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Delivering Culturally Competent Care: Strategies for Clinicians

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Moderated by:
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Delivering Culturally Competent Care: Strategies for Clinicians

August 28, 2018

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continued

Objectives

1. Define cultural and linguistic competency.
2. List cultural and social factors that may have an impact on a patient's experience of illness.
3. Describe factors that affect a therapist's ability to provide culturally and linguistically competent care

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continued

Introduction

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Definitions and Terminology

- Cultural and linguistic competency is defined as “the capacity for individuals and organizations to work and communicate effectively in cross-cultural situations”
- Cultural and linguistic differences can result in
 - Miscommunication
 - Lack of understanding regarding diagnosis or treatment
 - Other consequences that may negatively influence health outcomes

(HHS OMH, 2013)

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Definitions and Terminology

- Culture
 - Integrated pattern of thoughts, communications, actions, customs, beliefs, values, and institutions associated, wholly or partially, with racial, ethnic, or linguistic groups as well as religious, spiritual, biological, geographical, or sociological characteristics
- Culturally and linguistically appropriate services (CLAS)
 - Services that are respectful of and responsive to individual cultural health beliefs and practices, preferred languages, health literacy levels, and communication needs

(HHS OMH, 2013)

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Definitions and Terminology

- Persons with limited English proficiency (LEP)
 - Persons unable to communicate effectively in English (HHS OCR, 2003)
- Health
 - Encompasses physical, mental, social, and spiritual well-being (HHS OMH, 2013)
- Health disparities
 - Health differences closely linked with social, economic, and/or environmental disadvantage (HHS OMH, 2011)
- Health care disparities
 - Differences in the receipt of, experiences with, and quality of health care (IOM, 2003)

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Other Definitions of Culture

- “A culture, in the anthropological sense, is the set of beliefs, rules of behavior, and customary behaviors maintained, practiced, and transmitted in a given society. Different cultures may be found in a society as a whole or in its segments, for example, in its ethnic groups or social classes.” (Hahn, 1995)
- “The cluster of learned and shared beliefs, values (enrichment, individualism, collectivism, etc.), practices (rituals and ceremonies), behaviors (roles, customs, traditions, etc.), symbols (institutions, language, ideas, objects, and artifacts), and attitudes (moral, political, religious) that are characteristic of a particular group of people and that are communicated from one generation to another.” (Gardiner & Kosmitzki, 2005)

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What is Culture?

- Culture is learned
 - Transmitted from one generation to the next; learned through interactions with others (Carpenter-Song, et al, 2007)
- Culture is localized
 - Meaningful cultural elements are shared with some, but not all, individuals within a society
- Culture is patterned
 - Essential to develop patterns for behavior that minimize ambiguity and avoid having to renegotiate every interaction (Yerxa, 2002)

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What is Culture?

- Culture confers and expresses values
 - Values are embedded in culture and in individual behavioral decisions and choices (Fowers & Davidov, 2006)
- Culture is persistent but adaptive
 - Cultural identity is relatively stable, but also adaptive
 - Changes over course of life with new encounters and experiences (Whaley & Davis, 2007)

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Why is Cultural Competence Important?

- Culture shapes our language, behaviors, values, and institutions
- Cultural competence can help improve
 - Quality of care for diverse patients
 - Patient safety
 - Patient satisfaction

(Beach et al., 2004; Goode, Dunne, & Bronheim, 2006; Betancourt, 2006; Brach & Fraser, 2000; Thom, Hall, & Pawlson, 2004)

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Demographic Changes

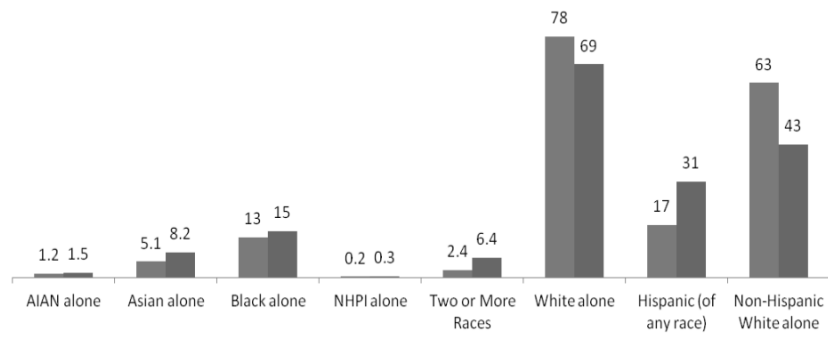
- The U.S. Census Bureau projects that by 2060, the United States will become an even more multicultural society (U.S. Census Bureau, 2012)
- Demographic changes within the health care workforce have not kept pace with society as a whole (Genao, Bussey-Jones, Branch, & Corbie-Smoth, 2003; IOM, 2004b; Sullivan & Mittman, 2010)
- About 70% of the allied healthcare workforce is non-Hispanic/white
 - Workforce diversity can lessen the cultural gap

