

migrant-friendly hospitals

Subproject C:

Staff training towards cultural competence:

Enable hospital staff to better handle cross-cultural encounters

Modules for staff training towards cultural competence

Vienna, November 14, 2003

Considerations and preparations before starting the training

Needs assessment to structure training content

Needs assessment results are important material for developing a specific design for the training. The training content should be based on actual incidents/problems that participants have encountered in their workplace and in providing service to diverse consumers. Case studies that are drawn directly from participants experiences are a particularly powerful tool for practicing the skills taught in training. For developing case studies at the base of workforce experience check the manual Cultural Competence in Health Care. A Guide for Trainers, Anand 1999: 3-21 till 3-29

Developing the training content and design of course is a crucial task for the trainer, having the responsibility for conducting the training. But the planning should be done in cooperation with the subproject focal person to ensure that training content and design refers to hospital and department specific needs.

Selecting a trainer

A cultural competence trainer requires

- Good knowledge of and background in cultural diversity issues
- Good process competence
- Familiarity with the routines and procedures in a hospital, so that he or she can relate well to the challenges of everyday work for the various professions represented
- Skills in facilitation and management of diverse opinions, as the subject is one that raises strong feelings

migrant-friendly hospitals

As for cultural competence training to be effective, it must work at both the intellectual and the emotional levels. If people feel rather “talked at” than “talked with”, they will shut down and lose interest. Getting them engaged and really talking truly makes a great difference. The trainer must carefully facilitate the sharing of feelings, so the workshop does not become a “group therapy” session.

For Trainer criterions see Gilbert 2003: 9f and Anand 1999: 1-3 till 1-16

Selecting a training team, preferable mixed ethnicity and mixed gender can be taken in consideration. See Anand 1999: 1-23 till 1-26 for benefits and potential drawbacks

Composition of staff attending the training/Participant Profile

Separate or combined training for staff needs to be considered. Following the expert advice of Shani A. Dowd workforce with similar practice realities could be combined, as their problem areas are similar. E.g. physicians, advanced nurse practitioners and physician assistants are combined in a training class and hospital based nurses are in a separate class. As the training content is developed on basis of experienced problems within the workspace the suggested staff separation allows a more practice-specific proceeding. Also training success will strongly be affected by the openness of communication culture practiced in hospital. The composition of training participants should allow people to speak frankly during the course, which might be more likely among people with similar work experience.

Subproject focal person should take part on the training course.

Group size

The group size should be kept small. Not more than 20-25 participants at the time should be trained. This increases the chances for a better outcome and more engaged participants (Dowd 2003).

Timeframe

For best results, don't leave more than a one weeks gap between Module 1 and 2. Module 3 (Follow up 1) is suggested to be staged four weeks after Module 2. Module 4 (Follow up 2) should be conducted four weeks after Module 3. If your hospital has difficulties placing four appointments, Module 4 is optional, but keep in mind that best results are achieved by running through the full course.

Suggested timelines for specific Modules:

Module 1 – 3 hours (or 4 hours)

Creating the initial training session 3 or 4 hours enables participants to really get into the subject. Consider that people need time (at least one hour) to clear there minds and stop thinking about work that will be waiting for them when they return to practice.

Module 2 – 3 hours (or 2 hours)

Module 3 – 2 hours

Module 4 – 2 hours

Modules for the Training

Getting approval of training from hospital staff

Participation of the training should be voluntary but heavily championed by the management (Dowd 2002). Still some participating staff might not always feel comfortable or approve with the idea of having to attend a training course, reasons can vary, e.g. some might doubt, that a 10 hour training can change anything, or see no need of action from their own side. All the more it is necessary to clear-cut the relevance of the forthcoming training. This can be done while recruiting the training participants or at the beginning of the first module. Getting staff to cooperate right from the start will improve the quality of training!

- cultural competence as skill to help staff members handle problems created by cultural diversity
- training is about staff and their problems, they are the focus of interest
- staff satisfaction might improve quality of care which indicates positive consequences for patient care

Content of the training course

As cultural diversity training often elicit strong emotions in participants, it is important, that participants feel safe enough to openly share their feelings, experiences and thoughts. Therefore it is advisable to establish norms or ground rules to ensure a sense of safety (e.g. be open, no dumping or blaming, confidentiality). Also in establishing norms, participants agree on how to work together during the course of the workshop. For suggested norms see Anand 1999: 4-8 till 4-9.

