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**4th Cross-Cultural Health Care Conference:
Collaborative and Multidisciplinary Interventions; January 16-17, 2015**

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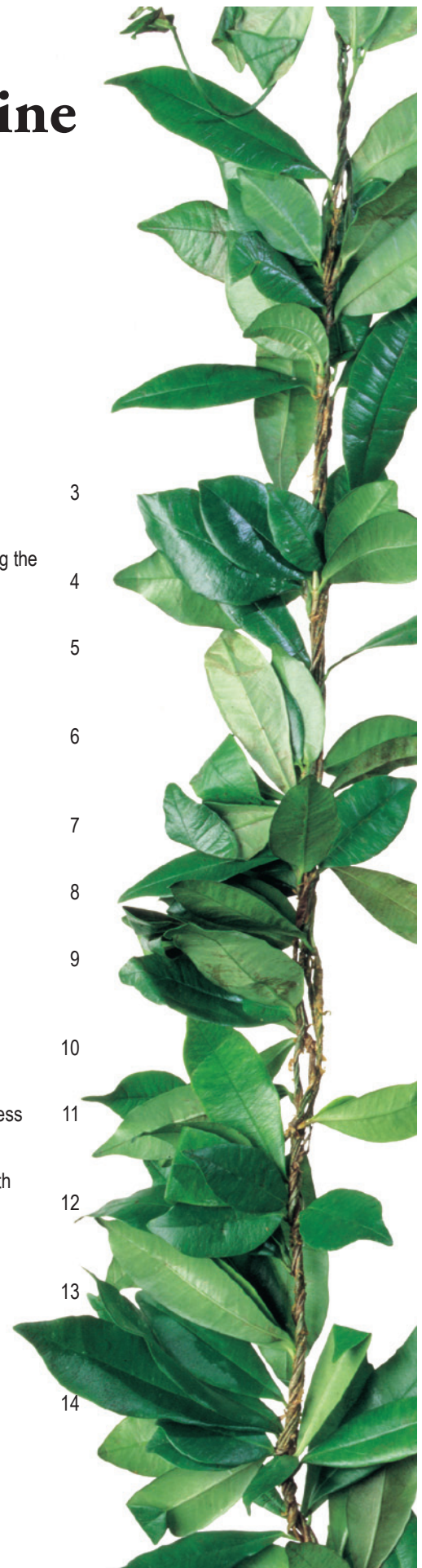
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4th Cross-Cultural Health Care Conference: Collaborative and Multidisciplinary Interventions, January 16-17, 2015

Maria B.J. Chun PhD, CHC, CPC-A and Danny M. Takanishi Jr. MD, FACS; Co-Guest Editors

The *4th Cross-Cultural Healthcare Conference: Collaborative and Multidisciplinary Interventions*, which was held on January 16-17, 2015, is a biennial symposium designed to provide an overview of critical issues facing healthcare professionals who care for diverse patient populations. This symposium, as well as those previously held, provided a forum to discuss the prevailing, cutting-edge, “evidence base” regarding cross-cultural healthcare training and treatment interventions. Utilizing a broad, multidisciplinary perspective, the focus was on how cultural factors can and have been incorporated into the training of healthcare professionals and how culture can potentially influence treatment decisions. The content of presentations and workshops demonstrated how specific interventions can be and have been implemented in educational, community, and private practice settings. Case-based discussions and instruction on use of tools, both validated and evolving, to assess cultural competency in individual treatment, training programs, and healthcare organizations were presented.

The objectives of the conference were to:

1. Identify the role of culture in the delivery of care in various healthcare settings (eg, clinic, hospital, community-based);
2. Demonstrate whether healthcare information (both verbal and written) is presented in a culturally and linguistically appropriate manner; and
3. Utilize existing cross-cultural healthcare resources to aid in the training of healthcare professionals, the delivery of care, and/or conduct of research.

One special feature of this year’s conference, generously supported by an educational grant from The Doctor’s Company Foundation, was the attendance of 113 students from medicine, nursing, psychology, and public health, as well as eight residents in training. We welcomed 244 participants from Hawai’i and the continental U.S., in addition to colleagues from Australia, Canada, New Zealand, and the United Kingdom. Making a welcome return to the plenary sessions were renowned Harvard scholar Joseph Betancourt, MD, MPH, who spoke on the role of culture in patient-centered care, and the Deans’ panel, comprised

of Dean Jerris Hedges (JABSOM), Dean Mary Boland (Nursing), Dean Noreen Mokuau (Social Work), Dean Maenette Benham (School of Hawaiian Knowledge), and Director Kathryn Braun (Public Health), who presented their collaborative efforts to eliminate health disparities and promote interdisciplinary learning and research. First-time speakers included Tawara Goode, from Georgetown University, who captivated the audience with the video vignettes incorporated in her presentation on training and mentoring minority students.

Afternoon breakout sessions allowed attendees the opportunity to learn more about regulatory updates regarding culturally and linguistically appropriate services, tools being developed to measure the efficacy of cultural competency, and the great community-based work of organizations such as Kokua Kalihi Valley.

Following are selected abstracts from the symposium by faculty who opted to share their work via this venue. The entire conference agenda can be viewed at www.cchc-conference.com. The 5th biennial conference will be held on February 17-18, 2017.

Conflict of Interest

The authors report no conflicts of interest.

