CULTURE CARE CONNECTION

Increasing the cultural competence of health care providers serving culturally diverse populations

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Funded by UCare

How Well Do You Meet National Cultural and Linguistic Standards?

Assess how well your organization meets the national Culturally and Linguistically Appropriate Services (CLAS) Standards by taking the Culture Care Connection CLAS Assessment. The CLAS Standards are a set of 14 mandates, guidelines, and recommendations developed by the Department of Health and Human Services, Office of Minority Health, to guide organizations in providing culturally competent care to patients.

Caring for patients starts with providing care the patient needs in a timely and efficient manner. Has your clinical staff been trained to work with interpreters effectively? Does your front line staff provide a welcoming environment that encourages patients to seek proper care?Taking the assessment can help you:

- Identify strategies to address cultural challenges
- Understand more fully how your organization's systems, policies, and practices impact its ability to meet CLAS Standards
- Establish a baseline from which to measure future improvement

The full survey includes three sections: *Culturally Competent Care, Language Access Services*, and *Organizational Supports*. To get started, complete the first section, Culturally Competent Care.

Once you have gotten your feet wet with the first section, go on to take the *Language Access Services* and *Organizational Supports* sections. After completing all or part of the survey, you will receive results and recommended actionjs to address cultural gaps.

Read some of the comments we have received from clinic staff who have taken the assessment:

- "The analysis was most helpful for me. It helped me formulate our clinic goals for the year."
- "Just completing the first section on Culturally Competent Care opened my eyes to the kinds of things that help create a welcoming environment—like having staff from the same countries as our patients, who also speak the same languages—and displaying translated posters and materials that reflect their ethnic backgrounds."
- "Everyone in our clinic who greets or works with our patients and their families can impact their experience here. Taking the assessment helped us realize what we need to do to meet the cultural and medical needs of our patients who come from other countries and may not speak English."
- "The analysis and recommendations provided guidance on how to expand the work we are already doing, such as getting educated on the cultural and health beliefs and practices of our patients."

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Culture Care Focus: Karen People in Minnesota

Nearly 4,000 Karen (pronounced kuh REN) refugees from Burma and refugee camps in Thailand live in Minnesota. St. Paul is home to the largest Karen refugee population in the U.S.

An ethnic minority in Burma (located in Southeast Asia between India and China), the Karen people constitute more than one-fourth of Burma's population. The Karen arrived in Burma more than 4,000 years ago and live mostly in the hills bordering the eastern region and in western Thailand.

The Karen people are often referred to as the hill tribes or indigenous people of Burma. The Red Karen include several groups, including the Padaung or Kayan, famously recognized for the neck rings worn by women of the tribe. The White Karen include the Sgaw and Pwo Tribes.

The Karen people have been fighting for independence from Burma for the past 60 years. Since 1962, Burma has been a military dictatorship. The military has tortured, raped, and killed thousands of Karen people. Many have been forced to relocate and work for the military. Thousands died on month-long walks to reach refugee camps in Thailand.

In 1989, Burma was renamed Myanmar, but because of its negative military overtones, most minority ethnic groups refuse to use the new name; they still refer to their country as Burma.

Myanmar (Burma)

Social Structure

The Karen population consists of smaller subgroups of people who speak different dialects. A common interpretation problem is expecting one person from Burma to understand another.

Karen people from Burma identify themselves with their ethnic group; they do not refer to themselves as Burmese. The cultural rift between Karen and ethnic Burmese runs very deep. It can hamper interpretation efforts, affecting the comfort of the individual and confidentiality of information. Karen often prefer no interpretation assistance to assistance from another ethnic group.

The Karen are known for their friendliness, hospitality, traditional red or blue woven shirts and dresses, and festival dances. Many men display elaborate, extensive tattoos that are a mark of character and protection against harm. In Burma, most Karen were farmers and many have little education.

Traditionally, the Karen people do not have surnames, which can create confusion in a health care setting. They normally address each other by terms that denote kinship.

