

## **Cross-Cultural Communication**

**By Marcia Carteret**

### **Interacting with Difficult Patients: A Cross-Cultural Perspective**

July is going to be a busy month for cross-cultural trainings in the CCHAP participating practices. As I prepare for what's coming this month, I reflect on what I've learned from the trainings I completed in May and June. In this newsletter, I'd like to address one question that has been asked consistently by training participants: How can I deal with patients from other cultures who are insistent and hard to please.

It seems every practice has at least one story about a family that is especially challenging to deal with during office visits. In some cases, no matter how accommodating the provider and staff try to be, they can't achieve a satisfying interaction with a particularly difficult parent or family. The parent(s) never seem satisfied with the medical advice, attention, and treatments recommended. They don't accept an answer if it isn't what they want to hear. They push to get the answer they want. In short, there's always tension.

In answering this pressing question, we start by recognizing that people from all cultures can be challenging in healthcare settings. We must avoid stereotyping. Not all Asians are soft spoken and compliant. Not all Hispanics have low English proficiency and a relaxed attitude towards time. So if we are experiencing a patient/family as being insistent and hard to please, we need to avoid seeing that behavior as entirely cultural. In some cases, it may be much more a part of an individual's personality than his or her culture. Think of people in your own family and social groups. Surely you can think of one or two who can be "difficult." I had an uncle who was polite and courteous in most situations, but in restaurants he was impossible to please and impatient with waiters. I avoided dining out with him. That had nothing to do with his being American. It was *his* personality.

Once we've adjusted our mindset to avoid stereotyping, we can look for some helpful clues via cultural generalizations to understand patients who tend to be a challenge during office visits. While it is impossible to make precise characterizations of a culture and people with any degree of accuracy, there are commonalities and unique characteristics in every culture. Remember that the definition of culture includes the following: *Culture influences what people perceive and guides people's interactions with each other.*

Two cultures mentioned as sometimes being challenging to deal with are Indian and Russian. Let's take a quick look at these two cultures as generalized examples of how behavioral norms don't always translate easily cross-culturally.

Based on research in the field of intercultural communications (see reference at end of article), people from India may be highly perseverant. In other words, they believe that if they don't give up and accept a situation as it is, they will get what they want. In an over-crowded country such as India, people have to persevere to survive. Scarcity is a fact of life for many. If you know these things about the culture of India, it makes sense that during an office visit people from India may be very determined and persistent by American standards. The squeaky wheel gets the grease, and taking NO for an answer is culturally unacceptable especially when the stakes are high— often the case in healthcare situations. To get the answer or outcome one needs or desires, it proves effective to try and try again. This is acceptable and even normal behavior in many countries of the world.

When looking at Russian culture, we can see some similarities in approach. Russian culture traditionally emphasized status difference and an unequal distribution of wealth. When the communist regime took over, the system seemed to favor equality among people, and yet, there were always privileges to be had. One got what one needed through connections to people who could make things happen. People learned to rely on a system of favors. If it took three days standing in line to get a drivers license, it made sense to find someone who had the right connections who could speed up the process. If it took half a day standing in line to get a loaf of bread, people naturally learned to be very assertive in those bread lines. Only by pushing and working the system could one survive. Taking NO for an answer could truly be unacceptable from a survival standpoint. A Russian immigrant relatively new to the US is not going to be able to shift gears immediately and operate as an American naturally would. Even those immigrants who have been living in the US a while will fall back on old behavioral patterns when things don't go smoothly and obstacles need to be overcome. The average American has the same obstacles to overcome in dealing with the US healthcare system.

We push too; we just do it in ways that are culturally normal for us. For example, in American culture it is perfectly acceptable to ask to speak to a manager when there's a problem. We take the issue to another level of seriousness by doing so. This approach is unfamiliar to people from many other countries. Culture-specific assertiveness – it would actually make an interesting cross-cultural topic to study at greater length.