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Shared Decision Making & Patient Decision Aids in Diverse Patient Populations: Applying the Latest Innovations in Cultural Targeting and Tailoring in Your Health Care Practice

Dana Alden PhD; Maria L. Jibaja-Weiss EdD; and Chirk Jenn Ng MMed, PhD

Culturally sensitive patient decision aids (DAs) play increasingly important roles in encouraging shared decision making (SDM) among patients with diverse value orientations. Drawing on a recently published paper (<http://www.sciencedirect.com/science/article/pii/S0277953614000057>), Professor Alden presented the advantages and challenges of cultural targeting and tailoring DAs. Incorporation of cultural psychology theories and measurement scales provided participants with a deeper understanding of how culture can be operationalized in the development of DAs. A model that emphasizes the interaction of culture, individual differences and context was offered to assist participants with production of their own health communication tools. Thereafter, two SDM interventions that used cultural targeting and tailoring in DA development were presented. The first case from Dr. Maria Jibaja-Weiss focused on “A Patchwork of Life: One Woman’s Story” — a web-based, publicly available DA that addresses the cultural and linguistic needs of medically underserved women with early stage breast cancer and prepares them for making informed decisions (www.bcm.edu/patchworkoflife). It emphasizes the particular needs of ethnic women (Hispanic and African-American) in the United States with lower literacy and limited computer experience. The second case, presented by Dr. Chirk Jenn Ng, emphasized the importance of considering cultural values during the development of DAs in diverse multicultural settings such as Kuala Lumpur, Malaysia. The “Decision Making on Insulin Therapy (DMIT) DA” aims to enable patients with type 2 diabetes mellitus from diverse backgrounds to make informed decisions about starting insulin. The DA comes in booklet, *iPad* application and website versions and is available in four languages. Challenges faced during implementation of the DA reinforced the importance of considering the local healthcare culture, religion and health beliefs, family roles, and health-related myths (<http://dmit.um.edu.my>).

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Diversity Leadership from the Inside Out

Janice L. Dreachslin PhD

Diversity best practices are far more common now than in the 1990's when the concept of strategic diversity management first captured the attention of American business leadership. The business case for diversity and inclusion is supported by over two decades of research and experience. And, cultural competence and diversity management in health care are mainstream practices, supported by the Affordable Care Act and prominent national organizations including the AHA, ACHE, ACGME, NCQA, NQF, and others. But far too many health care organizations still don't treat diversity management as a business imperative and a driver of strategy, and we have yet to achieve full inclusion in the workplace and amelioration of disparities in health and health care. Recently published results from the Institute for Diversity in Health Management's Benchmark Study of US Hospitals (AHA 2012), found that while 77% of responding hospitals collected the recommended patient demographic data, only 18% used these data to benchmark gaps in care. Fewer than half provided comprehensive cultural competency training; only 54% had strategic planning goals for improving care for culturally and linguistically diverse patient populations, and fewer than 40% for recruiting and retaining a diverse workforce. Why have health care organizations been slow to adopt a strategic approach to diversity management? Results from the recently completed National Center for Health-care Leadership (NCHL) Diversity Demonstration Project are used to address this question. Two health systems participated in the demonstration project, each providing an intervention hospital and a control hospital. The pre-post intervention assessment battery evaluated the impact of systematic interventions on organizational practices, individual diversity leadership competencies, and organizational outcomes. Results point to greater pre-post improvement at the intervention as compared to the control hospitals. Findings support adoption of a systems approach to strategic diversity management in tandem with training and executive coaching to develop diversity leadership skills, knowledge, and abilities, focusing first on senior hospital leadership.

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**4th Cross-Cultural Health Care Conference:
Collaborative and Multidisciplinary Interventions, January 16-17, 2015**

— Invited Speakers —

**Future Role of the College of Health Sciences & Social Welfare:
Inter-Professional Cross-Cultural Diversity**

Noreen Mokuau DSW; Jerris Hedges MD, MS, MMM; Mary Boland DrPH, RN, FAAN;
Kathryn L. Braun DrPH; and Maenette Benham EdD

The health professions contain distinct professional cultures. These cultures are reflected in professional attire, titles, organizations, and working relationships. At times these professional cultures may clash and get between the health professionals and the needs of the patient/family. Yet, cultures also are of value in setting public and professional expectations (ie, standards of care). Health care is being re-designed. The future will see a blend of population-based, outcomes focused (systems) and individual-need focused (personalized) care. This dualism balance will impact both prevention—primary care and specialty care. There also will be a gradual evolution of reimbursement for care designed to avert futile care, especially by specialists. The implications for the College is that inter-professional education using simulation will need to help learners identify situations when the team should be following standard care protocols and when an individualized deviation (including implementation of comfort care) is needed. Communication between team members and the patient/family will be critical to successful outcomes. Thus, educational curriculum will increasingly be team based, systems & outcomes focused while attuned to patient/family perceptions and needs. These approaches will be guided by inter-professional care research that addresses both patient needs and population-based outcomes.

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**4th Cross-Cultural Health Care Conference:
Collaborative and Multidisciplinary Interventions, January 16-17, 2015**

— Invited Speaker —

College of Health Sciences and Social Welfare: *Kahua Hana*

Maenette Benham EdD

The vision and mission of the University of Hawai‘i at Manoa (UHM) states that we will gain international recognition as a leading land, sea, and space grant university because our work is grounded in the traditional values of our host culture that insists that we strive for excellence in teaching, research, and community engagement while promoting environmental sustainability and human justice. The College of Health Sciences and Social Welfare lives into this vision and mission as they move toward cross-sector convergence in which the barriers between traditional sectors are being redefined. The fire that drives this collaborative is the spirit of commitment and willingness to address complex problems both pragmatically and innovatively in an interdisciplinary, intra- and inter-organizational manner that is informed by a *Kanaka ‘Oiwī* worldview. The *kahua*, the foundational pillars that define collective advocacy for the health and well-being of our people are embedded in three value propositions. First, *He ali‘i ka ‘aina, he kauwa ke kanaka* (The land is chief, the people are its servants). The idea of ‘*aina* confronts the constructed barriers between our colleges, our families, and our communities. The notion that knowledge and learning occurs only in the schoolhouse and nowhere else is disputed by ‘*aina* because the relationships and reciprocity of ‘*aina* reclaims the idea that valuable learning occurs in multiple ecosystems. So, to embrace ‘*aina* compels the health sciences to *ho‘opili*, to link together the spiritual, physical, intellectual, and ecological well-being of people and place. Second, ‘*A‘ohe pau ka ‘ike i ka halau ho‘okahi* (All knowledge is not contained in one source). This speaks to the concept of relations. Each of the units that comprise the collective tirelessly navigate the complex webs of their diverse communities and contexts. They explore and apply knowledge to ensure the life and vitality of our people and our communities. This work is strengthened by their commitment to work together to achieve greater collective impacts; to ensure the health and well-being of all of Hawai‘i’s people. Third, *Mai ka piko o ke po‘o a ka poli o ka wawae, a la‘a me na kīhi ‘eha o ke kino* (From the top of the head to the bottom of the feet and all four corners, the body is sacred). Abundance is the clarion call of this final *kahua*. The message that you will hear from this consortium is not one of deficit.

