



## **Beyond Medical Interpretation:**

The role of Interpreter Cultural Mediators (ICMs) in building bridges between ethnic communities and health institutions

*Selecting, training and supporting key outreach staff*



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Community House Calls  
Harborview Medical Center  
Seattle, Washington

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*Community House Calls serves to reduce barriers to health care for refugees and immigrant families.*

## Foreword

The interpreter cultural mediator (ICM) model described in this manual was developed through the joint efforts of Dr. Ellie Graham, Dr. Carey Jackson, and their colleagues at Harborview Medical Center (HMC) in Seattle, Washington. Called Community House Calls, the demonstration program was initially funded by the Opening Doors Initiative of the Robert Wood Johnson and Henry J. Kaiser Foundations. It began in January, 1994 to with the goal of decreasing sociocultural barriers to healthcare for non-English speaking ethnic populations receiving their care at Harborview Medical Center. The demonstration program received matching funds from the Washington State Department of Health and Human Services, additional funding from Harborview Medical Center, and training assistance from the Pac Med Cross Cultural Health Care Program in Seattle.

Since the first publication of this manual in 1995, Community House Calls has moved beyond the demonstration phase, gaining hospitalwide acceptance and finding a long-term home at Harborview through administratively merging with the medical center's Interpreter Services. The support of Harborview Medical Center has been crucial to the ongoing success of the program. As a result of Harborview's support, interpreter cultural mediators can be found in primary care clinics and inpatient clinics throughout the hospital, as well as in some specialty clinics, such as mental health and the burn unit. The Community House Calls Program has received several awards since 1994, including an award from the American Public Hospital Association, another from the Foster McGaw Foundation, and most recently, the 1998 Ambulatory Pediatric Association Health Care Delivery Award. The Joint Commission Accreditation for Health Organization (JCAHO) has also commended Harborview Medical Center for the Community House Calls Program and the interpreter cultural mediator (ICM) model.

In the earlier version of this manual, we briefly described EthnoMed, an interactive electronic database developed by Community House Calls faculty and staff. EthnoMed is a website which contains medical and cultural information on refugee groups in the Seattle area, and it has greatly expanded in the three years since this manual was first published; we encourage you to locate the EthnoMed website on the Internet, after reading about it in this edition of the manual.

The Cambodian Girls Program, a “spin-off” of Community House Calls, is another award winning program, begun in an attempt to involve teenage community advisors in a program focused on education and job training; it illustrates yet another creative way that community advisors and community involvement can decrease some of the pressing problems facing immigrants and non-English speakers in the United States.

In this revision, we again identify commonly encountered pitfalls, including cultural, political and personal issues which will inevitably arise during program development. Program participants inevitably encounter snags during program development of any type; such difficulties are especially sensitive when a number of persons, with differing community agendas and ethnic backgrounds, attempt to work together. Therefore, those who use this manual should know that “between the lines” lie the misunderstandings and frustrations normal to any process which attempts to build bridges between lay and professional agendas.

Before beginning, we urge you to acknowledge and prepare for the great expenditure of time and emotional energy which will be required to negotiate and maintain productive working relationships with ethnic communities, case managed families, interpreter cultural mediators, and other team members. Efforts to improve communication do not always lead to satisfaction; indeed, there are times when even after an ambiguity is resolved, the respective parties continue to disagree. The success of a program like this therefore requires administrators and staff who anticipate such problems and are able to budget the time, energy, and good humor needed to sustain community involvement. We encourage you to make the effort; the rewards are great!





*The Tigrinya ICM (left) involves family and community strengths and resources in an integrated problem-solving effort.*

## Executive Summary

This manual provides a basic overview of steps one may take in order to develop an interpreter cultural mediator (ICM) program. The program model integrates ethnographic and medical anthropological principles with current medical care practices and medical education goals. Key aspects of Harborview Medical Center's ICM program, known as Community House Calls, include:

- Use of interpreter cultural mediators and community advisors as part of the health care team, allowing access to cultural information and cultural traditions that are in transition, but which still strongly influence refugee families.
- Development of a structure which allows clinical and public health aspects of care to be addressed at the same time.
- Development of an expanded role for interpreters, in which they provide culturally sensitive case management and follow-up, and educate providers, residents and medical students about the cultural issues surrounding their client's care.
- Increased collaboration between all of the departments of medicine with respect to teaching residents and medical students about cross cultural health care.
- Development of EthnoMed, an electronic ethnic data base which allows ethnic communities to directly inform providers about their specific cultural beliefs, health care needs, and community resources.

The interpreter cultural mediator model implemented at Harborview Medical Center has proven to be highly effective in facilitating dialogue about health and social issues between providers and their patient population. Through it, patients have greater access to culturally knowledgeable providers and access to health services in their own language; providers receive more cultural and social feedback during interpreted patient encounters; and medical and pediatric residents are provided with a more intense experience and exploration of cross cultural health issues. The model encourages more appropriate use of medical services and a decreasing use of inappropriate urgent and primary care services. It also encourages opportunities for increased visits from patients who might otherwise not be seen.

The Community House Calls program has provided training and supervision to expand the role of eight interpreters, into the more comprehensive position of interpreter cultural mediator. Since the program's inception, clinic providers have expressed delight in having medical interpreters who work as direct outreach workers and cultural trainers. The broadened role of interpreter cultural mediator is connected to a broader view of case management. The ICM model moves away from the traditional approach to case management, which tends to focus on weaknesses and deficits. Instead, it is designed to encourage participants to recognize the strengths and resources of the patient or family, and to engage in an integrated problem solving effort, using the family's and community's strengths and resources as much as possible.

The ICMs provide a range of services, including interpretation, cultural mediation, case management, advocacy, follow-up, assistance in accessing ESL classes and citizenship classes, coordination of patient care, health education, and home visits. They give didactic presentations at the hospital and in the community, and work with the community and institutions to identify and remove barriers to health care. Since the first publication of this manual, the ICM role has remained essentially the same, but the job has expanded to encompass medical interpretation and cultural advocacy not only for their own case-managed clients, but for other patients as well (in conjunction with the administrative merging of services mentioned earlier). Their role in providing cultural information and information about cultural health care practices and beliefs has become an established part of provider training and patient care in many contexts within the medical center.

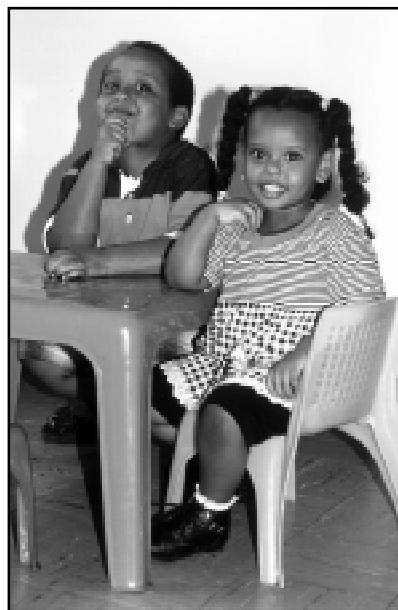
The ICMs at Harborview Medical Center provide services to patients from the following language groups: Cambodian; Somali; Tigrinya speaking peoples from Eritrea and Ethiopia; Amharic and Oromiffa speaking peoples from Ethiopia; Spanish; and Vietnamese.

### ***A Word about Institutional Support***

Many of the ICM program goals require the support of key administrators within the institution. Obtaining funding for program continuance and expansion, development of institutional innovations such as expanding the role of interpreters or developing a cross-cultural health curriculum for medical students and residents, and removal of institutional barriers that limit access to non-English speakers all require the enthusiastic support of key department heads, clinic administrators, administrators for nursing, ambulatory care and social work, as well as key front line staff, including receptionists and charge nurses. The barriers which the ICM program seeks to lessen or eliminate occur at all levels of care, and thus all levels of the health care system must participate in order for the program to be fully effective.

