Improving Your Practice and Advocacy of Cultural Competence through the Skills-based ASCN Model

Presented by the

Western Region Public Health Training Center, California State Office of Rural Health and Southwest Telehealth Resource Center

Welcome

WRPHTC region – Arizona, California, Hawai'i, Nevada, and the US Associated Pacific Island

SWTRC region – Arizona, Colorado, New Mexico, Nevada, and Utah

Fellow HRSA grantees

All other participants from the US & abroad

Approved Continuing Education Credits

- 1.0 CNE contact hours
- 1.0 CECH for CHES
- 1.0 CPEU for RDs

Continuing Nursing Education Information

Learning Objectives

Upon completion of this presentation, the participants will be able to:

- Describe the Ask, Share, Compare, and Negotiate (ASCN, pronounced: “askin”) model and how this skills-based approach to culturally competent care can be applied to your clinical setting.
- Demonstrate familiarity with the Culturally and Linguistically Appropriate Services (CLAS) standards of the US Department of Health and Human Services (HHS) Office of Minority Health (OMH) and how they impact the ethical responsibilities of healthcare service providers.
- Define “health disparities” and how they disproportionately affect ethnic and racial minority populations in the United States.
- Recognize that “ethnicity,” “race,” and “culture” are fluid categories that overlap and also include other aspects of identity such as religion, sexual orientation, gender, geographical region, etc.

Continuing Nursing Education Information

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- The planners and presenters have no relevant financial relationships to disclose.

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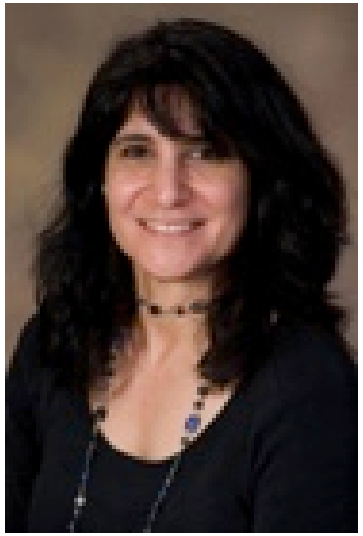

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The Key Elements of Cultural Competence

- Cultural Self-Awareness
- Awareness of Other Cultures
- Tools for Establishing Therapeutic Alliances & Bridges Across Cultures
- ***Cultural Competency is an Ongoing Process, Not Just a Checkbox***

Brief Cultural & Health Beliefs Self-Assessment

1. Describe yourself culturally & ethnically.
2. Discuss how you think your grandparents or great-grand-parents would behave when seeking treatment for a health issue. What kind of approaches or providers would they prefer? What would be their cultural and linguistic preferences?
3. What is you first memory of receiving healthcare? What was the context? How did it feel? How does that influence how you perceive your role as a healthcare professional today?
4. Have you ever experienced miscommunication with a healthcare professional? What happened?

Agency for Healthcare Research and Quality (AHRQ) National Healthcare Quality Report

In 2013, the AHRQ, which works to improve healthcare quality and effectiveness, noted **patient-centered care** as a core component of quality healthcare. The AHRQ quoted the Institute of Medicine, saying:

- [Healthcare] that establishes a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients' wants, needs, and preferences and that patients have the education and support they need to make decisions and participate in their own care (IOM, 2001).

Sources: 1) https://www.ahrq.gov/research/findings/nhqrdr/nhqr13/chap6.html. 2) Institute of Medicine. Envisioning the National Health Care Quality Report. Washington, DC: National Academy Press; 2001.

Minority Health Disparities

In 2003, The Institute of Medicine released a report entitled "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care" (ed. Smedley et al) which defined "health disparities" as those differences between health outcomes for *majority versus under-represented minority populations* that **cannot** be explained by:

- *Patient preferences*
  - *E.g., gender, race, status of provider*
- *Access to care*
  - *E.g., insurance, socio-economic status*
- *Disease severity*
  - *E.g., genetic predispositions, preventable hospitalizations*

- At worst this represents ongoing institutional racism and social injustice; at best, widespread inequality of care according to culture and ethnicity

Healthcare Disparities, Economics & the "Triple Aim"

Developed by the *Institute for Healthcare Improvement* in 2007 for:

- Improving the patient experience of care (including quality and satisfaction)
- Improving the health of populations
- Reducing the per capita cost of health care

Through:

- *Defining "quality" from the perspective of an individual member of a defined population*