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**Figure 1 - Population by Race and Hispanic Origin:
2012 and 2060**

(percent of total population)

■ 2012 ■ 2060



Source: U.S. Census Bureau, 2012

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Health and Health Care Disparities

Contributing Factors

- Social determinants of health
- Lifestyle choices
- Patients' care-seeking behavior
- Linguistic barriers
- Variations in the predisposition to seeking timely care
- Degree of trust
- Ability to pay for care
- Location, management, and delivery of health care services
- Clinical uncertainty
- Beliefs of health care practitioners

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Health and Health Care Disparities

- Well documented across many cultural and linguistic groups
 - Persons of different races
 - Members of the lesbian, gay, bisexual, and transgender (LGBT) communities
 - Individuals with physical disabilities
 - Individuals living in rural areas

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Health and Health Care Disparities

- For example:
 - Racial and ethnic minorities experience higher rates of chronic disease and disability, higher mortality rates, & lower quality care, compared to non-Hispanic Whites (HRET, 2011; IOM, 2003)
 - Suicide is the third leading cause of death among youth aged 15 to 24 years especially among LGBT youth (Hatzenbuehler, 2011)
 - Individuals with lower incomes are more likely to experience preventable hospitalizations (HHS CDC, 2011)

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Why Cultural Competency Matters

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Importance of Culture

- Culturally appropriate services are respectful of and responsive to an individual's culture (HHS OMH, 2013)
- Culture shapes our language, behaviors, values, and institutions.
- Differences in culture may result in misunderstanding or lack of compliance

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Culturally Appropriate Care

- Culturally appropriate care is an urgent need
 - Many cultural and linguistic groups receive lower quality of health care (IOM, 2003; HHS OMH, 2001; HHS OMH, 2013)
 - Bias, stereotyping, prejudice, and clinical uncertainty also contribute to health care disparities (IOM, 2003)
- Cultural and linguistic competency skills may help reduce health care disparities

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Terminology

- Bias
 - A preference or an inclination, especially one that inhibits impartial judgment; or an unfair act or policy stemming from prejudice (IOM, 2003)
- Assumption
 - A basic underlying assumption is an unconscious, taken-for-granted belief and value that helps determine behavior, perception, thought, and feeling (Schein, 2010)
- Prejudice
 - Negative attitudes toward a specific group of people (Pincus, 2006)

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Terminology

- Stereotype
 - An oversimplified conception, opinion, or belief about some aspect of an individual or group of people (Purnell, 2005)
- Discrimination
 - Actions that deny equal treatment to persons perceived to be members of some social category or group (Pincus, 2006)

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Why Competency Matters

- To reduce the burden of illness, injury, and disability, and to improve health and function
- Provide healthcare that is:
 - Safe
 - Effective
 - Patient-centered
 - Timely
 - Efficient
 - Equitable

(IOM, 2001)

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continued

Factors Affecting Competency

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continued

Self-Awareness

Awareness of one's own values and those of the health care system is the foundation of culturally and linguistically competent care

(Leonard & Plotnikoff, 2000; Barnes, 2004)

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continued

continued

Ethnocentrism

- A belief that one's way of life and view of the world are inherently superior to others and more desirable
- May prevent effective treatment
- Can compromise the therapist-patient relationship
- May lead to mistreatment or insufficient treatment

(Greipp, 1995; Leininger & McFarland, 2002)

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continued

Essentialism

- Defines groups as “essentially” different, with characteristics “natural” to a group
- Does not take into account variations within culture
- Can lead to stereotypes

(Fuller, 2002)

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continued

Power Differences

- Reflect the power imbalance in patient-provider relationships
- Some cultural groups may feel powerless
- Without knowing about power differences, therapists can perpetuate health care disparities

(Hewison, 1995; Johnson & Webb, 1995; Farmer, 1997; Singer & Clair, 2003)

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Factors Influencing Competency

- Therapists may have stereotypes about patients
- They may impose beliefs that contradict their patients'
- Manner of speech may transmit bias

(Pope, 2002)

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Positive Effects on Patients