## ***Introduction:*** **Beyond Medical Interpretation**

### *The Need for Cultural Mediation and Provider Training*



*Cultural mediation services provided by the ICMs allows the health care provider to address the patients' needs in a more effective way.*

Clinics and hospitals which only 25 years ago served few non-English speakers now see large numbers of non-English speaking refugees and other immigrants. At Harborview Medical Center (HMC) in Seattle, health care providers treat patients from seventy different language groups with the help of an interpreter service which costs more than \$2 million per year. In spite of the frequency with which health care providers treat non-English speaking patients and the fact that skillful medical interpreters are involved, the results can be less than adequate. Nationwide, most health care providers still do not receive training in the practice of cross-cultural medicine, nor do they have adequate access to cultural information about their patients. And medical interpreters, skillful though they may be, cannot overcome important language and cultural barriers through limited, discrete interpretation sessions which do not provide for cultural advocacy or dialogue.

Medical interpretation is an inherently difficult task, even under the best circumstances. It is especially difficult when it is confined to brief sessions such as one typically encounters in a medical setting. When language and culture are worlds apart or when trauma related to war or refugee experience is involved, it becomes increasingly difficult for the interpreter to adequately communicate the patient's concerns, or for the provider to address the patient's health needs in an effective way. Both patient and health care provider need a more sophisticated approach to interpretation which involves an expanded understanding of the language and cultural beliefs which affect their communication. A more detailed understanding of the patient's family structure, health and cultural beliefs, and present situation is necessary before the provider can accurately address many health problems.

"Cultural interpretation" or "cultural mediation" provides a more comprehensive understanding of the patient because it addresses aspects of health care and culture of which the provider may be completely unaware. For example, some Southeast Asian patients may strongly believe that the provider's directive to give their child oral rehydration fluids will cause their child to become even sicker. Unless the medical interpreter is capable of (and willing) to explain this notion to the provider, it will probably remain unexpressed. However, the

parent's opinion on the matter will certainly influence what happens after the family leaves the clinic, and the provider may never know whether the oral rehydration fluids were actually given to the child. Ideally, in a situation like this, the parents would be able to express their concerns through an interpreter cultural mediator, and a more agreeable option such as the use of a special porridge could be identified. Another example: an Oromo parent may feel undervalued by the suggestion that her child be given "water" when so many other medicines are available. However, if the interpreter cultural mediator can explain the function of the rehydration fluids in a culturally competent manner, it is more likely that the Oromo parent will make an informed decision to use or reject rehydration therapy and/or to explore other methods for rehydrating her child.

To be fully effective, cultural mediation is combined with case management. The interpreter follows a family or patient over a period of time, becoming fully aware of the family's needs, problems, and strengths. A case management approach enables the interpreter to provide cultural interpretation and mediation, and to advocate for appropriate treatment based on a more thorough understanding of the patient. The interpreter can thus communicate cultural facts and social/familial histories to the health provider, offering the provider a way to gain valuable insights which can positively impact patient care. Problems such as poor housing, lack of child care or support for new parents, depression, isolation, and mental health problems can be identified and addressed using the interpreter cultural mediator approach.

While the interpreter cultural mediator cannot solve all the problems a family may contend with, avenues for communication are vastly broadened and cultural gaps in information more easily bridged when an ICM is involved in patient care.



*The medical director and a Somali interpreter work as a team to care for an elderly Somali woman.*

## **Interpreter Cultural Mediator (ICM) Program Goals**

Community House Calls has established the following programmatic goals, in recognition of the inherent difficulties that arise when health providers attempt to offer quality health care to a number of ethnically diverse populations, within a confined time frame and without adequate knowledge of patients' language, cultural background or current living situation. These goals can be realistically achieved within the context of the ICM team approach as described in this manual.

- **Create a common fund of knowledge between medical and ethnic cultures**
- **Decrease language barriers to care**
- **Change institutional practices that particularly decrease patient satisfaction for non-English speaking families**
- **Improve cross cultural health care education for providers and trainees**
- **Enhance efficient utilization of resources by “high risk/high need” families**

These goals are achieved through providing a variety of health care and educational services, including continuity of interpreter services; case management for families with complex social or medical needs; home visits by ICM staff and health care providers; training for families, enabling them to make their own clinic appointments and obtain pharmacy refills; community health education; and training for health care providers in the practice of intercultural medicine.

# EthnoMed: Ethnic Medicine Guide

<http://www.hslib.washington.edu/clinical/ethnomed>.

## *History*

EthnoMed began in 1994 through a collaborative effort between Community House Calls physicians and the Harborview Medical Center library director. The project has been funded by an Integrated Advanced Information Management System (IAIMS) implementation grant from the National Library of Medicine, together with support from the Allen Project Fund which is administered by the UW Libraries Administration. For a detailed history of EthnoMed's origins and development please refer to "EthnoMed: A Medical Anthropology Work in Progress," by Howard and Means, in *The Library Web*, edited by Julie M. Still, Information Today, Inc., 1997.

## *Background*

EthnoMed is a clinical tool containing medical, cultural and community information about refugee groups and other non-English speaking immigrants living in the Seattle area. Its purpose is to make previously difficult to access information about culture, language, health, illness and community resources directly accessible to health care providers when they need it. For example, just before seeing a Cambodian patient with asthma, a provider can use a computer terminal to access EthnoMed and read about how the concept of asthma is translated in Cambodian and what common cultural and interpretive issues surround asthma management in the Cambodian community. A practitioner may also download patient education materials (some in the native language) to give to the patient at the end of the medical visit.

## *Content*

Included in EthnoMed at the time of this writing are profiles on the Amharic, Cambodian, Eritrean, Oromo, Somali, Tigrinian, and Vietnamese cultural groups. Other ethnic groups will be included as materials are written. One file has been created for each cultural group. Each file is identical in structure so that once familiar with the organization of a file representing one population, a clinician can quickly navigate the other files. The following information is available for each cultural group:

- **A brief cultural description**
- **A section on health and illness**
- **Information about community resources**
- **Patient education materials**
- **Interactive user dialogue site**

## *Collaborative Opportunities*

The information included in EthnoMed has been researched and reviewed by health care providers and researchers who work with refugee and immigrant patients. EthnoMed is intended to be a community voice, and thus the majority of materials on the Website are produced in conjunction with community members. Feedback from the target population is invited at all times; user feedback is essential. As providers learn from their patients, we urge them to share this information on the EthnoMed site. Through interactive growth and development, we hope that EthnoMed will capture the dynamic, changing nature of the cultures involved, reflecting traditional beliefs and the subtle changes which come with acculturation.

Community House Calls staff welcome the receipt of short (one to two page) documents on cultural and health topics ranging from teen violence to breastfeeding to the common cold, for possible inclusion on the website. Examples of desirable topics include: How do Cambodians express the concept of depression? What are Eritrean folk remedies for fever? Do Vietnamese refugees practice male circumcision? Patient education materials in native languages are also welcome. As EthnoMed develops, we hope to collaborate with other groups in developing similar files for other ethnic communities.

## *Resource Library*

A community based resource library, still in the early stages of development, is being established at Harborview Medical Center specifically for the use of ICMs, other interpreters, staff and non-English speaking patients. The resource library will be a space where interpreters can view a health education video or listen to a health education tape which has been produced in their native language, use the computer to access EthnoMed, and gather information to give to their clients. A variety of printed, audio and video information is to be included in the collection; Community House Calls staff and interpreters from the various ethnic communities share responsibility for reviewing documents and determining whether they should be included in the resource collection.

*\*Note: For further reference, see the sample EthnoMed file found in the appendix.*

## Cambodian Girls Project

The ICM model provides a springboard for numerous creative efforts tailored to fit the needs of specific cultural communities. During the Community House Call demonstration program in 1994-95, for instance, the Cambodian program coordinator recognized the need for a program which specifically targeted Cambodian youth who lived in the Seattle area. At the time, the interpreter cultural mediators were working with over forty Cambodian families. These families were struggling with many problems, including depression, illiteracy in their own language, inability to speak English, unfamiliarity with urban life (either in Cambodia or the United States), perceived and actual loss of control over their teenage children, and perhaps most profoundly, post traumatic stress disorder related to their experiences during the Khmer Rouge regime.