(Source: http://www.ihi.org/engage/initiatives/TripleAim/Pages/default.aspx)

The Culturally and Linguistically Appropriate Services (CLAS) Standards of the HHS Office of Minority Health (OMH)

- ***Promoting equity at every point of access***
- The main standards for promoting culturally and linguistically appropriate care
- Why are we required to know about them?
  - Professional organizations that recognize CLAS training and practice as ethical obligations include:
    - National Association of Boards of Pharmacy (NABP)
    - National Council of State Boards of Nursing (NCSBN)
    - American Medical Association (AMA)

Culturally and Linguistically Appropriate Services

- Principle Standard: "*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*."
- Office of Minority Health (OMH) revised its Culturally and Linguistically Appropriate Services (CLAS) guidelines in 2013 to include not only racial, ethnic and linguistic groups, but also:
  - geographical
  - religious
  - spiritual
  - biological (e.g., epigenetics, population groups)
  - sociological characteristics

(https://www.thinkculturalhealth.hhs.gov/pdfs/NationalCLASStandardsFactSheet.pdf)

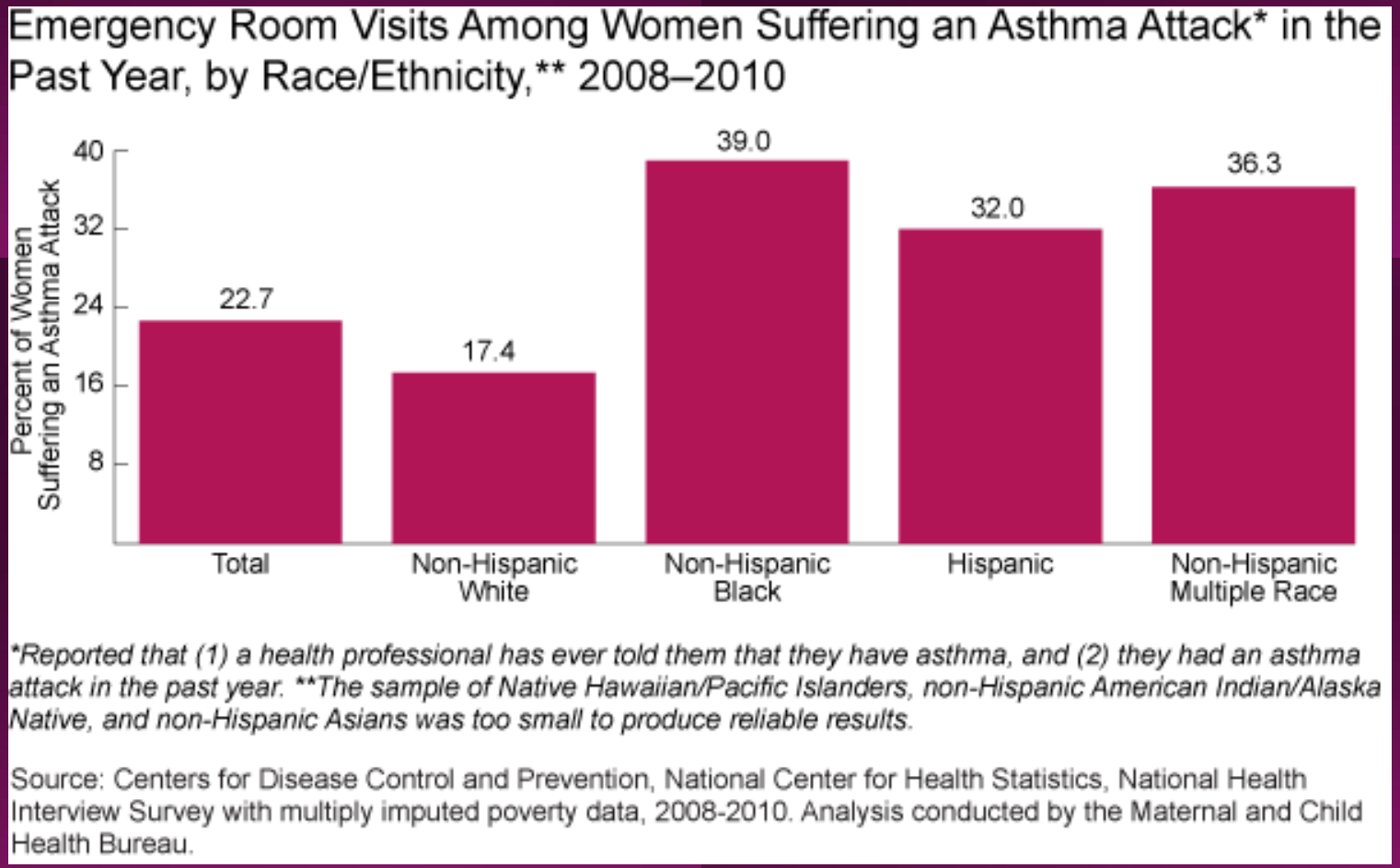
Origins of Culturally and Linguistically Appropriate Care Standards in the U.S.

