TB & CULTURAL COMPETENCY

Notes from the Field

Northeastern Regional Training and Medical Consultation Consortium Issue #6, June 2007

A Patient-Centered Approach

Introduction

This case is from a Northeastern state with a high incidence of TB (case rate of 5.8). As is true in much of the Northeast, the state's TB cases are predominately non-US born. Case rates vary widely among counties in the state, with suburban areas experiencing rates much lower than those in more densely populated, predominately urban counties. State health department representatives often collaborate with county-based TB staff on complex cases, such as the following case.

A Reluctant Patient

A native of South Korea, Mr. Kim was 64 years old and had been in the United States for about 15 years when he presented to a private hospital in a suburban part of the state complaining of a persistent cough, fever, and night sweats. A chest x-ray showed a large cavitary lesion, but before he could be fully evaluated for TB disease, Mr. Kim left the hospital without being discharged.

Three months later, he appeared again at the same hospital and was diagnosed with TB. The hospital contacted the county TB Control Program, and a team of county and state TB Control personnel went to the hospital the same day to conduct an interview. Mr. Kim spoke very little English, however several of the healthcare providers caring for him were of Korean descent and spoke Korean, so we spoke to Mr. Kim with their assistance.

Mr. Kim said that he lived alone and had no family in the U.S. His family was in South Korea, and one of his grown children there had died recently of cancer. He worked as a laborer, but said that he was not currently employed and had not been able to work regularly for some time, because he felt very weak. He described his overall health as poor and said that he had gradually lost more than 30 pounds over the last several years. He reported that he had been diagnosed with diabetes, but that he was not receiving treatment for it. While in the hospital, he was also

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Patient-Centeredness and Cultural Competency

The case discussed in this newsletter describes how TB program staff used a patient-centered approach to work through linguistic and cultural barriers to help a patient successfully complete TB treatment. Patient-centeredness and cultural competency share the overarching goal of improving the quality of health care by integrating the patient's perspective. Both approaches include criteria for patient-provider interactions as well as service delivery. Many insights and principles that are central to the concept of patient centeredness are also essential elements of cultural competency.

In essence, patient-centeredness involves viewing health care from the patient's perspective and then adapting care to more closely meet the needs and expectations of patients. Patient centered care focuses on individualized care personal relationships. Like cultural competency, patient centeredness refers to aspects of provider-patient interaction as well as to characteristics of health care systems.

Patient Centered Care and Culturally Competent Care: Two Complementary Approaches

A PATIENT-CENTERED APPROACH	A CULTURALLY-COMPETENT APPROACH
• Sees the patient as a unique person	• Uses interpreters effectively to improve communication and gain an understanding of the patient as a unique individual
• Views the diagnosis and treatment from the patient's perspective	• Recognizes the role culture plays in health and illness, and values diversity in culture
• Builds a trusting relationship between provider and patient	• Seeks out information or resources about other cultures in order to establish common ground with patients
• Incorporates patient needs, preferences, and patient values into treatment plans	• Develops treatment plans that are congruent with explanations of diagnosis, appropriate treatment, and desired outcomes

A PATIENT-CENTERED HEALTH CARE SYSTEM	A CULTURALLY-COMPETENT HEALTH CARE SYSTEM
• Offers patient education materials appropriate to patient populations	• Provides interpreter services and patient materials in appropriate languages
• Allows for the coordination of diverse services into a continuum of care	• Provides on-going staff training in issues related to cultural competence
• Promotes overall well-being as well as treats specific conditions	• Develops its work force to reflect major patient groups served
• Provides services that are easily accessible and convenient for patients	• Partners with community groups to offer services that meet population priorities, needs, and preferences

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diagnosed with hypertension.

Mr. Kim was initially willing to be interviewed and provided us with an address where he rented a room. Soon, however, he seemed to grow suspicious and stopped answering our questions. He had not given us names or any other information that would help us locate potential contacts, and refused to sign a release of medical information. In fact, he tried several times to leave the hospital room, and a guard had to be placed at his door.