Cambodian parents, in an effort to control and protect their teenage children, often place heavy restrictions upon the teens, limiting their access to extracurricular activities, jobs, sports, and other activities that American teens take for granted. Family conflict is high, and the teens are vulnerable to damaging behaviors such as dropping out of school, drug and alcohol use, and joining gangs.

Based on these concerns, the Community House Calls Cambodian program coordinator developed a Young People Community Advisor Program which ultimately became the Cambodian Girls Program. The program blends job creation, education and mentoring for Cambodian teens with mandatory parenting classes and discussion sessions for their parents. The program was designed to reinforce exchange of information between teens and parents, enabling both parties to better understand what is involved in attaining high school graduation, working at a specific job, opening bank accounts, and otherwise functioning in the mainstream of the American economy. Mandatory tutoring and study sessions are part of the program; regular counseling sessions are provided for the teens, aiding them in growing emotionally and allowing them to better handle stress at work and in school. Each teen takes on an internship at the medical center, where she learns basic job and time management skills. The program develops opportunities for good role models, mentoring relationships, and other long term opportunities, making it more possible for the girls to succeed in their adult lives.

Funding for the Cambodian Girls Program comes from Harborview Medical Center and the federal government's Safe Future Initiative, in coordination with Seattle's Parks and Recreation Department.



*Yodit, Amharic-speaking ICM and Rozy Ramirez, Spanish-speaking ICM.*

## **Developing an Interpreter Cultural Mediator Program:**

### *The ICM Team*

While a medical-anthropological approach to improving cross cultural health care is central to the ICM program design, a well-integrated health care team and institutional support are crucial to achieving success. ICM team members include interpreter cultural mediators, the nurse supervisor, community advisors, the program administrator and medical directors, and other health and social services professionals. Together, the team members create a case management approach which is culturally appropriate, comprehensive, and which provides ample opportunity for dialogue, education and mediation around issues which often pose great barriers to the practice of cross cultural medicine.

### *Interpreter Cultural Mediators (ICMs)*

Interpreter cultural mediators are bicultural, bilingual persons who are familiar enough with the biomedical and American cultures that they can act confidently within the health care system, be known and trusted by the institutions and have influence with providers and clinic teams. The ICM's bicultural, bilingual background at the same time enables him or her to serve as a trusted contact and advocate for non-English speaking families of the same ethnic background. Often, the ICM has worked before as an interpreter in a medical setting. For a thorough understanding of the ICM's work related responsibilities, please see the section entitled "On the Job: ICM Responsibilities and Tasks," in this manual. A detailed job description is included. ICMs are salaried employees, preferably full-time staff, of the institution for which they work.

## *Nurse Supervisor*

The Nurse Supervisor is responsible for the daily supervision and clinical support of the interpreter cultural mediators. The position requires someone who is experienced working in a cross-cultural health setting and who has a strong interest in the details of different cultural perspectives on health care. In addition, the nurse supervisor must be able to represent the program to a broad

spectrum of people in the community and at the medical center.

The nurse supervisor position was not included in the earlier version of this manual. Initially, bilingual and bicultural program coordinators supervised the ICMs, and clinical support came from the medical directors and other



*The Nurse Supervisor (seated left) works closely with ICMs and health care providers in the community*

providers. Over time, the need for a supervisor who could provide clinical support as well as supervision and direction became increasingly apparent. The program coordinator position of three years ago has thus evolved into two distinct positions: the nurse supervisor and the program administrator. The nurse supervisor job description follows.

The nurse supervisor's major responsibilities include:

- (1) Meet with the ICMs regularly, monitor ICM caseloads, oversee ICM schedules;
- (2) Accompany ICMs on home visits as necessary, charting and performing regular progress reports, evaluations and personnel updates;
- (3) Provide or procure health care expertise needed by ICMs to perform their jobs, which involves coordinating regular continuing education and directly providing information and access to further resources;
- (4) Contribute to health education in the communities served by the ICMs;
- (5) Coordinate medical residents' outreach experience with ICMs;
- (6) Serve as a liaison to public health nurses, social workers, and other health care providers in the community;
- (7) Contribute to problem solving with respect to barriers to care for non-English speaking patients at the medical center.

Note: Approximately eight ICMs per full time nurse supervisor appears to be a realistic ratio in a program which has already been in operation for several years. When developing a new program, a lower ratio is recommended, at least at first.

## *Community Advisors*

In the early stages of Community House Calls and the ICM Program, monolingual community advisors from each ethnic group were identified and sought out as cultural informants and program assistants. They were selected on the basis of their knowledge of traditional forms of healing, their role in decision-making within the families and larger community, their strong presence in

the community, and the fact that they retain much of their former culture. Our goal then and now is to integrate community advisors into the overall treatment plan for families being cared for at the primary care clinic, at least during the time period in which refugee or immigrant families are newly arrived and in transition.

One of the primary responsibilities assigned to the community advisors during the demonstration phase of the program was to assist the ICMs in training families to contact the primary care clinics by phone in order to obtain pharmacy refills and to explain to families how to make appointments. However, it became apparent that this role was not desired by the community advisors,

and that the ICMs were more comfortable handling these responsibilities themselves.

Because they continue to represent



the traditional cultural values of their communities and because they are active in the social life of their communities, community advisors continue to play an important role in the ICM program, but their role has been redefined.

Community advisors serve in two ways: First, they act as resource persons whom the ICMs can contact when they are trying to reduce the social isolation of certain families. For example, the ICMs engage the assistance of specific community advisors when they need help reinforcing a client's involvement in the community, developing a parenting group, finding childcare or creating other services for their clients. Second, community advisors play an important role in the area of cross cultural health research: they often serve as members of focus groups which help inform the design of cross cultural health research projects. Examples of these projects include a Canadian/U.S. cervical cancer research project and a tuberculosis research project.

Rather than receiving a stipend for their work, community advisors are now hired on an hourly basis. Professionals who are bilingual and bicultural also provide important feedback and guidance through their involvement as members of the community advisory board.

### *Program Administrator and Medical Directors*

The program administrator and medical directors of the primary care ambulatory clinics participating in the program have formed an administrative team which oversees Community House Calls. The program administrator is responsible for the daily management of the program; the medical directors meet regularly with the administrator and other program staff and are available to provide consultation whenever their services are needed. The ongoing

*Community Advisors meet to develop and evaluate services for their communities.*

*The management team made up of the medical directors, nurse supervisor and department manager coordinates changes in clinic policy.*



involvement of the medical directors is essential to the program's continuity and integrity within the medical setting. Their leadership, promotion of the program,

and involvement in physician and patient education provides legitimacy for the ICMs within the clinics and larger teaching institution; results in smooth integration of new health care team

members into existing clinic settings; and has resulted in adoption of the ICM model as both an essential service and important training experience at the medical school.

The program administrator position requires a person who is capable of handling the long-term planning and budgetary responsibilities of an executive administrative position, who understands the conceptual basis of the ICM program, and is able to successfully represent the program at the executive administrative level. At Harborview Medical Center, Community House Calls has merged with the interpreter services program; therefore, administration requires careful synthesis of the mission and goals of each program, and the ability to create a greater whole which functions well in several different arenas. The program administrator works with the medical directors to coordinate selection and hiring of the Interpreter Cultural Mediators, nurse supervisor and other staff. The program administrator also works with the medical directors to oversee data collection and evaluation of the program.

### *Physicians, Residents, Nurses, Social Workers, and Other Health Care Providers*

Other health care providers participating in the Community House Calls Program include primary care physicians, residents, interns, public health nurses, mental health professionals, and social workers who become involved with the case managed families. Health care providers and social workers generally possess a varied level of experience working with patients from other cultural backgrounds, from fairly experienced to relatively inexperienced. According to research conducted at Harborview Medical Center, even providers with a fair amount of cross cultural experience often lack adequate preparation and skills to communicate fully with their non-English speaking patients (even with the help of interpreters).

Through using the services of the ICMs and becoming involved in the provider training sessions made available, providers are able to more accurately address relevant health care issues facing their patients, and incorporate appro-

priate cultural knowledge into their treatment of patients. This effort is enhanced through using EthnoMed and through participating in the cross cultural health rounds sponsored monthly by Refugee Clinic, Children's Clinic and Community House Calls.