Awareness, knowledge and skills are the framework of the training. Within those concepts different approaches can be implemented. The following presentation should allow some orientation but is considered optional. Try to design the content of the training as close as possible to your hospitals problem reality. Developing case studies drawn from your own workspace will acknowledge staffs experience and encourage involvement.

Module 1

Part 1: Raising Awareness (2 hours)

Goals:

- Increasing self-awareness and receptivity to diverse patient populations
- Increasing awareness of participant's own biases and experiences with difference

Increasing self-awareness (25 min)

In interactive small groups participants reflect on their own cultures and how those influence their personal points of views on illness and health care. They also should explore the extent to which the "medical culture" has become incorporated into their

migrant-friendly hospitals

cultural outlook. Distinguish between disease and illness to underline the discussion about cultural influence on health perception (see also Carrillo 1999: 829f).

Attitudes are not an issue of the awareness module, attitudes will be respected as a private matter. Rather the question is asked how proper patient care for all kind of patients can be insured despite different attitudes and carrying it further, despite biases.

Receptivity of diverse patient populations (25 min)

Each patient's situation is unique and is influenced by personal and social factors as well as by culture. Awareness of cultural diverse backgrounds and their influence on people's perceptions, interpretations and behaviour are part of this lesson. Distinguish between refugees, immigrants and native citizens who are minorities.

Use a case study (develop your own story) that illustrates core cultural issues.

E.g.: "A 34-years old, healthy Egyptian woman presents as a new visitor to a physician. She is accompanied by her husband. Her husband seems somewhat domineering, answering all of the medical history questions himself....see Carrillo 1999: 830).

Then get participants to discuss their impressions of the story and how issues may be influenced by social and cultural factors.

Increasing awareness of participant's own biases (1 hour)

The participants should become aware of their internalised beliefs, values, norms, stereotypes and biases, of how ethnocentrism operates in all cultures and get encouraged to be attentive to the possibility of ethnocentrism in their own thinking and in their interaction with patients.

Lecture 6 (30 min)

Exercise 11 (30 min)

See manual Cultural Competence in Health Care. A Guide for Trainers, Anand 1999: 4-41 till 4-43 and 4-113 till

Part 2: Providing Knowledge (1hour)

Goals:

- Knowledge about problems concerning staffs encounter with diversity and solutions
- Expanding knowledge and competence to work effectively in a multicultural environment and serve diverse consumers

Providing knowledge as training content has to be understood as a practical approach to explore the various types of problems that are likely to occur in cross-cultural encounters and to learn to identify and deal with these as they arise. In this area you need to refer to practical problems which occur in your hospital concerning staff in their encounters with people of diverse cultural background. Possible problem areas are: different personal communication styles; diversity in perception of illness and disease and their causes; relevant belief systems relating to health, healing and wellness; help-seeking behaviours and attitudes toward health care providers; specific types of social

migrant-friendly hospitals

support provided by family and community relevant in the situation; specific spiritual and religious needs, etc.

Expanding knowledge about the legal situation of migrants and refugees, migration medicine and available community support structures.

Possible solutions have to be looked for and shall conclude every problem discussion!

Possible designs for training area proceedings:

- If you have noticed that **different personal communication styles** are considered a problem by staff:

Exercise 20 (30 min)

Discussion on barriers to cross-cultural communication – use Lecture 12 as checklist (30 min)

See Anand 1999: 4-57 till 4-59 and 4-143 till 4-146

- If staff has problems with **non compliance of diverse patient population** understanding the **patient's explanatory model and the patients social context** can be a useful training subject:

Exercise 16 (45 min)

See Anand 1999: 4-127 till 4-130

- or: Develop your own case study as training material
- or: Use Provider Case Study #5: a healthy Appetite and follow instruction of the manual. See Anand 1999: 4-197 till 4-198

Providing knowledge does not mean to learn every aspect of each culture that could influence medical encounters, this can be considered rather impossible. But references about culture specific literature can be provided and handed out to interested staff.

Module 2

Part 1: Providing Knowledge (1 hour)

Continue working on the above discussed area.

