Providing Culturally Competent Care in Your School Based Health Center

Catch Them Before They Fall:
School Based Health Centers as a Safety Net for Youth
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Objectives

- Identify health inequities and racial and ethnic healthcare disparities, and the importance of cultural competence in eliminating these disparities.
- Define Patient-Centered Care.
- Describe the importance of Provider Cultural Competence, Organizational Cultural Competence, and Structural Competency in quality, patient-centered healthcare.
- Recognize the pervasive and negative impact that attitudes such as stereotyping and blaming the victim generate.

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Determinants of Health

- Biological Features (Age & Genetics)
- Patient’s Culture
- Individual Lifestyle Factors
- Social & Physical Environment
- Socioeconomic, Cultural & Political Environment

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Health Inequities

Differences in health status and mortality rates across population groups that are systematic, avoidable, unfair, and unjust.

(Whitehead, 1991)
Social Determinants of Health

- “The conditions in which people are born, grow, live, work and age. These circumstances are shaped by the [unequal] distribution of money, power and resources at global, national and local levels…”
  (World Health Organization, 2010)

- “Those inter-related social and economic factors that influence health. Social determinants of health include, but are not limited to housing, income and employment, education, transportation, air quality, access to healthy food, neighborhood conditions, criminal justice, access to healthcare, racism, working conditions, social relationships, democratic participation.”
  (Alameda County Department of Public Health, 2010)
Healthcare Disparities

Racial and ethnic differences in the quality of healthcare that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention.

(Smedley et al, 2003)
Unequal Treatment

- 2003 landmark report by the Institute of Medicine (IOM).
- Reviewed over 100 studies that assessed the quality of healthcare for racial and ethnic minorities across the U.S.
- Confirmed disparities in healthcare.
- Vast majority of studies in this review showed minorities are less likely than whites to receive necessary services, even when controlling for potential confounding variables.

(Smedley et al., 2003)
Studies Cited in *Unequal Treatment*

- **Cardiovascular Disease**
  African Americans, Hispanics, and Asian Americans were significantly less likely than whites to receive coronary angiography, CABG and/or angioplasty, even when controlling for primary diagnosis, age, gender, insurance type, income, and co-morbid factors.

  *(Smedley et al, 2003)*
Studies Cited in *Unequal Treatment*

- **HIV/AIDS**

  African Americans and Hispanics received less quality of care than whites; they were less likely to receive antiretroviral therapy, prevention measures for a dangerous type of pneumonia, and protease inhibitors.

  *(Smedley et al, 2003)*
Studies Cited in *Unequal Treatment*

- **Analgesia**

  Among Hispanic and non-Hispanic white patients with long-bone fracture treated at a major university-affiliated health center emergency department, Hispanics patients were twice as likely as white patients to receive no pain medication, even after controlling for patient, injury, and physician characteristics.

  *(Smedley et al, 2003)*
Unequal Treatment Conclusions

- Identified several sources of health care disparities.
- Noted that some evidence suggests that bias, prejudice, and stereotyping on the part of healthcare providers may play a significant role.
- Suggested that all current and future healthcare providers can benefit from cross-cultural education.
- Recommended cross-cultural education for healthcare professionals which addresses providers’ attitudes, knowledge, and/or skills.

(Smedley et al, 2003)
Quality, Patient-Centered Healthcare

Biological Features (Age & Genetics)

Patient’s Culture

Individual Lifestyle Factors

Social & Physical Environment

Socioeconomic, Cultural & Political Environment

Provider Cultural Competence

Organizational Cultural Competence

“Structural Competence”

Adapted From Alameda County Department of Public Health

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Patient-Centered Care
Care that is “respectful of and responsive to individual patient preferences, needs, and values and ensures that patient values guide all clinical decisions.”
Patient-Centered Care is one major component to quality healthcare.

(IOM, 2001)

Structural Competency, Organizational Cultural Competence, and Provider Cultural Competence are needed to achieve Patient-Centered Care.
Structural Competency

- Goes beyond the cultural specificities of patient care to confront the larger social inequalities of place, race, and economy.

- “Seeks to impart the ability to discern how a host of issues defined clinically as symptoms, attitudes, or diseases (e.g. depression, hypertension, obesity, smoking, medication ‘non-compliance,’ trauma, psychosis) also represent the downstream implications of upstream decisions about such matters as healthcare and food delivery systems, zoning laws, urban and rural infrastructure, medicalization...” (p. 216)

- Calls for increased recognition of how social and economic forces produce symptoms and interact with genes.

- Emphasizes need for more medical models for structural change.