They often communicate indirectly. Rather than coming straight to the point, they discuss other subjects first and may say "no" as a demonstration of modesty. They avoid confrontation and don't like talking about themselves. Public displays of anger and other negative emotions are considered shameful.

The Karen don't engage in public displays of affection. Although, women are often physically affectionate with each other, naturally holding hands or hugging a female visitor. Men may hold hands with one another. Unmarried women and men do not touch, although handshaking is

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common when greeting Westerners, regardless of sex.

In the Karen community, men and women are equal. They trace their lineage through the mother and maternal ancestors and tend to be family oriented. Parents, children, and grandparents often live under the same roof.

Dress is usually conservative, with women wearing sarongs and both men and women carrying woven shoulder bags. Shoes are usually removed and left at the door. Women sit with their feet faced away from others. When walking between others, it is considered polite to bend over so that one's head is not above others. Stepping over people or passing things over others is considered impolite.

The Karen are often recognized for the brass neck rings worn by women from the Padaung or Kayan tribes. The neck rings distort the growth of their collarbones and make them look as if they have long necks. The rings do not actually stretch their necks, but squash the vertebrae and collar bones. A woman may have twenty or more rings around her neck. This practice may begin when girls are 5 or 6 years old.

Diet

Meals are served in family groups and may also include neighbors. A large container of rice is accompanied by smaller side bowls of meat or fish, vegetables, chillis, fermented fish paste, and other foods and spices. In Minnesota, Karen refugees receive welcome packages of rice, other traditional foods, a rice cooker, etc. from the Karen community. when they arrive.

Religion

In the U.S., most Karen people are Evangelical Christians, with a small percentage of Buddhists and Animists. Karens make up the majority of the congregation of St. Paul's First Baptist Church, where they participate in choirs and bands. The church helps the newly-resettled refugees connect with American Baptist-USA and Cooperative Baptist Fellowship churches throughout the U.S. so that they can reconnect with families across the country and around the world.

Many Minnesota organizations support these new arrivals, including the Karen Organization of Minnesota and the Karen Community Minnesota. Several churches and many of the Karen living in Minnesota help new immigrants find food, clothing, social services, and housing.

Other organizations that support the Karen people in Minnesota:

- Local public health agencies, schools, and churches
- Catholic Charities
- Council on Asian-Pacific Minnesotans
- Hmong American Partnership
- International Institute of Minnesota
- Lao Family Community of Minnesota
- Lutheran Social Services
- Minnesota Council of Churches
- SEARCH Ministries
- Vietnamese Social Services
- World Relief Minnesota

Health Beliefs and Practices

While many Karen hold traditional beliefs about health and illness, they tend to believe that Western medicine can cure anything. Many became familiar with Western medical practices, such as use of antibiotics, IV fluids, and birth control, from traveling medical staff when they were living in refugee camps.

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Traditional Karen health beliefs emerged from a lack of medical resources when they lived in isolation in the mountains and rural areas of Burma. Like many groups from Southeast Asia, Karen may attribute illness to imbalance in the natural forces of wind, fire, and water. Many believe that each person has 37 souls, some of which are found in the body or in the external world.

The abdomen is significant in causing and understanding illness. Menstrual flow and related issues are highly significant among women. Chewing a derivative of the betel nut, which stimulates parts of the nervous system, is common among women and men. Although it helps relieve dental pain, it is associated with submucosal fibrosis, oral leukoplakia, and squamous cell carcinoma.

Health providers are often evaluated by the Karen people from the moment of first contact. They seem to prefer a warm, yet business like approach. Translation and interpretation can be challenging in cross-cultural health encounters. It can be handicapped by attempts to use translators from different ethnic groups. Karen often prefer no assistance to assistance from a translator from other ethnic groups.

Choosing the simplest treatment routine possible, explaining prescribed medications, and asking the patient to repeat or demonstrate the treatment routine is most effective.

Printing the treatment plan on a separate sheet of paper is also helpful. Even if the patient does not read, he or she may have a neighbor who does. Follow-up and home visits may be required. Patient education should include:

- Signs and symptoms of common illnesses
- Taking medications correctly
- How to take a temperature
- Hygiene and self care
- Dental care
- When to call or see a provider

End of Life

Karen people in the U.S., who are Christian, may acknowledge death according to the practices of their Christian churches.