This final value speaks to the significant commitment that this college has made to work collectively in and with community through an asset-oriented perspective. Their work is to *kako‘o*, to support community members to “re-vision” their lives as powerfully vibrant and healthy in a more *pono* place.

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**4th Cross-Cultural Health Care Conference:
Collaborative and Multidisciplinary Interventions, January 16-17, 2015**

— Invited Speaker —

College of Health Sciences and Social Welfare

Mary G. Boland DrPH, RN, FAAN

In 2013 the Deans from the School of Nursing and Dental Hygiene, Myron B. Thompson School of Social Work, John A Burns School of Medicine, and the Director of the Office of Public Health Studies, activated the UH Manoa College of Health Sciences & Social Welfare (CHSSW). We are joined in this effort by the Dean of Hawai'i inuiakea School of Hawaiian Knowledge (our *hanai* sister). The mission of the College is to serve society by increasing, refining, disseminating, applying, and sharing knowledge, wisdom, and values relating to the health and social welfare concerns of the public with a deep appreciation for culture within the context of social and economic determinants that impact health. We recognize that improving health requires an interprofessional approach to advancing education, practice, research, and community service. Second, we must be responsive to the increasing cost of academia and the loan burden of our students. By leveraging existing assets and resources, we can expand our individual reach and steward precious human and fiscal resources. We consulted with our respective faculties and executed a formal Memorandum of Understanding whereby each school maintains its autonomy and governance. We meet regularly as a Council of Deans and have prioritized three areas for joint action based on state need: Native Hawaiian health; gerontology; and interprofessional education (IPE). To date, CHSSW has engaged faculty leaders to set the agenda for IPE; expanded interprofessional research; and share core services for biostatistics, grant development, and technology based learning. We have a clinical practice plan that includes both medicine and nursing (UCERA) and participate in a program to retain Hawai'i primary care providers that includes loan repayment for physicians, physician's assistants and nurse practitioners. The *kahua*, the pillars that define our collective relationship, are our guide as we begin this journey.

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**4th Cross-Cultural Health Care Conference:
Collaborative and Multidisciplinary Interventions, January 16-17, 2015**

— Invited Speakers —

***Ha Kupuna*: National Resource Center for Native Hawaiian Elders**

Kathryn L. Braun DrPH; Colette Browne MSW, DrPH; and Noreen Mokuau DSW

Native Hawaiian elders are recognized as sources of wisdom and transmitters of knowledge to younger generations. Unfortunately, Native Hawaiians experience poorer health than other ethnic groups in Hawai'i. Established in 2006, the goal of *Ha Kupuna*: National Resource Center for Native Hawaiian Elders at the University of Hawai'i at Manoa is to create and disseminate knowledge on the health of *kupuna* (elders) to improve *kupuna* health and the delivery of services to them. Researchers affiliated with *Ha Kupuna* emphasize an interdisciplinary approach, which draws from the College of Health Sciences and Social Welfare (CHSSW), with primary emphasis from social work and public health. The Center has conducted numerous quantitative and qualitative studies over the past decade. Findings from quantitative studies confirm that Native Hawaiians continue to have the lowest life expectancy and highest rates of death before age 70 compared to Japanese, Filipino, and Caucasian residents. Findings from qualitative studies suggest that Hawaiians elders may be unaware of their worse health status. Like other ethnic groups, however, they prefer to age in place and receive respectful and accessible services. While family members are the primary caregivers, meeting the challenges of aging requires additional resources and support. Data are synthesized and presented through multiple avenues accessed by Native Hawaiian communities, scholars, and instructors in the CHSSW. For example, an article in *The Gerontologist*, assigned in several UHM classes, which summarizes health data from research by *Ha Kupuna* and other CHSSW researchers, posits reasons for poorer health among Native Hawaiian elders, and recommends changes to practice that will improve outcomes. Along with its two sister National Resource Centers for Native Elders—in Anchorage and in North Dakota—*Ha Kupuna* won the 2015 award for excellence in multicultural aging from the American Society on Aging.

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— Invited Speakers —

RMATRIX II: Multidisciplinary Collaboration in Health Disparities Research in the College of Health Sciences and Social Welfare (CHSSW)

Jerris Hedges MD, MS, MMM and Noreen Mokuau DSW

While Hawai‘i enjoys the status of being the “healthiest state” in the nation, there are still many people who experience disparate health. RMATRIX-II (2014-2019), the RCMI Multidisciplinary And Translational Research Infrastructure eXpansion program provides an infrastructure for research that improves health and reduces health disparities particularly among Native Hawaiians, Pacific Islanders, and Filipinos. The strategic goals of the program are to: (1) foster clinical and translational disparities research, (2) build institutional and community synergy, and (3) advance career development and mentoring of health disparities investigators, with priority in the areas of nutrition and metabolic health; growth, development and reproductive health; and aging and chronic disease prevention/management. Due to growing evidence that effective health care is delivered by coordinated multidisciplinary teams RMATRIX-II supports investigators across the CHSSW and throughout the University of Hawai‘i system who engage in multidisciplinary research with special attention to community-based partnerships. Support is provided in core functions including Professional Development, Collaborations and Partnerships, Community-Based Research, Biostatistics and Health Sciences Data Analytics, Regulatory Knowledge and Support, and Clinical Research Resources and Facilities, with an Evaluation component to provide overall assessment. In order to optimize services, RMATRIX II works with other large NIH funded projects to leverage resources. A special feature of the RMATRIX-II is its pilot project program which supports investigators through mentorship, educational forums, linkages to other resources, and competitively, with financial support. In creating a strong foundation for multidisciplinary health disparities research, RMATRIX II is striving to create a healthier place for the diverse peoples of Hawai‘i.

