

Learning About Other Cultures: Is it Effective Use of Cultural Generalizations Or Is It Stereotyping?

By Marcia Carteret

Effective Use of Cultural Generalizations Prevents Stereotyping

In almost every cross-cultural program I deliver, the question comes up about generalizations and stereotypes. It's an ever-present issue because people are afraid of saying something unacceptable and being viewed by others as insensitive, critical, backwards, or worse. The truth is, that we all do plenty of generalizing and stereotyping, and it's useful, for starters, to acknowledge that. Only then can we begin to explore the predisposition all humans have for classifying other humans and themselves. It isn't hard to learn to distinguish between stereotyping, which inhibits cross-cultural communication, and generalizing which can be used to interpret and attribute meaning to what we experience when interacting with other cultures.

To survive in this complicated world, we use our senses every moment to acquire information about the surrounding environment and our immediate situation. This cognitive process is truly miraculous. Without the capabilities of our brains to make sense of the input that bombards us, we wouldn't be able to function. Through the perception process, we make sense of what we have observed. We select the information we take in, simplify it, and categorize it using general labels. We even fill in gaps for information we don't have to piece together an understanding of ourselves and other people based on appearance, roles, interactions, and categories of belonging. A person is male or female, young or old, etc. He or she plays certain roles in life – doctor, student, attorney, wife, and so on. We consider social behavior and personality. Is a particular person friendly, helpful, aloof, nervous? We also decide about a person's belonging. Is he or she a republican, an immigrant, a Christian, etc.

The final stage of our cognitive processing is attributing meaning to what we have observed and categorized. We rely on socialization and our own recurring experiences to *interpret* what we've put into mental categories.

When someone says in a corrective tone, "you're generalizing," it suggests that we are guilty of sloppy thinking. However, considering the complexity of processing all the stimuli in our experience, it is arguably more accurate to think of generalizing as a natural and necessary function of the human brain. In cross-cultural situations, there's a lot of information to take in, and generalizations help with the sorting. Generalizations are useful in summarizing the shared values, beliefs, and practices of cultural groups. If we use generalizations carefully as a starting point for learning about people from other cultures, we can gain useful understanding. However, if we apply a generalization to every person in a group, if we fail to consider whether or not a statement we make is appropriate to an individual, we have stereotyped. We must always test our generalizations and be aware of those individuals who do not fit the mold, so to speak.

I find that healthcare providers who worry about stereotypes and generalizations are the ones least likely to offend. Their awareness of the negative impact cultural insensitivity can have on provider-patient relationships and health outcomes means they are likely to use generalizations about cultures appropriately, modifying their own behaviors to improve interactions with patients. There's certainly nothing sloppy in that. Quite the opposite. It's what being culturally aware is all about.

Let's look at a few examples:

- 1.) We can generalize about immigrants to the United States being people from lower classes who haven't had the benefit of education in their countries of origin. This is, in fact, often the case. However, there are also immigrants in the US who are highly educated, having given up prestigious careers in their home countries. Perhaps they work menial jobs in America, but were once university professors or doctors. Individuals with this experience can become extremely frustrated when people talk down to them because their command of English is imperfect and they have joined the low-income class in the US.
- 2.) We often generalize that Asian women are quiet and submissive. Well, this might be true of women from traditional Asian cultures. The time-honored role of women in many Asian countries emphasized these qualities. To avoid stereotyping, we need to consider the background of the individual. How long has she been in the US? Which Asian country is she from; there are important cultural differences between the Chinese, Japanese, and Koreans, to name a few. How educated is the woman? Many Asian American women are out-spoken and assertive. Many are successful entrepreneurs who contribute significantly to their family's income. An introverted individual may appear to fit the traditional stereotype, when in fact her behavior isn't about culture. It's about who she is.
- 3.) People from countries around the world generalize that white middle-class Americans don't learn to speak foreign languages. While it is true that our schools don't place as great an emphasis on learning foreign languages as schools do in many other countries, plenty of white middle-class Americans are bi-lingual. I've encountered a number of staff in CCHAP pediatric practices who speak Spanish fluently in addition to English. These individuals certainly don't fit the mono-lingual American generalization. How might they react to a person from Spain expressing astonishment that an American actually speaks Spanish?

