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Development of a Web-based educational intervention to improve cross-cultural communication among hospice providers

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Abstract

This paper describes the theoretical foundation, development, and content of a Web-based educational intervention to improve cross-cultural communication about end-of-life concerns and reports on the preliminary evaluation of this intervention using a qualitative study design. The data were collected with non-structured questions in a convenience sample of 21 hospice providers. Participants reported that they found the training appropriate and useful. Participants also reported finding the online delivery convenient and the interactive format valuable. Improving the quality of cross-cultural patient-provider communication can contribute to reducing disparities at end-of-life.

Keywords

hospice providers; cultural competence; Web-based education; communication; end-of-life curricula

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Although death is a universal human experience, there is ample evidence that health care disparities at end of life (EOL) exist among cultural groups and across health care settings (Fortier & Bishop, 2004). Within the biomedical culture, the dying process is often accompanied by excess pain, suffering, and symptom burden (Doorenbos, Given, Given, & Verbitsky, 2006). Furthermore, use of medical treatments, such as analgesics for patients with similar medical profiles, has been found to differ by race and ethnicity. For example, African American cancer patients are less likely than white patients to receive pain medication (Bernabei et al., 1998). Hispanic trauma patients are also less likely than white patients to receive pain medication, even when physicians judged their pain severity to be the same as that of the physicians' white patients (Todd, Samaroo & Hoffman, 1993). In addition, people of color tend to make less use of palliative and EOL services such as advance directives (Blackhall et al., 1999) and hospice care (Greiner, Perera & Ahluwalia, 2003; Randall & Csikai, 2003). As a result, ethnic and cultural minorities are at increased risk for worse EOL outcomes than white patients, including lower quality of care (Krakauer, Crenner & Fox, 2002) and lower quality of life at EOL (Wright et al., 2008).

In 2002, the Institute of Medicine (IOM) report *Unequal Treatment* highlighted racial and ethnic disparities in health care in three distinct areas: (a) worse outcomes from medical care; (b) inferior access to most services; and (c) poorer experiences during medical care encounters (Smedley, Stith, & Nelson, 2003). To address these disparities, one of the IOM's key recommendations was to integrate cross-cultural education into the training of all current and future health care professionals. Additionally, the panel report from the 2004 National Institutes of Health (NIH) State-of-the-Science Conference on Improving End-of-Life Care called for more research on effective communication interventions, particularly those that focus on the recognition of cultural differences in EOL care planning (NINR, 2006).

In response to these recommendations, a Web-based, cross-cultural communication training intervention for hospice providers, with a particular focus on social workers was developed. Improving communication between social workers and patients and increasing the ability of providers to recognize potential barriers to care and negotiate culturally-relevant EOL care plans, are a promising way to improve the quality of EOL care (Csikai & Raymer, 2005). Social workers are actively involved in the communication about palliative and EOL care in a number of settings (McCormick, Engelberg, Curtis, 2007). In this paper, we provide a rationale for focusing on cross-cultural communication in EOL care and describe the theoretical foundation, development, and content of a Web-based educational intervention to improve cross-cultural communication about EOL concerns. We also describe the preliminary evaluation of this intervention using qualitative analyses of focus groups conducted with hospice care providers.

Focusing on Communication at End-of-Life

Findings from studies focusing on communication at EOL indicate that effective communication results in a more positive health care experience for both patient and family (Csikai, 2006; Curtis, et al., 2004; Steinhauer, et al., 2000; Tulskey, 2005; Wright, et al., 2008). There is evidence of less effective communication about EOL issues between patients of color and health care providers than between white patients and health care providers (Carter, et al., 2006; Pham, et al., 2008; Thornton et al., 2009). This deficit is thought to contribute to observed disparities in EOL care (Kwak & Haley, 2005; Ashton, et al., 2003; Gordon Sharf, & Soucek, 2006). Providers may be uncomfortable talking about death and EOL decisions (Csikai, 2009), even when they share common cultural backgrounds and expectations with patients and families. When cultural beliefs and expectations differ, unrecognized barriers can make communication about EOL even more difficult. For

example, providers may lack knowledge about patients' health belief models that shape the patients' decision making about their conditions (Gehlert, 2006), language may be a barrier to nuanced communication (Pham, et al., 2008; Thornton et al., 2009), and differences in religious or spiritual beliefs and practices may affect communication and clinical decision making (Maclachlan, 2007).