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**4th Cross-Cultural Health Care Conference:
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— Invited Speaker —

The Culturally and Linguistically Appropriate Services (CLAS) Standards, Hawai'i's Language Access Law, and the Office of Language Access

Serafin Colmenares Jr. PhD

Since the adoption of the CLAS standards as a policy by the Office of Minority Health, many states have tried to implement it either through the passage of language access laws or legislation requiring some form of cultural competency training for all or part of their workforce. Hawai'i passed its comprehensive language access law in 2006 and unsuccessfully proposed legislation in 2013 which would have required multicultural health awareness and education training for nurse's aides. Hawai'i's language access law not only requires all agencies receiving state funds (including county and nonprofit agencies) to establish and implement language access plans, but also established an office of language access (OLA) to provide oversight, central coordination, and technical assistance to state funded agencies in their implementation of the requirements of the law. In addition, OLA monitors state agencies for compliance, and resolves complaints on language access through informal methods. Since its establishment in 2007, OLA has undertaken various projects and activities that support CLAS—particularly standards 5-8 (communication and language assistance). It educates the public about language access, the Limited English Proficiency (LEP) population about their rights, and the agencies about their responsibilities. It has held annual conferences focusing on cultural and linguistic competency, held trainings and workshops for both agencies and language service providers, and passed legislation establishing a language access resource center and multilingual website. In addition, it has supported the Hawai'i Language Roadmap Initiative, the establishment of a single state contract for translation services, and has proposed legislation for state certification of health care interpreters. The diversity of Hawai'i's cultures and languages is a huge challenge, but OLA hopes to further promote and ensure cultural and linguistic competency in Hawai'i the best it can.

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— Invited Speaker —

National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care

Gerald Ohta MPH

The existing national CLAS guidance standards were enhanced in 2013 by the Office of Minority Health, US Department of Health and Human Services. Former Surgeon General Regina Benjamin reminded us that if our patients don't understand us well enough to make good health-care decisions, we didn't treat them. CLAS is intended to improve quality and help eliminate health care disparities. The fifteen standards are a blueprint for providing effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. The standards address three areas—governance, leadership, and workforce; communication and language assistance; and engagement, continuous improvement, and accountability. While they are “not statutory” and are of “equal importance,” many elements are required for accreditation and the communication and language assistance standards are required for federally assisted agencies to help meet Title VI, Civil Rights Act, requirements. Failure to do so may result in withdrawal of federal assistance or administrative review or suit. Responsibility is with both the provider and client, although legal responsibility is generally that of the provider.

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**4th Cross-Cultural Health Care Conference:
Collaborative and Multidisciplinary Interventions, January 16-17, 2015**

— Invited Speakers —

Sustainable Health-Care Insurance for the COFA Micronesian Migrants in Hawai'i: A Challenge for Hawai'i and for Its COFA Residents

Neal A. Palafox MD, MPH; Sheldon Riklon MD; Joakim Peter; Innocenta Sound-Kikku; Gavin Thornton JD; Barbara Tom RN, PHN; and Noda Lojkar

Developing a rationale and sustainable health-care insurance program for vulnerable Micronesian Migrants from the US Compact of Free Association (COFA) Pacific Island nations residing in Hawai'i has been challenging. Our goal is to assess the operationalization and impact of the current plan to provide health-care coverage for the COFA migrants through the Affordable Care Act (ACA), the Hawai'i Health Connector (HC), and the Hawai'i Department of Human Services (DHS). The assessment is made in the context of the HC/DHS efforts to: provide comprehensive health-care insurance coverage, achieve the stated \$27 million dollars cost savings for the State of Hawai'i, and to solve the practical challenges of implementing health insurance coverage through the HC. A descriptive narrative regarding the process and outcomes of HI's effort to provide health-care insurance for the COFA migrants will include, (1) the history of the COFA, (2) the history of health-insurance coverage for the COFA migrants in the United States, (3) the 2015 dialogue and problem solving that is taking/took place between HC/DHS and the COFA migrants, (4) the impact on Hawai'i's general population and health system, (5) the impact on the COFA migrants, and (6) the sustainability of the HC/DHS plan. The justification of this assessment is to illustrate how implementation of the HC/DHS plan requires comprehensive planning and active participatory engagement of the COFA community to ensure success.

Conflict of Interest

The authors report no conflicts of interest.

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HI-PRAISE: Implementation of Incentives Program to Improve Chronic Diseases among Medicaid Recipients

Ritabelle Fernandes MD, MPH; Chuan C Chinn PhD; Rebecca Rude Ozaki PhD; Dongmei Li PhD; Tim Frankland MA; Robin Arndt MSW; Misha Tajima MEd, MBA; Uyen Vu MS; and Zi Wang MS

The Hawai'i Patient Reward And Incentive to Support Empowerment (HI-PRAISE) Project is a health economics demonstration grant focused on the use of incentives to improve chronic disease management for adult Medicaid recipients with diabetes. The goal of the HI-PRAISE project is to assess the implementation and effectiveness of an incentives program in patient-centered medical homes at nine federally qualified health centers (FQHCs). An incentives satisfaction survey was administered to participants at three FQHCs in November 2013. Focus groups were conducted in May 2014 for the HI-PRAISE participants as well as for the FQHC staff implementing the project. A semi-structured interview was developed to elicit the key domains, with follow up probes to elicit details. Open-ended questions that were asked in the focus groups revolved around choice of incentives, cultural issues, challenges, and program integration into patient-centered medical homes. Of the 56 survey respondents, 100% agreed that rewards were given to them on time and 98% agreed that rewards helped set goals. Eighteen participants and twenty-three FQHC staff participated in the focus groups. There was high participant satisfaction with the incentives program and average incentive amount was \$20. Program managers mainly chose gift-cards over cash incentives for ease of administration and tracking. Health coaches and diabetes care coordinators have observed improve access to behavioral health and vision services through the use of incentives. Barriers identified were related to transportation and child-care. Implementation of incentive programs requires buy-in from key players at the FQHCs. Incentives may improve access and reduce barriers for persons with chronic diseases.