For Buddhists, death marks the transition from this world to the next. Karma the deceased accumulated during life begins a process of determining the next in a series of rebirths. Death has major religious significance, but is not considered a time to be sad. It provides an opportunity for the family to assist the deceased into a new existence. The corpse is cremated to allow the spirit to escape.

Ceremonies honoring the deceased can be held for up to 100 days between the period of death and rebirth. Ceremonies mark the death as a fundamental reminder of the Buddhist understanding of life's impermanence. After the funeral, a monk may return to the home to offer a sermon on behalf of the deceased. Survivors may hold an almsgiving ceremony to assist in an enhanced rebirth or for the relief of suffering in the deceased's new existence.

Infectious diseases are the greatest health problem for Karen immigrants.

Other health risks include:

- Anemia
- Anthrax
- Cholera
- Chronic mental health problems
- Dengue fever
- Diabetes mellitus 2
- Hepatitis B
- HIV/AIDS
- Hookworm
- Hypertension
- Leprosy
- Malaria
- Malnutrition
- Parasite infections
- Post-traumatic stress disorder secondary to war, torture, rape
- Injuries
- Sexually transmitted infections
- Tapeworm
- Tuberculosis
- Typhus
- Yaws

Minnesota's Increasing Diversity

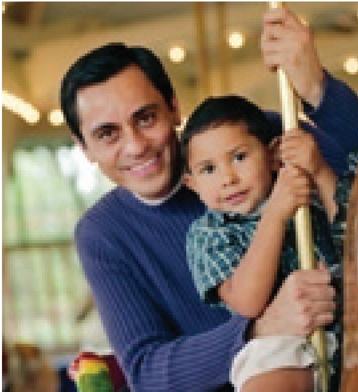
Health care providers across Minnesota are caring for increasingly diverse patient populations. Changing demographics of the state will require a mindful approach to providing effective clinical care. For more information on these multicultural populations: www.culturecareconnection.org.

Did You Know?

The numbers of African American, Asian, and Hispanic/Latino Minnesotans are expected to more than double over the next 30 years, while the number of white Minnesotans is projected to fall.

Minnesota has the largest Somali population in the U.S.

The Hispanic/Latino population in Minnesota is projected to nearly triple by 2035, from 196,300 in 2005 to an estimated 551,600.



The aging of the baby boom population will produce a significant increase in the number of people ages 55-69. By 2035, 22 percent of the population will be age 65 or older.

Minnesota's Hmong population is second only to California, and St. Paul is home to the largest urban population of Hmong in the world.

Following are a few health particulars about some of Minnesota's diverse populations.

- African Americans are affected disproportionately by the leading causes of death in the U.S., including cancer, obesity, diabetes, heart disease, hypertension, and HIV/AIDS. Death rates for African Americans are more than one and a half times higher than whites in most age groups.
- The top causes of death in the American Indian population are heart disease, cancer, unintentional injuries, diabetes, and stroke. American Indian women are seven times more likely than white women to receive inadequate care or no care during their pregnancy.

- Asian Indians in the U.S. have a high prevalence and risk of coronary artery disease—three times as high as the general population. Type 2 diabetes is common in this population due to hypertension and a genetic resistance to insulin.
- Common health problems for older Cambodian refugees who came to this country 30 years ago include nutritional deficits, hepatitis B, tuberculosis, malaria, HIV/AIDs, and post-traumatic stress disorder.
- Common health issues for Ethiopian immigrants are the long-term effects of malnutrition, the physical and psychological trauma from war, and infectious diseases.
- Many Iraqi refugees are torture victims and have lost family members. They may still be struggling to cope with loss and torture after many years and have unique treatment needs.
- Common diseases seen in Russian and Eastern European immigrants include diabetes, hypertension, coronary disease, tuberculosis, mental illness, and alcohol and substance abuse.
- Because of exposure to Agent Orange during the Vietnam War, older Vietnamese immigrants are at risk for cancers, immune deficiency, endocrine disruption, and neurological damage.