- Taking patients' cultural values and language preferences into consideration
 - Positive effect on delivery of care
 - Improved outcomes
 - Improved compliance
 - Improved satisfaction
 - Improved treatment adherence
 - Improved interactions

(Esposito, 2013; Castro & Ruiz, 2009)

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Factors With Negative Impact

- Bias
 - A preference, especially one that inhibits impartial judgment
- Discrimination
 - An action that denies equal treatment to individuals
- Ethnocentrism
 - The belief in superiority of one's ethnic group

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Factors With Negative Impact

- Essentialism
 - Viewing other groups as essentially different
- Power differences
 - The power imbalance in the patient-provider relationship
- Stereotypes
 - Oversimplified conceptions, opinions, or beliefs about some aspect of an individual or group

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Self-Assessment Tools

- Help you learn about your own assumptions, biases, and stereotypes.
- An important step toward improving cultural and linguistic competency
- Be aware of your patients' beliefs about health/care
 - Do not make assumptions based on your own beliefs or training

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continued

Importance of Self-Assessment

- It is helpful to examine individual beliefs and behaviors, because they can lead to differential care of patients based on bias or stereotypes
- Critically examine your own beliefs, biases, and assumptions and continually monitor them
- Treat based on direct experience, not assumptions or hearsay

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continued

Models for Becoming Culturally Aware

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continued

Overview

- Campinha-Bacote Culturally Competent Model of Care
 - Driven by cultural desire and encourages health care providers to seek cultural encounters, obtain cultural knowledge, develop skills to conduct culturally sensitive assessments, and developing self-awareness
- Purnell Model for Cultural Competence
 - Explains the complexity of a person's worldview in terms of social, gender, age, and culture and stimulates progress from unconscious incompetence about patients' cultural beliefs to providing culturally sensitive care

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Campinha-Bacote Model of Care

Self-assessment questions

- Awareness
 - Are you aware of your biases and the presence of racism?
- Skill
 - Do you know how to conduct a cultural assessment in a sensitive manner?
- Knowledge
 - Do you know about different cultures' worldviews and the field of bio-cultural ecology?
- Encounters
 - How many face-to-face interactions and other encounters have you had with people from different cultures?
- Desire
 - Do you "want to" become culturally and linguistically competent?

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continued

Purnell Model for Cultural Competence

- Overview/heritage
 - Concepts related to the country of origin, current residence, topography, emigration, education, occupation
- Communication (verbal)
 - Concepts related to dominant language and dialects
- Communication (nonverbal)
 - Concepts related to nonverbal communications, such as eye contact and body language

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continued

Purnell Model for Cultural Competence

- Family roles and organization
 - Concepts related to roles of head of household and by gender; family roles, developmental tasks, child-rearing
- Workforce issues
 - Concepts related to autonomy, acculturation, assimilation, health care practices
- Biocultural ecology
 - Variations in ethnic and racial origins, metabolism of medications

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continued

Purnell Model for Cultural Competence

- High-risk behaviors
 - Tobacco, alcohol, drugs, physical activity, safety measures
- Nutrition
 - Having adequate food, food choices, health and wellness
- Pregnancy
 - Fertility practices, birth control, birthing, postpartum treatment

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continued

Purnell Model for Cultural Competence

- Death rituals
 - Rituals and behaviors to prepare for death
- Spirituality
 - Religious practices and the use of prayer
- Health care practices
 - Focus of health care, beliefs, self-medicating practices, views toward mental illness, organ donation, transplant
- Health care practitioners
 - Status, use, perceptions of health care providers

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An Ongoing Process

- Competency development is an ongoing process
- Repeated practice helps one to recognize one's own assumptions and biases (Singleton & Krause, 2009)
- Understanding yourself is the starting point for integrating new knowledge about other cultures into your knowledge base and health interventions (Purnell, 2005)

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Understanding the Health-Related Experience

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Disease Versus Illness

- Disease refers to physiological and psychological processes
- Illness refers to the psycho-social meaning and experience of the perceived disease for the individual, the family, and those associated with the individual
(Kleinman et al., 1978)
- Individuals seek health care because of their experience with illness
- Health care providers are trained to treat disease
- A provider's treatment of disease coupled with a patient's need for treatment of illness can cause a disconnect

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Health and Illness

- Health and illness are influenced by culture.
 - What is meant by health
 - How illness is defined
 - How the body is understood to function
 - What constitutes disability
 - Assumptions about how illness is caused
 - How illness can be cured
 - Who does the curing