Part 2: Developing Skills (2 hours)

Goal: Building specific professional skills in the area of cultural competence

This skills are:

- Skills that enable health care staff to assess their own responses, biases and cultural preconceptions on an ongoing basis

Modules for the Training

migrant-friendly hospitals

- Skills as communication tools and strategies to elicit patients social, family and medical histories, as well as patients health beliefs, practices and explanatory models
- Skills for negotiating conflicting patient/provider perspectives

Communication skills:

Introduce the LEARN-Model by Berlin and Fowke and practice upon it
Exercise 23 (45 min) see Anand 1999: 4-157 till 4-159

Conflict solving skills:

Lecture 15 can be used as theoretical background on conflict negotiation

See Anand 1999: 4-65 till 4-66

Then use your **own case study** to demonstrate a conflict and work on problem solution on basis of personal skills (45 min). Use the underneath described negotiation model:

Negotiating explanatory models (see Carrillo 1999: 831)

- Explore patients explanatory model
- Determine how the explanatory model differs from the biomedical model and how strongly the patient adheres to it
- Describe that biomedical explanatory model in understandable terms, using as much of the patients terminology and conceptualisation as necessary
- Determine the patients degree of understanding and acceptance of the biomedical model as it is described
- If conflict remains, reevaluate core cultural issues and social context (e.g. bring in family members or maximize interpretation)

An simple but practical example from The Perinatal Program (Health Resources and Service Administration):

“...in Hispanic culture ... there is a strong believe about a fallen fontanel, the soft spot, when a baby’s soft spot is sunken, or low around the hole in the skull, that’s a bad thing, so they will hold up the baby upside down by the feet and shake it s little so the hole fills back up. Medically, the western belief is that it is sunken from dehydration. So not to blow this tradition off, we say, ‘what you have done so far, ok, you held the baby upside down, good, you need to do that, but you also need to give the baby lots of water or breast milk or formula. So every time you see this, do the holding upside down, but also make sure the baby gets lots of liquids.’

This example shows the value of the information from the community being integrated into medical care to ensure medical attention of the children. A negotiation between consumer and health car workers has taken place.

To conclude Module 2 let **participants reflect on their learning** from the training and strengthen them in taking action. The intention is to move from what *can* I do to what *will* I do.

Exercise 26 (15 min) gives detailed instructions

See Anand 1999: 4-171 till 4-173

Module 3

Follow up 1 – Experiential learning (2 hours)

Goals:

- Share experiences about actions taken in everyday practice resulting from the initial training
- Problem discussion and developing further skills are on the agenda

Find out from workshop participants:

What changes related to cultural competence have been made in their jobs?

Are there any new insights about doing the job differently?

Are improvements noticeable?

Any stumbling blocks, what are they and why do they occur?

Work on:

Remaining problems and try to find solutions

Identify limits of personal involvement for staff: some problems might be of organisational matter and can not be solved with individual effort. To know about limits can relieve personal pressure from health care professionals. As limits of personal acting are becoming clear also areas of responsibility are confirmed.

Subproject focal person works as mediator between identified organisational and structural problems and hospital management.

Experiential learning is about taking people and their concerns serious and should not be seen as an evaluation program of the training content! Hospital professionals are able to experience that their actions towards cultural competence are having consequences, that mistakes are there to learn and to improve one's situation as well as to help others getting awareness on the relevant subject.

Module 4

Follow up 2 – Experiential learning (2 hours)

Goals: further development of skills on the basis of experiences in everyday practice

Let people talk and share their experience about cultural competent work and keep working on developing skills for emerging problems.

Follow up 2 will allow to deepen the cultural competence work and will value previous and present efforts. Good results should be at this time evident and raise acceptance.

For using training for sustained and successful developments in hospital practice, experiential learning should become a permanent implementation, e.g. every 6 month or at least once a year!

References

Anand, Rohini (1999): Cultural Competence in Health Care. A Guide for Trainers. Washington

2 copies of this manual were forwarded to the participating hospitals in October 2003.

Carrillo, Emilio et al. (1999): Cross-Cultural Primary Care: A Patient-Based Approach. Annals of Internal Medicine. 130, p. 829-834

Forwarded as part of the Appendix to the Draft Pathway on September 1, 2003

Dowd, Shani A. (2002): Improving cultural Competence: A Systems Perspective. Best Practices for Culturally and Linguistically Appropriate Services in Managed Care. Harvard Pilgrim Health Care – Boston (presentation)

<http://www.cms.gov/healthplans/quality/project03.asp>

Dowd, Shani A. Expert Adviser. Harvard Pilgrim Health Care: (2003): Comment on draft pathway, September 2003

Gilbert, Jean (Ed.) (2003): Principles and recommended standards for cultural competence education of health care professional. The California Endowment – Woodland Hills

Forwarded as part of the Appendix to the Draft Pathway on September 1, 2003

Health Resources and Service Administration. US Department of Health and Human Services (Ed.) (2001): Cultural Competence Works.