Unfortunately, little research is available as to the most effective methods for training hospice and EOL providers in cross-cultural communication (Kagawa-Singer & Jassun-Lakah, 2003; Back et al., 2007; Goldstein et al., 2004). Most of the effort to date has focused on educating and training health professionals (pre-licensure) about cross-cultural communication (Colvin-Burque, Davis-Maye, & Zugazaga, 2007), with scant attention to the enhancement of cultural competence among practicing providers. Web-based training has the potential to make cross-cultural communication skill development available to social workers and EOL clinicians to use at their own pace, and accessible across different locations (e.g., urban and rural agencies, at home, and at health care facilities).

Web-Based Educational Interventions

Web-based training can provide a solution for some of the difficulties in creating accessible, effective educational programs to improve cross-cultural communication. The delivery of cross-cultural communication education via the Internet has the ability to (a) reduce costs associated with scheduled in-service education, (b) increase active learning by providing a self-paced format, (c) increase the consistency of instruction and experiential learning within and between sites, (d) allow for rapid customization of content to accommodate the unique needs of providers in diverse communities, and (e) facilitate online tracking of cultural competence training at the organizational level and provide organizations with feedback on problem areas (Bennett & Glasgow, 2009). A meta-analysis of 201 articles on Web-based training for health professionals found Web-based training to be associated with large positive effects on knowledge outcomes, on skills, and on learner behaviors and patient effects when compared with no intervention. The study found the effectiveness of Web-based training to be similar to that of traditional educational methods (Cook et al., 2008). Another advantage of a Web-based format is that content can be easily updated to reflect current cultural issues, new insights in cultural knowledge, or changes in cultural demographics.

Several implementation-related themes have emerged in the literature on Web-based training: (a) high rates of attrition (Eysenbach, 2005), (b) the promotion of utilization (Hurling et al., 2007), and (c) availability of Internet infrastructure. However, computer-based interactive video exercises offer many advantages without the time and personnel costs associated with in-person educational programs (Schim, Doorenbos, & Borse, 2006). Web-based video vignettes can teach and promote the application of new skills by modeling behaviors in video format and then offering providers the chance to reflect on what they have seen and on their own approaches to similar situations. The opportunity to see both best-practice and non-ideal examples of approaching various situations can engage providers on a deeper level and prompt critical thinking and self-assessment.

Conceptual Foundations

The conceptual foundation of this educational intervention is derived from the Three-Dimensional Model of Cultural Congruence, a framework that articulates the connection between provider-level, cross-cultural communication skills and patient/family-level constructs (Schim, et al., 2007). The model is based on the idea that cultural competence is always evolving, so providers must continually improve their quality of communication in order to improve quality of patient care.

The provider level of the cultural congruence model has four components: (a) cultural diversity, (b) cultural awareness, (c) cultural sensitivity, and (d) cultural competence. *Cultural diversity* recognizes the fact that the population of the United States is increasingly diverse in terms of language, immigration status, and cultural heritages. *Cultural awareness* is a cognitive construct. Knowledge and thought are necessary to appreciate the ways in which cultures vary and are similar, the ways that cultural contexts influence personal meaning, and the profound effects that culture has on health care from both provider and recipient perspectives. *Cultural sensitivity* is an affective or attitudinal construct. Providers' attitudes about themselves and others and their openness to learning about cultural dimensions and diversity are essential to cultural sensitivity. *Cultural competence* is a behavioral construct consisting of actions in response to the demands of cultural diversity, awareness, and sensitivity.

The patient/family level of the model consists of those patient, family, and community attitudes, beliefs, and behaviors that represent the areas of greatest similarity and difference both among and within cultural groups, subgroups, and individuals. The patient/family level of the model suggests that some of the cultural dimensions that lend themselves to assessment and educational interventions can lead to more effective cross-cultural communication and understanding. Which specific aspects, at the patient/family level, are particularly salient to health care in general, and palliative and EOL care specifically, may vary depending on the nature of the community of service at any given point in time.

Cultural congruence is the process through which providers, patients, and families create an appropriate fit between professional practice and what the patients and families need and want in the context of relevant cultural domains. Cultural congruence results from effective cross-cultural communication between the provider and the patient and family.

