TB & CULTURAL COMPETENCY

Notes from the Field

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"We are going to go through this together"

by Qiong Pan, BSN, RN

Introduction

Asians and Pacific Islanders are among the fastest growing ethnic groups in the United States. Compared to non-Hispanic white Americans, Asians and Pacific Islanders are 10 times more likely to have TB, and this proportion is even higher for older individuals. They are also more likely to experience significant obstacles to diagnosis and treatment, including language barriers and fears of compromising their immigrant status or that of their family members. As is true in many cultural groups, Asian and Pacific Islander immigrants may fear the stigma of TB if they are identified as having the disease and thus may delay seeking appropriate care. As relative newcomers in the U.S., some may not be aware of the availability of treatment for TB, or know how to access such treatment. Finally, like so many immigrants, they may fear that taking the time for health care may jeopardize their jobs and employment opportunities. All of these factors, along with the inherent diversity of the Asian and Pacific Islander populations, present a challenge to effective health care. At the same time, working with this population provides a valuable opportunity for health care workers to become more knowledgeable about this important group of Americans and develop skills to provide culturally competent care.

In areas where Asian immigration has been concentrated, cultural awareness is a fundamental part of TB control efforts. The following case from a Pacific Northwestern city illustrates key dimensions of culturally competent case management. It comes from a nurse case manager who, as a native Mandarin

Continued on page 2

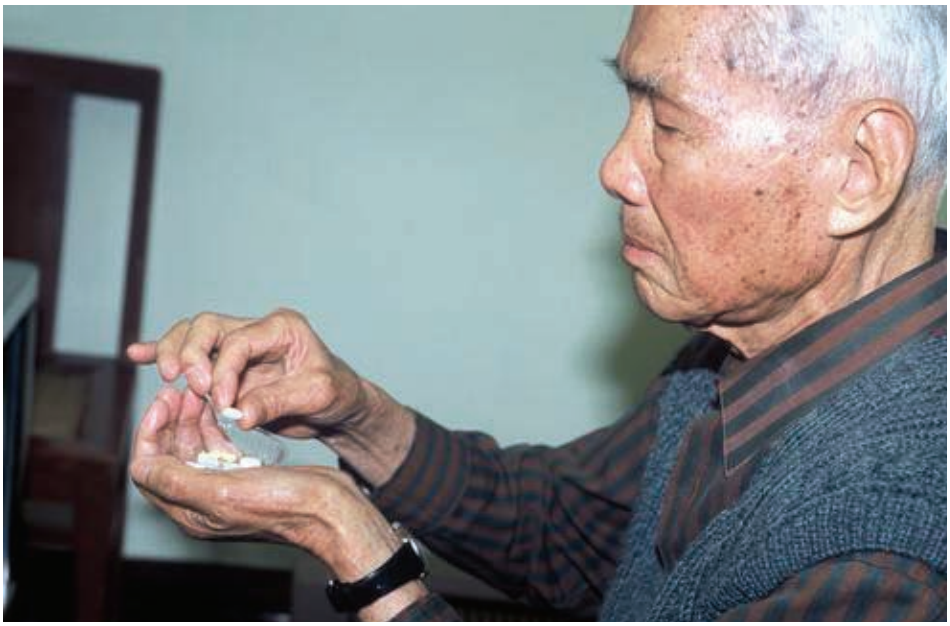
Did You Know?

- "Asian" refers to those having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- "Pacific Islander" refers to those having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. The Asian and Pacific Islander population is not a homogeneous group; rather it comprises many groups who differ in language, culture, and length of residence in the United States. Some of the Asian groups, such as the Chinese and Japanese, have been in the United States for several generations. Others, such as the Hmong, Vietnamese, Laotians, and Cambodians, are comparatively recent immigrants. Relatively few of the Pacific Islanders are foreign born.

Reeves, Terrance and Claudette Bennett, 2003. *The Asian and Pacific Islander Population in the United States: March 2002*, Current Population Reports, p20-540, U.S. Census Bureau, Washington, D.C.

