

ELIMINATING DISPARITIES IN CARE

Case Study: Improving Care by Bridging Gaps Between Expectations and Practices of Patients and Providers

Project goal: To contribute to the well being of refugee and immigrant patients, families and communities through a partnership that promotes culturally competent care.

Reason for project: To effectively address gaps in the delivery of care to refugee and immigrant populations by better understanding the health care expectations and practices of immigrant patients and health care providers.

Sustained accomplishments: Long-term, trusting relationships with patients, families, communities, providers, hospital staff and administration resulting in strong channels of communication and the capacity to negotiate patient and family-centered, culturally competent care.

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Organization: Harborview Medical Center

Program: Community House Calls

Location: Seattle, WA

Summary:

Prompted by a large increase in refugee and immigrant families, physicians at Harborview established the Community House Calls program 15 years ago to bridge gaps between health care expectations and practices of immigrant patients and care providers. Using a modified case management approach, Community House Calls works with immigrant communities to establish two-way and open communication between Harborview and these communities.

Working with various community elders and leaders, Community House Calls develops partnerships that promote culturally sensitive care. Caseworker/cultural mediators play an integral role, providing casework, interpretation and cultural mediation services in addition to navigation and advocacy in health, social services, education, immigration and legal venues. Cultural Mediators have recently begun providing case management for chronic disease

patients dealing with asthma and diabetes. The caseworker/cultural mediators also provide formal presentations to residents, providers and staff about their respective communities and cultural consultations on an as needed basis

NOTE: Some programs are in the initial stages for data collection and reporting, while others are small in scope and have not yet established benchmarks. Where there is data available, it is provided in the questions and answers below.

Q&A:

1. **How did the organization decide to create a program that addresses patients with limited English proficiency (LEP)?**

Following the arrival of large numbers of immigrant and refugee families from Africa, Asia and Latin America, physicians at Harborview noted gaps in the delivery of care to refugee and immigrant populations. Dr. Ellie Graham and Dr. Carey Jackson (in charge of the Children's and Refugee clinics, respectively) realized the need for a better understanding of health care expectations and practices – both on the part of immigrant patients and care providers. The Community House Calls program began with a Robert Wood Johnson Opening Doors grant in 1994.

The program's name came from the need to facilitate two-way and open communication between Harborview, as an institution, and the communities it serves by actively reaching out to those communities.

Community House Calls started with four languages: Amharic, Cambodian, Somali and Tigrigna. With the addition of Spanish and Vietnamese, there are now six languages covered, representing the most commonly spoken foreign languages at Harborview.

In recent years, the caseworker/cultural mediators have developed expertise in working with patients and providers in the areas of psychiatry, oncology and chronic disease.

2. **The program now tracks substantial data such as case management activities and clinical consultations. Did the program track data from the beginning?**

Tracking quantitative data is relatively new for Community House Calls. Fifteen years ago when the program started, quantitative data was not a large part of the conversation. In the early days, qualitative data was collected by interviewing patients served by the program.

Community House Calls now tracks case management, interpretation, home visits, outside agency visits and clinical consultations for each referred patient. Caseworker/cultural mediators also track community outreach and provider education activities. A diabetes tracking system is currently being developed to capture diabetes management activities and clinical outcomes.

3. How do LEP programs impact disparities in health care delivery?

Every community has different beliefs about health and expectations of how health care should be delivered. By being proactive in educating the hospital community as well as by building relationships within different ethnic communities, the care providers can be better, more efficient and effective.

One example is a multicultural diabetes class. Caseworker/cultural mediators regularly inform nutritionists, educators, pharmacists and others involved in planning and executing the diabetes classes about the food habits, traditions and beliefs of target populations. This makes a big difference in the efficacy of the classes. The people planning them are more informed about the populations they are trying to serve and, as a result, the impact is greater.

4. Are there interventions built in to the Community House Calls program? If yes, how are those implemented?

Patients can be referred to the Community House Calls program in a number of ways. If an LEP patient with diabetes presents in a clinic with poor health indicators, if it is apparent that the patient has not made any lifestyle changes or if there is no sense that the family understands this is a serious illness, the clinic staff will refer the patient to one of the program's caseworker/cultural mediators. This caseworker will follow-up and begin working with the patient to improve access to care and disease management.

Another "intervention" scenario might be an inpatient or emergency situation when a mediator, who is bilingual, bicultural and trained to negotiate difficult situations, is needed to deal with patient, family or community concerns.

Among some populations, it is common for more than 100 people to gather in the hospital's waiting room when a person is near death. In these situations, it is very helpful to have someone who understands the beliefs of the community – from who should be allowed in the room to

how bodies should be handled for burial – serve as liaison for the extended family and medical staff. Additionally, having caseworker/cultural mediators go into the community proactively to teach hospital protocols can be very beneficial.

In short, having an established, trusting relationship and well-educated staff can prevent a crisis.

5. How is the program funded?

At the end of a two-year demonstration project, which was grant funded, program leadership and hospital medical staff approached the hospital administration about including funding as a part of the budget under the interpreter services department.

The hospital was open to the idea that the people at heart of the program – caseworker/cultural mediators – would be available to do interpreting as well as casework. Since the hospital was already contracting with vendors to provide needed interpreters, this arrangement seemed likely to benefit the immigrant communities while also saving the hospital money. Fifteen years later, Harborview continues to fully fund the program.

6. Were other stakeholders (i.e., community groups) involved?

Community elders in the target communities serve as a community advisory board and cultural informants. Caseworker/cultural mediators from each community were hired with input from community leaders.

7. What challenges or obstacles had to be overcome?

One of the biggest challenges in establishing cultural competency is a hospital's own culture surrounding time. When everyone is very busy, it can be difficult to see that investing time upfront to garner information about how patients view their illness, or how a community views illness and health care, pays off in efficiency, cost savings and improved care. Over time, this value has been recognized at Harborview, but there can be initial resistance.

Another challenge is financial. It takes a financial investment and long-term commitment to implement a new program, even when it is likely to result in a decrease in the no-show rate and an increase in medication adherence.

Building relationships with immigrant populations takes time. Improvements should not be expected in the first six months because these relationships are not built in six months.

8. **What advice would you give others wanting to improve care in similar ways?**

Start small. Instead of two or three language groups, start with one. Once you see demonstrable results, begin to expand the program.

Think about the program through the lens of the continuum of interpretive need and interpretive response. One-size does not fit all. Some patients will do fine with a telephone interpreter. Others need someone in the room, perhaps because they are mentally ill, hard of hearing or have never seen a health care provider. Some need a navigator to help beyond interpreted visits. Think through how to manage that continuum of need effectively and cost efficiently.

Build long-term relationships with communities by listening to and honoring community concerns, being clear about what you can and cannot do and delivering on your promises.

Incorporate cultural competency training, including information about how to work with interpreters and about the populations served in your institution, into residency programs and staff training. Patients may or may not subscribe to their cultural mores, but providers should be aware of what those mores are and how they may impact expectations for health care.