Conflict of Interest

The authors report no conflicts of interest.

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**4th Cross-Cultural Health Care Conference:
Collaborative and Multidisciplinary Interventions, January 16-17, 2015**

— Breakout Session Speaker —

Native Hawaiian Model of Drug Prevention

Susana Helm PhD

A community-university partnership to develop a Native Hawaiian model of drug prevention was initiated in 2006 by a rural Hawaiian community. We are using a participatory action research approach in which youth, elders, and other community leaders have developed the framework for an intervention based on Hawaiian epistemology. The intervention development phase was described at the Cross Cultural Health Care Conference in January 2015, which was based on a youth photovoice project (UH IRB approved). Qualitative analyses highlighted the youths' and their adult leaders' experiences and recommendations in order to improve future implementation and evaluation processes and outcomes. Analyses were further clarified and validated in a series of community-wide cultural auditing activities. Highlights include using the lunar calendar for implementation cycles in which traditional practices are engaged (eg, *loko ia*; *loi kalo*; *hula, mele, oli*), along with didactic activities mirroring the prior photovoice and PAR techniques. In conclusion, the Native Hawaiian population has experienced geo-political and socio-economic colonization for over 200 years. Colonization and marginalization has continued in the present day in terms of Hawaiian populations having been excluded from the evidence base on what works in prevention. As a result, few interventions have been developed with Hawaiian epistemology at the core. This program of research demonstrates that a community-university approach to participatory action research has potential for repositioning Native Hawaiians as leaders in developing the evidence to eliminate substance use and related health disparities in their communities.

This presentation is based in part on the following manuscript: Helm S, Lee W, Hanakahi V, Gleason K, McCarthy K, Haumana. 2015. Using photovoice with youth to develop a drug prevention program in a rural Hawaiian community. *American Indian and Alaska Native Mental Health Research*. 22(1),1-26. doi: 10.5820/aian.2201.2015.1 (Haumana: haumana refers to the apprentices/students (about 20 people), from both the community and the university who contributed to the project since its inception).

Conflict of Interest

The authors report no conflicts of interest.

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**4th Cross-Cultural Health Care Conference:
Collaborative and Multidisciplinary Interventions, January 16-17, 2015**

— Breakout Session Speakers —

Activity and Diet Assessments with Wearable Technology in a Rural Setting

Jillian Inouye PhD, APRN, FAAN; John Mercer PhD; Connie Mobley PhD;
Mohamed Trabia PhD; Du Feng PhD; Katharyn Daub PhD; and Kirsten E. Connelly MPH

Because of the importance of accurately measuring and reinforcing diet and activity, it was hypothesized that wearable technology will improve physical and dietary assessments. A feasibility study using single group repeated measure design was used to recruit a convenience sample of nine participants (seven females, two males) from a rural Federal Qualified Community Health Clinic in Hawai'i (two patients diagnosed with type 2 diabetes for 15 and 5 years, respectively; and seven staff members). Of the nine participants between 30-62 years of age Mean=43, SD=13.05), seven were Asian American/Pacific Islanders. Following informed consent, demographic and 24-hour diet recall measures were obtained on the first and third day. On the first day, participants were given a pedometer, Fitbit®, and camera to track dietary intake along with physical activity. On the third day, a satisfaction questionnaire was obtained and incentives distributed. Information on steps walked was downloaded as well as pictures before and after each meal. Participants found the Fitbit® to be unobtrusive and easy to use and reinforced increasing their physical activity; however, success using the watch was highly variable with the number of picture attempts ranging from 4–16 across the three days. Results from the 24-hour diet recall indicated diets higher in fats and added sugars and lower in proteins than recommended daily values. In conclusion, the use of wearable technology as a means for intervention to modify physical activity and diet behavior will ultimately be dependent on the ease of use as well as the quality of data returned to the user. It was also recommended that further studies include using wearable devices that allow the subject to view the picture taken immediately, having a researcher who is familiar with local cuisine to accurately assess dietary intake, and access to the number of steps taken to reinforce activity.

Conflict of Interest

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Cultural Orientation and Information Framing: A Theoretical Approach for Enhanced Cancer Treatment

Ekaterina V. Shapiro BS and Jon M. Shapiro PhD

This study examines the process of information framing in the introduction of medical alternatives to patients within disparate ethnic and socioeconomic backgrounds. Based on Systems Theory, this research considers how healthcare providers can deliver critical information strategically, that factors-in sociocultural backgrounds and learning styles. While assisting within a privately-owned hospital setting with cancer survivors, clients' communication styles and treatment challenges were ascertained. Over a two-year period, outreach policies that reflect the holistic conditions of the clientele were developed. Overall, information framing affects client decisions, enhances dyadic communications, and leads to improved medical solutions. When providing treatment programs to temporary cancer survivors, information delivery utilizing a synthesis of cultural theoretical perspectives introduced by Hall and Hall (1987), Hofstede (1991), and Kluckhohn and Strodtbeck (1961) helps facilitate more effective treatment decisions and enriches physician-client relationships. Among the variables of highest strategic importance are context, human-nature, man-nature relationship, face, and guilt versus shame. Principal examples demonstrate interrelationship between information framing and cultural factors. For instance, high-context clients tend to benefit from more verbal and visual depictions, as well as enhanced interactions with multi-hospital-stakeholders to make optimal decisions. Additionally, information regarding treatments, as well as drug access and affordability, should be introduced early within the process and as a highly salient attribute among face, high-context, and lower-socio economic clientele. Overall, it is critical that healthcare stakeholders are provided with information based upon cultural backgrounds. Corresponding materials were developed throughout the study that reflect different learning styles and cultural backgrounds.

Conflict of Interest

The authors report no conflicts of interest.

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Black and Minority Ethnic Communities and Dementia: Where are We Now?