- Impact of the Civil Rights Movement socially, and, legally, the Civil Rights Act of 1964
  - "No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance" (Civil Rights Act of 1964)
- Establishment of the Office of Minority Health in 1986
  - First standards for Culturally and Linguistically Appropriate Services (CLAS) standards in 2000
  - Revised CLAS standards in 2013

Legal Mandates for CLAS

- Civil Rights Act of 1964 (Title IV)
  - Requires all entities receiving Federal financial assistance, including healthcare providers accepting Medicare or Medicaid, to ensure that limited English proficiency (LEP) persons have meaningful linguistic access to the health services they provide.
- Americans With Disabilities Act (ADA) of 1990
  - Provides language access accommodations for individuals who are deaf, hard of hearing or speech-impaired.
- The Joint Commission on Accreditation of Healthcare Organizations (2006)
  - Requires hospitals to provide culturally and linguistically effective communication for each patient.
- National Committee for Quality Assurance (2009)
  - Stipulates that the provision of healthcare interpreters is essential to overcome the communication gap between providers and non-English-speaking patients.
- State Laws
  - Some states (including Massachusetts, Maryland, California, and Rhode Island) and some cities (such as Washington, DC and New York City) have specific statutes requiring language access in healthcare.

ER Visits for Asthma Attacks in Women by Race/Ethnicity



The Terms We Use & Why: Race

- US Census Bureau (2014): "The racial categories included in the census questionnaire generally reflect a social definition of race recognized in this country and not an attempt to define race biologically, anthropologically, or genetically. In addition, it is recognized that the categories of the race item include racial and national origin or sociocultural groups."
- "*A human group defined by itself or others as distinct by virtue of perceived common physical characteristics that are held to be inherent*." (Cornell and Hartmann 2007; sociology)

The Terms We Use & Why: Ethnicity

- "*a collectivity within a larger society having real or putative common ancestry, memories of a shared historical past, and a cultural focus on one or more elements defined as the epitome of their peoplehood*" (Cornell/Hartmann 2007; Schermerhorn 1978)
- "Ethnicity" as a term first used in the early 20th Century U.S. by government agencies to differentiate between different Europeans:
  - groups from Northern Europe (e.g., English and Germans) seen as "White" and East or South Europeans (e.g., Jews, Irish, Greeks & Italians) seen as "Ethnics"
- "Ethnicity" gradually generalized in mid-20th century to "non-Whites" – i.e., African Americans, Hispanics, Native Americans, and Asians – all of whom, in America's increasingly multi-ethnic & bi-racial society, may also claim other racial and ethnic heritages simultaneously