For our purposes in this newsletter article, we need to focus on the practical aspects of dealing more effectively with the “difficult” patients in cross-cultural interactions? First, keep in mind that there are culture-specific ways of interpreting dialogue, so understand that “no” doesn't mean ABSOLUTELY NO in many cultures. In cultures where bartering and haggling are common, the first “no” is never really a final answer. In some cases, it can be seen as the first step in a back and forth process where both people end up meeting in the middle. As a healthcare provider or staff member, if you really do mean “no” when answering a patient, try to cushion your response with words of understanding. But make the final answer clear. “I understand what you are asking, and I would like to be able to help you, but my answer is no. It is out of my hands. There is nothing more I can do.”

It is critical to remember that “difficult” patient behavior is often born out of intense emotions such as anxiety, fear, anger and even sadness. Simply recognizing and validating your patients' frustrations and concerns may improve the therapeutic relationship. If you find yourself in a situation that is escalating out of control, take a time out if possible. Tell the patient, "I understand this is very upsetting to you, and I empathize with what you are feeling." Then leave the room to give the patient time to absorb what is happening. Give them five minutes or so. If your job is handling patients at the front desk, it will be hard to take a time out. Perhaps you can ask a co-worker to step in. Sometimes a new face in the conversation will de-escalate the situation. However, be sure that there is a unified voice among the providers and staff. If one person says no and the next person says yes, then the patient learns to keep asking until she finds the person who will tell her what she wants to hear.

Finally, don't take the American idea of customer service to an extreme. We are just about the only country in the world where “the customer is always right.” Try taking that attitude to India or Russia. Try taking it to France if you really want a cross-cultural shake-up. Unfortunately, some new immigrants to the US do get carried away with this perceived advantage. Like a magic trick, they need to keep convincing themselves it really works. As a private pediatric practice, you are running a business. You determine what's acceptable in interactions with your

customers, not the other way around. You set the tone. You are in a position of authority and should not be afraid to act accordingly. Being courteous in a professional way will actually gain the respect of patients.

One practice I visited had a very good philosophy about dealing with difficult patients. One of the nurses told me, "Our philosophy is that we're not going to let it get to us," she says. "We try to identify the patient's real problem. Maybe they're afraid we won't take them seriously, are anxious about money or were treated poorly elsewhere. We do the best we can and then move on. The next time we see that patient, we treat it like a new opportunity to have a good interaction. We start fresh."

Now that's what I'd call a highly effective cross-cultural mindset.

(Referenced for this article: Culture's Consequences by Geert Hofstede, second edition.)

For another article on the "Angry Parent," in our Newsletter #9  
(<http://www.cchap.org/newsletter-nine/#two>)

## **New Medicaid Rates – Dramatic Increases Starting in July**

The Colorado Department of Health Care Policy and Financing (the Department) administers the State's public health insurance programs such as Medicaid and CHP+. Under the leadership of Joan Henneberry, the Executive Director, and staff in the Department, the legislature approved provider rate increases effective July 1, 2008. This is reflective of commitment by Governor Ritter, the Department, and the legislature as to the importance of preventive care and increasing provider capacity. Effective July 1, 2008, reimbursement rates for many services will be increased up to 90% of Medicare. Those practices participating in the CCHAP medical home project will also receive enhanced reimbursement for EPSDT well-child visits in addition to the July increases. The Colorado Chapter of the American Academy of Pediatrics, Ruth Aponte (their lobbyist) and the many pediatricians that have been attending meetings with the Department over the past several years should also be acknowledged for their efforts.

A table showing all of the new rates for all codes is available at [www.cchap.org/nl20/#2](http://www.cchap.org/nl20/#2)

## **Practice Manager's Corner**

### ***Clarification on Medicaid Waivers***

There are 4 children's Medicaid waivers at this time. For the waivers, the parents' income is waived (not counted). Only income in the child's name is counted.

