Cultural Competence in Healthcare: From Evidence to Action

Presented by:
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President and CEO

About Us: Critical Measures
- National management consulting and training firm focusing on diversity and inclusion.
- Two-thirds of our work is in cross-cultural health care.
- Provides organizational assessments and training (classroom-based and e-learning).
- Work favorably discussed in: AMA News, Forbes, Health Affairs, Managed Health Care Executive, Minority Nurse, Hispanic Business, American College of Healthcare Executives

Today’s Agenda
1. Three Demographic Megatrends
2. Implications of these Trends for Medicine
3. Evidence-Based Assessments
4. E-Learning Training Interventions
5. Questions and Answers

Changing Demographics

Changing Demographics – Race
- Between now and the year 2050, almost 90% of U.S. population growth will come from Asian Americans, African-Americans and Hispanic-Americans.
- Today, people of color are already a majority in 48 of the nation’s 100 largest cities.
- Today, five states have “minority majorities.” They include: California, Hawaii, New Mexico, Texas and Florida.
- Five other states: Maryland, Mississippi, Georgia, New York and Arizona have non-white populations around 40%.

Three Demographic Megatrends
1. Race
2. Immigration
3. New Cultural Influences
**Trends in U.S. Immigration**

- 1 of 10 global citizens today is a migrant.
- Immigration to the U.S. has tripled in the last 30 years.
- During the 1990s, the U.S. received over 13 million immigrants – the largest number in our nation’s history.
- We broke even that mark during the last decade.
- Significantly, most immigrants today no longer come from Western European nations with whom we have the most in common historically.

**Source:** The Economics of Necessity: Economic Report of the President Underscores the Importance of Immigration. American Immigration Law Foundation

**Immigrants’ Top Countries of Origin - 2009**

<table>
<thead>
<tr>
<th>Minnesota</th>
<th>United States</th>
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<tbody>
<tr>
<td>1. Somalia</td>
<td>1. Mexico</td>
</tr>
<tr>
<td>2. Ethiopia</td>
<td>2. China</td>
</tr>
<tr>
<td>4. Liberia</td>
<td>4. India</td>
</tr>
<tr>
<td>5. Mexico</td>
<td>5. Dominican Republic</td>
</tr>
<tr>
<td>7. India</td>
<td>7. Vietnam</td>
</tr>
<tr>
<td>8. Thailand</td>
<td>8. Columbia</td>
</tr>
<tr>
<td>9. China</td>
<td>9. South Korea</td>
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</table>


**Immigrants Bring New Cultural Influences**

- Religion: Islam is now the fastest growing religion in the U.S.
- Language: 20 percent of Americans 5 years old and older speak a language other than English at home, with nearly half of those claiming to speak English less than “very well.”
- America is now more linguistically diverse than Western Europe.
- 43% of California’s population now speaks a language other than English at home.

**What is Cross-Cultural Healthcare?**

1. Racial and Ethnic Disparities in Patient Outcomes
   - A. Collection of Patient Race, Ethnicity, Language Data
   - B. Tying Demographic Data to Patient Outcomes
2. Providing Language Access to LEP Patients/Families
   - A. Medical - Quality/Safety Issue
   - B. Legal - Civil Rights Issue (Title VI, ADA)
3. Medical Disparities Resulting from Globally Mobile Populations
Cultural Competence Timeline

- 2000: CLAS Standards Adopted (1st National Standards)
- 2002: Institute of Medicine Report "Unequal Treatment" - Disparities
- 2004: AAMC requires every U.S. medical school to teach cross-cultural medicine.
- 2004-06: Three states modify physician licensing laws to require additional training in cross-cultural medicine. (CA, WA, NJ)
- 2009: Obama administration steps up Title VI enforcement efforts.
- 2009-10: Joint Commission, NCQA and the National Quality Forum announce new cultural competence standards. Efforts will focus on language access from standpoint of patient quality, safety.
- 2010: Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act, addresses health disparities.