We assumed the interview process was making Mr. Kim uncomfortable, but Korean-speaking hospital staff also described Mr. Kim as unusually uncommunicative and even suspicious about their medical activities. He was resistant to receiving insulin shots for his diabetes, and refused any invasive diagnostic procedures. Some of the staff said that he was simply uncooperative and mistrustful of all medical providers; others commented that he seemed depressed and at times disoriented. Some also seemed surprised that Mr. Kim did not have a family network to rely on and that he lived a solitary life.

Building Trust

Our strategy for developing a relationship with Mr. Kim was two-pronged. We were very explicit about what he should expect from TB control. Through hospital staff, we explained that TB treatment would last 6 to 9 months and that he would see us daily for directly observed therapy. Because he was generally non-responsive, we took our time with this discussion, and paused frequently to ask him to confirm that he understood what we were saying. We also explained the legal ramifications of refusing treatment.

We also assured him that our goal was to see that he was cured of TB and would help him with daily necessities while he was on treatment. Even as we were probing for information, we looked for areas in which we could help him in order to build trust. Although Mr. Kim refused to name any contacts and insisted that he had no family or close friends, he kept pulling his cell phone out of his coat pocket and fiddling with it. We asked if he wanted to make a call, and he indicated that the phone was discon-

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nected. Here was an opportunity: we offered to get the phone turned back on for him. In the process we were able to engage him in conversation about his recent past and learned a little bit more about him. We asked whom he had wanted to call, and while he did not answer directly, he pulled a few pieces of paper with telephone numbers out of his wallet. One of them was his landlord, for whom he worked as a day laborer in lieu of paying rent. Others he did not seem to recognize. He also showed us his expired resident alien card.

While this was not a lot of information, it was a start. We visited his address and found that it was an unauthorized rooming house, where several Mexican immigrants also lived and worked in construction in exchange for room and board. Discussion with these residents confirmed that while they rented rooms in the main part of the house, Mr. Kim lived apart from them in the basement. They did not socialize or share meals with him, and we concluded that they were not close contacts of Mr. Kim. The landlord, when we spoke to him, seemed troubled at the idea of public officials investigating the residence and said that he was about to evict all the boarders. He said that he could store Mr. Kim's belongings for a few weeks, but that if he did not come to collect them within that time they would be discarded.

We went back to Mr. Kim with this news and again asked him for names of family members or someone he could go to when he was discharged. He repeated that he had no one, and said that he didn't care anymore where he was going or what happened to his belongings. Nevertheless, it was our responsibility to arrange for him to be discharged to a setting in which he could complete treatment. We were left with his expired resident alien resident card and a few scraps of paper with telephone numbers scribbled on them. We went to work on these options, starting with the phone numbers

Most of the numbers were non-working, but one led us to a Korean businessman, Mr. Park, who had sold Mr. Kim a car some years before. After the sale Mr. Kim had called a few times just to talk with Mr. Park. Based on those conversations, Mr. Park confirmed our impression of Mr. Kim as a lonely man who found it difficult to connect with others, whether American or Korean. He was distressed to hear that Mr. Kim was hospitalized and offered to come visit him one evening.

Mr. Kim was only slightly more animated when talking to his friend than with Korean hospital staff, but it seemed as though he understood Mr. Park a little better. More importantly, he opened up to us somewhat after he saw us in friendly conversation with Mr. Park. Mr. Kim appeared to have accepted his diagnosis and the inevitability of DOT. He also agreed to our plans to house him once he was discharged, until he had completed TB treatment. He even agreed to let the TB Control Program's social worker help him get his resident alien card renewed, so that he would be eligible for some social services.

