



# migrant-friendly hospitals

## Subproject C

### Improving cultural competence: Training hospital staff for providing cross- cultural health care

*Pathway for implementation and evaluation*

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## Executive summary

### The problem

The literature consistently shows disparities between majority groups and minority/migrant groups in health care and health outcomes. These disparities can be attributed in part to cultural unawareness, misunderstandings, and prejudices.

A lack of cultural competence on behalf of the hospital staff is not only a problem for the patients, but also a challenge for the quality of health care professionals' work and satisfaction, as well as for hospitals' interest in efficient service provision and consumer satisfaction.

### Solutions

The expert discussion mentions three different entry points for solutions to reduce the cultural gap: staff training, organizational development and patient education.

Subproject C focuses on staff training, supported by specific organizational development measures in selected model departments. Transfer of the model to the overall hospital should be facilitated by presentations of experiences and results.

### Characteristics of the proposed training

- Voluntary but heavily championed participation of health care professionals and other staff with regular contact to migrant/minority patients.
- The training should be conducted by a team of professional trainers having mixed backgrounds with respect to ethnicity, gender, etc.).
- The training addresses the following:
  - Awareness: self, other
  - Knowledge: problem areas in health care provision with ethnic groups, migrants, refugees, and/or undocumented persons, etc.; migration medicine, community support structures
  - Skills: primarily communication
- The course should promote emotional and cognitive learning.
- The training should take place on several days with an overall length of approximately 10 hours including a follow-up after a few weeks.

### Supporting measures on the model wards:

- Strong and explicit support by the management
- Integration of new principles and skills in everyday routines
- All relevant stakeholders should be consulted in the planning of the measure
- Provision of relevant materials (manuals, etc.)
- Networking with specialists in the field in question



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## **Roles and tasks for implementation**

- Focal person or subproject focal person: manage subproject
- Top management: support the subproject
- Department management: support and collaborate with the subproject
- Staff representatives: agree with and support the subproject
- Trainer or team of trainers: design and conduct the training (incl. evaluation)
- Patient and community representatives: agree with and support the subproject
- European project/LBISHM: support the subproject

## **Evaluation**

- Evaluation before and after the cultural competence training using focus group techniques on hospital staff participants.
- Evaluation of the implementation of supporting measures using parts of the Migrant-Friendly Quality Questionnaire (MFQQ) developed in the framework of the MFH project.



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# 1. The Problem

## ***Why specific attention to improving health care and health promotion for migrants and ethnic minorities?***

European populations are becoming increasingly more diverse in the 21<sup>st</sup> century. As for other Europeans, health is a central issue for people with a migration or ethnic minority background, especially as migrants and ethnic minorities often find themselves in socially disadvantaged situations that negatively affect their health. Appropriate health care, equal access to health care, and health promotion to increase health literacy are particularly important for people with "different" ethnic backgrounds.

Health care and health promotion for migrants and ethnic minorities do not always run smoothly. There is a wide range of scientific evidence to the effect that not only is the health status of minority groups worse than that of the majority population in many areas, but also that health care provision is unequal (see a current review of the literature, Bischoff 2003, p. 97). Problems can be located on both sides: on the one hand, migrants' health literacy – e.g., their knowledge of European health care systems – can be limited, and on the other hand, European health services are frequently not tailored to accommodate the diversity in question.

## ***Why specific attention to improving the cultural competence of hospital staff?***

Communication between health professionals and migrant or ethnic minority patients is complicated not only by language barriers but also by cultural misunderstandings (Bischoff 2003, pp. 50). Hospital staff's work is based on implicit cultural assumptions – e.g., with regard to the roles of patients and providers and also to the proper way to diagnose and treat illness. These assumptions often do not correspond with the expectations of migrant and ethnic minority patients who in many cases have different conceptions of health and illness, values and beliefs concerning health care and frequently are unfamiliar with mainstream European health systems.

On the other hand, migrant and ethnic minority patients' needs and expectations may not be understood by health professionals – due to language barriers, of course, but also due to a lack of awareness of values and beliefs related to the patients' cultural backgrounds. Differences in expectations that are not acknowledged and not managed also present major obstacles for health care professionals in effectively performing their jobs and for hospitals in efficiently providing services and achieving consumer satisfaction.

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In the United States of America, the discussion concerning cultural competence in health care has been ongoing since the 1980s, but increased in intensity in the 1990s. Robert Like (2002), a distinguished expert in that field, sums up the rationale for "culturally competent health care":

- Responding to demographic changes
- Eliminating disparities in the health status of people of diverse racial, ethnic, and cultural backgrounds
- Improving the quality of services and outcomes
- Meeting legislative, regulatory, and accreditation mandates
- Gaining a competitive edge in the marketplace
- Decreasing the likelihood of liability/malpractice claims

Also in the specific needs assessment of the mfh project, conducted in the spring of 2003, a lack of cultural competencies of hospital staff has been identified as a main problem area in many partner hospitals and thus has been selected as a subproject area in the MFH project.