Racial Disparities in Healthcare

People of Color Driving U.S. Health Insurance Market

<table>
<thead>
<tr>
<th>Demographic Group</th>
<th>1990</th>
<th>2001</th>
<th>Growth</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>White (non Hispanic)</td>
<td>140.7</td>
<td>144.6</td>
<td>3.9</td>
<td>3%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>13.2</td>
<td>22.7</td>
<td>9.5</td>
<td>72%</td>
</tr>
<tr>
<td>African-American</td>
<td>21.7</td>
<td>25.4</td>
<td>3.7</td>
<td>17%</td>
</tr>
<tr>
<td>Asian</td>
<td>5.3</td>
<td>9.3</td>
<td>4.0</td>
<td>76%</td>
</tr>
</tbody>
</table>
| Other                      | 0.9   | 0.8   | (0.1)  | (10%)
| Total                      | 181.8 | 202.8 | 21.0   | 12%|
| Total People of Color      | 41.1  | 58.2  | 17.1   | 42%|
| “Minority Share”           | 23%   | 29%   | 81%    |    |

Source: Census Data: Dr. Tango Analysis

Institute of Medicine Finds Racial and Ethnic Disparities in Quality of Care

- People of Color receive lower-quality health care than whites do, even when insurance status, income, age and severity of conditions are comparable.
- People of Color more likely to be treated with disrespect by the health care system and more likely to believe that they would receive better care if they were of a different race.
- Major disparities found in many key diagnostic areas: cardiovascular disease, cancer, stroke, kidney dialysis, HIV/AIDS, asthma, diabetes, mental health, maternal and child health.
- The overall death rate for blacks today is comparable to the white death rate of thirty years ago. 100,000 blacks die each year who would not die if the death rates were equivalent.

Racial Disparities Have Worsened Since Issuance of the IOM Report

- It has now been seven years since the Institute of Medicine issued its clarion call for improving the quality of healthcare for the nation’s minorities.
- While some strides have been made, quality gaps continue. A recent Agency for Healthcare Research and Quality (AHRQ) report notes that over 60 percent of disparities in quality of care have stayed the same or worsened for blacks, Asians and poor populations while nearly 60 percent of disparities, including but not limited to quality issues have stayed the same or worsened for Hispanics.
Joint Commission Now Requires Collection of Race, Ethnicity Patient Data

- Currently, 19 states have state-based mandates to collect race and ethnicity data in hospitals.
- The AHA has not, as yet, taken a policy position on the collection of race, ethnicity and language data.

Few Hospitals Collect Race/Ethnicity Data and Tie it to Quality/Outcome Data.

- NPHII asked hospitals that collect race and ethnicity data whether they used it to assess and compare quality of care, utilization of health services, health outcomes or patient satisfaction across their different patient populations.
- Sadly, less than 20 percent of surveyed hospitals collect patient race and ethnicity information and tie it to patient outcomes and quality improvement.

Language Access For Limited English Proficient Patients

Business Case for Language Access in Healthcare – Growing Numbers

1. The percentage of Americans who do not speak languages other than English at home is growing dramatically.
   A. Americans who speak a language other than English at home increased by 140 percent over the last three decades. (Total U.S. population increased 34% from 1980-2007.)
   B. Today, fully 55 million Americans or roughly 20 percent of the population does not speak English at home.
   C. Between 12 and 23 million Americans are Limited English Proficient – meaning that they speak English "less than very well."

More Hospitals Seeing LEP Patients

1. More hospitals are seeing LEP patients.
   A. 80% of American hospitals encounter LEP frequently.
   B. 43% of hospitals encounter LEP patients daily, 20% of hospitals encounter LEP patients weekly, 17% of hospitals encounter LEP patients monthly.
   2. Yet less than 30 percent of U.S. hospitals have quality improvement efforts underway to improve the quality of their language access programs.