### *Ethnic Community Associations*

Ethnic community associations are involved in Community House Calls in a variety of ways. They represent refugee and other immigrants in their local area, participate in recruitment of ICMs and community advisors, and provide a meeting place for community health education and outreach activities. After coming on board, program staff and faculty invest as much time as possible in developing and nurturing relationships with the ethnic community associations, as the support of community leaders will have a great impact on how well the ICMs will be integrated into the fabric of community life. The ICM will be able to work most effectively if she or he is supported by the larger community.

With the help and support of the community, activities such as youth associations, daycare, women's groups, ESL, and other forms of support become established in the neighborhood. These forms of support are often important components of the case management solution sought by the ICM team.

### *Social Service Agencies*

Representatives of local and state social services institutions, including the departments of health, social services and housing agencies are often informal ICM team members. Case managed families have a number of needs related to housing, nutrition, schooling for their children, mental health, and other social services. Those who are refugees often live with post traumatic stress disorder, fear and depression. Other immigrants feel isolated, lacking access to their traditional social structures and the rich cultural traditions which provided support for their families in their home country. As ICMs become more familiar with the case managed families, they often become involved in negotiating with social services agencies, interpreting for the families in those settings, and educating the families about how to access appropriate resources.

The ICMs work closely with certain designated representatives of these social service agencies, interpreting, clarifying issues and providing training related to their clients' cultural background. In this way, cross-cultural issues become more familiar terrain for the representatives of these agencies, and a collaborative working relationship can develop, enhancing the process for all involved.

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## **Recruiting and Selecting ICMs**

### *Role of Community Groups in Recruiting Applicants*

Recruiting and selecting persons for the position of Interpreter Cultural Mediator requires the use of routine human services/personnel activities, combined with a community based approach which allows management to identify candidates who meet the specific, unique needs of each ethnic commu-

nity. Advertisements for the position can be placed at the university, at the primary care clinics, medical center personnel office, local newspapers, agencies serving refugees and non-English speakers, and ethnic community association headquarters and newsletters. Posted ads in the community, formal presentation of the ICM program at ethnic community association meetings and word of mouth are important avenues for recruiting ICMs.

Community involvement in the recruitment and selection of Interpreter Cultural Mediators is important for a number of reasons, perhaps most importantly to (1) ensure that the individual ethnic communities feel a sense of ownership in the program, and (2) incorporate the insights of community leaders who can guide the selection team toward candidates who are truly capable of representing their community. If a community advisory board is organized at the outset, community leaders can be meaningfully involved in recruiting candidates. Ultimately, the selection team, comprised of the program administrator and medical directors, must balance the qualifications of candidates who are desirable from the community's perspective with their own sense of which candidates offer the best qualifications for the program, while at the same time meeting the hiring criteria set by the larger institution, e.g., the university or public hospital. Community support of the applicant is an important component of the selection process, influencing whether the candidate will be able to work successfully in the role of Interpreter Cultural Mediator.

### *Selecting a Focus*

It is helpful to choose a focus around which the Interpreter Cultural Mediators can frame their work. Community House Calls initially chose a maternal-child focus, working primarily in the refugee and children's clinic. The focus helped define training style and content, criteria for case management referral, and other aspects of the program, which was especially helpful during the demonstration phase of the program. After the administrative merging of Community House Calls and Interpreter Services at Harborview Medical Center, all of the primary clinics and some inpatient clinics at the hospital have become involved in the program.

### *Qualifications*

Candidates for the position of Interpreter Cultural Mediator must be fluent in English, fluent in one or more of the target languages, have experience in a medical setting, preferably as a medical assistant or medical interpreter, and experience with community work in the target populations. Beyond these requirements, potential ICMs are judged by attributes such as their ability to work well with people from diverse cultural and professional backgrounds, flexibility, willingness to learn, ease in visiting people in their homes, ability to work as part of a team, and ability to build and cultivate relationships with community members.

### *ICM Position Description*

The following list of duties provides an overview of the Interpreter Cultural Mediator's responsibilities. More detailed discussion of the ICM's responsibilities may be found in the section "On the Job: ICM Responsibilities and Tasks."

## **The Interpreter Mediator Will:**

- Interpret and mediate for families in the targeted primary care clinics
- Interpret and mediate for the provider in the targeted primary care clinics
- Focus on cultural and social circumstances which may affect care, as well as basic health information, during the patient-interpreter-provider interaction
- Determine the family structure and social and health care needs for all members of the families assigned to the ICM for case management, with the assistance of other clinic staff
- Make home visits and coordinate care with other social service agencies for families on their case management panel
- Provide cultural information to the clinic providers and staff in didactic training and case conferences
- Provide telephone assistance and triage for families in the family's native language
- Work with the Community Advisors to provide social support for families and to provide broader health education to the targeted ethnic communities
- Work with clinic quality improvement committees to remove barriers to care for the target communities
- Evaluate and assist in design of educational materials
- Keep accurate records of work through specific data collection and reporting mechanisms
- Serve as a representative of the ICM Program to outside agencies
- Work as a team member with the nurse supervisor, medical directors and other health providers, program administrator, community advisors and other participants

*Carey Jackson, Medical Director, examines a Cambodian patient with the help of Jeniffer Huong, Cambodian ICM.*

## ***On the Job:*** **ICM Responsibilities and Tasks**



### *Balancing Competing Demands*

ICM job responsibilities include medical interpretation, cultural mediation and advocacy, educating providers about specific cross cultural health issues, case management of families, training families to access care, and providing community health education and outreach.

Providing interpretation, cultural advocacy and case management services in the clinic and during home visits are top priorities for the ICMs in terms of time management. However, locating housing, clothing, and other social service needs can easily take up much of the ICM's time. It is difficult, but each ICM must learn to balance the competing demands placed upon him or her by clients. This feat is accomplished primarily through hands-on experience and clear direction from the nurse supervisor, who provides frequent review, consultation, and mentoring.

The following activities categories and percentages illustrate the amount of time one can expect ICMs to spend in various activities during the initial development of the program. Much depends upon the needs of the particular ethnic communities and the patients themselves, as well as the structure of the hospital or clinic. In the case of Community House Calls, we have found that for most of the ICMs, the case managed families have become more proactive over the last few years, and can handle many of the logistical items themselves, including making telephone calls to the clinic, scheduling appointments, etc. Some of the clients have settled in well, and no longer need assistance with basic needs such as housing or clothing. Other ICMs, however, are actually seeing increases in new clients as refugees arrive in Seattle, fleeing wars and atrocities which have been increasing in some countries. The ICMs with newly arriving clients continue to spend more of their time on acquisition of basic items such as shelter, furniture and clothing.

### *Interpreting and mediating in the clinic*

In 1995, the ICMs estimated that they spent between 10%-80% of their time interpreting and mediating for clients in the clinic, with a majority reporting that they spent 60%-80% of their time in this activity. In 1997, in-clinic interpretation/mediation activities were generally in the 20%-40% range.

### *Making home visits*

In 1995, the ICMs reported spending 10%-80% of their time making home visits. The amount of time spent making home visits was basically the inverse of the time spent in the clinic; that is, the ICMs who spent 60% of their time in the clinic generally spent 20% of their time on home visits, and vice versa. In 1997, home visits were reported as generally falling in the range of 10%-25% of the overall time spent by the ICMs, with variation from ICM to ICM, depending upon the needs of each community.

### *Assisting in seeking housing, shelter, and household goods*

In 1995, the ICMs reported that they could easily spend at least 20% of their time dealing with requests for assistance in finding household goods, such as baby clothes and cribs, as well as locating emergency shelter and permanent housing. They recommended that only 5% of their time be spent in such activities. In 1997, many of the ICMs reported that the need for such services had dropped off dramatically, since many of the families had been settled. However, some communities still see a large number of new arrivals, and the ICMs representing those communities continue to work heavily in the area of housing and shelter.