Mr. Yen *Continued from page 1*

Chinese speaker also proficient in Cantonese, has worked with Chinese-speaking patients for some years. The case describes a 58-year old Chinese man, "Mr. Yen," who had been in the United States for some 25 years, and lived with his wife and grown daughter.



A Rocky Start

Mr. Yen did not believe that he had TB. By the time he came into the TB clinic, his initial symptoms had subsided. He said that his cough started when he choked on a piece of food. When it persisted for a few weeks, accompanied by bloody phlegm and a fever, he went to his doctor. There, the provider prescribed antibiotics, and collected a sputum sample. The sample was smear-negative but culture-positive for TB, and that was when the case was referred to our clinic. Because he spoke Cantonese and little English, I was assigned Mr. Yen's case. I couldn't reach him on his cell phone, but I spoke with the adult daughter listed as a contact. He arrived for our standard 3-hour initial visit, including x-rays, sputum collection, and basic TB education. I took his medical history and explained the home-based isolation protocol that he would have to follow as a smear-negative, culture-confirmed TB case. The protocol states that patients should avoid contact with others unless the TB program approves in advance, and that patients should wear a mask when indoors with others. He was to follow the protocol until he had been on TB treatment for at least two weeks and had produced three consecutive smear-negative sputum samples. He nodded in agreement as I spoke and signed a form consenting to follow the home isolation protocol. I also explained the process of contact investigation, which would begin with his closest circle of family members. I told him, as I tell many patients, "This is going to be a long road, but you don't have to go down it alone. We are going to go through this together." I offered him home DOT, which he refused even after I assured him that there would be no health department cars parked by his house, or any DOT workers in lab coats at his door. He was adamant. He came in for the first few days of clinic-based DOT, but was resistant to my doing a home visit, saying that he would only be available certain days at specific time periods.

I wondered why he had so little time available for the visit when he was in isolation at home. I thought of his place at the head of the family he supported, and of the job that might be jeopardized by his extended absence. I thought about his own explanation of his cough, and his insistence that he felt fine. I wondered if he might have continued to go to work. I called his work place and was able to confirm that he was still on the schedule. After discussing the situation with my supervisor, I made another call, this time to Mr. Yen's daughter. I approached the subject gently, going through the reasons that we use home isolation, its benefits for her father, and for the people close to him. I ended by telling her that it seemed likely to me that he was going to work, which was against our agreement, and that we were going to contact his employer. She admitted that he had been working, suggesting that although she worried about his continuing to work, she did not want to challenge his decisions, and thus his authority, directly.

My supervisor and I worked as a team: she contacted the employer, and I contacted Mr. Yen. The employer agreed to arrange for Mr. Yen's immediate co-workers, who were all Chinese, to attend an on-site educational session with me and be offered tuberculin skin testing. As a woman in her thirties, I approached Mr. Yen conscious of certain cultural norms that we shared: the younger generation should demonstrate respect for its elders in general and especially for male elders. I was careful not to be confrontational or threatening, but after laying out the situation, I asked some open-ended questions about what motivated him to deviate from our home isolation agreement and continue working. I perceived that his concerns primarily

Continued on page 3

Mr. Yen *Continued from page 2*

emanated from his doubt and discomfort with his diagnosis. He did not feel sick, so he questioned whether he truly had TB. He was uncomfortable about being identified publicly as a TB patient. He seemed to share the widespread view that TB was a disease of poor and marginalized people who could not afford good hygiene and food. I did not argue with him; instead I returned to several TB education topics, reviewing transmission and the onset of disease, the effectiveness of treatment, and the reasons for isolation. I emphasized that our priority was his health and the health of people around him. This time, he agreed to home DOT.