**The Children's Hospital Annual Ethics Conference
Immigration and Health Care Ethics: Crossroads and Borders**

**Friday, March 14, 2008
The Children's Hospital**

Purpose

Health care professionals and institutions recognize the current social conflicts regarding immigrants in the United States. Current safety net systems attempt to meet the health care needs of this population, but lack of awareness, coordination and funding make efficient and effective care difficult. This conference will investigate current legal, ethical, and economic aspects of immigration policy, with special attention to rights and duties related to health care issues.

Objectives

Upon completion of this conference, participants should be able to:

- Clarify the rights of immigrants to health care in Colorado.
- Determine the duties of clinicians in providing treatment for immigrants in various therapeutic relationships.
- Provide guidelines for individuals and institutions in developing sustainable safety net systems for immigrant health care.
- Suggest processes that are confidential, respectful and beneficial for patients from immigrant families who seek care at our institutions.
- Review proposed changes in immigration policy to determine the potential impact on the health of immigrants.

Target Audience

This conference will be of interest to those who serve in the health professions or in organizations, institutions, and networks that provide care to immigrant families.

This will be an opportunity to deepen understanding of immigration issues and to advance the coordination of community programs.

Acknowledgements

We gratefully acknowledge the generous unrestricted educational grants from Kaiser Permanente and The Program in Bioethics at The Children's Hospital in support of this conference.

Agenda - The Children's Hospital Conference and Education Center

7:30 a.m. Registration and Continental Breakfast

8:00 Welcome - Mark Yarborough, PhD

8:10 Health Care Ethics and Immigration: Problems for Professionals - Stefan Mokrohisky, MD

8:45 Immigration Law 101 - Philip Alterman, JD

9:30 Immigrant Rights: Myths and Realities - Sonal Ambegaokar, JD

10:15 Break

10:30 Experience as Teacher: Lessons from Health Care Practice

Panel Discussion – Clinicians in Practice - Moderator: Peter Hulac, MD

12:00 p.m. Lunch (provided)

12:30 Grand Rounds: Immigrant Health Care: Barriers to Access - Sonal Ambegaokar, JD

1:45 Healthcare for Immigrants: Building the Network –Saving the Safety Net

Panel Discussion – Community Resource Representatives -Moderator: Jackie Glover, PhD

3:00 Summary, Conclusions, Plans for Action - Audience Participants

3:30 Evaluation 3:45 Adjourn

Visit www.cchap.org/nl16/ for registration form

Practice Manager's Corner

By Christina Ells

As of December, 2007, the process for billing Synagis has changed. Please read the excerpt below that was in the December 2007 Provider Bulletin sent by Medicaid:

Synagis Immune Globulin

Synagis (Palivizumab) is used to prevent serious lower respiratory tract disease caused by Respiratory Syncytial Virus (RSV) in pediatric patients at high risk for RSV disease. Synagis is administered by intramuscular injections, at 15 mg per kg of body weight, once a month during expected periods of RSV frequency in the community.

When Synagis is administered in a Provider's Office or Outpatient Hospital:

Prior Authorization is not required if:

- The client is under age 3 at the start of the current RSV season or at the time of the first injection for the current RSV season, with a chronic lung or respiratory condition, and was either full term or premature.
- The client was born prematurely, less than 28 weeks, and is under the age of 12 months at time of first injection, with or without a chronic lung or respiratory condition (e.g., ICD9 765.0).
- The client was born prematurely, 29-35 weeks, and is under the age of 6 months at time of first injection, with or without a chronic lung or respiratory condition (e.g., ICD9 765.1).

Prior authorization is required for:

- Children ages 3 or older at the start of each RSV season, or
- Children who do not meet the above criteria but whose physician believes that they medically require Synagis.
- The client's risk is increased due to one or more of the following conditions, as recommended by the American Academy of Pediatrics:
 - Body Mass <5kg
 - Birth within 6 months before onset of RSV season
 - Congenital Heart Disease
 - Day care attendance
 - Low Socioeconomic Status
 - Two or more individuals sharing a bedroom
 - T-cell immunodeficiency
 - School age siblings
 - Passive smoke exposure
 - Multiple births

Providers administering Synagis in the office must furnish the immune globulin and must use CPT code 90378 to bill Synagis on the CO 1500 or 837 professional claim format. Bill one unit per 50mg vial; limit 6 units per day.