David Truswell BSc, MSc, MBA

This paper was produced for the Race Equality Foundation's *Better Health* briefing paper series. The Race Equality Foundation is a United Kingdom (UK) not-for-profit organisation that seeks to influence national policy on support and services for black and minority ethnic communities by developing evidenced-based better practice to promote equality. This briefing looks at developments in the UK since the launch of the National Dementia Strategy in 2009. It uses census data to estimate the number of black and minority ethnic people living with dementia in the UK, and proposes innovative solutions for care, including the use of community dementia navigators. The briefing argues that: (1) existing UK policy recommendations have not been taken into account when developing information and services to meet the needs of black and minority ethnic communities; (2) the prevalence of dementia in some black and minority communities in the UK has been significantly underestimated; (3) dementia is misunderstood and highly stigmatised in many UK black and minority ethnic communities; (4) there is an economic case for financing improvements in "living well" with dementia for people in black and minority ethnic communities; and (5) there should be a vision of a culturally appropriate approach to the dementia pathway that starts from raising awareness, leads to facilitating early diagnosis, and lasts into appropriate end-of-life care.

Conflict of Interest

The author reports no conflict of interest.

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Applications of The Cultural Awareness, Skill, & Knowledge (C-ASK) Interview Tool: Cultivating Cultural Competence

Ann-Marie Yamada PhD

Culturally competent practice requires an examination of one's own attitude and values, and the acquisition of the values, knowledge, skills, and attributes that allow an individual to work appropriately in cross cultural situations (MCHB, 1999). The Cultural Awareness, Skill, & Knowledge (C-ASK) Interview Tool was developed in a diverse urban community mental health setting to help practitioners gain awareness of the cultural background and social issues of their patients (Yamada & Brekke, 2008). While administering the tool is straightforward, training providers to use the information generated from this interview tool is a challenge that has received little attention. Determining how to best train providers to cultivate the cultural data in a way to promote competent practice is imperative and was the focus of our current phase of research. In-depth follow-up qualitative interviews were conducted with ten mental health care providers trained to administer the C-ASK. Providers were asked to identify key sociocultural issues identified through the C-ASK administration. Results indicated that providers struggled to identify such content. Challenges impeding their use of this tool included limited time for assessment, lack of integration of the tool into routine practice, and common cognitive errors such as selective or inaccurate observation of the obtained information. To address these barriers we developed an additional 90 minute training session to demonstrate effective ways to: (1) link cultural assessment with meaningful outcomes, (2) adapt the tool to agency/client needs, and (3) share findings with patients to prioritize treatment goals and shared decision making. Through additional training and resources (eg, a patient interview video, sample billing, case notes) it is hoped that providers will be able to cultivate sufficient skills to do more than elicit sociocultural issues; providers must extract the relevant data and apply it to meaningful patient goals and treatment plans. Pilot testing of these applied training materials will be conducted to further determine the most efficacious means of capturing and applying the information gleaned from the C-ASK interview.

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Guidelines for Teaching Cross-Cultural Clinical Ethics

Fern Brunger PhD

This paper describes an innovative curriculum in cross-cultural clinical ethics developed by faculty in the Health Ethics and Law program at one Canadian university. The pedagogical approach explicitly uses the notion of relativism in bioethics to encourage (rather than compromise) the use of a standard western bioethics framework for ethical decision-making. It offers an argument, at the intersection of medical anthropology and bioethics, for a pedagogy in ethics that encourages clinicians to challenge Euro-American constructs such as “autonomy” while simultaneously working within a principles-based framework for ethical decision-making. This approach is based on the premise that training in cross-cultural clinical ethics requires a “critical consciousness” approach to cross-cultural health care. Such an approach is enhanced by the use of cases that illustrate how the ideas and practices of medicine itself are culturally embedded and socially, economically, and politically constituted. A pedagogical approach to clinical ethics that works from within a critical consciousness framework encourages a critique of Euro-American based normative assumptions of bioethics while working within a principles-based framework for ethical decision-making. The curriculum features six key learning points taught through case-based discussion. The learning points emphasize culture in its relation to power and underscore the importance of viewing both biomedicine and bioethics as culturally constructed.

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The author reports no conflict of interest.

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The Journey: Living Cancer Out Loud Narrative Intervention and Community-Based Participatory Research (CBPR) in Breast Cancer Health Literacy

Olga Idriss Davis PhD and Tenisha Baca MA

Translating survivor narrative data into effective prevention messages and strategies for African American women that can be disseminated widely within the community, shows that narrative discourse, or stories, as a mode of health literacy, can support culture-based health intervention efforts. Why is it important to culturally promote a health literacy intervention using narrative performance? Our goal is fourfold: (1) to highlight the lived experience of breast cancer survivors and caregivers in the African American community of Phoenix, AZ; (2) to educate audiences through narrative performance; (3) to raise awareness of breast cancer screening, diagnosis, education, and survivorship through sharing the story, and (4) to demonstrate how narrative performance can be a viable avenue for breast cancer health intervention. Using Community-based Participatory Research (CBPR) forged community-driven recruitment and selection of participants from Coalition of Blacks Against Breast Cancer (CBBC). Participatory collaboration with CBBC for structured interviews N=6: 3 survivors, 2 caregivers, 1 both survivor, and caregiver. Structured interviews were 2.5 hours per participant. Prompts were derived from survivor focus group and narrative theoretical framework. Interview data was coded and common themes emerged in interpretive analysis. Narrative data were translated into breast health and prevention messages that coded lived experience as personal data. Script was crafted based on narrative theory and shared decision-making efforts with community participants. Adaptation of the script became structured monologues for narrative performance, where the voice of survivors and caregivers of CBBC guided, transformed, and translated the development of the narrative intervention naming it, *The Journey: Living Cancer Out Loud*. Important themes emerged from interviews and served as a foundation for writing the script—*Spiritual uplift; Family; Overcoming adversity; Hair stories; Share your story/community; and Taboo*. The study concludes with next steps/best practices in the CBPR process with publically-held auditions of local actors, talk-back with audience at post performance, and pre-post test design to evaluate the efficacy of narrative performance.

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The authors report no conflict of interest.