(Metzl, 2012)
Organizational Cultural Competence

A set of congruent behaviors, attitudes and policies that come together in a system, agency or among providers, and enable that system or agency, or those providers to work effectively in cross-cultural situations.

(Cross et al., 1999)
CLAS Standards

- National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (2000; 2013)
  - Advance Health Equity
  - Improve Quality
  - Help Elimination Health Care Disparities

- Principal Standard (Standard 1):
  - Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

- Governance, Leadership, and Workforce (Standards 2-4)

- Communication and Language Assistance (Standards 5-8)

- Engagement, Continuous Improvement, and Accountability (Standards 9-15)

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Provider Cultural Competence

- The ability to move beyond good intentions in cultural relations.

- A lifelong process of acquiring knowledge, attitudes, values, and skills that helps one to:
  - Understand other cultures along with one’s own culture;
  - Facilitate understanding among different cultures;
  - Confront the inconsistencies, biases and unconscious assumptions of these cultures; and
  - Take action to level the playing field.

- Cultural competence encompasses all dimensions of diversity.

(Ryan and Parker, 1999)
Culture

The values, beliefs, arts, customs, language, folklore, and institutions, that a group of people have discovered, invented, and/or developed...and that comprise a way of life that can be taught, learned and reproduced.

(Simon Shuster, 2001; Ryan & Parker, 1999)
Dimensions of Diversity

A broad set of qualities that make up human identity, including but not limited to race, ethnicity, and gender.

Age
Ability
Race
Religion
Ethnicity
Country of Origin
Gender
Sexuality
Family Status
Socio-economic Status
Education
Job status
Interests and hobbies

(Ryan and Parker, 1999)
Stereotyping

- The process by which people use social categories (e.g. race, sex) in acquiring, processing, and recalling information about others.

- Can exert powerful effects on thinking and actions at an implicit, unconscious level, even among well-meaning, well-educated persons who are not overtly biased.

- It also may wield “self fulfilling” effects, as patients’ behavior may be affected by providers’ overt or subtle attitudes and behaviors.

(Smedley et al, 2003)
Communication Skills
Essential for Provider Cultural Competence

- Active Listening
- Assertive Communication
- Cultural Brokering
  - A health care intervention through which the professional increasingly uses cultural and health science knowledge and skills to negotiate with the patient and the health care system for an effective, beneficial health care plan.

(Wenger, 1995)
The Drawbridge

As he left for a visit to his mother’s castle, the girl was warned by her father: “Do not leave the castle while I am gone or I will punish you severely when I return!”

However, as the hours passed, the young baroness grew lonely, and despite her husband’s warning, she decided to visit her lover, who lived in the countryside nearby.

The castle was located on an island in a wide, fast-flowing river. A drawbridge linked the island to the mainland at the narrowest point in the river.

“Since my husband will not return before dawn,” she thought, and ordered her servants to lower the drawbridge and leave it down until she returned.

After spending several pleasant hours with her lover, the baroness returned to the drawbridge, only to find it blocked by a garrison, wildly waving a long, cruel knife.

“Do not attempt to cross this bridge, Baroness, or I will have to kill you,” he cried. “The beacon warned me to do so if I should find you outside the castle.”

Feeling for her life, the baroness returned to her lover and asked for help.

“Our relationship is only a romantic one,” he said, “I will not help you.”

The baroness then sought out a boatman on the river. Thinking she could save her life by getting back to the castle through a different route, she explained her plight to him, and asked him to take her across the river in his boat.

“I will do it only if you pay me the cost of the boat ride.”

“But I have no money with me!” the baroness protested.

“Then we are done. This is the rule. No money, no ride,” said the boatman.

For two mornings, the baroness continued to try to cross the bridge and, after explaining her desperate situation, begged for enough money to pay the boatman his fee.

“If you had not disobeyed your husband, this would not have happened,” the boatman said, “I will give you no money.”

With dawn approaching and her last resource exhausted, the baroness returned to the bridge in despair, attempted to slip past the garrison and cross the castle. Also, spotted her, and she was slain by the garrison.

Responsibility for the death of the baroness, in order from most responsible to least responsible:

1. 
2. 
3. 
4. 
5. 
6. 

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Blaming the Victim

The tendency to place the blame of societal ills on those people who are actually victims of those same social ills.

(Ryan 1976)
Ally

Someone from a dominant group, who works with and/or acts in support of non-dominant group members; someone who is united with another for a common cause.

Allies take action, reflect on their own thinking and beliefs, seek out learning opportunities, and take initiatives in interpersonal relations.

(Ryan & Parker, 1999)
Questions

Thank you!
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