(Fortier & Bishop, 2003; Swami et al., 2009; Conrad & Barker, 2010)

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Factors Influencing Illness

- Socio-economic standing
- Immigration status
- Language
- Religious traditions
- Worldview
- Family relationships

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Factors Influencing Illness

- Beliefs about the supernatural world
- Fatalism
- Environmental impacts
- Food intake
- Understanding of causation of illness

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For Example

- Some Native Americans believe that healing will result from sacred ceremonies using symbolic visions and plants
- Some Asian cultures believe that illness is caused by spirits
- Some Hispanic cultures practice traditional medicine and folk remedies
- Rich tradition of herbal/home remedies among African-American culture

(Galanti, 2004; Management Sciences for Health, 2006)

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Understanding the Patient

- Understanding interpretation of illness is related to understanding alternative sources of care
 - Traditional or folk models of care and treatment
 - May be driven by poverty and lack of access
 - Complementary and alternative medicine
 - Complementary medicine used in combination with conventional medicine
 - Alternative medicine used in place of conventional medicine

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Guidelines to Address Folk Beliefs

- Become aware of the commonly held medical beliefs and behaviors in the patient's community
- Assess the likelihood of a particular patient or family acting on these beliefs during an episode of a specific illness
- Arrive at a way to negotiate successfully between the two belief systems

Partner with and incorporate patients' traditions and personal views into effective plans of care: Patient compliance and satisfaction improves

(Pachter, 1994; Ericksen, 2002)

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Patient-Centered Care

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Patient-Centered Care

“Establishes a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients’ wants, needs, and preferences and solicits patients’ input on the education and support they need to make decisions and participate in their own care”

(IOM, 2001)

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Principles of Patient-Centered Care

- Dignity
- Unbiased
- Control
- Collaborate

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continued

Communication Techniques

- Approach a new patient slowly
- Greet the patient respectfully
- Provide the patient with a quiet setting
- Sit a comfortable distance away and lean slightly toward the patient
- Allow sufficient time for your meeting
- Explain
- Listen

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continued

Balancing Knowledge-Centered and Skill-Centered Approaches

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continued

Knowledge-Centered Approach

- Relies on specific information about cultural beliefs of various groups and on demographic data that highlight group differences
- Can help to establish rapport, create trust, prevent unintended cultural offenses, reduce misunderstandings
- Risk of cultural and racial stereotypes
- Need to balance with direct communication

(DeRosa & Kochurka, 2006; Ingram, 2012)

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Knowledge-Centered Approach

- Beliefs about health and illness can be categorized in many ways
- Causes of Illness
 - Many cultures may believe that illnesses have supernatural causes

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Knowledge-Centered Approach

- Religious Beliefs
 - Prayer may be seen as a method of healing and may serve as a complement or alternative to medical care in many cultures (Barnes, Powel-Griner, McFann, & Nahin, 2004)
 - Beliefs about fate or the “will of God” have significant impacts on decisions to seek health care and adhere to preventive health care guidelines (Kaiser Permanente, 2001)

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Knowledge-Centered Approach

- Historical and Current Influences
 - Historical and current disadvantages are commonalities for many minority populations
 - Disadvantages include racial discrimination, denial of equal education, economic discrimination, political disenfranchisement
 - Though many barriers have been removed, some still exist in healthcare

(HHS OMH, 2013)

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Knowledge-Centered Approach

- Contemporary factors contributing to medical mistrust
 - Shortage of racial and ethnic minority health care providers
 - High number of minority patients residing in medically underserved areas
 - Reliance on traditional non-Western cultural medical practices

(Williams & Johnson, 2002)

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Knowledge-Centered Approach

- Role of Family
 - In some cultures, family members are expected to play an important role in treatment decisions

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Knowledge-Centered Approach

- Health Care System Behavior
 - Some cultural and religious groups may prefer health care providers of the same gender (Jenko & Moffit, 2006)
 - Health care providers may blend Western and traditional healing practices for successful treatment and prevention of health problems (Management Sciences for Health, 2006)

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Knowledge-Centered Approach

- Treatment
 - About 1/3 use complementary or alternative medicine
 - Most do not disclose to their healthcare provider

(HHS National Center for Complementary and Alternative Medicine, 2012; Ahn et al., 2006)

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Skill-Centered Approach

- Seek each patient's understanding
- Develop communication skills to understand cultural context
- Self-awareness
- Reflection about cultural identity and beliefs

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Skill-Centered Approach Principles