More Physicians Seeing Non-English Speaking Patients

1. While nearly 97 percent of physicians have at least some non-English speaking patients, only slightly more than half of physicians (56%) were in practices that provided interpreter services in 2008.
2. Likewise, 22 percent of physicians indicated that their practice has IT capable of reporting patients’ preferred language but only a third of these physicians (7%) routinely used this capacity.
3. Nearly half (48.6%) of all U.S. physicians in 2008 reported that difficulty communicating with patients because of language or cultural barriers was at least a minor problem affecting their ability to provide high quality care. Modest and Uneven, Feb. 10, 2010.
**Business Case for Language Access in Healthcare – Benefits**

1. Improved Market Share
   - Hispanic patients and their families choose hospitals primarily on the perceived quality of the hospital’s language services.

2. Cost Effectiveness
   - When physicians cannot understand LEP patients, they order more tests and admit patients to the hospital for “observation.”
   - LEP patients who did not receive a professional interpreter at admission and discharge had an increased LOS of 0.75 to 1.47 days and were more likely to be readmitted within 30 days.

**Medical Case for Language Access in Healthcare – Improved Quality, Safety**

1. Language barriers are associated with poor quality of care in emergency departments; inadequate communication of diagnosis, treatment and prescribed medication; and higher rates of medical errors.

2. According to one study, no interpreter was used in 46% of emergency department cases involving patients with LEP.

3. Few clinicians receive training in working with interpreters; only 23 percent of U.S. teaching hospitals provide any such training and most make it optional.

4. Glenn Flores conducted research on mistakes by inadequately trained interpreters. His results showed:
   - An average of 31 mistakes per doctor-patient visit
   - Two-thirds could have negative consequences for patients

5. According to the Joint Commission, fully half of LEP patients who reported adverse events experienced some degree of physical harm – compared to less than a third of English speaking patients.

6. The same report found that the rate at which LEP patients suffered permanent or severe harm or death was more than twice that of English-speaking patients.

**New Joint Commission Requirements**

- In 2012 Joint Commission requires that:
  - “The hospital identifies the patient’s oral and written communication needs, including the patient’s preferred language for discussing health care.”
  - “The hospital communicates with the patient during the provision of care, treatment, and services in a manner that meets the patient’s oral and written communication needs.”
  - “Qualifications for language interpreters and translators may be met through language proficiency assessment, education, training, and experience”

**U.S. Patient Satisfaction Data – Language**

1. Research has highlighted that patients with limited English proficiency (LEP) have more difficulty communicating with health care providers and are less satisfied with the care they receive than those who are proficient in English.

2. Studies show that the perceived quality of the interpreter is strongly associated with patients’ assessments of quality of care overall.

3. Patients who needed and got an interpreter rated their hospital experience and the care they received more positively than those patients who needed an interpreter but did not get one. Other studies have found that linguistic minorities of any race reported worse care than did English-speaking racial and ethnic minorities.

**Legal Case for Language Access**

1. Federal Law - Language Access for LEP & the Disabled
   - Title VI of the Civil Rights Act of 1964 – lack of linguistic access as national origin discrimination.
   - ADA, Sect. 503 Rehabilitation Act of 1973

2. State Law – All 50 states now have language access laws.

3. Other regulations and accreditation standards: CLAS Standards, Joint Commission, NCQA, Magnet Status for Nurses

4. Four major legal risks for physicians: medical malpractice, informed consent, breach of duty to warn, breach of patient’s privacy rights.

5. Most medical malpractice insurance policies do not cover language access/civil rights claims.
Language Access Settlements

1. A hospital was ordered to pay a $71 million damage award because a patient was not treated promptly for a ruptured artery. The paramedics interpreted a 22 year-old Spanish-speaking patient's complaint of “intoxicado” as meaning that he was “intoxicated” rather than “nauseated”, and the hospital delayed a neurological evaluation while doing a drug and alcohol workup. The patient ended up a quadriplegic. See: P. Harham, A Misinterpreted Word Worth $71 Million, Medical Economics, 289-92 (June 1984).

2. In a 2008 New Jersey case, a physician refused to honor a patient's request to employ an American Sign Language (ASL) interpreter because the interpreter's charges would exceed the physician's hourly rate. The physician was required to pay a $400,000 jury verdict in the patient's favor as a result.