The Terms We Use & Why: Culture

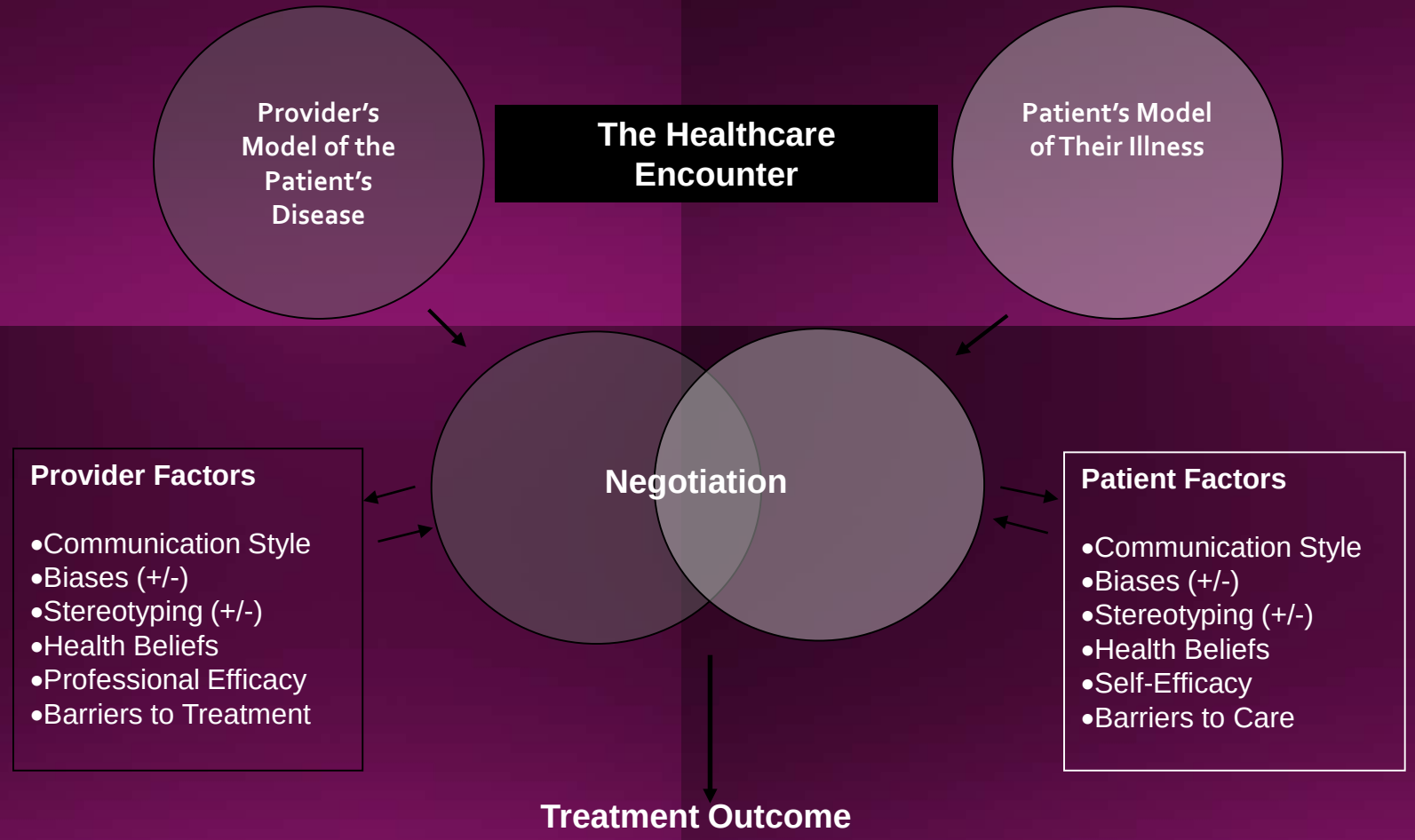
- all learned human behavior patterns (anthropology)
- the behaviors and habits of social, racial, ethnic, regional, age, and many other groups: e.g., *Persian culture; transgender culture; professional culture; spiritual cultures (e.g., Latter Day Saints, Muslims, Buddhists, Catholics)*
- is contextual, online, dynamic and constantly changing, so
- "*individuals within any given society are essentially free to choose from all the available possibilities within this frame*" (Kline & Huff 1999)
- ***Culture*: an opportunity. A chance to open both provider and patient to expanded modes of more effectively knowing, understanding, and communicating with each other.**

Agency for Healthcare Research and Quality (AHRQ) Categorical Approach to Ethnicity by National Origin (2008)

ASCN (Ask, Share, Compare and Negotiate) Model

- You won't always be able to know everything about every patient's cultural background, but you should make an effort to know as much as you can about the **cultures and health beliefs** of the main ethnic and cultural groups in your practice area
- **All patients and providers** have cultures that shape the healthcare encounter, thus including race/ethnicity as well as LGBTQ, class, spirituality, rural, and other intersecting and over-lapping cultural identities, so…
- *Always be sure to **ask** about each individual patient's relationship to their health beliefs and cultural values*

Kutob's Model of the Cross Cultural Health Encounter (based on the work of Kleinman)



Adapted from: Kutob RM, Senf JH, Harris JM. Teaching culturally effective diabetes care: Results of a randomized controlled trial. Family Medicine 2009;41(3):167-174.

The ASCN Model

- **A - Ask** about health beliefs *and* behaviors.

  Asking the patient directly about their view of their problem, its prevention, and its treatment reduces the potential for stereotyping and gives important clues as to diagnostic and treatment options.