We had no problem locating housing for Mr. Kim, as we had contracts with a few local motels to provide rooms for patients on DOT. However, his meals were more difficult, because Mr. Kim was adamant about eating only Korean food. We did not have a relationship with any Korean restaurants in the area to provide food for DOT patients. It took a bit of searching to find one that could prepare a meal to be picked up by his DOT provider. When the restaurant owners understood the situation Mr. Kim was in, they agreed to provide both lunch and dinner for the price of one meal. We got him some second-hand clothes and some toiletries, and moved him into his motel. He may not have looked forward to daily visits from the DOT provider, but he came to expect them and had no trouble taking his daily TB medications.

The Challenge of Co-occurring Diseases

Mr. Kim had never mastered giving himself insulin injections and didn't seem to take the medication prescribed for his hypertension, either. Within a

few months, his DOT provider twice arranged for him to be taken to the hospital for complications from diabetes. Still generally mistrustful of medical personnel, Mr. Kim refused to go in the ambulance that arrived for him the second time, until his DOT provider reassured him that the ambulance would only take him to the hospital and that it was safe to get in. While Mr. Kim was hospitalized for the second time, he was diagnosed with depression and dementia. It

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became clear to us that Mr. Kim was not going to be able to live on his own once he finished his course of treatment.

Fortunately, Mr. Park had told us about a public hospital in an adjacent county with a long-term care floor dedicated to exclusively to Korean patients. When we contacted the admissions officer for this floor, he took on the task of exploring the best options for Mr. Kim. Eventually, he identified another facility that specialized in providing culturally-appropriate long term care for Korean patients. This facility had Korean staff, served Korean food, and observed many holidays familiar to the residents. While Mr. Kim was still hospitalized for complications related to diabetes, arrangements were made for Mr. Kim to go to the long-term facility once he had completed TB treatment.

LESSONS LEARNED:

Take a Patient-Centered Approach

By making Mr. Kim's concerns a priority and integrating those concerns into his health care plans, we were able to achieve the goal of seeing him through his TB treatment. The relatively small gesture of activating his cell phone led us to better information about Mr. Kim's contacts and acquaintances, one of whom was very helpful in identifying necessary services. Providing him with appetizing food every day solidified the DOT provider's relationship with Mr. Kim, and the provider was able to encourage him to remain in care for diabetes, even when he was reluctant to return to the hospital. Along the way, we linked him to resources for long term care and ensured that he received care for other conditions.

Collaborate to Treat Co-Occurring Conditions

TB treatment can be a gateway to care for a myriad of neglected health problems. In order to address all related medical and social challenges that may affect a patient's ability to complete treatment, TB control programs should build effective collaborations with other health care and social service organizations. In addition, the local business community can provide invaluable resources and support, as was true in the case of Mr. Kim's DOT arrangements and preparations for his long term care.

Reconstruct Social Support Networks

While many immigrants find support in established ethnic or national networks, those who are outside of such networks may find themselves doubly isolated in U.S. society.

We initially assumed that Mr. Kim would interact easily with other Korean speakers, but this was not the case. His undiagnosed depression, or perhaps inter-cultural differences, may have led to communication difficulties and isolation from the strong Korean community that existed in his locality. We were eventually able to locate a health care setting for Mr. Kim that met his culturally specific needs and preferences. We believed that this setting would also facilitate the development, over time, of meaningful support networks that would contribute to Mr. Kim's overall quality of life.

PHOTO: COURTESY THE KOREAN COMMUNITY SERVICES OF METROPOLITAN NEW YORK, INC.

MENTAL ILLNESS AMONG ASIAN-AMERICANS

Although research on the subject is sparse, available evidence suggests that the overall rate of mental disorders among Asian-Americans is similar to that of the American population in general. Several studies of populations without mental illness diagnoses, including one of Korean immigrants, found that Asian-Americans reported *more* symptoms of depression than did white Americans. However, their rate of mental health service utilization is amongst the *lowest* of all ethnic groups in the U.S. Furthermore, Asian immigrants, when they do present for mental health services, do so much later when symptoms are more severe, than do white Americans.

Asian-American's relatively low use of mental health care systems may stem from many factors, including pervasive stigma, challenges finding culturally and linguistically appropriate services, and lack of insurance.

