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Cultural competence in action: A framework and practical strategies for clinicians

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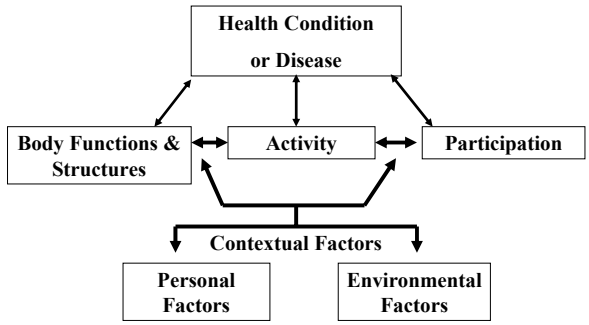
What is cultural competence?

- A core component of clinical competence
- A developmental process that requires:
  - Commitment to lifelong learning
  - Acquisition of specific knowledge, skills, and attitudes
    - Knowledge – Knowing critical content areas
    - Skills – Applying content to our everyday practice
    - Attitudes – Embracing key values in our conduct as professionals

Culturally Competent Clinical practice is based on:

- Application of the World Health Organization's International Classification of Functioning and Disability (ICF 2001)
- Application of the ASHA Code of Ethics
- ASHA Document – *Knowledge and Skills Needed by Speech Pathologists and Audiologists to Provide Culturally and Linguistically Appropriate Services* (ASHA, 2004)
- Commitment to evidence-based practice

WHO Model – International Classification of Functioning, Disability, and Health (ICF, 2001)



Evidence for Practice

- ASHA Strategic Plan
- Focused initiative
- Position Statement on Evidence-Based Practice in Communication Disorders

ASHA Position Paper on Evidence Based Practice

- It is the position of the ASHA that audiologists and SLPs incorporate the principles of EBP in clinical decision making to provide high quality clinical care.
- The term EBP refers to an approach in which current, high-quality research evidence is integrated with practitioner expertise and client preferences and values into the process of making clinical decisions.

De-Mystifying EBP True or False

- Evidence from systematic research is the only acceptable basis for clinical decision making.
- EBP requires clinicians to spend many hours each week scouring the hundreds of newly published articles and textbooks for evidence.
- Clinicians can or should be able to 'stay current" on every aspect of clinical practice.
- Studies with certain designs , especially RCT, always provide high quality evidence.

All False
Dollaghan, C. (2004, April 13). Evidence-based practice: Myths and realities. The ASHA Leader, pp. 4-5, 12.

Framework for Evidence Based Clinical Decision Making

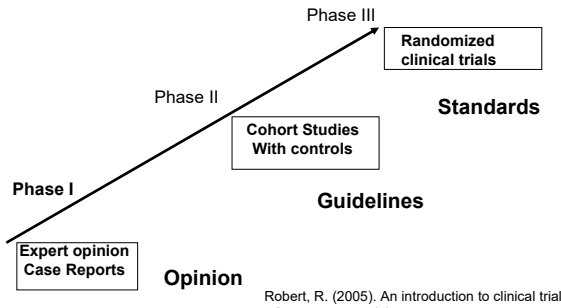
Key Principles of EBP

- Pose an answerable question
- Search for the evidence
- Critically appraise the evidence for validity and relevance
- Integrate the evidence with clinical experience and patient/client values
- Evaluate performance after acting on the evidence

Evidence-based practice (EBP)

- Sackett and colleagues (1996) define EBP as "... the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of **individual patients** by integrating individual **clinical expertise** with the best available external **clinical evidence** from systematic research"
- Committing to EBP requires us to become aware of and apply existing published evidence, but also equally extends to our commitment to contribute to the evidence base as well.

What is Evidence?



Robert, R. (2005). An introduction to clinical trials. ASHA Leader. 10(7).

Levels of Evidence Based Clinical Recommendations

- Standards
  High degree of certainty based on very strong phase II or III levels of evidence
- Guidelines
  Moderate degree of certainty based on Phase II or strong consensus from Phase I
- Opinion
  Evidence based on opinion, case studies, general practice

ASHA Code of Ethics

- **Principle 1:** "Individuals shall hold paramount the welfare of the persons they serve professionally or participants in research and scholarly activities….."
- **Principle 2:** "Individuals shall honor their responsibility to achieve and maintain the highest levels of professional competence".
- **Principle 3:** "Individuals shall honor their responsibility to the public by promoting an understanding of the professions, by supporting development of services to target unmet needs of the public….."