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Migrant Seasonal Farmworker Health Care in Southwest Michigan: Models for Successful Cross Cultural Intervention

Jonathan Hagood PhD and Clara Schriemer

Recent studies report that 94,167 migrant seasonal farmworkers (MSFW) and their family members reside in Michigan, and many are Hispanic. Because social determinants of health persist across generations, significant improvement to MSFW health care is challenging and requires the work of champions who battle for the rights of the underprivileged. Dr. Vern Boersma, a pediatrician who began his work in the 1950s, and Carolee Besteman RN, who began her work in the 1990s, each championed the cause of MSFW health care in southwest Michigan for decades. Models for successful intervention into community health issues are numerous, highlighting effective characteristics such as inter-sectoral actions, partnerships, and community outreach. Although the importance of collaboration and cultural sensitivity to health care intervention is well established at the organizational level, illustrations of these traits at the personal level, particularly in cross-cultural contexts, is lacking. Using archival records and oral history interviews with Boersma, Besteman, and migrant farmworkers, the project presents Boersma and Besteman's contributions as a model for successful cross-cultural health care intervention. This analysis assesses cultural sensitivity as defined by Resnicow, et al, in "Cultural Sensitivity in Public Health: Defined and Demystified" (1999) and collaboration as defined by Roussos and Fawcett in "A Review of Collaborative Partnerships as a Strategy for Improving Community Health" (2000). The project proposes that improvements to cross cultural health care require champions who are culturally sensitive and work collaboratively to facilitate gains in wellness and institutional strength.

Conflict of Interest

The authors report no conflict of interest.

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Needs Analysis for Home Care Workers in Hawai'i

Kendi Ho MA

Foreign-born workers or immigrants have been increasing in long-term health care, but may lack the language, training, and cross-cultural competence to be successful in home care.¹ The purpose of this study was to determine the areas of cross-cultural competence, types of skills training employers in Hawai'i need for their immigrant workers, as well as how certification was valued. Using a mixed methods approach, an online survey, with three checklist items, 18 five-point Likert-scale items, and 13 open-response items, was developed from five semi-structured interviews with directors of home health and home care agencies, and a coordinating volunteer elder care program, and sent to care agencies throughout Hawai'i. Interpretation of qualitative data, using grounded theory, informed, confirmed and expanded descriptive and Principal Component Analysis (PCA) of Likert-scale data. High internal-consistency reliability (Cronbach's $\alpha = 0.816$) for these items indicates consistent measurement. A 0.30 cut-point for magnitudes of five components, guided understanding relationships of variables. Fifteen employers identified a need for training in three main areas: (1) cross-cultural competency to communicate with the elder, the family, and the office staff, (2) literacy skills to complete assessments and reports, (3) initial and ongoing Alzheimer's training. Some employers further indicated clients' negative perception of immigrant workers' accents. Results validate research literature that cross-cultural competence and compassionate qualities are esteemed, but also indicate that employers value these qualities over certification. Future research into the perspectives and needs of all stakeholders is necessary to build a defensible language curriculum to bridge the cross-cultural communication and literacy disparity.

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The author reports no conflict of interest.

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Reference

1. Brown CV, Braun, KL. Immigration and the direct long-term care workforce: Implications for education and policy. *Gerontology and Geriatrics Edu.* 2001;29(2):172-188.

Breast Cancer and Clinical Breast Exams: Linguistically and Culturally Focused Ways to Provide Educational Information to Filipino Women in Waipahu, Hawai'i

Pamela Miyashiro RN, MSN and Patricia Burrell PhD, APRN, BC, CNE

The large number of breast cancers diagnosed in Asian women in general, and in Filipino women in particular, is partially attributed to lack of screening on the part of the client and lack of understanding of their cultural ways on the part of the primary care provider. Providing education about Breast Cancer and clinical breast exams by an advanced practice nurse (APRN) in the three major dialects, Ilocano, Tagalog, and Visayan, spoken by the Filipinos in Waipahu, Hawai'i, will improve the preventative health practices of the women of that community. Educational information on breast health and familiarity with one's own breast was provided by the APRN, as well as a clinical breast exam, explaining what the women needed to do at home. The study was supported by the Susan G. Komen Fund and the Filipino Cultural Center, and was approved by the Hawai'i Pacific University IRB. Questionnaires in their specific dialects about their breast health/cancer knowledge were provided pre-education, services were provided in dialect, and a post-survey about their satisfaction with the whole process in their dialects was also provided to the 30 participants. Analysis indicated that 50% had no knowledge about breast cancer and the purpose of screening. Twenty percent believed injury lead to breast cancer and 30% had misinformation. Overall, the majority indicated no knowledge about breast cancer. They noted that doctors and screening weren't available in the Philippines. And they didn't mention the word cancer because it might bring about the disease. All participants were very satisfied with the linguistically, culturally focused education about breast cancer and how to do a correct self-exam through demonstration by the APRN during the clinical breast exam.

Conflict of Interest

The authors report no conflicts of interest

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Cultural Knowledge, Self-awareness, and Practical Skills: A Curriculum Model for Teaching Cultural Competence and Spiritual Care to Health and Human Services Professionals

Cindy Visscher PhD

Culturally competent organizations can reduce communication errors, increase patient satisfaction, improve patient outcomes, and increase health equity. Providing spiritual support increases patient satisfaction, improves patient outcomes, and is required to meet accreditation guidelines. The Western Michigan University online graduate certificate in Spirituality, Culture and Health was developed to train health and human service professionals in cultural competence and spiritual care as foundations for patient centered care. Core principles of the curriculum include: (1) patients and providers experience culture and religion/spirituality in a dynamic manner, (2) education covering cultural competence, world religions, and spiritual care promotes a deep inter-cultural understanding of illness and health, and (3) the curriculum should promote empathetic attitudes and practical skills. Learning objectives include: (1) awareness and knowledge of spirituality, culture, and religion in relation to patient care, (2) competency in using practical tools for addressing religious, spiritual, and cultural diversity, (3) advanced understanding of the impact of religious belief, spirituality, and culture on patient and provider communication, and (4) ability to act as an organizational and community consultant. Teaching methods include: (1) narrated interactive lectures with self-reflection exercises and video interviews to help build awareness and empathy, (2) case study assignments and student led discussions requiring resolutions for each case, (3) advanced readings on the body, health, and illness in multiple religions and cultures, (4) production of a set of teaching plans for use in student's professional setting, and (5) completion of a field practicum. Our early discoveries in offering the online curriculum include: (1) interdisciplinary collaboration with health, comparative religion, and organizational leadership programs is essential to fulfill the learning objectives, (2) non-traditional and working students need significantly flexible hours for student contact and assistance, and (3) students entering graduate level courses after a gap in education enrollment need a re-orientation to learning strategies.