- Understanding self in terms of culture
- Reflecting upon personal beliefs about cultural competency
- Understanding how race, ethnicity, gender, spirituality, and other issues play a role both in delivery and perceptions of health care
- Understanding the community served and the different cultures within the community

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Skill-Centered Approach Principles

- Examining family beliefs, roles, and constructs in the community
- Developing cultural humility
- Practicing cultural etiquette
- Considering cultural competency as a series of stages of development or a commitment to life-long learning, rather than a specific achievement

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Skill-Centered Approach

Balancing knowledge-based approaches (without stereotyping patients) with skill-centered approaches can help you deliver better culturally and linguistically competent, patient-centered care

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Incomplete Information

- In culturally rich situations, clinicians always work in the absence of complete information
- No health care provider can ask all of the possible relevant questions
- You must act, make decisions, make recommendation, treat, and help heal

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When Time is Limited

- Every interaction is an opportunity for both assessment and treatment
 - Informal conversation may provide useful information
- Attend to observed behavior in designing interventions
 - For example, where does the spouse sit while being instructed on an intervention?
- Ask questions, demonstrate techniques, and practice skills more than once
 - Ask relevant questions repeatedly; over time answers may be more complete

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continued

When Time is Limited

- Watch carefully for verbal cues to meaning
 - For example, pauses, hesitation, changes in voice tone, word choice, repetition, and contradictions
- Note behavioral cues to meaning
 - For example, body posture, eye position, motor activity
- Check your information!
 - Check your interpretations with the individual, other cultural informants, with the literature

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continued

Culturally and Linguistically Competent Organizations

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Culturally Competent Organizations

- Accept and respect differences among and within different groups
- Continually assess policies and practices regarding culture
- Expand cultural knowledge and resources
- Adapt service models to better meet the needs of different cultural groups

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Culturally Competent Organizations

- Work to hire staff who are unbiased and those who represent the cultural communities being served
- Seek advice and counsel from their clients
- Are committed to policies that enhance services to a diverse clientele

(Cross, Bazron, Dennis, & Isaacs, 1989)

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Culturally Competent Organizations

- A culturally diverse staff that reflects the community served
- Qualified interpreters and translators to provide language assistance services
- Training for providers to better understand the culture the people they serve and communicate effectively with them
- Signs and written instructions in the patients' language(s) that are consistent with cultural norms

(Anderson, Scrimshaw, Fullilove, Fielding, & Normand, 2003)

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Culturally Competent Organizations

- What can you do?
 - Educate yourself about culturally and linguistically competent care (Salimbene, 2004)
 - Educate your colleagues and organization leaders about the characteristics of culturally and linguistically competent organizations
 - Consider cultural and language needs of patients when you recruit and hire new staff

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Culturally Competent Organizations

- Convene a cultural and linguistic competency committee, work group, or task force
- Ensure that the organization's mission statement commits to cultural and linguistic competency as an integral component of all its activities
- Find out which culturally diverse groups the organization serves and how their services differ
- Conduct a comprehensive organizational cultural and linguistic competency self-assessment

(Kerr, Struthers, & Huynh, 2001)

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Incorporating into Daily Practice

- Elicit the patients' explanatory model through an interview
- Effectively listen, explain, acknowledge, recommend, and negotiate health information and instructions
- Elicit psychological and social contexts of the patient's health experience
- Identify the patient's explanation of illness, treatment, and traditional treatment practices accepted in the patient's culture

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Therapists as Advocates

- Better access to health care
- Fewer medical errors
- More effective preventive services
- Greater patient satisfaction
- Improved patient understanding and compliance

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Advocacy Skills

- Ability to communicate effectively with patients and their families, other health care providers, and staff within the organization
- Knowledge of the cultural beliefs, practices, patient preferences, competencies, legal parameters, and tasks related to the issue
- Ability to work collaboratively to promote change
- Willingness to serve as a change agent
- Commitment to diversity and provision of quality care to all, regardless of personal characteristics

(Mallik, 1997)

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Case Study

Culturally Competent Care

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Context

- Nearly 26 million Americans have diabetes – 8.3% of the population (CDC, 2011)
- Racial and ethnic minorities have higher rates
 - 16.1% for American Indians/Alaska Natives
 - 12.6% for Blacks
 - 11.8% for Hispanics
 - 8.4% for Asian Americans
 - 7.1% for non-Hispanic Whites
 - Slightly higher rates for Puerto Ricans in the US

(Ho et al., 2006)