Applying these philosophical principles to a clinical scenario……..

Case scenario

- ***Referral:*** MG, a 70-year old man, of Armenian ethnicity, was referred by his neurologist, after a LH CVA five months ago.
- Applying the ICF model, relevant information available about MG is as follows:
  - **Body structures and functions**
    - 1st left hemisphere CVA 5 months ago; hospitalized for 8 days.
    - Right hemiparesis; using a cane for mobility
    - Risk factors being currently treated: Hypertension, diabetes, high cholesterol levels
    - Evidence of oromotor and limb apraxia
    - Evidence of nonfluent aphasia

ICF model applied to MG contd….

- **Activity**
  - Able to hum to music; able to say names of his wife, daughter, and brother
  - Cannot communicate verbally or nonverbally without significant cueing or assistance
  - Cannot ambulate independently
  - Cannot use the toilet or perform ADLs without moderate assistance
- **Participation**
  - Unable to drive or operate his self-owned gas station
  - Unable to welcome guests or make a toast at a significant social event in his life - his daughter's upcoming wedding

MG – ICF Contextual factors

Language History and Current Use

- Multilingual in 4 languages premorbidly – fluent in English, Farsi, Armenian, and Turkish.
- Post-stroke: Understands mostly Armenian and some English. Verbal responses limited to single words (nouns) mostly in Armenian; occasionally in English.
- Has two stereotypies – *"Samuil"* (MG's brother) and "Sharice" (MG's daughter).

Personal History

- MG is a 1st-generation immigrant; has lived and worked in the US for 30 years. Has always been a pleasant and affectionate man.
- MG is married; has a loving and supportive spouse; two adult children – 1 son and 1 daughter.
- MG's daughter, Sharice, is getting married shortly. Family was preparing for this wedding when MG had his CVA.

MG- Contextual factors contd..

Family Impressions:

- Communicative ability has improved in last 5 months
- MG's greatest difficulty is in expressing his needs and wants and he gets very frustrated
- Mobility improving and some ADLs improving
- Family feels unclear about what is the best they can do to help MG in terms of home set-up as well as arranging for clinical services
- Worried about limited coverage of services offered through his secondary insurance company, Kaiser Permanente.

Some key questions SLPs and AUDs would have about working with MG

1. What should I know about MG's ethnic group (Armenian-Americans)?
2. How should I conduct the clinical interview with the client and his family?
3. Should MG be assessed in non-English languages?
4. What type of screening and assessment should be done with MG?
5. What goals should be targeted for MG and his family?

1. What should I know about MG's ethnic group?

- Armenian Americans are a small but growing ethnic minority in the U.S.
- Armenia is a Middle-Eastern country of almost 3 million persons. Its capital is Yerevan and it is located in Southwestern Asia, east of Turkey.
- The primary language is Armenian and is spoken by 96% of the residents.
- Families tend to be male-dominated and may have diverse religious identification (Islam, Christianity).
- Families tend to be private about health-related issues and sometimes believe that therapy is too intrusive.

Armenian Americans in the U. S.

- Per the 2000 United States Census, approximately 385,488 persons of Armenian ancestry live in the U.S.
- The states with the largest Armenian-American populations include:
  - California- 204,631 persons
  - Massachusetts- 28,595 persons
  - New York- 24,460 persons
  - New Jersey- 17,094 persons
  - Michigan- 15,746 persons

Immigration history of Armenian Americans

- Armenians began to emigrate from their country to the United States in the 1880s during the Ottoman rule (Turks).
- Deteriorating relations between the Armenians and the Ottoman Empire during World War I, particularly the 1915 Genocide of the Armenians by the Ottoman Empire, led to a major emigration to the United States and other countries.

Epidemiological data

- Dr. Daderian-Huckabay studied 432 Armenian immigrant men and women, between the ages of 19-92, and found that the weights of Armenian adults were significantly higher than those recommended by the Metropolitan Life Insurance guidelines. Of their sample:
  - 21% were hypertensive
  - 8.3% were diabetic
  - 37.4% had chronic illnesses
  - 12.2% had heart problems
  - 52.7% were taking prescription medications
- These findings suggest that Armenian American mature adults may be at fairly high risk for stroke and its consequences on language use.