3. In a 2010 Minnesota case, North Memorial Hospital agreed to pay $105,000 to settle charges that two disabled patients were not provided access to qualified sign language interpreters. One of the patients had to read lips or write notes to communicate with doctors and nurses, despite his repeated requests for an interpreter. The same patient did not learn that his wife had terminal cancer until three months after the fact due to the lack of interpreters.

Global Clinical Competence

Impact of Culture on Quality/Safety – Two Patient Cases.

• Hmong immigrant patient with long history of smoking and COPD was treated with steroids. Patient died. Autopsy revealed that patient had an infectious, parasitic disease (Strongyloides). Treating the condition with steroids disseminated the disease and killed the patient. Treating physicians never asked about and killed the patient country of origin or investigated diseases from Asia that look like COPD.

• Anglo-American female patient presented with fever and flu-like symptoms. Treated for flu, her conditions continued to worsen. Result: patient had acquired malaria from a recent humanitarian trip to Haiti where she had helped earthquake victims.

Impact of Culture on Quality/Safety – Examples (continued)

• Both of these examples show that “the global has become the local”.
• Immigrants and refugees from all over the world are immigrating to the United States.
• At the same time, American citizens are traveling to the most remote parts of the globe and returning home.
• As a result, American physicians must become clinically competent in a truly global medical environment.
• Words matter. The goal is not culturally competent physicians but rather clinically competent physicians who are capable of practicing global medicine.

From Evidence to Action
Eliminating Racial Disparities

1. Train hospital admissions personnel on why collecting race, ethnicity and language data is needed and how best to do it.
2. Be clear about what types of patient demographic data should be collected and integrated into the electronic patient record.
3. Implement rigorous patient demographic data collection policies.
4. Tie resulting patient demographic data to patient outcomes through an ongoing process of Hospital Patient Equity Reports.
5. Stratify patient outcome data, patient complaints, patient satisfaction and sentinel events by race, national origin and language.
6. Consideration should be given to having clinical leaders participate in the Disparities Solutions Center’s Disparities Leadership Program.

Improving Language Access

Evidence-Based Assessments

1. CLAS-Based Organizational Assessment
2. Language Access Audit
3. Physicians Cultural & Linguistic Competence Assessment

Are U.S. Hospitals in Compliance With The CLAS Standards?

1. See: “Do Hospitals Measure Up to the National Culturally and Linguistically Appropriate Services Standards?” by Lisa Diamond, MD, MPH; Amy Wilson-Storrs, MPP; and Elizabeth Jacobs, MD, MPP. Medical Care, December 2010.
2. The researchers surveyed hospitals across the United States to gather data about how often they incorporated the 4 language-related CLAS standards into practice. (CLAS Standards 4-7)
3. The researchers sampled 239 hospitals using 2 different sampling methods: a stratified national sample and a judgment (Best Practice Hospitals) sample. Both samples were generated as part of the Joint Commission’s “Language and Culture” project.
4. The survey was launched in January 2008 and completed in June 2008. The response rate was 135/235 (57%).
Nebraska Language Access Assessment

The Nebraska Context
- Successive waves of recent immigration have made Nebraska a much more culturally and linguistically diverse state than in the past.
- Although Nebraska ranks among the middle to lower half of U.S. states in terms of immigration, it ranks 8th in the nation in terms of the percentage of its population that is Limited English Proficient. As a result, the medical need for high quality language access services may be greater in Nebraska than in other states.
- Nebraska is one of only 13 states nationally that provides Medicaid and SCHIP reimbursement for interpreter services. Therefore, one might expect that the quality and professionalism of language access services might be greater in Nebraska than in other states.