## 2. Solutions for improving cross cultural health care provision

In a logical analysis, measures and interventions can be distinguished according to whether they are oriented toward persons or social situations:

- a) Increasing the levels of relevance and available resources on the personal level: the awareness and competence of the persons concerned are to be improved; interventions can target not only hospital staff but also (potential) patients, their relatives and communities
- b) Increasing the levels of relevance and available resources in the social situation: the organisational structure and culture of health care organisations – hospitals and others – are to be developed to create a favourable environment for competent cross-cultural health care provision

In the literature, the main focus is on staff training and organisational development. There are also some patient education programs with an outreach approach (Bischoff 2003), but we focus in the MFH project on measures that aim at developing the competency of the hospital:

- Staff training for cross-cultural health care provision: here, personal (clinical) cultural competence is the goal of training, to be achieved by raising awareness, offering knowledge and developing skills (for an overview on a wide range of US programs see Betancourt et al. 2002, Gilbert 2003a)

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- The organizational dimension of cultural competence is addressed in the literature in a number of ways: as organizational support for professional cultural competence (Gilbert 2003b:5), as organisational and systemic cultural competence (Betancourt et al. 2002:17), or as a systems approach to cultural competency (Dowd 2002), etc. Building culturally competent organisations is considered a long-term project. An organisational development (OD) approach addresses the following:
  - o Changing hospital structures (cultural mediators, hiring diverse hospital staff, etc.); and
  - o Changing the hospital culture (commitment of management on various levels, inclusion into mission statements, diversity training for hospital staff, etc.)

## 3. Proposed solutions in the framework of the MFH project: Training in model departments

### *The approach*

The selected approach is to **offer training courses** for all members of staff, not generally for all hospital staff interested in the subject but in a first step for 2-3 model departments that volunteer for the project, following an internal call for tenders by the hospital management (invitation to participate/ to “bid” to all or selected hospital departments).

The following aspects were the basis for suggesting training courses as Subproject intervention:

- The hospitals' declared interest in training courses
- Feasibility with limited additional effort
- Feasibility in planned running time of the project
- Likelihood of visible success
- Wide range of ongoing initiatives as well as several models with positive evaluations (especially in the USA, e.g. Carrillo et al. 1999, Culhane-Pera 1997) and systematic reviews
- Suggestions for standards, principles and implementation strategies derived from experiences in training courses expected for the planned European Recommendations

The model-department approach is suggested in order to accomplish the following:

- Avoid too much complexity
- Reduce needed time and resources (in comparison with an overall approach)
- Avoid the risk of too much resistance arising from a top-down overall organisational approach

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- Avoid the risk of no organisational impact if an overly non-obligatory, volunteer-based approach is taken

Training courses can serve as the starting point for more in-depth developmental processes in a hospital department's culture, starting a new "migrant-friendly" culture or strengthening an already existing one. In the MFH project, we address the organisational development dimension in the "overall project" as well.

## ***Planned steps and phases:***

- Agenda-setting at the management level – in meetings, conferences, symposia, etc., to raise awareness and provide information (Gilbert 2003b);
- Issue of a call for tenders for 2-3 model departments
- Organisation and carrying out of courses for doctors, nurses and other staff who have regular patient encounters in the model departments
- First step in the course: group interview and/or discussion (assessment of the specific needs in the department) as the basis for fine-tuning and conducting the course, and as a baseline for training evaluation
- Cross-cultural competence training in health care includes the following:
  - o Awareness of influence of culture on peoples' (self and others) perception and behaviour
  - o Knowledge about important aspects of diversity
  - o Skills for appropriately, effectively, efficiently, and sustainably handling diversity
- Participation on the part of all relevant model department staff that although it is voluntary is heavily championed by management
- Short evaluation at the end of the course, and a follow-up meeting after 1-4 weeks (depending on the frequency of contacts with culturally diverse patients), in order to work on problems and further issues
- Public presentation of results to all hospital staff at the end of the pilot phase, in order to facilitate transfer to other departments and develop a basis for sustainability at the overall hospital level.

## ***Supporting measures in model departments :***

- Strong explicit support by management
- Ensure that participation in training be reckoned as regular work hours in order to underline the importance of cultural competence
- invitation of all relevant stakeholders to consult in the planning of the course (including staff representatives and community representatives)
- integration of new principles/ skills in everyday routines
- provision of fact sheets, handbooks, intranet information etc.

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- networking with specialists for cultural mediation, religious authorities, community resources etc.