For most waivers, a family must get a denial from SSI based on income. Once that is in writing, the family applies for a waiver through the Single Entry Point. You can find the list of SEP agencies on the HCPF website (on the tree on the left hand side, go to Medical Assistance Programs, the, Long Term Care and Home and Community-Based Services, the Single Entry Point Agencies). HCP offices or Family Voices can answer specific questions families have about this complicated process.

### ***Specialty Care Referrals for Medicaid***

If you need to find a specialty provider for a Medicaid client, Medicaid Provider lists are located in two places. (1) On the website under References [http://www.chcpf.state.co.us/HCPF/refmat/Reference\\_Include.asp](http://www.chcpf.state.co.us/HCPF/refmat/Reference_Include.asp) and (2) Through the Web Portal Medicaid Provider Lookup option on the main menu. You can search by Specialty, County, City and Zip.

When looking for something specific on the Department's website, use the Google feature on the home page to save time and effort.

### ***Colorado Access and CHP+***

Starting July 1, 2008, Colorado Access assumed the state CHP+ contract. That means that all claims for dates of service July 1, 2008 forward should be sent to Colorado Access. If you haven't already, I encourage you to contact Colorado Access for an in-service training about what the conversion means to your practice.

### ***Name change~!!***

Erlinda Diaz has had a name change! Her new last name is DeLuna and we will be changing all of our handouts and informational sheets to reflect that change. We have also corrected the incorrect number listed for her in the Orientation Manual. We apologize for any inconvenience that caused.

**Resource Guide:  
Contact Information on Resources for Families**

To help you locate commonly used resources for low-income families, we have created a comprehensive Resource Guide available on the password-protected portion of the web site. A 5 page list of the most commonly used resources is available on the front page of the web site near the bottom on the front page, entitled [Resource List of community services for low income families](http://www.cchap.org/information-library/poverty/CCHAP-Resources-for-Families.pdf) or at <http://www.cchap.org/information-library/poverty/CCHAP-Resources-for-Families.pdf>

**Child Development**  
**By Bill Campbell, MD**

**Developmental Screening**

Many of you are already aware of professional society recommendations regarding standardized developmental screening. The recent edition of Bright Futures, several policy statements by the American Academy of Pediatrics, and an article by S. Hamilton, MD in The Journal of Family Practice (May 2006) all advocate for regular developmental screening and surveillance. To this end, for more than a year now, I've been working with the Colorado ABCD Project. Our primary mission is to promote the use of standardized developmental screening tools in health care settings to facilitate early intervention and referral – particularly for infants and toddlers.

A frequently asked question is “what standardized developmental screening tool do you recommend?” While the answer depends on your patient population and the setup of your practice, I tend to favor the Ages & Stages Questionnaires (ASQ). It's effective, inexpensive, fast, easy to score, and family friendly. It also makes it clear when a referral is needed.

Depending on what your clinic is already doing for developmental screening, the ASQ does involve some work for clinic support staff. But it can actually shorten the visit length for the physicians and other clinicians doing the health maintenance exams, partly because the ASQ can be completed before the physician/clinician visit, and partly because the ASQ gives the physician/clinician (and the parents) a clear picture of what the developmental concerns are, if any.

As noted in an earlier edition of this newsletter, the ASQ is a well respected screening tool. It has very good sensitivity and specificity (at least in the 70-80% recommended by the AAP and others), and it is standardized across various common minorities. Health care providers have identified the following advantages:

- \* Completed by parents – 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.
- \* Simple to score – Only three responses:
  1. Yes, child performs specified behavior = 10 points
  2. Sometimes, occasional or emerging response from child = 5 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.

I've been impressed with how family-friendly the ASQ is. It's at 4th-6th grade reading level and includes specific examples and illustrations. Parents get an idea of what kinds

of things their children are doing, and what skills they should be getting ready to develop. Families can take the completed ASQ home to work on the “sometimes” and “not yet” activities. And the ASQ system now comes with supplemental activity sheets to help the parents know what kinds of activities and toys would be developmentally appropriate for their children between well visits.