### *Other Activities*

In 1995, paperwork, community meetings, provider teaching, resource identification and distribution activities accounted for at least 10% of the ICMs' time. In 1997, some of these categories have greatly enlarged. For instance, staff education (including provider education) can range from 10% to 30% in a given month; paperwork takes up about 10%; phone visits have increased to approximately 10%-15% for many of the ICMs, particularly with respect to families with whom they have already developed good rapport and a solid working relationship; and finally, communications with and visits to other agencies on behalf of their case managed clients can range from 2%-10% of their time, depending upon the month.

### *Medical Interpretation*

One of the goals of an ICM program is to decrease language barriers to health care. Most of the ICMs involved in the Community House Calls program worked as medical interpreters prior to becoming interpreter cultural mediators. Skillful interpreters are called upon to enhance the primary relationship between provider and patient; facilitate trust-building between patient and provider; and inform the provider when miscommunication occurs, as well as to make good judgments about the type of interpretation required in a particular situation (e.g., literal, conceptual, or cultural equivalency). All of these steps require a high level of skill, confidence, cooperation between interpreter and provider, and trust on the part of the patient.

ICMs are provided with additional training which enables them to further develop and refine their interpretation skills. They also become the appointed interpreter for given patients, providing continuity of interpreter services to patients where previously interpretation was provided on a case by case basis only. The ICM is able to develop a more complete knowledge of the patient's medical history and cultural concerns, greatly improving the quality of the medical interpretation.

Certain terms or concepts, such as "virus," are difficult to translate because similar concepts do not exist in the target language. When translation difficulties emerge during the medical visit, the ICM is encouraged to address the problem, seeking a solution rather than pretending that the problem doesn't exist. Confronting the provider about miscommunication takes a great deal of confidence; many interpreters do not feel comfortable challenging the health provider in this way. The ICM model recognizes that this type of confidence is built up over time, and provides special training to enable the ICMs to develop this skill. When a provider recommends a treatment which the patient does not understand or value, the ICM informs the provider and explains why the patient feels this way. The ICM also helps providers approach sensitive issues such as sexual behavior in a culturally appropriate manner.

### *Cultural Mediation and Advocacy*

Along with medical interpretation, the ICM is responsible for interpreting the cultural and social circumstances which may affect care during the patient-interpreter-provider interaction. Since the ICM model provides for home visits as well as clinic visits, it is possible for the ICM to gain an excellent understanding of the patient's situation and health needs. Often, the ICM will spend ten or twenty hours with a family or patient over a period of weeks, allowing adequate time to understand the family's needs and problems. When the ICM provides this information to the provider, the provider is able to more fully comprehend the precise needs of the patient as well as the barriers which may prevent the patient from improving.

For instance, in the case of a four year old boy with asthma, it was impossible for anyone to know how to reduce the child's frequent midnight visits to the emergency room, prior to the ICM's discovery that the child's mother did not know that the mold and mildew found in the house contributed to the child's asthma. Similarly, the mother did not perceive the importance of properly cleaning the child's nebulizer. Following discussions with the ICM, as well as assistance in cleaning the equipment, removing mold, and covering the boy's mattress with a removable, washable cover, the child improved considerably and his emergency visits declined.

### *Educating Providers About Specific Cross Cultural Health Issues*

The ICM model for improving the health status of refugee and other non-English speaking patients focuses heavily on developing the provider's fund of knowledge in the areas of cross-cultural health care, interpreted medical encounters, and basic knowledge about the cultures encountered.

Several different types of health care provider training are available under the ICM model.

- (1) The ICM, as a “culture broker,” provides cultural information during the patient’s clinic visit, and brings problems to the attention of the provider, something which interpreters in the past have often been taught not to do.
- (2) Didactic training sessions are provided to staff and trainees through special conferences and cross-cultural rounds.
- (3) Medical residents receive training about cross-cultural health care through a core curriculum which has been developed by Community House Calls physicians and staff.
- (3) Home visits to case managed families broaden the provider’s understanding of cultural and social issues which affect the health care of patients from other cultures.
- (4) Finally, EthnoMed, the computerized data base developed by Community House Calls, allows providers to easily and quickly access cultural and health information, enabling them to further develop their fund of knowledge and make better treatment decisions for their patients from other cultures.

### *Case Management*

The ICMs determine the family structure and social and health care needs for all members of the case managed families. Through their ethnic background and language comprehension, the ICMs can obtain in-depth family and social histories. They communicate their insights and observations to the health provider, and work with the provider, social worker, public health nurse and other team members to provide coordinated care for the family. They develop a plan which helps the family assess their own strengths and resources, and enables them to more readily access resources available in the larger community.

### *Drawing upon the case managed family’s strengths*

A key value of the ICM program relates to the view that case management not only identifies the family’s needs, but ultimately defines and draws upon the strengths of the family in resolving problems. Strengthening social networks within the target ethnic communities is essential to healthy families and to decreasing dependence. Linking families to ethnic community activities and to the community advisors decreases social isolation for the whole family, but especially for the women who are often limited in their ability to leave the home. The ICMs therefore work hard to increase social networks for their case managed families, to the benefit of the whole family.

For example, the Oromo ICM in Seattle explored health club services and organized a group of women in her community to attend classes so that they could get regular exercise. The Tigrinya speaking ICM has used the Tigrean women’s organization to organize showers for expectant mothers and arranged for a mentally ill father to regularly visit the community center during the day to relieve stress on his wife and children. A cooking class for Cambodian women patients who live in a large housing project was organized by the Cambodian ICM. Working with a community group, the Amharic speaking ICM helped organize and conduct English as second language classes, and the Somali ICM and community advisor organized a Somali Women’s Organization which meets

monthly. These types of efforts assist women in establishing networks with other women of their own culture, and help them more easily promote the health of their families.

Case managed families request information and assistance on any number of issues. Cultural constraints make it difficult for many ICMs to say no to requests, and they put great effort into helping families whenever they can. Although this sense of responsibility and community connection is one of the reasons the program is so successful, it also creates situations in which the ICMs become stressed and fatigued. Management must be aware that such requests will be common, and should assist the ICMs in locating community resources which will make their response to requests faster and easier. In the Community House Calls program, the ICMs work closely with social workers and have become comfortable knowing that they can deliver only what is available. Requests are most urgent for families who have recently immigrated, and tend to lessen over time.

### *Training Families to Access Health Services*

ICM involvement both decreases and increases utilization of services. Utilization decreases with improved communication, especially around identification of social stresses that may manifest as medical symptoms or interfere with parents' ability to care for their children. Handling problems through triage on the phone also decreases utilization. On the other hand, persons who

have untreated problems or had not received preventive care are more likely to be brought into the health system when an ICM is involved.

When ICMs first began working with case managed families, the family members generally had very little experience making phone calls to the clinic, setting up appointments, and handling other logistical steps. In order



to improve the ability of families to access clinics independently, Community House Calls developed a training program for families. Scripts were written in each target language including common questions asked by the reception staff (e.g., patient name, hospital number, sick or well visit, need for interpreter, and so forth). Over time, families have been trained to handle these calls without assistance. This training process was facilitated by the ICMs, using a voice mail service at the refugee clinic. Patients have access to voice mail recordings in their own language, and can also leave messages in their own language.

Case managed families have been taught how to contact clinics and obtain pharmacy refills over the phone. Staff have developed a manual which explains how to call the primary care clinics and pharmacy, and gives an overview of information needed and common terms used to make appointments. The manual is available in each of the targeted languages.

*caption*

### *Community Health Education & Outreach*

The ICMs are responsible for providing broad health education to the target ethnic communities. Community health education and outreach often takes the form of identifying a pressing need, then locating a resource person who can address this need through a special educational event. For instance, the ICMs have identified parenting classes as being an important health education activity which was not provided to most of the ethnic communities. Community House Calls staff organized parenting classes for the communities; the ICMs encouraged their case managed families to attend the sessions and provided interpretation services

during and afterwards. They also facilitated dialogue about the sessions to discern how helpful they were to the parents.

Other health education/outreach/support sessions

organized by the ICM team include topics related to social and medical issues such as intergenerational conflict, family planning, and medical issues such as parasites, malaria, hepatitis B, TB, asthma, rickets, and infant feeding. ICMs distribute information on these and other topics at the community centers and also directly to case-managed families.