## 4. Suggestions for specific characteristics of the course

The literature (e.g., Anand 1999, Gilbert 2003, Carrillo et al. 1999, Dowd 2002) discusses options for organising/ conducting these training courses; in deciding, it will be necessary to take into account the specific hospital and hospital department context (what are the specific needs, what has been established already etc.).

### ***WHO should participate?***

Options: Voluntary or mandatory participation; unselected hospital staff or staff of specific departments; single- or multi-professional approach

- Following Dowd (2002) and other authors we propose participation that, although it is voluntary, is heavily championed by the management of the department and the hospital.
- In general, the literature seems to favour a broad and rather voluntary approach. In the framework of the planned common intervention period (October 2003 – April 2004), we nevertheless suggest a two-step strategy with a model-department approach that can be widened after the end of the common intervention period
- Concerning a single- or multi-professional approach, the literature favours a rather multi-professional, cross-hierarchical general approach in the beginning of a cultural-competence training. This allows an understanding of the complexity and relevance of such a training from many different perspectives. The literature advocates more specificity at a later stage, when technical aspects such as medical interviewing are on the agenda.

### ***WHO should conduct the course?***

- The literature contains lists that include a wide range of occasionally very ambitious criteria (see Appendix; e.g., Anand, Gilbert,..).
- In general, what is minimally required is a professional trainer for communication skills who has:
  - o Good knowledge of and background in cultural diversity issues
  - o Good process competence
  - o Familiarity with the routines and procedures in a hospital, so that she or he can relate well to the challenges of everyday work for the various professions represented
- There also is a trend toward suggesting a team approach with a trainer team that is "mixed" with respect to ethnical background, gender, etc.

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## ***WHAT should be the content?***

- Awareness of cultural diverse backgrounds (health professional vs. lay patient, ethnicity, class, gender, age, migration history, etc.) and their influence on people's perceptions, interpretation of and behaviour in the world. It is crucial to make sure from the first that participants develop an awareness for the fact that their impressions, assumptions, prejudices, etc., are influenced by their own specific cultural backgrounds. This cultural backgrounds can include ethnicity, religion, profession, social class, gender, age, etc.
- Knowledge about the following:
  - Problem areas such as:
    - 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 support provided by family and community relevant in the situation
    - Specific everyday routines such as nutrition and hygiene that are relevant to the situation
    - Specific spiritual and religious needs
  - Legal situation of migrants and refugees.
  - Migration medicine – specific medical problems
  - Available community support structures
- Skills: a patient-centred approach that focuses on the individual and avoids stereotyping should be advocated. The LEARN-Model by Berlin and Fowke is an example:
  - (L) Listen to the patient's perspective
  - (E) Explain and share one's own perspective
  - (A) Acknowledge differences and similarities between these two perspectives
  - (R) Recommend a treatment plan
  - (N) Negotiate a mutually agreed-on treatment plan

## ***HOW should work be organised?***

- The course should promote cognitive and emotional learning, which suggests the use of diverse and interactive educational methods such as case studies, role plays (up to drama elements), discussions, panel discussions to demonstrate different perspectives, the use of guest speakers on certain topics, etc.
- Diversity of educational methods also recognizes participants' different learning styles

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- Size and make-up of groups that work together in group activities should vary in the course
- The purpose of each activity, exercise and lecture should be made clear to every participant
- It is recommended to start and to end with activities which have a low potential to create powerful emotions
- The training should take place in a safe, non-judgemental and supportive environment

## ***RESOURCES – what is needed?***

- Time
  - o there is no consensus on the overall length of the course, as many authors/ groups argue that the development of cultural competence is a long developmental process; nevertheless the suggested length of specific training courses ranges between 8 hours to full week; we suggest approximately 10 hours
  - o how should these hours be used: as literature gives no clear advice on that topic, we suggest to offer the course in several modules on several days, which allows the participants a phase of reflection and practice between two modules.
  - o A follow up is recommended by literature, but no specific details for it are given. As outlined above we propose a follow up meeting after 1 – 4 weeks (depending on frequency of contacts with culturally diverse patients) to work on problems and/or further issues
- Room: Depends on the design of the training course
- Technical equipment, copies, etc.: Depends on the design of the training course
- Costs: Depends on the design of the training course (number of participants, status of training - part of working time or not, length of training, trainers, room, materials)

## **5. Implementation: roles and tasks**

### ***MFH project team (focal person or subproject focal person)***

- Facilitate and support the process
- Prepare the call for tenders for the model departments and promote it in the hospital
- Negotiate with top-level and department-level management
- Select a trainer or team of trainers in collaboration with department management
- Achieve agreement on aims, content, and design with the trainer (team) and with all relevant stakeholders (management, minority/community representatives, staff representatives)

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- Achieve agreement on evaluation with all relevant stakeholders including oneself, the subproject manager, the eval. specialist(s) in the framework developed for the European project
- Implement evaluation
- Make a public presentation of results to all hospital staff at the end of the pilot phase