Reaching out through Education

I arrived at my scheduled session with Mr. Yen's co-workers armed with a teaching board that a colleague and I had developed. Along with visuals downloaded from the CDC's website, it features pictures we had taken of our DOT clinic— everything from a skin test being given to pills and medication bottles. During the session, the workers joked about TB and who among them seemed sick, and I used those jokes as opportunities to explain various aspects of the disease and treatment. Afterwards, I distributed materials in Chinese, spoke individually with them and helped them to fill out paperwork in order to be skin tested. I answered other questions too, about what services the health department offered and where they could get health care at no or low cost. They seemed impressed that I had taken the time to come to them and answer their questions; and they were all evaluated. Eventually, all who were offered treatment for LTBI accepted it.

Creating a Network of Patient Care

Mr. Yen was adherent to his treatment, even when it was complicated by hepatitis and the need for a lengthy, liver-sparing regimen. In order to fully explain the complications of hepatitis, I had to ask a native-Cantonese speaker to interpret for me – my fluency in Cantonese did not extend to the details of how drugs are metabolized! As I monitored him I realized that he had other health problems, which were not being adequately addressed. Although he had been diagnosed with diabetes and hypertension, he was unsure about what medications he had for which condition, and he did not take them regularly. I discovered that he tended to see a different doctor each time he went to his clinic, and that created a discontinuity in his care. With his permission, I got in contact with the doctors' office and informed them about his TB regimen and the hepatitis. Eventually, I was able to get him assigned to a single physician, make some necessary appointments for him, and monitor his medications better. I often contacted his daughter about his appointments, and she expressed gratitude, saying that she worried so much about her father's health but that she could not challenge his decisions about his own health. As a health professional, my words counted for a little more, even though I was a woman and of a younger generation.

Despite the complications, the extended regimen, and the need for prolonged follow up, I think Mr. Yen appreciated my concern for his health. His TB was treated successfully and he got his diabetes and hypertension under control. I had to push a little, but I also showed that I cared about his well-being. When you educate people about this disease, you might put some fear into them, but you emphasize that you are going to be there to get them through it safely. And in the end, Mr. Yen and I did go through it together.

Lessons Learned

Confirm that the patient understands crucial information by asking him or her to verbalize key points. Nodding one's head or simply saying yes may indicate confusion or embarrassment, or signify politeness and respect, rather than actual agreement. Be prepared to re-educate: patients who are absorbing a recent diagnosis may need to go over complex points more

Continued on page 4

Assess and Respond to Cultural Factors in TB Care

TO ASSESS:	ASK:	RESPOND WITH:	RESULTS:
Fears surrounding immigration status	• What are your concerns about your illness? • Are you worried about immigration problems because you have TB?	• Assurances of confidentiality • Clarification of laws affecting immigrants with TB • Alternate locations for DOT	• Increased trust • Accurate information • Increased willingness to accept and adhere to treatment
The impact of TB-related stigma	• How do you feel about TB? • How does your family [co-workers, etc.] feel about your TB?	• Education about TB transmission and treatment for patients, their contacts, and their communities • Assurances of confidentiality • Alternate locations for DOT	• Greater motivation to accept and adhere to treatment • Enhanced social support for patients during the course of treatment
Culturally-specific health practices	• Some of my patients go to traditional (Filipino, Vietnamese, Chinese, or Korean) healers. Is this true for you? • Do these treatments help you? How so?	• Indications of tolerance for culturally-specific treatments • Exploration of ways to incorporate traditional treatments and beliefs in treatment plan • Advice about side effects	• Better awareness of how patients deal with TB treatment • Patients perceive that that providers understand their needs • Better adherence to treatment

Adapted from: Association of Asian Pacific Community Health Organizations, Cross-Cultural Tuberculosis Guide. Cultural Influences on TB-related Beliefs and Practices of Filipinos, Vietnamese, Chinese and Koreans, page 17

Mr. Yen *Continued from page 3*

than once.

Work within cultural values and norms as much as possible to achieve treatment goals. Remember that patients may disagree about their diagnosis or the origin of their illness, but still be receptive to treatment. Mr. Yen's nurse case manager showed respect for familial, generational, and gender roles, and exercised authority based on the prestige that many Asian cultures accord to health professionals.