Perception of health care services by Armenian Americans

- In a comparison of Americans of Vietnamese versus Armenian origin, Jamin, Yoo, Moldoveanu, & Tran (1999), Armenian Americans were:
  - Less likely to accept x-ray or irradiation procedures than Vietnamese Americans
  - Generally more wary of the medical establishment than Vietnamese
  - Tended more towards self-treatment
  - Very skeptical of informed consent, feeling that it indicated that the health provider was incompetent or afraid of a lawsuit.
- Jamin et al. concluded that perceptions of U.S. health care systems in Armenian Americans is correlated with the level of acculturation.

Suggestions to implement *before* meeting with MG

- Call them and introduce yourself; forecast what will happen at the first meeting.
- Ask a few specific questions about fluency in languages spoken and frequency of usage–this may help to determine the need for an interpreter.
- Obtain some background knowledge about the client's ethnic community OR identify a cultural informant, if possible, to obtain relevant information or resources about MG's ethnic community.
- Request and review medical record and case history information carefully.

2. How should I conduct the clinical interview with MG and his family?

- Provide an overview of the purpose of the interview. Explain your (clinician) and their (family/client) roles during the interview. Let MG and his family know that they can ask questions at any time.
- Use an ethnographic style of interviewing.
- Consider having a trained interpreter present, if required.
- Obtain information about predictors of acculturation – e.g.: length of time in the U.S., educational experiences, languages spoken and/or understood, socialization patterns, and religious affiliations (Payne, 1997).
- Can determine level of acculturation of MG and family. May use Paniagua's (2005) *Brief Acculturation Scale*.

3. Should MG be assessed in his non-English languages?

- Preferably YES, although, this decision can depend on several practical constraints, client's preference, and prior language history.
- **Suggestion:** Have MG's family member/s complete a language experience questionnaire ref: languages that he was completely fluent in premorbidly and languages that he regularly used.
- Determine if you can get access to a trained interpreter speaking Armenian.
- If no interpreter is available, ask questions about disparate language abilities in different languages
  - Is automatic speech preserved in Armenian and English?
  - Does he spontaneously speak in Armenian or English?
  - Does he use nouns and verbs in both languages or only nouns in one, verbs in the other etc?
  - Does he appear to make linguistic selection errors more in one language?
  - Does he read or write better in one language?

4. What type of screening and assessment is appropriate for MG?

- **Screening**
  - Sensory losses - Hearing and vision
  - Depression – Geriatric Depression Scale (GDS) directly to MG OR Informant Version of GDS to MG's wife

MG's assessment

- Alternative assessment methods – dynamic assessment, environmental observation
- Assessment at the three ICF levels of body functions/structures, activity, and participation
- Standardized and/or nonstandardized assessment in English - *Western Aphasia Battery* or Communicative Abilities in Daily Living-2nd Ed)
- Possibility: Standardized assessment in Armenian – *Bilingual Aphasia Test (Western Armenian edition)* – if a trained interpreter is available
- Informal assessment in Armenian (for example, asking caregiver about receptive and expressive language comprehension in Armenian).
- Communicative Effectiveness Index (CETI, Lomas et al., 1989
- ASHA's Quality of Communication Life Scale (Participation level)

SWOT analysis (Cheng, 2006) of MG's case

- **S - Strengths**
  - MG's personality, his family's support and their attitude
  - Amount of spontaneous recovery in 5 months
  - Much improved physical functioning ref: mobility and swallowing.
  - Receiving in-home PT 2 x per wk and group OT 1 x per wk
- **W - Weaknesses**
  - Verbal communication severely limited
  - Oromotor and limb apraxia – affects ability to use gestures and to perform ADLs
  - Mild impairment in auditory comprehension

SWOT analysis for MG contd….

- **O - Opportunities**
  - Assess functional communication
  - CG training for MG's family members
  - Aphasia support group for MG and his wife
  - Request therapy reauthorization based on well-documented ongoing progress
  - High motivation for 3 specific goals: talking on telephone, greeting people, making a toast at daughter's wedding
- **T - Threats**
  - Limited therapy coverage by Kaiser Permanente
  - Family unable to pay for services out of pocket

5. What tx goals should be targeted for MG and his family?

- **MG**
  - Individual therapy – Work on facilitating communication of basic needs and wants (using a communication board)
  - Incorporate goals for which MG has high motivation
  - Consider group therapy
- **Family education**
  - Warning signs of CVAs and TIAs
  - Importance of medical mgmt of risk factors
  - Home set-up ref: safety concerns and supervision of MG
  - Cueing and conversational strategies to be used with MG

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