Providers may not ask clients to obtain Synagis from a pharmacy and bring it to the practitioner's office for administration. Outpatient hospitals should bill using the appropriate revenue code.

Prior Authorization Requests (PARs) should be sent to:

PARs

P.O. Box 30

Denver, CO 80201-0030

For questions, providers may contact the fiscal agent's prior authorization line at 303-534-0279 or 1-800-237-7647

When Administered At Home Or In a Long-Term Care Facility:

A prior authorization is required when Synagis is dispensed by a pharmacy and administered at home or in a long-term care facility. The prior authorization will be approved for six months for a

diagnosis of RSV or the prevention of RSV. Only physicians and pharmacists from long-term care pharmacies and infusion pharmacies, who are acting as the agents of the physicians, may request a prior authorization. When the prior authorization is approved, the pharmacy should bill Colorado Medicaid electronically at the point of sale. Prior authorizations may be requested by calling or faxing a Pharmacy Prior Authorization Request (PAR) to the ACS prior authorization help desk:

Phone number: 1-800-365-4944

Fax number: 1-888-772-9696

CCHAP Newsletter Immunizations Corner

By Tiffany Brown and Christina Ells

As you may know, CCHAP is in the process of working with CCHAP practices to implement immunization reminder recall for all of your Medicaid patients. Immunization rates of Medicaid and CHP+ children have been dramatically lower in Colorado than the rates for commercially insured children; and raising the immunization rates for these children poses greater and different problems than commercially insured children. With this in mind, CCHAP's Director of Continuous Quality Improvement has created a simple guide to improving record keeping for the Immunization Registry and that will also assist you with reminder recall in the future.

We know the process of reminder recall can be difficult and time intensive, and this simple guide was developed with that in mind. Please feel free to post this guide wherever data is entered into the Immunization Registry or use as an informational handout for your support staff.

Tips and Tricks for Immunization Registry Data Entry and Reminder-Recall

Tips for getting the most out of the CIIS database for reminder-recall:

- Make sure first and last names are in the correct order
- Double check for correct spelling of child's name
- Make sure the date of birth includes all four digits of the year
- Make sure middle initial gets in the correct text box
- Make sure hyphenated or dual last names are in the correct format
- Update contact information on the patient upon every contact with the practice (phone call, office visit)
- Get parent's cell phone number (The parents are likely to keep this phone even if they move)
- Update Medicaid number to keep current
- Track previous Medicaid numbers
- Update registry information on a consistent basis so data pulls on late kids are up-to-date

Steps to start setting up future ongoing reminder-recall:

- Ask for current contact information at every opportunity (i.e. phone calls to the practice, office visits)
- Ask parents for permanent reminder contact information and permission to contact (i.e. grandparent)
- Obtain e-mail address
- Obtain cell phone number (in addition to land line phone number)
- Ask and indicate preferred method of contact (mail, email, cell, text)
- Link family members together (i.e. needed services on siblings in order to contact a family once for multiple children)
- Don't wait until a child is late with their immunizations, send a reminder that immunizations are coming due soon. (For example, you can set up a card system if you don't have a formal recall system of patients by birth date and monthly pull kids a month before the immunization schedule indicates that a child is due and send them a postcard.)
- Inform/Educate/Remind parents about upcoming immunizations needed over the next year at the time of a visit (at point of care, with signs/posters in waiting room and exam rooms)

Child Psychiatry Telephone Consultation on Medicaid Children

The Behavioral Health Organizations and the Mental Health Centers in the greater metro area have very generously made available **telephone consultation by child psychiatrists** to help providers in CCHAP – affiliated practices manage their **Medicaid children with complicated mental health issues or complicated medication regimens.** These child psychiatrists are also willing to come visit your practice to get to know you and even to discuss cases. We are very grateful for this very generous support for your Medicaid children.