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Context

- Racial and ethnic minority groups lack access to adequate/appropriate health information, treatment, culturally sensitive interventions (AHRQ, 2011)
- Interventions must fit cultural values and preferences

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Context

- There are about 4 million Puerto Ricans in the US
 - Second largest Hispanic group in continental US
 - Lower high school completion rate (roughly 66%)
 - Higher poverty rate
 - Roughly 40% speak primarily Spanish at home and report that they do not speak English very well

(US Census Bureau, 2010; US Census Bureau, 2007)

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continued

Background and Social History

- MD office in Chicago, IL received a call from a woman who wanted to make an appointment for Mrs. Sylvia Hernandez
- Caller reported weight loss, dizziness, thirst, lack of energy
- Previously treated by MD in New York City

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continued

Medical History

- Type II diabetes, diagnosed 20 years ago
- Not on insulin
- Medications include glipizide 15 mg once a day and Metformin 1000 mg twice a day
- Instructed to monitor blood sugar each morning
 - Shown by the nurse how to do so
- Moderate hypertension
 - Taking 2 medications to manage HTN

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Social History

- 62-year old Puerto Rican woman; moved to US at 18
- Married her husband who was also 18 at the time
- Lived in NYC
- Husband worked as an auto mechanic
- Pt. stayed home with children; son now aged 38 and 2 daughters now aged 36 and 35
- Pt. lived in NYC until husband died 7 years ago from kidney failure secondary to long-term HTN
- Pt. moved to Chicago with her oldest daughter

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Social History

- Pt. left school at 16
- Family lived in a Puerto Rican neighborhood where Spanish was the main language
- English proficiency is limited
- Pt. worked sporadically as a housekeeper

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Office Visit

- Appointment made by her daughter
- Pt. arrives at the office alone

“I feel tired all the time. I have no energy. I don’t want to do anything but I am supposed to fix supper for everyone. I’m thirsty and I’m getting too skinny. Sometimes I sweat too much. I feel really bad.”

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continued

Occupational Therapy

According to the daughter

- Pt. is a good cook who enjoys hearty Puerto Rican food
- Pt. cooks several times a week, helps with light housekeeping
- Fills her time watching Spanish language soap operas
- In winter, pt. is often house bound
- Watches TV at night in her room
- Does not want to interfere with her daughter’s family

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continued

Occupational Therapy

- Devout Catholic; attends Mass every Sunday
- Church is closing; new church is over 1 mile away
- Will require car or public transportation to attend
- Pt. never learned to drive and is dependent on others

“Well you know, she doesn’t do any of this now. I think she has gotten kind of lazy. She doesn’t get out of bed some days.”

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continued

Physical Therapy

Using an interpreter

- Never exercised; in NYC lived in 4th floor walk-up
 - Made the trip up and down frequently
- Current residence has an elevator
- Transported by van to Senior Center
- Little physical activity
- Gentle exercise program 2X per week
 - Does not enjoy, but participates because her friends do

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continued

Nutrition

- Prefers traditional Puerto Rican
- Cooks this type of food 2-3 times each week
- Daughter frequently brings in fast food from neighborhood restaurants
- Roughly 30 pounds over ideal weight for her 5'3" frame

"The doctor said something about sugar, but I don't worry about it. I just eat what I've always eaten because that's the best thing to do when you don't feel well."

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continued

Questions to Ponder

- What additional information would you need in order to determine why the client is having difficulty right now?
- What background information might you need about beliefs and values held by individuals from Puerto Rico with regard to health in general and diabetes specifically?

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continued

Questions to Ponder

- As noted in her social history, the client's English is limited. What strategies would be helpful in making sure you get an accurate history and that you convey your findings so that she can understand them?
- How certain are you that the information from the previous physician, her daughter, and the interpreter is accurate?
- What steps could you take to ensure accuracy?

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continued

Questions to Ponder

- What do you see as your unique role for your discipline in working with this client?
- What other disciplines might be helpful in this situation?
- How might you work most appropriately with those professionals?

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continued

Questions to Ponder

- How might your own ethnicity and language impact assessment and care in this situation?
- What if the client were from a different ethnic, racial, or socioeconomic background?
- How might care differ? (e.g., Muslim, Working class, Vietnamese)

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continued

Follow-Up

- Pt. has a better understanding of dietary recommendations, procedures for monitoring blood sugar, and value of physical activity
- Appreciates that dietician gave suggestions consistent with dietary preferences
- Lab values are within desirable range
- Pt. feels somewhat more energetic
- Pt. has not found exercise routine she likes and will follow

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continued[®]

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