Build trust and cooperation by showing concern for the whole patient, not just the disease. Mr. Yen's TB treatment became a gateway to improved health care overall when his case manager facilitated continuity of care for the management of diabetes and hypertension.

Use interpreters when necessary. Even fluent health care workers may encounter specific situations in which they cannot convey technical or medical information so that the patient clearly and completely understands what is being said.

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A Foot in Both Worlds

Research on cross-cultural health care demonstrates that many patients whose health beliefs differ from the Western, biomedical model are nevertheless accepting of Western medical treatment and services. An immigrant may dispute the medical explanation that his or her TB disease was caused by exposure to bacteria and still adhere faithfully.

See G. Green et al., "We are not completely Westernized:" Dual medical systems and pathways to health care among Chinese migrant women in England, *Social Science and Medicine* 62 (2006), 1498-1509.

Health Care that Responds to Immigrant Needs

"Since any interruption of the immigrant laborer's health threatens his livelihood, a campaign to promote general health (with tuberculosis screening an important component) might have greater appeal than a campaign focusing solely on tuberculosis."

M-J Ho, Sociocultural aspects of tuberculosis: a literature review and a case study of immigrant tuberculosis: *Social Science and Medicine* 59 (2004), 759.

RESOURCES

A Community of Contrasts: Asian Americans and Pacific Islanders in the United States
Asian American Justice Center and Asian Pacific American Legal Center. 2006

This socio-demographic profile of Asian Pacific populations in the United States can be downloaded at:
http://www.advancingequality.org/files/ComCont.pdf

Cross-Cultural Tuberculosis Guide: Cultural Influences on TB-related Beliefs and Practices of Filipinos, Vietnamese, Chinese and Koreans
Association of Asian Pacific Community Health Organizations. Oakland, CA 2000

Drawing on 18 focus groups held in California, Hawaii, Massachusetts, New York, and Washington, this report contains chapters on individual ethnic groups as well as background information on culture and TB and summaries of the information presented. Available through *www.aapcho.org, or by calling (510) 272-9536, extension 100.*

California Standards for Healthcare Interpreters: Ethical Principles, Protocols, and Guidance on Roles and Interventions
California Healthcare Interpreters Association. 2002

This comprehensive guide to effective interpreting services can be downloaded at:
http://www.calendow.org/reference/publications/pdf/cultural/TCE0701-2002_California_Sta.pdf

Reducing Health Disparities in Asian American and Pacific Islander Populations: Introduction to Cultural Competency
Management Sciences for Health Electronic Resource Center.

These self-study modules highlight the benefits of cultural competency and introduce strategies that are appropriate for specific Asian and Pacific Islander populations. Access them at:
http://erc.msh.org/aapi/index.html

Culturally and Linguistically Appropriate Services in Health Care
Office of Minority Health, US Department of Health and Human Services.

The Office of Minority Health has developed national standards for providing culturally and linguistically appropriate health care, which may be downloaded at:
http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=15

Tuberculosis Education and the Congregate Setting Contact Investigation: A Resource for the Public Health Worker
New Jersey Medical School Global Tuberculosis Institute. 2004

This guide to conducting group TB education in the context of a contact investigation includes a modifiable PowerPoint® presentation, a TB fact sheet, and a list of frequently asked questions. It can be downloaded at:
http://www.umdnj.edu/globaltb/products/congregatesetting.htm

We would like your feedback!

1. Did you find this newsletter easy to read? ❑ yes ❑ no

   Why?_____

   _____

2. Was the newsletter's length: ❑ too long ❑ too short ❑ just right

3. Will you apply anything from this newsletter to your current practice? ❑ yes ❑ no

   If yes, what specifically _____

   _____

4. What **cultural competency** topics would you like to see in future newsletters?

   _____

   _____

We need cases to highlight!

Many of you are out in the field doing great work with people from a variety of cultural backgrounds.

Would you be willing to contribute or be interviewed for a case study or article? If so, please provide your contact information. Fax this page to 973-972-1064

Many of the photos in this newsletter are courtesy of the Stop TB image library at: http://stoptblpipserver.com/

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