Denver County – Rick March, MD – 303-504-1520

Jefferson County – Don Bechtold, MD – 303-432-5172

Adams, Arapaho and Douglas Counties - Joe Pastor, MD – 303-853-3888

**PROVIDER RESOURCE HOTLINE
(Clarification of previous information)**

**To Help You Find All Appropriate Services and Resources
for Your Chronically Ill or Special Needs Patients**

Including Case Management or Care Coordination for the Child

And Education Resources and Support Services for Their Parents

Call 1-877-731-6017

Fax: 303-691-0846

Email: providerhotline@familyvoicesco.org

The PROVIDER RESOURCE HOTLINE assists providers to identify all appropriate services and resources for children with chronic illness or special needs and for their parents:

- Case management
- Care coordination
- Specialized services, resources, medical equipment, therapies
- Parent/patient education about chronic illness / special needs
- Parent/patient support services
- Help in finding funding for uncovered services

Examples:

- You are seeing a new patient (new to Denver) who is an infant with 22q Deletion Syndrome, congenital heart disease, cleft palate and an oxygen requirement of undetermined etiology. Parents want to link up with all of the support services and a parent group like they had where they used to live.
- A child with multiple developmental delays also has behavioral problems. The parents are not sure they are getting all the help their child is entitled to and they want a parent support group and they are asking for counseling.
- A parent with a disabled child wants your help in applying for some sort of waiver that you aren't familiar with.

Monday thru Friday from 8AM to 4PM

Voicemail available 24/7

Provides follow-up with the provider office and with families

CLARIFICATION

Contact Erlinda or Lorena with CCHAP at PHONE 720-744-5522; FAX 303-751-9048

- **When you are only wondering about socio-economic issues like food stamps, housing, Medicaid eligibility, legal aid, abuse, etc.**

If the hotline can answer your questions immediately, you can pass the information to the family while they are in the office or we can contact the family and give the information to them.

If the information is not immediately available, we will research the question or case and provide the information to you and the family later in what ever manner you and the family wish (via phone, fax, or email).

If you feel the family needs more assistance or follow- up, just let us know and share the family's contact information with us or provide the family with our number for them to contact us directly.

When contacting us, please provide us with the following information:

Your provider office and PCP name

Name of Child

Date of Birth

Medical Condition / Primary Disability

Type of insurance

Resource or service requested

Who should we contact with information?

Family Contact Information

How is it best to provide information back to you: phone, fax, email or voicemail

DOWNLOAD A REFERRAL FORM AT

<http://www.cchap.org/nl16/>

DOWNLOAD AN 8 x 11 FLIER TO KEEP ON HAND AS A REMINDER AT

<http://www.cchap.org/nl16/>

Next time you see a special needs child, call us to see how we can help

Questions about the hotline? Call 1-877-731-6017

*The Provider Hotline Is Sponsored By
Family Voices and CCHAP*

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Integrating Developmental Screening Into a Pediatric Practice

- The Colorado Assuring Better Child Health & Development (ABCD) project has received a three year grant to provide training and technical assistance to providers to implement a “validated” developmental screening tool at well child visits for infants/toddlers birth to five.
- The ABCD project is partnering with CCHAP to provide training and support to pediatric practices to implement developmental screening.
- **Medicaid will reimburse \$34.00 to providers if you use a standardized, validated developmental screening test at an EPSDT visit.**
- The Colorado Chapter of the AAP supports the ABCD project.
- Early detection and intervention improves outcomes. Many delays in children’s development are missed in the first 4-5 years of life without a standardized, validated screening test.
- The **most time-efficient tool** is one in which the parent completes a questionnaire.
- **To comply with 2010 recertification guidelines by the American Board of Pediatrics,** documentation will be required to show levels of involvement in practice improvement initiatives. By implementing the use of a **“validated” developmental screening with a sensitivity and specificity rating of 70% or greater like the ASQ or PEDS,** practices are taking steps to integrate quality improvement into their practices.
- What are providers saying about implementing either the ASQ or the PEDS parent questionnaire developmental screening tool:
 - **It takes 1-2 minutes for an MA, LPN or RN to score.**
 - **It takes less than a minute of the provider’s time if the MA, LPN or RN scores the questionnaire.**
 - In many instances, it reduces the length of the visit.
 - It helps providers concentrate on the concerns/priorities of the parents.
 - It reduces the number of concerns that come up as you are walking out the door at a well care visit.
 - It improves patient satisfaction.
 - It promotes positive parenting practices.
 - It increases provider confidence in decision-making for when to refer a child for further developmental evaluation.
- Eileen Auer Bennett, the Colorado State ABCD Coordinator and her team are available to assist providers in getting started. Training and technical assistance will be provided to practices to implement a standardized tool such as the ASQ or PEDS. Support will also be given to office staff on how to incorporate a standardized developmental screening tool into the current office work flow.