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The author reports no conflict of interest.

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Biostatistical Guideline for HJM&PH

The following guidelines are developed based on many common errors we see in manuscripts submitted to HJM&PH. They are not meant to be all encompassing, or be restrictive to authors who feel that their data must be presented differently for legitimate reasons. We hope they are helpful to you; in turn, following these guidelines will reduce or eliminate the common errors we address with authors later in the publication process.

Percentages: Report percentages to one decimal place (eg, 26.7%) when sample size is ≥ 200 . For smaller samples (< 200), do not use decimal places (eg, 26%, not 26.7%), to avoid the appearance of a level of precision that is not present.

Standard deviations (SD)/standard errors (SE): Please specify the measures used: using “mean (SD)” for data summary and description; to show sampling variability, consider reporting confidence intervals, rather than standard errors, when possible to avoid confusion.

Population parameters versus sample statistics: Using Greek letters to represent population parameters and Roman letters to represent estimates of those parameters in tables and text. For example, when reporting regression analysis results, Greek symbol (β), or Beta (b) should only be used in the text when describing the equations or parameters being estimated, never in reference to the results based on sample data. Instead, one can use “b” or β for unstandardized regression parameter estimates, and “B” or β for standardized regression parameter estimates.

P values: Using P values to present statistical significance, the actual observed P value should be presented. For P values between .001 and .20, please report the value to the nearest thousandth (eg, $P = .123$). For P values greater than .20, please report the value to the nearest hundredth (eg, $P = .34$). If the observed P value is greater than .999, it should be expressed as “ $P > .99$ ”. For a P value less than .001, report as “ $P < .001$ ”. Under no circumstance should the symbol “NS” or “ns” (for not significant) be used in place of actual P values.

“Trend”: Use the word trend when describing a test for trend or dose-response. Avoid using it to refer to P values near but not below .05. In such instances, simply report a difference and the confidence interval of the difference (if appropriate), with or without the P value.

One-sided tests: There are very rare circumstances where a “one-sided” significance test is appropriate, eg, non-inferiority trials. Therefore, “two-sided” significance tests are the rule, not the exception. Do not report one-sided significance test unless it can be justified and presented in the experimental design section.

Statistical software: Specify in the statistical analysis section the statistical software used for analysis (version, manufacturer, and manufacturer’s location), eg, SAS software, version 9.2 (SAS Institute Inc., Cary, NC).

Comparisons of interventions: Focus on between-group differences, with 95% confidence intervals of the differences, and not on within-group differences.

Post-hoc pairwise comparisons: It is important to first test the overall hypothesis. One should conduct *post-hoc* analysis if and only if the overall hypothesis is rejected.

Clinically meaningful estimates: Report results using meaningful metrics rather than reporting raw results. For example, instead of the log odds ratio from a logistic regression, authors should transform coefficients into the appropriate measure of effect size, eg, odds ratio. Avoid using an estimate, such as an odds ratio or relative risk, for a one unit change in the factor of interest when a 1-unit change lacks clinical meaning (age, mm Hg of blood pressure, or any other continuous or interval measurement with small units). Instead, reporting effort for a clinically meaningful change (eg, for every 10 years of increase of age, for an increase of one standard deviation (or interquartile range) of blood pressure), along with 95% confidence intervals.

Risk ratios: Describe the risk ratio accurately. For instance, an odds ratio of 3.94 indicates that the outcome is almost 4 times as likely to occur, compared with the reference group, and indicates a nearly 3-fold increase in risk, not a nearly 4-fold increase in risk.

Longitudinal data: Consider appropriate longitudinal data analyses if the outcome variables were measured at multiple time points, such as mixed-effects models or generalized estimating equation approaches, which can address the within-subject variability.

Sample size, response rate, attrition rate: Please clearly indicate in the methods section: the total number of participants, the time period of the study, response rate (if any), and attrition rate (if any).

Tables (general): Avoid the presentation of raw parameter estimates, if such parameters have no clear interpretation. For instance, the results from Cox proportional hazard models should be presented as the exponentiated parameter estimates, (ie, the hazard ratios) and their corresponding 95% confidence intervals, rather than the raw estimates. The inclusion of P -values in tables is unnecessary in the presence of 95% confidence intervals.

Descriptive tables: In tables that simply describe characteristics of 2 or more groups (eg, Table 1 of a clinical trial), report averages with standard deviations, not standard errors, when data are normally distributed. Report median (minimum, maximum) or median (25th, 75th percentile [interquartile range, or IQR]) when data are not normally distributed.

Figures (general): Avoid using pie charts; avoid using simple bar plots or histograms without measures of variability; provide raw data (numerators and denominators) in the margins of meta-analysis forest plots; provide numbers of subjects at risk at different times in survival plots.

Missing values: Always report the frequency of missing variables and how missing data was handled in the analysis. Consider adding a column to tables or a footnote that makes clear the amount of missing data.

Removal of data points: Unless fully justifiable, all subjects included in the study should be analyzed. Any exclusion of values or subjects should be reported and justified. When influential observations exist, it is suggested that the data is analyzed both with and without such influential observations, and the difference in results discussed.

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Our Mission
to nurture collaboration
to foster multidisciplinary intervention

Objectives

- 1. Identify the role of culture in the delivery of care in various healthcare settings (e.g., clinic, hospital, community-based).*
- 2. Demonstrate whether healthcare information (both verbal and written) is presented in a culturally and linguistically appropriate manner.*
- 3. Utilize existing cross-cultural healthcare resources to aid in the delivery of care and/or conduct of research.*

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