conjunction with American Geriatrics Society, California Area Health Education Centers, & Natividad Medical Center

CULTURAL HUMILITY: THE NEXT LEVEL OF CULTURAL COMPETENCE

Dr. Nancy Hikoyeda, DrPH, MPH, Associate Director, Stanford GEC

August 9 2012
About the Presenter

Dr. Nancy Hikoyeda is Associate Director of the Stanford Geriatric Education Center and a Consultant in Aging, Health, and Diversity. She received her B.S. in Education from the University of Utah, an M.P.H. and Certificate in Applied Social Gerontology from San Jose State University, and a Doctor of Public Health (Dr.P.H.) from the UCLA School of Public Health. Dr. Hikoyeda’s areas of expertise are in ethnogerontology and ethnogeriatrics – issues of aging, ethnicity, and health with a focus on Asian/Pacific Islander elders, health literacy, long term care utilization, and end-of-life issues. She has co-authored and edited numerous curriculum and training materials as well as chapters on Asian American elders in Social Work Practice with the Asian American Elderly; Cultural Issues in End-of-Life Decision Making; the Handbook of Geriatric Care Management (3rd ed); and Ethnicity and the Dementias (2nd ed).

Dr. Hikoyeda is the retired Director of the San Jose State University (SJSU) Gerontology Program; served on the Executive Committee of the Santa Clara County Aging Services Collaborative; Past President of the California Council on Gerontology and Geriatrics; and is Coordinator of the Stanford Geriatric Education Center Faculty Development Program in Ethnogeriatrics.

Cultural Humility: The Next Level of Cultural Competence

Nancy Hikoyeda, DrPH, MPH
Associate Director
Stanford Geriatric Education Center
August 9, 2012
Introduction & Background

Why are cultural competence & cultural humility important?

- Desire to provide the best health care possible
- U.S. population is increasingly more diverse & complex
  - Need to learn about history/culture of patients/clients to understand their health behaviors & beliefs

Introduction & Background (cont'd.)

- IOM reports: Crossing the Quality Chasm (2001) & Unequal Treatment (2003) emphasized patient-centered care & cultural competence to:
  - Meet the needs/preferences of a diverse population
  - Improve provider/patient communication & gain trust to eliminate racial disparities in health care
  - Reduce risk & medical liability (and meet other requirements)
  - Ultimately improve patient adherence & health outcomes

Patient-Centered Health Care

- Respect for patient’s values, needs, & preferences
- Information, communication, education needed/wanted by patients
- Accommodate physical comfort, emotional support, & family involvement
- Shared decision-making
Objectives

- Define culture, cultural competence (CC) & cultural humility (CH)
- Discuss their roles in our health care system
- Compare CC & CH assessment tools
- Identify communication strategies to enhance CH in the medical encounter
- Discuss a case example
- Reflect on ways to use today’s information to improve your work, your practice and/or your organization

What is CULTURE?

- Include learned core values, beliefs, norms, behaviors, customs shared & transmitted by a group of people
- People may be phenotypically similar, but culture is not race
- Dynamic, responsive, coherent systems; evolve/adapt; visible/invisible aspects
- Cultural processes differ within the same group due to: age, cohort, gender, political climate, class, religion, ethnicity, personality, sexual orientation, vocation, disability, language, immigration, & other factors

(California Endowment; Kagawa-Singer & Kassim-Lakha, 2003)
Culture from a Cultural/Social Anthropology Perspective

Seven Elements of Culture
- Environment
- Economy
- Technology
- Religion/world view
- Language
- Social structure
- Beliefs & values

(Hammond, 1978)

What is Cultural Competence?

Continuum of behaviors, attitudes, & policies that ensure that a system, agency, program, or individual can function effectively & appropriately in diverse cultural interactions/settings

Promotes understanding, appreciation, & respect for cultural differences/similarities within, among, & between groups

Goal that a system, agency, program, and/or individual continually aspires to achieve

(U.S. DHHS Workgroup)
**Organizational Cultural Competence**

**CONTINUUM OF CULTURAL PROFICIENCY**

- Destructiveness
- Blindness
- Proficiency
- Incapacity
- Competence

**Cultural Competence Training**

- Typically, in healthcare settings, CC training assumes gathering/hearing information about a culture results in mastery/expertise about that culture (technical skill).

- In general, CC training tends to be somewhat vague & frequently inaccurately used in the medical setting which can lead to:
  - Mere accumulation of knowledge
  - Lists of do's and don'ts
  - Creation of stereotypes

(From Kleinman & Benson, 2006)

**What is Cultural Humility?**
Cultural Humility (CH)

- On-going process of acquiring knowledge about health beliefs/practices of diverse patients
- Provider is “life-long learner” vs. “knower” with commitment to self-evaluation, critique, & reflection
- Focus on individual patients & not stereotypes
  - Patient is best source of information to understand how s/he sees, feels, perceives, & responds to illness
  - Mutually respectful, beneficial, non-paternalistic, clinical partnership between providers, patients, families, & communities

(Tervalon & Murray-Garcia, 1998)

Cultural Humility (cont’d.)