Is Generational Poverty a Societal Problem That Can Be Solved?

Inequality of income in America has increased over the past 25 years, with more than 20 percent of households controlling the income. The number of families living in poverty is increasing. In spite of these statistics and a national minimum wage that is insufficient to sustain basic needs, children born into homelessness, hunger, and illiteracy are believed to have the same opportunities as children born into privilege. *Donna Beegle, Communication Across Barriers 2007*

In 1959, anthropologist Oscar Lewis originated the social theory of the "culture of poverty." In Five Families: Mexican Case Studies in the Culture of Poverty, he offered more than 70 characteristics of families that corresponded to this concept. He described a system that led to a subculture where children are "socialized into behaviors and attitudes that perpetuate their inability to escape the underclass." He reasoned that people living in a culture of poverty feel inferior, unworthy, powerless, and dependent. They feel that they do not belong—as though they were aliens in their own country. They know only their own problems, neighborhood, local conditions, and way of life.

Economists describe a culture of poverty as a set of factors or events (e.g., illness, divorce, death of the head of household, etc.) that initiate poverty, and will continue unless there is outside intervention. The poor remain poor because they adapt to the burdens of poverty and do not have the financial capacity, education, or connections to escape a cycle of poverty.

In A Framework for Understanding Poverty, teacher and author Ruby Payne contrasts situational poverty with generational poverty. Families in situational poverty have fallen into poverty because of a traumatic event such as illness or divorce. Families in generational poverty have lived in poverty for at least two to three generations. They have formed their own culture with different values, habits, and lifestyles than families in the middle class. For example, "Joanne doesn't plan for the future. Why bother? It's not in her control. When she gets money, she spends it quickly on flashy new shoes for her kids or a night on the town for herself." Payne says, "Being proactive, setting goals and planning ahead are not a part of generational poverty…(families) often don't have the tools to organize their lives."

Payne describes the disorganization and disorder that is characteristic of families in generational poverty:

- Constant background noise from TV and noisy conversations
- Emphasis on entertainment, story telling, and humor
- Casual language and an oral tradition of story-telling coupled with the lack of formal language skills
- A survival orientation where people talk about people, relationships, and temporary jobs, rather than academics or building a career
- A belief in fate—they don't have a choice in what happens

For these families, the future does not exist. They live in the moment. Life is so uncertain that they don't see anything as everyday, such as work or school. "It's difficult to think about planning for a future when you and your family are hungry today."

Even though many policy-makers have never studied the history of poverty in the U.S., decisions are made, policies are developed, and funding is allocated without regard to the poor, perpetuating a cycle of poverty.

As reported in the 1965 Moynihan Report, the culture-of-poverty concept strongly informed U.S. public policy makers and politicians in implementing Lyndon Johnson's War on Poverty during the 1960s.

Since that time, however, sociologists and anthropologists have argued that data do not support the culture-of poverty-concept. *(Goode and Eames, 1996)*

As early as 1970, political scientist Edward Banfield described a permanent culture of poverty, where government aid to the poor would make the givers of aid feel virtuous, but wouldn't improve the lives of those who received it. He, too, separated the "people with middle-class values who could benefit from government aid" because they could recover from a setback (e.g., disability, unemployment, divorce) from the true lower class who could not improve their situation because they had a present-oriented outlook that does not value work, sacrifice, or self-improvement.

A study conducted in the 1990s by University of Chicago sociologist and self-described liberal Susan Mayer seems to validate Banfield's argument that society cannot correct the worst problems of child poverty—that money doesn't matter much in improving a child's life. More

important are skills, diligence, honesty, good health, and reliability. Children with these attributes do well even if their parents do not have much income. After finishing the study, Mayer admitted feeling depressed by the realization that ending poverty may be beyond the capacity of even a rich nation.