Nebraska Language Access Assessment

Critica Measures, LLC
4627 Nicollet Avenue South, Minneapolis, MN 55419 | www.criticalmeasures.net | Phone: (612) 746-1375
M.D. Cultural Competence Assessment

Critical Measures’ assessment addresses the following topics:
1. Extent of formal training in cross-cultural health.
2. Opinions regarding health disparities.
3. Self-assessed preparedness to treat immigrants, LEP and patients whose health beliefs may be at odds with Western medicine.
4. Knowledge of and adherence to language access laws and self-disclosed use of language access resources.
5. Knowledge of and actual practice behavioral adherence to national best practices in cross-cultural medicine, immigrant and refugee health & travel medicine.
6. Interest in receiving additional training in cross-cultural medicine.

Physician Assessment – Typical Results

- Few physicians have had formal training in cross-cultural medicine but substantial majorities would like to receive such training.
- Significant numbers of physicians believe that they are less than well prepared to provide care to immigrant and refugee patients, patients who speak languages other than English and whose religious or cultural values may be at odds with Western medicine.
- Most physicians are not familiar with current language access laws, hospital language access policies or had formal training on how to work with interpreters.
- Most physicians do not demonstrate practice behaviors in accord with national best practices for treating culturally diverse patients.
- Physicians’ practice behaviors with respect to patients of color and LEP frequently raise concerns about patient communication, safety, informed consent and risk management.

Language Access Results from Recent Client MD Cultural Competence Survey

- Preliminary findings from the Client/Physician and Advanced Practice Provider Survey indicate that:
  - 97% of all MDs treat LEP patients (same as the U.S. average).
  - 48% of all MDs (and 47% of MDs who treat LEP) felt that they were less than well prepared to provide care to patients who speak languages other than English.
  - 58% of Nurse Practitioners and Physician Assistants felt that they were less than well prepared to provide care to LEP patients.
  - Primary care MDs often fell least prepared to provide care to LEP patients.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Very Well</th>
<th>Well</th>
<th>Less Than Well</th>
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</thead>
<tbody>
<tr>
<td>Family Medicine MDs</td>
<td>37% (13)</td>
<td>63%</td>
<td>63% (22)</td>
</tr>
<tr>
<td>Pediatric MDs</td>
<td>63% (10)</td>
<td>37%</td>
<td>37% (6)</td>
</tr>
<tr>
<td>OB/GYN MDs</td>
<td>67% (4)</td>
<td>33%</td>
<td>33% (2)</td>
</tr>
<tr>
<td>Int. Medicine MDs</td>
<td>40% (6)</td>
<td>60%</td>
<td>60% (9)</td>
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</tbody>
</table>

- 43% of all MDs (and 43% of MDs who treat LEP) are less than familiar with organizational policies and procedures relating to language access.
- 30% of all MDs (and 30% of MDs who treat LEP) are less than familiar with techniques for working with medical interpreters.
- 44% of all MDs (and 47% of MDs who treat LEP) have never had any formal training on the impact of miscommunication on patient safety.
- 62% of all MDs (and 62% of MDs who treat LEP) are unfamiliar with legal requirements for working with interpreters.

- Additional findings: 27% of client MDs do not “always” use a qualified interpreter to obtain patient’s informed consent and 53% of MDs who treat LEP patients do not “always” document the use of an interpreter in the patient’s medical record.

Create A Language Access Plan (LAP) for Your Institution

- A. Creation of an LAP is proscribed by law (Title VI).
- B. An effective LAP contains five core elements:
  1. Identify individuals who have limited English proficiency and need assistance.
  2. Decide on how best to meet language access needs (both oral interpreters and written translated documents).
  3. Train Staff.
  4. Notify LEP patients of legal right to an interpreter and written translated materials at no cost to them.
  5. Monitor and update your policy frequently.

Train Staff

- Train staff on all language access policies and procedures (use of interpreters, non-use of friends, family-members and minors).
- Train physicians and nurses on how to use qualified medical interpreters when working with LEP.
- Train physicians and nurses on how to use over the phone or other remote language access services.
- Train physicians and nurses on how to use ASL interpreters when working with patients with disabilities.
- Train physicians and nurses on the language access laws.
JAMA: Train MDs on Law to Change Physician Behavior

- A 2006 JAMA article suggested that teaching physicians about the law and patients’ rights to interpreters can change practice behaviors. An interesting aspect of the article suggested that physicians’ use of qualified interpreters increases (and use of children and family members decreases) when physicians are taught about LEP patients’ legal right to language access resources.
- See: Resident Physicians Use of Professional and Non-Professional Interpreters – A National Survey, Letters to the Editor, Journal of the American Medical Association (JAMA), September 6, 2006, Volume 296 number 9 at pages 1050-1053.