For more information, please contact:

Eileen Auer Bennett
720-333-1351
ileanben@yahoo.com

The Ages & Stages Questionnaire (ASQ)

The Ages & Stages Questionnaire (ASQ) is a well respected screening tool. It has the best sensitivity and specificity. It is standardized across various common minorities. Health care providers have identified the following advantages:

- Parent completed—Parents are partners in their child’s assessment and intervention activities.
- Serves as a talking guide with parents identifying a child’s strengths as well as things the child is not doing yet.
- Practical—Scoring takes 1-2 minutes and can be done by paraprofessionals.
- Cost-efficient—May be photocopied repeatedly.
- Scoring is simple—Only three responses:
 1. Sometimes, occasional or emerging response from child = **5 points**
 2. Yes, child performs specified behavior = **10 points**
 3. Not Yet = **0 points**
- If the child’s total score falls in a shaded area of the bar graph for any developmental area, further diagnostic assessment is recommended.

Visit www.brookespublishing.com to view and order the ASQ tool online.

The Parents’ Evaluation of Developmental Status (PEDS)

PEDS is another tool commonly used by practices involved in a pediatric surveillance program. Provider feedback has been positive. “The PEDS is nice because physicians value knowing the issues parents want to address before going into the room.”

Below are other advantages outlined in an article by Frances Glascoe, PhD, Associate Professor, Division of Child Development, Vanderbilt University School of Medicine:

- Developed out of four cross-validation studies on a nationally representative sample of families.
- Uses parent concerns or judgments about the child’s development and behavioral status.
- Easy to score—two minutes to elicit and interpret.
- Enables health care providers to determine the need to refer and where.

Visit www.pedstest.com to view and order the PEDS tool online.

Spanish Interpretation Training for Pediatric Practices

CCHAP offers a convenient, time-efficient, cost-efficient medical Spanish interpretation training program for pediatric office staff and providers. It is provided as a telephone conference, during practice office hours at lunch time.

Training in medical Spanish interpretation includes:

- Medical (pediatric) terminology
- Subtle differences in the two languages in word selection and grammar
- Culturally appropriate communication skills
- Professionalism and etiquette of interpretation
- Confidentiality and HIPPA issues

Who: This program is for people in the practice who already speak Spanish and English

How: The sessions will be conducted via telephone, using handout materials and the Internet, and will also include role-playing.

When: Wednesdays from 12:15 to 1 pm. The next session will begin as soon enough people are interested in attending.

How long: 45 minute sessions weekly for 6 weeks

Registration: Email the information below to ilssoto@aol.com.

Name of student:

Job title:

Pediatric practice name:

Work phone number:

Home phone number:

Is your first language English or Spanish?

If Spanish is your second language, how long have you been speaking it?

What time is your usual lunch hour?

What is your goal in enrolling in this class?

Price: \$20 per session.

After your registration and start date is confirmed, please send a check for \$120, payable to International Language Services
12572 West Brandt Place, Littleton CO 80127.

An assessment of each individual's skill level will be done during a 5-10 minute phone call prior to first telephone conference/class. Maria will contact you to schedule this initial individual telephone call upon receipt of your registration email. A certificate of completion will be given after completion of all 6 sessions. The faculty is Maria Soto, a certified Spanish interpreter and trainer with International Language Services.