- Physician/provider relinquishes role of the expert; emphasis on patient/client’s priorities, beliefs, concerns
- Power imbalances & inequities in physician & patient communication are reduced due to emphasis on patient/client-focused interviewing & care

(Tervalon & Murray-Garcia, 1998; Juarez, Marvel, Brezinski, et al., 2006)

How are Cultural Competence & Cultural Humility Assessed?
## Assessment Tools

<table>
<thead>
<tr>
<th>Cultural Competence</th>
<th>Cultural Humility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multicultural Counseling Inventory</td>
<td>Interview skills training</td>
</tr>
<tr>
<td>Cultural Self-Efficacy Scale</td>
<td>Case studies; role plays</td>
</tr>
<tr>
<td>Inventory for Assessing the Process of CC among Health Professionals</td>
<td>Journals</td>
</tr>
<tr>
<td>Cross-Cultural Adaptability Inventory</td>
<td>Site or home visits</td>
</tr>
<tr>
<td>Culture/Ethnic Attitude Scale</td>
<td>Simulations/videotape with feedback</td>
</tr>
<tr>
<td>Multicultural Awareness, Knowledge, &amp; Skills Survey</td>
<td>Videos – “Hold Your Breath” or “Color of Fear”</td>
</tr>
<tr>
<td>Cultural Competence Self-Assessment Questionnaire</td>
<td>Panels/Key Informant interviews</td>
</tr>
<tr>
<td></td>
<td>Immersion/Community feedback</td>
</tr>
<tr>
<td></td>
<td>Use of art, music, writing</td>
</tr>
</tbody>
</table>

## Shortcomings of Assessments

<table>
<thead>
<tr>
<th>Cultural Competence</th>
<th>Cultural Humility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equate culture with ethnicity &amp; race; neglect dominant group</td>
<td>CH more difficult to teach &amp; evaluate</td>
</tr>
<tr>
<td>Assess awareness, familiarity, knowledge &amp; change</td>
<td>Time intensive methods</td>
</tr>
<tr>
<td>Whiteness is the norm</td>
<td>Need trainers with right knowledge &amp; skill set</td>
</tr>
<tr>
<td>Imply that problems lie in the disadvantages borne by minority groups – not in the privileges of dominant group</td>
<td>May need trained observers</td>
</tr>
<tr>
<td>Do not assess practices – how people use the knowledge gained</td>
<td>Costs may be higher</td>
</tr>
</tbody>
</table>

(Kumas-Tan, Beagan, et al, 2007)

## CC & CH Summary Comparison

<table>
<thead>
<tr>
<th>Cultural Competence</th>
<th>Cultural Humility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cookbook Medicine: Impossible to know everything</td>
<td>“Cultural literacy” = on-going &amp; lifelong personal process</td>
</tr>
<tr>
<td>Eurocentric stereotypes</td>
<td>Multiple aspects of culture</td>
</tr>
<tr>
<td>Not supported by robust research (e.g., improvement in clinical services, cost efficiency?)</td>
<td>Learn from patients/clients</td>
</tr>
<tr>
<td>Culture not always at the root of every case/problem</td>
<td>Reduces power inequities</td>
</tr>
<tr>
<td>But basic introductory information is needed</td>
<td>Mutually respectful partnership &amp; negotiation</td>
</tr>
</tbody>
</table>

(O’Brien, 2011)
The Journey toward Cultural Humility

Communication Strategies to Enhance CH

Interview strategies to transition from "Knower to Learner"

- LEARN [Listen, Explain, Acknowledge, Recommend, Negotiate] (Berlin & Fowkes, 1983)
- PEARLS [Partnership, Empathy, Apology, Respect, Legitimization, Support] (Steele & Harrison, 2002)
- Six Steps of Culturally Informed Care (Kleinman & Benson, 2006): (1) ethnic identity; (2) what is at stake? (3) illness narrative; (4) stresses; (5) cultural influence on patient care & patient/provider relationship

Additional Communication Strategies to Enhance CH

- CRASH [Culture, Respect, Assess/Affirm, Sensitivity/Self-Awareness, Humility] (Rust, Kondwani, Martinez, 2006)
- RISK Assessment [Resources, Individual Identity, Skills to Cope/Adapt, Knowledge about Ethnic Groups] (Kagawa-Singer & Kassim-Lakha, 2003)
- QIAN [Self-Questioning, Immersion, Active Listening, Negotiation] (Chang, Simon, & Dong, 2010)
- 4 C’s of Culture [Call, Cause, Cope, Concerns] (Galani, 2008)
Things to Remember

- CC is important but not an endpoint in the provider/patient encounter
- Elicit patient information respectfully to make an accurate diagnosis/assessment = Build trust!
- Negotiate mutually satisfactory goals
- Learn & Incorporate various interview strategies
- Utilize self-reflection about personal biases, use of traditional medicine, healers, etc.
- In practice: if you don’t know, ASK; if you do know, ASK! This is the essence of CH.

The Case of Mr. Chang

Mr. Chang is a 65 year old Chinese male who appeared in the Emergency Dept. with chest pain lasting two weeks. His vital signs are all normal. He speaks only Mandarin Chinese.

What information is missing in this introduction that is needed to provide culturally appropriate care for Mr. Chang?

Reflect on specific ways you can use what you’ve learned today to improve:

1. your own work
2. your practice or
3. your agency/organization
Thank you!

Nancy Hikoyeda, DrPH, MPH  
Stanford Geriatric Education Center  
Phone: (408) 251-3736  
hikoyeda@stanford.edu  
hikoyeda@sbcglobal.net

Q & A

- We now have some time to answer your questions. If you have any questions, please use the “Chat” feature located on the right side of your screen.
- After the Q and A, We would like to ask each of the participants to answer the short evaluation questionnaire.

Please complete our short survey. We appreciate your feedback.

NOTE: Continuing Education Participants must complete a final survey in order to receive CEU/CME credit.

Thank You for Participating!

Reminder: Please complete our short survey. We appreciate your feedback.

NOTE: Continuing Education Participants must complete a final survey in order to receive CEU/CME credit.
Cultural Humility: The Next Level of Cultural Competence

Nancy Hikoyeda, DrPH, MPH – August 9, 2012
Stanford Geriatric Education Center Webinar Series -
Tackling the Tough Topics in Ethnogeriatrics

References