So if a culture of poverty exists, what is to be done about it? Political scientist Robert J. Samuelson suggests that it may be best to maintain an adequate safety net that meets most families' basic needs without being overly generous, so as to create more dependence. Allowing states to experiment with benefits and work requirements may prove which policies succeed.

Generational Poverty: What Would You Do?

Do you have the skills to survive in generational poverty?

1. If you have not lived within a culture of poverty, try to identify with those who do, and imagine how you would survive if you had to deal with some of the daily issues presented below:
2. You have no money. How would you get by for three weeks while waiting for your first paycheck?
3. How would you get food stamps or welfare assistance?
4. Where can you cash a check without identification? How much would it cost?
5. What would you do if you were evicted and had no money to move?
6. How would you survive Minnesota winter nights without heat?
7. How would you (and your children) go for several days without food?
8. How do you keep food cold without a refrigerator?
9. Which agencies and churches give free clothes without stains and shoes without holes?
10. Explain how to give off an aura of violence to avoid trouble.
11. Describe how to smoothly change the subject to avoid answering humiliating questions.

Generational Poverty Survival Skills, www.combarriers.com

Calendar of Events

Healthy Sexuality, Healthy Youth Workshop

October 14 and 21 (two consecutive sessions), Minneapolis, MN

Learn how to play an important role in helping youth better understand healthy relationships and sexuality. Explore ways in which adults can effectively communicate with youth to help them learn the facts and components of human sexuality. Facilitated by Brooke Stelzer, Annex Teen Clinic. Presented by the University of Minnesota Youth Work Institute for those who work with and on behalf of youth.
More>

DiversityRx 2010 Seventh National Conference on Quality Health Care for Culturally Diverse Populations

October 18-21, Baltimore, MD

The conference will offer 15 preconference trainings, 50 workshops, a film festival, poster sessions, and exhibits. Speakers will address the implications of new standards, health care reform, and other policy initiatives, as well as practice advancements and research on language access, culturally competent care, organizational cultural competence and other strategies to improve health care for minority, immigrant and indigenous communities.
More>

Minnesota Hospice Veteran Partnership Conference: Serving Rural Veterans with Hospice and Palliative Care Needs

October 19-20, St. Cloud, MN

A conference intended to increase awareness and develop pathways for increased health care services for Minnesota veterans in rural Minnesota.
More>

Calendar of Events

Many Faces of Community Health 2010 Conference: Time of Transformation – Roots and Redesign,
October 28-29, Minneapolis, MN

Stratis Health is proud to be a sponsor of the 5th annual Many Faces of Community Health 2010 conference. The two-day conference will examine how community-based primary health care will grow, develop, and change under national health reforms and under existing Minnesota reforms. Take this opportunity to assess the impact of health reform on the delivery of health care to medically under served populations. More>

Optimizing Shared Decision-Making in Health Care: Lessons, Challenges, Directions
October 29, St. Paul, MN

This conference will discuss shared decision-making for patients, providers, payers, and policy-makers. Internationally recognized speakers and local experts will share lessons learned in implementing shared decision-making. They will discuss the future direction of medical shared decision-making for Minnesota, based on needs of the community. More >

Minnesota Alliance for Patient Safety 2010 Conference: People and Partnerships
November 3-5, Brooklyn Park, MN

Stratis Health is proud to be a sponsor of this year's MAPS conference for health care professionals, leaders, managers, and educators. The conference will focus on the technical and cultural changes that drive patient safety improvement. It will build upon the creation and measurement of high reliability in delivering safe patient care, going beyond technical fixes to address adaptation and change.

Plan to attend Stratis Health's sessions on the impact of cultural competence on patient safety and using patient safety culture surveys to measure and support patient safety in all settings of care. See a special appearance by the Brave New Workshop, with improvisations on new ways to understand and tackle patient safety challenges. More>

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Stratis Health is a nonprofit organization that leads collaboration and innovation in health care quality and safety, and serves as a trusted expert in facilitating improvement for people and communities.

Stratis Health works toward its mission through initiatives funded by federal and state government contracts, and community and foundation grants, including serving as Minnesota's Medicare Quality Improvement Organization.

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