Virtually all ethnic and cultural groups attach some stigma to mental illness. Because stigma is expressed in culturally-specific ways, efforts to combat stigma should be culturally appropriate. Some studies have found that Asian-Americans are more receptive to mental health care service providers from similar ethnic backgrounds. More research is needed in order to develop culturally- and ethnically-appropriate mental health care interventions.

U.S. Department of Health and Human services (2001) Mental Health: Culture, Race, and Ethnicity - Supplement to Mental Health: A Report of the Surgeon General

THINGS TO CONSIDER:

Intra-cultural Differences

Shared membership in a common ethnic or cultural group does not guarantee that communication between two people will be smooth. Regional and dialect differences, as well as religious, class, gender and generational differences, can impede an interpreter's or provider's ability to effectively engage a patient of the same ethnic or cultural background. In the case described in this newsletter, Korean providers consistently reported difficulties in communicating with Mr. Kim, despite having no obvious language barrier. Clearly, shared ethnicity many not always mean shared culture.

A careful exploration of the underlying causes of their communication difficulties may or may not have revealed such intra-cultural tensions. For instance, younger professionals from cultures that hold the authority of elders in high regard (like Korea) may have difficulty demonstrating their expertise when working with older patients. In order to reassure patients that they are in good hands, young providers and interpreters can briefly describe their years of experience in their field. Younger professionals may also pair up with an older colleague when interacting with elderly patients. In addition, simply demonstrating respect for an older patient's years can help dissipate tensions related to generational differences.

Depression in Older Adults

Untreated depression can impact negatively on patients' ability to follow medical advice and on their quality of life. Depression often goes unrecognized, especially in older patients, who may be especially sensitive to stigma attached to mental illness and thus reluctant to describe symptoms of depression. Untreated depression can hinder adherence and make recovery more difficult; therefore it is important that depression be diagnosed and adequately treated when it co-occurs with other illness. Family members and providers of an older patient may attribute lethargy, insomnia, weight loss, social withdrawal, and even non-specific stomach complaints to the normal aging process, rather than possible symptoms of depression. Feelings of sadness and loneliness are normal following the loss of a spouse or close friend, but if those feelings are pervasive and last for months, evaluation for depression is warranted. In Mr. Kim's case, his unwillingness to communicate with health care providers or follow through on their directives, his social isolation before being hospitalized, and the recent death of his adult child, all suggested that a comprehensive assessment for depression might have been beneficial.

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Conclusions

For Mr. Kim, the diagnosis of TB opened the door to care for several other medical conditions that had gone untreated for some time. He was generally reluctant to accept medical treatment and tended not to volunteer symptoms, so it was only in the context of his extended relationship with the TB Control Program that his other conditions were diagnosed and treated.

In addition to his medical conditions, Mr. Kim needed assistance in locating social services. Although the TB Control staff could only directly provide resources related to TB treatment, we were able to connect him to other services he needed, both to update his residency status and to find adequate long-term care. This had value beyond the services he gained access to, because it helped build rapport and trust. By making an effort to renew his permanent residency status, we showed Mr. Kim that we cared about his well-being in general, not only about his TB disease. It solidified our relationship with him and helped him to accept what we told him about the need for TB treatment. Just as important, by reaching out to his friend Mr. Park, taking extra steps to bring him food that he enjoyed, and locating a Korean long-term care facility we demonstrated that we respected Mr. Kim's preferences, needs, and values. Over time he became more accepting of DOT and treatment for his medical conditions.

Establishing a relationship with Mr. Kim was challenging because he was non-communicative with the TB Control staff and Korean-speaking hospital staff. Even when Mr. Park came to visit, Mr. Kim's response was very subdued. In retrospect, we realized that his apparent unwillingness to communicate and his non-responsiveness may have been symptoms of depression. Despite this barrier, we were ultimately able to identify important issues that we could help address while he was being treated for TB, which helped create a bond between Mr. Kim and the TB Control staff.

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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