New E-Learning Program Trains Providers on Law of Language Access

- Provides Pre and Post Tests designed to assess learner mastery of medical and legal concepts presented in the course. 70% proficiency level required to “pass”.
- Understand why language access is needed. Provides the “business, medical (quality/safety) and legal cases” for language access.
- Resolve multiple, complex medical and legal issues in a comprehensive patient case study involving a Hmong patient. Follow Mr. Vang, a 68 year-old Hmong man as he deals with common language access problems in a health plan, clinic, emergency room, outpatient/pharmacy and hospital/inpatient setting. Debrief the case with national experts.
- Uses aspects from real cases prosecuted by the Office of Civil Rights to highlight the most common mistakes made by physicians in providing language access services.

Highmark BCBS Trains Providers on Language Access.

- Highmark is a national leader in delivering culturally competent medical care in accord with national best practices.
- Highmark is the first health plan in U.S. to train providers on “Language Access and the Law”
- Will train up to 1,000 providers on program.
- Provides 2.25 hours of CME

Initial Results Show That MDs Use Interpreters More, Family Less

- The average pre-test score was 59. The average post-test score was 83 – an improvement of 24 points or 29%.
- 96% of users strongly agreed or agreed that the program will help them to improve patient care.
- Most significantly, physician users stated that they increased their use of trained medical interpreters (including telephonic interpreters) by 34% after completing the program compared to their self-reported use rates prior to taking the program.
- Further, physician users self-reported use of family members and adult friends as interpreters decreased by 29% from pre to post activity completion.

New Grant Will Test E-Learning Program’s Effectiveness

- The CentraCare Health Foundation has just approved a grant request of $517,665 to test whether Critical Measures’ e-learning program on Language Access and the Law changes physicians’ use of qualified interpreters.
- Language access audit and a physicians’ cultural and linguistic competence assessment conducted in 2011-12. Results were less than satisfactory.
- CentraCare plans to train approximately 3,000 doctors and nurses on Language Access and the Law over a two year period. Significantly, CentraCare intends to pay providers for their time in taking the course.
- Hypothesis: More use of professional interpreters, less use of family members and friends and minor children as interpreters , improved patient-provider communication and medical care to patients improving as a result...
Most Client Providers Feel Less Than Well Prepared to Care for Immigrants & Refugees

1. Fully 92% of all Client MD’s treat immigrants and refugees (159 of 173)
2. Yet 59% of all Client provider survey respondents indicated that they felt “less than well prepared” to provide care to patients who are new or recent immigrants. (See detail.)
3. 62% of Client provider survey respondents indicated that they felt “less than well prepared” to provide care to patients who are new or recent refugees. (See detail.)

Client’s Providers Do Not Exhibit Best Practices in Care for Immigrants

1. 56% of all Client MD’s do not always ask patients who are immigrants and refugees about their country of origin.
2. 70% of all Client MD’s do not always ask immigrant and refugee patients about their recent travel history.
3. Schistosomiasis (Bilharzia) and Strongyloides Stercoralis are two of the top five infectious diseases afflicting immigrants and refugees in the U.S.
4. Results from the Client Provider Survey found that:
   - 58% of Client providers (52% of MDs) were relatively unfamiliar or unfamiliar with Schistosomiasis
   - 71% of Client providers (65% of MDs) were relatively unfamiliar or unfamiliar with Strongyloides;