***PLEASE  
WRITE A  
CAPTION  
FOR THIS  
SPACE!***

### *Data Collection and Record Keeping*

As busy as they are, writing reports can be one of the last tasks the ICMs get to. English is a second language for most of the ICMs, which can make the process difficult at first. Over time, this aspect of the job becomes much easier for all of the participants. During the demonstration program, the ICMs used palmtop computers, but after several technological “crashes” the program staff chose to use a daily log system, which is maintained by the ICMs and entered into a data base by a staff member hired specifically to work with data entry and analysis.

# Training

After being hired, Interpreter Cultural Mediators undergo intensive training to prepare for their new jobs. Many of the ICMs have worked previously as interpreters. However, further training in interpretation, through role playing and other techniques, is an important part of the training program. Community House Calls ICMs have provided feedback on the training they received in 1994, and their recommendations have been incorporated into the following training format and curriculum.

## *Training Format*

- I. Three to four weeks of intensive training comprised of the following elements:
  - A. Introduction to the role of the ICM
  - B. Didactic teaching sessions on a range of issues and services (see curriculum)
  - C. Role playing in medical and cultural interpretation techniques
  - D. Role playing in preparation for making home visits
  - E. Supervised home visit followed by debriefing
  - F. Contact with families in clinic setting prior to making home visits
- II. Ongoing training in negotiating with social services and health providers on behalf of the case managed families; presentation skills; medical terminology; and other inservice training which increases the effectiveness of the Interpreter Cultural Mediators and assists them in conducting their duties confidently and skillfully.

## *Curriculum Overview*

The general curriculum which follows is applicable to all of the Interpreter Cultural Mediators. Language and culture specific components applicable to ICMs from specific language groups are also available.

### **Goal 1: Understand the role of the Interpreter Cultural Mediator**

Curriculum:

- (1) An introduction to the ICM program
- (2) Description of ICM team members
- (3) Medical interpretation: definition, discussion, role-playing
- (4) Cultural mediation: definition, discussion, role-playing
- (5) Case management: definition, techniques, role-playing
- (6) The ICM's role in the day-to-day care of case-managed families
- (7) The role of the community advisor as resource person

### **Goal 2: Understand the resources and roles of the health and social institutions in the local area**

Curriculum:

- (1) The clinic, hospital, medical center as workplace: understanding the ambulatory care network, inpatient services, radiology and other ancillary services
- (2) WIC resources and mission
- (3) Neighboring medical centers and clinics

- (4) Public health department clinics: TB clinic, refugee screening, public health nursing
- (5) Department of Social and Health Services: eligibility criteria for assistance, periodic reviews, responsibilities of the department and the patient
- (6) Mental health resources available to case-managed families
- (7) Child protective services
- (8) Housing authority and shelter resources: eligibility and availability
- (9) Childcare resources and services: eligibility and availability
- (10) Parenting training available to case-managed families
- (11) Domestic abuse: where to seek help

**Goal 3: Learn to feel comfortable interacting with health care professionals**

Curriculum:

- (1) Describing who you are and your role in health care
- (2) How to talk to doctors and other health care providers
- (3) How to organize information about a sick child for nurses and clinic staff
- (4) How to ask clarifying questions
- (5) How to offer advice on cultural issues
- (6) Teaching providers how to use your services

**Goal 4: Understand the concepts of prevention**

Curriculum:

- (1) Western and biomedical practices of personal hygiene
- (2) Household sanitation and safety
- (3) Nutrition
- (4) Breast feeding and weaning
- (5) Immunizations: purposes and procedures

**Goal 5: Understand pregnancy from the medical view**

Curriculum:

- (1) The trimesters and what the mother experiences
- (2) The trimesters and how the baby grows
- (3) Nutritional needs during pregnancy
- (4) Common problems that can be controlled: gestational diabetes, pre-eclampsia, Rh incompatibility
- (5) The last stages of pregnancy and preparing for childbirth
- (6) The post-partum period and supporting breast feeding
- (7) Contraception

**Goal 6: Know basic first-aid**

Curriculum:

- (1) Understanding when and where to go for emergency services
- (2) How to give information about sick people
- (3) Taking temperatures and other vital signs
- (4) Cuts, scrapes, burns and bites
- (5) Poisonings
- (6) Diarrhea, dehydration, and fever
- (7) Colds, cramps, and the flu

### **Goal 7: Understand common conditions of childhood**

#### Curriculum:

- (1) Common illnesses and infectious diseases: otitis media, URI, gastroenteritis, asthma, diaper rash, eczema, allergies, chicken pox
- (2) Giving children medicines and storing medicines at home
- (3) Child growth and development and anticipatory guidance
- (4) Identifying specific home or traditional treatments that may be harmful (lead-containing medicine, chloramphenicol, tetracycline, etc.)
- (5) School and community tutoring and activity programs (especially for children with developmental delays)

### **Goal 8: Learn to review cases with medical staff**

#### Curriculum:

- (1) Case presentation skills development and practice sessions
- (2) Deciding which questions to ask providers before the case presentation

## *Orientation and Training Recommendations*

We recommend that an initial three to four week orientation and training program be pursued, comprised of a 50-50 split between didactic training sessions and hands-on clinical experience. This recommendation is based upon the feedback received from the Community House Calls ICMs, who reported that they had difficulty absorbing all of the information they received in their earlier two week orientation, comprised of eight hour days in which specialists from health care and social services presented pertinent information.

Too much information, too fast, was the chief complaint of ICMs interviewed for this manual during the demonstration phase. Many of them made statements such as the most important thing is the **working** experience. If you are working (in the clinic), then you are able to use the information; you have something to hang it on. It is easier for the ICMs to integrate the information they receive in the didactic sessions if they are working in the clinic at the same time. Community House Calls ICMs receive binders when they begin their training, which include all of the handouts and important information they will need. They often refer to this resource later on, and it is updated as needed.

Allowing plenty of time for questions and role playing is important. The Seattle ICMs stated that they were very nervous the first time they made a home visit. Role playing in preparation for this event is helpful. Continuing support from the nurse supervisor is important, especially in the form of making joint home visits the first few times, and then debriefing afterwards. Visiting case managed families is more stressful for some ICMs than for others, depending upon issues such as whether the community is welcoming or suspicious; whether the ICM has an outgoing personality or is shy; and whether conditions such as post traumatic stress disorder are present. The importance of the support provided by the nurse supervisor cannot be overstated.

As the ICMs become familiar with a range of information about clinical and medical services, social services, housing, emergency shelter, WIC, schools, parenting classes, daycare and other services which promote the health of families, they find themselves working closely with social workers and other non-medical professionals, interpreting for the families who are seeking help. Families can become rapidly dependent upon the ICMs to negotiate situations

for them. To avoid fostering this kind of dependency, the ICMs are trained to be aware of this dynamic and to recognize it if it develops. The nurse supervisor helps each ICM review the assets and skills of each family and look at ways to enhance the family's assets and skills.

Another area of training involves teaching the ICMs to assist families in meeting preventive care guidelines for their children. Primary care physicians who are involved in the ICM program can conduct chart reviews with the ICMs, giving each ICM a list of preventive health needs for each child in a family.

### *Continuing Education*

Following the orientation and initial training, the ICMs will require continued opportunities to expand their knowledge and reinforce their comprehension of their role and responsibilities. This development is provided through monthly continuing education coordinated by the nurse supervisor. These sessions include advanced interpreter training, discussion of pertinent issues such as confidentiality, medical terminology, and review/knowledge enhancement of the information originally presented during the first four weeks. The ICMs at Harborview Medical Center were especially interested in having further training in the policies and regulations of the Department of Social and Health Services, the housing authority, Medicaid, and other regulatory agencies and programs that had become more crucial to them as their case managed panel grew.

In addition to monthly continuing education meetings, the ICMs meet monthly to review issues. They also convene two hours per month in a community meeting, two to four hours per month in case reviews with the nurse supervisor, and one hour per month in clinic team meetings and teaching sessions. The ICMs attend updates on immigration law, welfare reform, housing and other topics, and attend conferences.