## ***Top management***

- Give the issue and the intervention high priority on the hospital agenda
- Authorise the call for tenders to identify the model departments (2-3 departments recommended)
- Decide whether participation will be reckoned as work hours
- Decide about financial resources, trainers, rooms, equipment, etc.
- Provide resources for supportive action – e.g., funds for information materials such as fact sheets, for a database on the intranet, etc.
- Discuss about issues of transfer and sustainability, which may include implementing the post of a cultural diversity co-ordinator or the like
- Provide public support on the symbolic level as well for cross-cultural health care and promote cultural competence on all levels
- Support the public presentation of results to all hospital staff at the end of the pilot phase

## ***Department management***

- Place a bid
- Select a trainer or a team of trainers with focal person or subproject manager
- Decide with trainer/-team upon voluntary/compulsory participation
- Selection of staff for training with trainer/-team
- Provide public support on the symbolic level as well for cross-cultural health care
- Implement evaluation
- Facilitate application of awareness and skills in everyday routines of the department – for example, by including cultural competence into standards or by setting aside resources such as working time
- Support the public presentation of results to all hospital staff at the end of the pilot phase

## ***Staff representatives***

- Agree and support
- Support the public presentation of results to all hospital staff at the end of the pilot phase

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## ***Trainer or team of trainers***

- Develop design and content, rules and forms of participation together with focal person and/or subproject co-ordinator (in agreement with all relevant stakeholders)
- Conduct needs assessment in the framework of a first session
- Develop specific objectives (together with focal person and in the trainings with the trainees)
- Decide if specific content and design is needed for the different target groups, which include clinical staff such as doctors, nurses and others, as well as other, non-clinical staff who are involved in direct communication with patients and their relatives.
- Decide on the specific design and sequence of each work session
- Conduct training
- Conduct evaluation at the end of the training
- Support the public presentation of results to all hospital staff at the end of the pilot phase

## ***Patient / Community representatives***

- Agree and support
- Collaborate
- Support the public presentation of results to all hospital staff at the end of the pilot phase

## ***What will be the support from the European project?***

LBISHM provides the following:

- Pathway arguing the rationale, options and steps for implementation (also, the English translation of certain tools upon request)
- Evaluation concept (in English) and specific instruments (translated into local language)
- Presentation and discussion of the pathway, and an evaluation concept, at the workshop in Reggio Emilia, Italy, September 18 – 20, 2003. This is in collaboration with experts from the field of cultural competency training (one expert is invited to describe their personal experiences and answer questions in Reggio Emilia).
- Bilateral or multilateral consultation on the [www.mfh-eu.net](http://www.mfh-eu.net) web platform and further consultation in two telephone conferences (in collaboration with an invited expert)

## 6. Evaluation outline

- Before-and-after design
- Basis: self-rating by participating staff
- Start of course with a group discussion; with specific needs assessment and baseline for evaluation; with a multi-perspective approach (from doctors to cleaning staff)
- End of course: group discussions with trained staff: what differences do the participants see in comparison with the start of the course?
- Evaluation of the implementation of supporting measures using parts of the Migrant-Friendly Quality Questionnaire (MFQQ) developed in the framework of the MFH project
- Measurement of changes in patient experiences? Rather difficult to measure in the short period, as there are too many possible confounders and no clear attribution of effects is possible



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## 7. References

- Anand, Rohini (1999): Cultural Competence in Health Care. A Guide for Trainers. Cultural Competence in Health Care. A Guide for Trainers - Washington
- Berlin, E.A./Fowke, W.C (1983) :A teaching framework for cross-cultural health care. West J Med 1983, 1(39), p. 934-938 (LEARN-Model)
- Carrillo, Emilio et al. (1999): Cross-cultural primary care: A patient-centered approach. Ann Intern Med. 1999, 130, p. 829-834
- Betancourt, Joseph et al. (2002): Cultural competence in health care: Emerging frameworks and practical approaches. The Commonwealth Fund – New York
- Bischoff, Alexander (2003): Caring for migrant and minority patients in European hospitals - A review of effective intervention. Neuchatel and Basel
- Culhane-Pera, Kathleen et al. (1997): A curriculum for multicultural education in family medicine. Fam Med 1997, 29(10), p. 719-723
- Dowd, Shani (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>)
- Gilbert, Jean (Ed.)(2003a): Principles and recommended standards for cultural competence education of health care professionals. The California Endowment - Woodland Hills
- Gilbert, Jean (Ed.)(2003b): A manager's guide to cultural competence education for health care professionals. The California Endowment - Woodland Hills
- Like, Robert (2002): Core Medical Education Curriculum Guidelines on Cultural Competence. NHMA Workshop on Developing Hispanic-Focused Cultural Competence Curriculum in Medical Education, National Hispanic Medical Association - Washington (presentation)