- **S - Share** your professional views.

  This step requires healthcare professionals to understand their own health behaviors, explanatory models (i.e., science) and the culture(s) of the healthcare professions.

- **C - Compare** both views.

  Focus on non-judgmental language and establishing a therapeutic alliance.

- **N - Negotiate** a treatment plan

  ….whilst acknowledging the cultural backgrounds of both the patient and provider.

Source: Kutob RM, Senf JH, Harris JM. Teaching culturally effective diabetes care: Results of a randomized controlled trial. Family Medicine 2009;41(3):167-174.

Health Encounter Using the ASCN Model

- *Mr. Bormanis is a 68-year-old German man visiting your clinic after an Emergency Department (ED) visit for an asthma attack. He has been sent to your office for follow up. His first language is German, but he has indicated that he does not require interpretation services. Mr. Bormanis is a widower here to spend the winter with his daughter, with whom he is living. He was given a prescription for an albuterol inhaler, 90 mcg/puff, 2 puffs daily, in the ED.*
- As the role play proceeds over the next 10 minutes, note how the provider uses the Ask, Share, Compare and Negotiate (ASCN) model to elicit the patient's health beliefs, explain the provider's beliefs, compare the two, and negotiate a treatment plan.

Health Encounter Using the ASCN Model II

- After collection of the basic details of the patient's recent medical history, the provider then begins to ASK about their health beliefs, their view of their illness, and what treatments they prefer or dislike.
  - *Note avoidance of biomedical jargon, a key element of cultural competence*
  - *Patient-centered care: non-judgmental asking patient about traditional medicine use*
- The provider then SHARES the healthcare model of treating the disease, in this case, asthma.
- The provider and patient COMPARE the merits and drawbacks of each of their preferred methods for treating the illness, asthma.

Health Encounter Using the ASCN Model III

- When the patient expresses mistrust of the healthcare and pharmaceutical industries, the provider uses non-judgmental language to ASK more about their health beliefs, to SHARE more about the standards and science of healthcare, and then guides the patient in COMPARING the two approaches, leading to:
- NEGOTIATION of a treatment plan that respects the patient's health beliefs while also educating the patient in the benefits offered by a respectful and integrated healthcare approach.
  - *Cultural competency also includes an awareness of the cost to the patient*

Key Concepts from the Role-Play with ASCN Points in **BOLD CAPS**

- Patient Health Beliefs (**ASK**)
  - Convictions (**ASK**)
  - Perceptions of Healthcare and Healthcare Systems (**SHARE**)
  - Mistrust of Healthcare Professionals (**ASK/SHARE/COMPARE**)
    - Physicians
    - Pharmaceutical companies
    - Insurance companies
    - Healthcare infrastructure, including hospitals, government agencies, et al
- Traditional medicine and healing practices (**ASK**)
- Immigrant health (**ASK**)

Key Concepts from the Role-Play with ASCN Points in **BOLD CAPS,** II

- Cross-cultural systems of healthcare (**COMPARE**)
  - *Germany vis-à-vis US in this webinar's vignette*
  - ***Pause and reflect**: how might this interaction play out with different cultural backgrounds?*
- Fear of manipulation by healthcare professionals (SHARE/COMPARE)
- Language issues (SHARE)
  - Individuals with Limited English Proficiency (LEP)
  - Jargon; need to use common language
- "Culture" is not just beliefs, but also language, power, inter-professionalism, institutional and/or organizational "cultures"

Summary

- Patients are empowered to make better healthcare decisions with healthcare providers as *allies*
  - Therapeutic alliances promote adherence, patient satisfaction, etc.
- The ASCN model can help you personalize care through engaging with the individual perspectives of patients from different cultural groups
  - Remembering in-group differences; avoiding stereotypes, recognizing the unique cultural and health beliefs of the person in front of you
- Cultural competence should be part of *every* encounter
- Use the CLAS standards to *promote equity at every point of access*

For More In-Depth Information and Practice with CLAS in Healthcare Encounters…

- Bormanis, J. "An Introduction to Culturally and Linguistically Appropriate Services (CLAS) and Minority Health Disparities." University of Arizona Office of Continuing Medical Education. http://cme.arizona.edu/event/using-clas-standards-and-cultural-competence-mitigate-minority-health-disparities-introduction. 2015.
  - 1.5 units of CME for physicians, Certificate of Completion for other healthcare professionals

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Q & A

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