# Supporting the ICMs in their work

## *Work Schedule*

At the start, the ICM often needs to work on a full time and/or daily basis, in order to absorb the fund of knowledge required and to become thoroughly familiar with the job's responsibilities and demands. However, over time, the FTE budgeted for a given ICM position depends upon the volume of clients in a given cultural group and the intensity of the issues involved. The emotional intensity involved in case management and the travel time required to move between clinic, office and patient homes must be taken into consideration when developing the appropriate FTE; within the Community House Calls Program, some ICMs work a full time schedule and others work part time.

A demanding schedule and intrusions into their private time makes ICM burn-out a real possibility; the nurse supervisor can guard against this problem through regular support and assistance in maintaining a good balance and setting priorities. Currently, the ICMs at Harborview Medical Center meet one half day per quarter to discuss problems as a group. Individually, the ICMs receive daily or weekly support, as needed, from the nurse supervisor and a social worker.

## *Caseload Management*

Case managed families are defined as having complex or multiple social or medical needs and/or being high utilizers of services. Each Interpreter Cultural Mediator handles a panel of case managed families which may range from fifteen or twenty families to over thirty-five families. Most case managed families are referred by clinic staff and social workers. A few referrals come from other organizations and the community itself. The nurse supervisor assists each ICM in prioritizing his or her work activities, triaging cases and identifying community resources and other forms of assistance. The nurse supervisor accompanies each ICM on several home visits each month.

## *ICM Adjustment to Position and Role*

Punctuality, scheduling, limit setting, assertiveness, record keeping and confidentiality are issues that are highly defined by cultural beliefs and practices. Conflicts can emerge in this area and need to be dealt with in a way which is helpful to the ICMs while preserving the function and credibility of the program.

The trials and traumas of the case-managed families can sometimes rekindle painful memories of the ICMs' own life experiences; this can be difficult, especially for newly trained ICMs. Supervision, support, continuing education, and counseling services help the ICMs adjust to the pressures of their jobs.

## *Evaluation and Professional Development*

The nurse supervisor is responsible for evaluating each ICM's work. During this process, the nurse supervisor identifies ways to further develop the ICM's skillfulness on the job. She also searches for ways to develop the ICMs' professional linkages with physicians, community leaders, and other professionals.

## *Facilitating Community Relations*

Any new program serving refugee populations is likely to encounter political conflicts which have been transplanted from the countries of origin. Each ethnic community will respond differently to issues as they arise, based upon the community's traditions, goals, and history, political and social dramas played out in the countries of origin, and the dynamics of the newly established refugee community. The ICM team must consciously work with the team to discern how these dynamics affect the program. To a great extent, the specific dynamics will be discovered only in the process of working closely with the ICMs and community leaders in each ethnic community.

The politics of community work must be anticipated; the nurse supervisor cannot help but become involved in the resolution of these problems. Occasionally, problems may not be easily resolved. The nurse supervisor will need support from the program administrator and medical directors in some cases.

To illustrate the politics of community work in the Community House Calls program, we offer the following example: East African ethnic groups initially had trouble meeting together in the same room due to conflicting political philosophies. Two ethnic communities, the Eritreans and the Tigreans, share the same language and both wanted ICMs to be selected from their ethnic group. The hospital could only fund one position and the best qualified candidate was from the Tigrean community, which also had more families using the medical center clinics. Selection of the Tigrean ICM resulted in anger on the part of some of the Eritrean community organization leaders. Although it has been possible to work productively with the Eritrean community advisors, there has been continuing conflict with the organization leadership.

Another example, this time from the Cambodian community, further illustrates the kinds of problems the ICM program staff may encounter. In this case, minor conflict has been experienced between Cambodian organizations which support small businesses, including a large number of Southeast Asian doctors, and the ICM program. The reason for the conflict is that the small business proponents have at times perceived the medical center as a competitor with the Southeast Asian community physicians.

Yet another example of political conflict at the community level is seen in the case of professional medical interpreters who respond to the creation of the Interpreter Cultural Mediator position as a competing force in the medical center. Professional interpreters who work on a contractual basis, providing interpretation for discrete encounters between providers and clients, are sometimes displaced by the ICMs, who offer a much broader range of services, including advocacy and long term relationship with the client through case management. The conflict between these two types of interpretation can lead to internal dynamics which negatively affect patient care if it goes unchecked; for instance, a patient might be directed, by an interpreter, away from clinics where ICMs are available and towards clinics less familiar with the ethnic culture of the patient, but more in need of that interpreter's services. At Harborview Medical Center, the fairly recent administrative merge between Community House Calls and Interpreter Services has eased this type of conflict. However, it is likely that a new program will encounter this and other types of conflict during the startup phase.

In summary, the creation of the new job title and set of responsibilities brings with it a "ripple effect" throughout the community and institution into

which the ICMs are placed. The new position affects not only the case managed families and ethnic communities, but the clinics, interpreter services, administration, social work, and other related ancillary services.

### *Logistics: Office Space, Technological Tools, and Travel*

The ICMs need a designated work space. Although the ICMs are out of the office making home visits or working in the clinic much of the time, they need a place to meet, receive messages, and do paperwork. We recommend that careful planning about location and cost of adequate office space and equipment be made early in the development of the program, in order to fully support the ICMs in their jobs.

Palm top computers were very useful during the demonstration phase of Community House Calls. The ICMs used the palm tops to enter and print out summaries of their contacts with families, and the medical center's interpreter services office found they could easily document billing of ICM interpreter contacts. We highly recommended them in the first edition of this manual, but unfortunately found that the palm tops did not always function well, causing data loss and other problems. Therefore, we recommend that other options for managing data and daily schedules be investigated. At Community House Calls, manual logs have replaced this particular technological tool. A data entry person puts all of the information onto a computer data base.

Pagers are an easy way for the ICMs and nurse supervisor to stay in touch with one another, and for case managed families to reach the ICMs. Even with a designated office and telephone message center, pagers are still recommended. ICMs continue to have voice mail in his or her native language, making it possible for non-English speaking clients to leave a message.

### *Secretarial, Computer Programmer, Research Assistant Support*

The amount of secretarial, computer programmer, and research assistant time required to implement Community House Calls in the first year was more extensive than originally projected. In the first publication of this manual, we recommended that additional FTEs be considered for research, evaluation, and secretarial support, and we continue to recommend that the support needs of the program not be underestimated.

# Program Evaluation

Two research studies were developed during the demonstration phase of the Community House Calls program to evaluate the impact of the program on patient satisfaction, provider knowledge and self-reported behavior. In the first study, we looked at patient satisfaction related to health care, comparing mothers enrolled in ICM care coordination with a control group that was not enrolled in ICM care coordination. We surveyed Cambodian mothers regarding their own health care and that of their children, before and after one year of program operation. Two major results came out of this study. First, it is very difficult, bordering on folly, to try to assess patient satisfaction with health care in a non-Western ethnic group which does not hold the cultural notion that a person has a right to be satisfied with the health care they receive. Second, the care-coordinated mothers were clearly able to identify the ICM as a helpful person who worked in the hospital and who could easily be contacted. The control group was not able to identify a hospital staff person who was a consistent contact for help with health issues. No other differences were identified between the attitudes of the two groups toward their health care experiences at baseline or after one year of operation of the program.

The second study compared the knowledge of pediatric residents about the refugee ethnic groups and management of an interpreted visit, with interviews taking place before the program was started and after one year of operation. Both groups of residents improved in their specific knowledge about the ethnic groups after their rotation at Harborview and two months of work with these patients in the clinic and ER. Residents who were exposed to the Community House Calls program and worked with ICMs had significantly higher scores on knowledge of native languages spoken by ethnic groups, countries of origin, and asylum. They also were significantly more likely to be aware of interpretation styles, have heard from interpreters that some words and concepts could not be translated and to be aware that age and gender of interpreters influenced the quality of the visit.