With the ASQ, it's easy to know when to refer. As far as where to refer, remember: “over 3, CDE; under 3, ECC”

In other words, if a child **three years or older** has any score in the shaded area, have the parents contact their **local Child Find office** (and give the family a copy of the ASQ, including the score sheet, so the Child Find team doesn't have to repeat the screening). The phone number for Child Find at the Colorado Department of Education (CDE) is 303-866-6943.

For **infants, toddlers, and children from birth up to their 3rd birthday**, if any of the scores fall into a shaded area, **refer to ECC** (Early Childhood Connections, 888-777-4041, [www.earlychildhoodconnections.org](http://www.earlychildhoodconnections.org)). Referral forms can be found on their website. Please fax at least the ASQ score sheet along with the referral form so that a developmental screening doesn't have to be repeated. In most counties, Child Find teams from CDE do the developmental assessments to help determine eligibility; the early intervention services themselves are coordinated by ECC, which falls within the Colorado Department of Human Services, Division for Developmental Disabilities.

For children of any age, you can pursue other appropriate evaluations (e.g., audiology, etc.) while awaiting the ECC/Child Find evaluations.

For more information about choosing developmental screening tools, here's a link to an article by Dr. Drotar and colleagues:  
[http://www.commonwealthfund.org/publications/publications\\_show.htm?doc\\_id=614864](http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=614864)

Please feel free to contact me with any questions or comments at  
[Campbell.william@tchden.org](mailto:Campbell.william@tchden.org)

Or to get started with a developmental screening tool in your practice you can call or email Eileen Auer Bennett [ileanben@yahoo.com](mailto:ileanben@yahoo.com) 720-333-1351

## Comparing the ASQ with the PEDS or the Denver II

Colorado's ABCD state team is frequently asked why we prefer the ASQ over other standardized screening instruments, such as the PEDS and the Denver II.

We generally prefer standardized developmental screening tools based on parent report (ASQ and PEDS) rather than direct administration (Denver II) because of ease of administration and because of the value of having parents report on what their children are usually able to do, rather than what the child does or doesn't do during the clinic visit. The Denver II also involves more staff training and work.

As mentioned in previous articles, the ASQ has moderate to high sensitivity and specificity (.7-.9), compared to the PEDS (moderate sensitivity and specificity – .7-.8) and the Denver II (low to moderate, around .5-.8), which is another reason we recommend the ASQ and PEDS over the Denver II.

The PEDS involves asking parents very important questions, and we do agree with Francis Glascoe and other experts that parents should be asked if they have any concerns or questions about how their children are developing, learning or behaving – regardless of the standardized developmental screening tool. We think the PEDS is great for developmental surveillance, but not as good as the ASQ for developmental screening. If developmental concerns are elicited using the PEDS (or anything else), there's good reason to refer (under 3, ECC; over 3, CDE – Child Find). But the parent's responses on the ASQ may reveal developmental concerns even when the parents didn't think there were any.

Our experience with the ASQ is that it is easier to use in many clinical settings than the PEDS.

The ASQ is also very family-friendly and educational – more than the PEDS and the Denver II, in our opinion.

Regardless of which standardized developmental screening tools you use, it's important to make sure they work well for your practice (e.g., ease of use) and for your patient population (e.g., how many of your referrals are found to be eligible for early intervention services).

For a comparison of developmental screening tools, here's a link to the PEDIATRICS July 2006 AAP policy statement, Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening:

<http://aappolicy.aappublications.org/cgi/content/full/pediatrics;118/1/405>

Please feel free to contact me with any questions or comments at [Campbell.william@tchden.org](mailto:Campbell.william@tchden.org)

## **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](mailto: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**

[www.cchap.org/nl20/#7](http://www.cchap.org/nl20/#7)

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

[www.cchap.org/nl20/#7](http://www.cchap.org/nl20/#7)

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*

FAMILY  VOICES  
COLORADO



## **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](http://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](http://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](mailto: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.