Most Client Providers Have Never Had Training on Cross-Cultural Health

1. 54% of all Client MDs and 47% of N.P.’s/P.A.’s have never had any formal training on cross-cultural medicine (Compare: 60% of U.S. physicians have never received any formal training on minority health issues...)
2. But 75% of all Client providers said that it was very important or important to them to receive additional training in this area. Those numbers include:
   - 71% of all (responding) physicians
   - 77% of all (responding) employed physicians
   - 80% of all (responding) Nurse Practitioners & P.A.’s

Overview: Viewpoints E-Learning Program . (6.0 Hours CME)

- Outlines new skills that providers will need to be clinically competent (as opposed to culturally competent) in a globally mobile world.
- Offers six interactive cross-cultural patient case studies. Although each patient has similar presenting symptoms (fever, flu-like condition) the correct differential diagnosis is radically different in each case.
- All of the cases provide the very latest in interdisciplinary scholarship. Each case offers medical/clinical, legal and cross-cultural advice from experts in each field.
- Each case is designed to simulate a typical patient encounter. Providers will have the opportunity to take a patient’s medical/social/cultural history, conduct a “physical examination”, order tests and obtain results, and generate a differential diagnosis.
- All six cases contain unique communication challenges that could negatively impact patient trust and the medical outcome of the case.
**Overview: Viewpoints E-Learning Program**

- Providers will meet six patients who are as culturally and linguistically diverse as today's multicultural medical practice. They include:
  - Abdi, a pediatric case involving a child visiting the U.S. from Nairobi, Kenya.
  - Jodie, a hard-of-hearing, Anglo-American nurse who has just returned from a humanitarian mission to Haiti with malaria.
  - Juan, a young Hispanic/Latino male, with acute HIV who is an undocumented immigrant to the U.S. from Lima, Peru.
  - Deepak, a highly educated, well-travelled, bisexual professional from India with Hepatitis B and Tuberculosis.
  - Tou Vang, a Limited English Proficient (LEP), Hmong American who has recently returned from a trip to Laos with a mysterious rash (Dengue fever).
  - Charlene Wilson, a middle-aged, African American female patient with substantial mistrust of the U.S. medical system who presents with a fever and flu-like symptoms.

**Viewpoints Faculty**

- Patricia F. Walker, M.D. – Medical Director, HealthPartners Center for International Health, Doctor of Internal Medicine and Tropical and Travel Medicine, HealthPartners Medical Group. Assistant Professor, Department of Medicine, Division of Infectious Disease & International Health University of Minnesota. Co-Editor of *Immigrant Medicine* (Elsevier, 2007) the first international textbook on immigrant and refugee medicine.
- William M. Stauffer, M.D. - Associate Professor, University of Minnesota. Department of Medicine. Division of Infectious Diseases and International Medicine. Dr. Stauffer serves as a medical/technical expert for the Division of Global Migration and Quarantine at the Centers for Disease Control and Prevention. National Center for Infectious Diseases, Atlanta. As a technical advisor with CDC, Dr. Stauffer prepares and writes the international and domestic medical guidelines for refugee resettlement. The guidelines cover all major infectious disease issues (i.e. parasitic, HIV, STI’s, TB, vaccine issues), environmental exposures (i.e. lead), nutritional and mental health issues among others.

**New Skills for the Clinically Competent Global Physician**

1. How to conduct a culturally competent patient examination/history using the LEARN Model (Listen, Explain, Acknowledge, Recommend, Negotiate)
2. How lack of knowledge of epidemiological and pathophysiological differences may lead to unintended iatrogenic consequences.
3. How to work with patients using qualified medical interpreters
4. Understanding the Law of Language Access (implications for informed consent and other legal issues)
5. Given the increase in globally mobile populations, physicians should know their patients national origin and travel history and be mindful of diseases endemic to other parts of the world that might share symptoms with diseases commonly seen in the U.S.
6. Health care providers should be aware of at least the five most common infectious diseases most commonly encountered in refugee populations.

**New Skills for the Clinically Competent Global Physician**

7. Cross-Cultural Medical Ethics (examples: cultural differences around death and dying, blood beliefs, surgery, organ transplants, mental health etc.)
8. Ethnopharmacology and its implications for current clinical practice

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