Several process measures have been monitored to evaluate the ICM role and look at cost comparisons with other interpreter services. Over time, more ICM contacts with families are by the telephone and fewer are at clinic and home visits. With regular communication, ICMs are able to prevent unneeded visits. This is a great benefit in a managed care environment. In the first year after ICMs started work, our pediatric Medicaid managed care enrollment, which had leveled off, jumped by 400 individuals. This same increase was not noted in any of the other community pediatric clinics serving the same populations. Review of this enrollment indicated it was all due to enrollment by the ICM language group patients. Providing user-friendly ICMs was an attractive marketing feature for the refugee and immigrant ethnic groups.

We are currently developing ways to monitor outcome measures on care coordinated individuals and compare it to known national standards and our general clinic populations. Measures included are immunization coverage levels in children aged 19-35 months, physical examinations within 6 months of EPSDT guidelines in children, TB skin test screening in children, Hgb A1C levels in diabetic adults, and blood pressure levels in adult hypertensive patients. We are also monitoring medication use in hypertension in adults and asthma and eczema in children. At this time, we do not have results on these measures.

## On the Job: Case Examples

The following case examples illustrate the types of interventions ICMs provide. These cases can be developed more fully to illustrate how the ICM team members work together to achieve success in a variety of situations.

### *Case One*

A thirty-five year old Khmer Cham single mother, whose four children range in age from four to fifteen years old, was recently diagnosed with diabetes. She was referred to Community House Calls by the Diabetes Nurse Educator, who recommended that the Cambodian ICM evaluate the patient's stress level and provide education about diet.

When the ICM went to the patient's house, the patient told her that the medication she was taking was causing breathing problems and dizziness. Without the following interventions on the part of the ICM team, it is likely that the patient would have simply discontinued taking her medications.

#### *Intervention plan:*

1. After meeting with the patient and ascertaining the information above, the ICM contacted the nurse supervisor, who arranged a conference between the patient and the triage nurse at the medical specialties clinic. The ICM accompanied the patient during this meeting.
2. The triage nurse instructed the patient to stop medication for a few days and then slowly start back. Dosages were carefully described.
3. The ICM provided moral support to the patient as she began to take the medication, and the patient is now successfully controlling her diabetes with use of the drug.
4. The ICM provided education on proper diet for a diabetic, providing information appropriate to the patient's cultural background.

### *Case Two*

A forty year old Tigray woman with breast cancer was referred to Community House Calls during the time she was receiving chemotherapy. The patient had undergone multiple hospitalizations secondary to dehydration secondary to the side effects of chemotherapy. One of the hospitalizations occurred because the patient had placed the IV fluid in her freezer and thus wasn't able to use the rehydration therapy at home. During the time the patient was undergoing chemotherapy treatment, her three children arrived in this country for the first time, after a six year separation. The entire family began living together in a one bedroom apartment in an area of town where gunfire is sometimes heard at night.

#### *Intervention Plan:*

1. The ICM began accompanying the patient to all chemotherapy sessions and other medical appointments. She also provided support during a surgery and continued to provide support during subsequent radiation and chemotherapy sessions, at the hospital and in the home. The incidence of hospitalizations decreased after the ICM became involved.

2. The ICM explained how the rehydration therapy should be used and how supplies should be stored.
3. The ICM spent much time seeking safer and more conveniently located housing for the family (in particular, a location which is near the hospital and clinic).
4. Finally, the ICM organized a “first American Christmas” for the patient’s children, providing a lamb (“like back home”) and an American style Christmas tree and presents.

### *Case Three*

A Mexican construction worker’s father was the only family member attending his son on the Intensive Care Unit, following the son’s motor vehicle accident. The ICM provided interpretation and social support to the father during the time he watched over his critically injured son. When the son died, the father wanted to transport the young man’s body home for burial. No funds were available. The ICM approached local churches for assistance in this matter and some funding was made available.

#### *Intervention Plan:*

This case is unusual in that it was a short term intervention, while most of the ICMs work with patients and their families for months or even years. However, this case exemplifies the broadening use of the ICMs throughout the medical center, especially in the medical specialty clinics including the burn unit, speech therapy, mental health, or in this case, the ICU. Although difficult to measure, certainly the interpretation and social support services provided by the ICM greatly affected the quality of life for this patient and his father during the patient’s last days. The ICMs’ work is not solely related to providing health care, but to restoration of hope, increasing patient and family knowledge regarding the situation they face, and promotion of social stability within the family.

### *Case Four*

Three generations live under one roof in this Somali family: the family includes an adult son with chronic mental illness, three teenagers, and an adult daughter and her two preschool aged children. The family was given assistance at the time the mother first arrived in the United States, and each additional arrival was enrolled at Harborview Medical Center and added to the caseload of the Somali ICM. The family was engaged in a dispute with the landlord. The landlord had refused to repair a bathroom leak, saying that it was the responsibility of the family. The leak had infused the ceiling of the basement where three family members slept and where the whole family sometimes gathered. The ceiling appeared to be dangerous.

#### *Intervention Plan:*

1. The ICM helped the family apply for county housing (and discovered in so doing that the landlord had given a poor reference).
2. The ICM referred the family to a law clinic working in tenant-landlord disputes.

3. The ICM and the nurse supervisor co-authored a letter to the county housing authority documenting housing conditions, lawyer involvement, and credibility of the family. Result: the family moved into King County Housing the following month.

### *Case Five*

An Amharic speaking young couple, ages 22 and 23, reside in Seattle with their two children, ages 18 months and 8 months. The mother is expecting her third child. The family was referred to the ICM because the two children were losing weight. The ICM made some home visits and became aware that the mother was very depressed. The mother had a hard time getting up in the morning because she could not fall asleep until four in the morning. When the children woke up a few hours later, she was tired and gave them a bottle rather than offering food. She did not seem to offer much food during the rest of the day.

The father spends much time away from the home during the day, taking English as a second language classes in the morning and spending the afternoon at the library. The family has been closely followed by the Interpreter Cultural Mediator, along with the primary care provider and a public health nurse.

Recently the mother came to the medical center with her eight month old child. He had a swelling on the left side of his head. The parents said that they did not know when and how the swelling occurred, but assumed he had fallen from the sofa or been hurt somehow while playing with his eighteen month old brother. The mother said she saw the swelling when she was combing his hair. She brought him to the clinic after four days, when the swelling did not subside. An X-ray was taken which showed the child had a skull fracture. Child protective services became involved in this situation along with the Interpreter Cultural Mediator team.

### *Intervention plan:*

1. The mother is enrolled in a parenting class with ten other East African women. The ICM is attending the same class. The ICM will give culturally relevant feedback to the parenting instructor at the end of the program, and will discuss parenting issues with the mother. The ICM encouraged the father to attend the class, too.
2. Full-time child care has been arranged for both children. Child Protective Services is paying for the child care. This gives the mother time to rest, take care of house work, and attend parenting and ESL (English as a second language) classes.
3. Following completion of the ten week parenting class, the mother will attend the "Born to Read" program offered to expectant mothers and mothers of children under one year of age. The class will cover prenatal care, nutrition, parenting, and basic survival skills. ICM team members will visit some of the sessions and give feedback to the instructor and program coordinator. The "Born to Read" class is part of an ESL curriculum. Community House Calls staff played an active role in the development of this program.
4. The ICM team recommended psychiatric intervention for the depressed mother, which she received, and counseling for the couple. The team is working to connect the couple with an East African counselor who speaks the same language and understands their culture well.

## *Case Six*

A Cambodian girl, aged two and a half, was referred for case management. She had been brought into the Children's clinic at Harborview Medical Center by her mother because she was getting weak and had yellow skin. Blood tests showed the child had a very low hematocrit.

### *Intervention plan:*

The ICM went out to the patient's home and noted that the child primarily drank milk and snacked on ice chips. She also found out that the mother wanted her four year old son to go to Head Start, but that she did not know how to apply.

1. The ICM talked with the mother and suggested she give the two and a half year old a wider variety of food. Initial recommendations were to add cereals and juice to the diet. Vitamins with iron were prescribed, and the ICM encouraged the mother to give her daughter the vitamins every day.
2. The ICM encouraged the mother to bring the daughter in for a follow-up blood test two weeks later.
3. The ICM sought out the form that was needed to apply for Head Start, helped the mother fill it out, and facilitated processing it.

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