Building from this theoretical basis, the Web-based training intervention uses the LEARN model (the acronym stands for Listen, Explain, Acknowledge, Recommend, Negotiate) (Berlin & Fowkes, 1983). While using LEARN, a provider is prompted to (a) Listen to the patient's conception of the illness, (b) Explain the biomedical model of the illness, (c) Acknowledge areas of agreement and potential conflict, (d) Recommend a treatment plan that involves the patient and incorporates culturally relevant approaches, and (e) Negotiate a treatment plan that creates a partnership between the patient and provider. The LEARN model enables social workers to address difficult communication situations by focusing on understanding and incorporating the patient's cultural context into the care plan.

Development of the Web-Based Educational Intervention

The primary objective in the development of the Web-based training was to provide realistic case studies that are relevant to hospice social workers and that EOL providers would recognize as situations they are likely to encounter. A second objective was to maximize active learning through self-reflection, critical thinking, and application of new knowledge, with feedback confirming or expanding the social worker's solution or conclusions. The Web-based cross-cultural communication training is called *Culture & End-of-Life*, and it uses case studies and multimedia instruction to teach about cross-cultural communication at EOL. The Web-based training, *Culture & End-of-Life*, is composed of six interactive case studies and the training is based on the application of the LEARN model. The cases are enriched with photos and audio recordings. Each begins with an introduction to the patient and his or her medical and cultural background. The cases then unfold, providing the learner with additional information interspersed with problem solving and instruction. Each case concludes with a summary of the lessons learned.

Creating *Culture & End-of-Life* for hospice providers required including the multidisciplinary hospice team, and situating the patients in outpatient or residential hospices. To ensure successful creation, 3 inpatient hospice providers (1 social worker, 2 nurses) were recruited and asked to critically review the training and assist with revisions. The six interactive case studies were modified according to their feedback to improve the relevance for hospice providers. The hospice version of *Culture & End-of-Life* presents the following six case studies:

1. A Hmong patient's beliefs about her illness and her treatment expectations differ from the provider's and inclusion of her uncle in decision making.
2. A Native American patient makes treatment choices that include a traditional therapy that is unfamiliar to the provider.
3. A Japanese daughter wishes to shield her father from full disclosure of his terminal prognosis.
4. An African American family doesn't trust the provider's suggestions for terminating tube feeding.
5. A Spanish-speaking family's open expression of grief and numerous questions overwhelm the provider.
6. A Southern Baptist patient is refusing a DNR order or advance directive and prefers to "let God decide."

Cases 2, 4, and 5 involve a hospice social worker; cases 1, 3, and 6 involve a hospice nurse; and case 6 also includes a chaplain. The first case provides the learner with frameworks and vocabulary for analyzing the case studies that follow and is introduced to the steps in the LEARN model.

The following description provides more detail about one of the cases. Case # 3, Mr. Sato was born in Japan and immigrated to the U.S. as an adult. He owns an Asian grocery store which he operated for many years. A few years ago he turned over management of the store to his daughter. He still bakes traditional Japanese ceremonial cakes on request from favorite customers. Mr. Sato speaks a little English and has relied on his daughter for translation and explanation while in the hospital. His wife is deceased. Mr. Sato's daughter was born in the U.S. She is fluent in English and Japanese and has a college education. She now runs the family grocery business.

Mr. Sato has been referred for hospice care. You are to do his admission. Mr. Sato's daughter is waiting for you in the hall and asks to speak with you before you talk with her father. She explains that it's her duty to care for and protect her elderly father. This includes shielding him from bad news and arranging for any care he needs. The daughter tells you that her father must not be told that he has a terminal prognosis. She argues that he will lose the strength and hope needed to cope if he is told of his terminal prognosis. What is your initial reaction to the daughter's request that you withhold full disclosure of her father's prognosis? Additional questions such as, "For hospice admission, generally patients are fully informed about their diagnosis and prognosis. Why do you believe this is necessary?" Another interactive question is, "Clinicians may decide to withhold full information about the patient's diagnosis and prognosis in certain circumstances. When would you consider withholding truth?" The case continues with feedback given to clinician responses.

The introductory information about the LEARN model is presented in the first two case studies in an interactive graphical format that enables learners to click each element for information. A Web format delivers content in small increments, allowing learners to set the pace at which they absorb information. In the subsequent case studies, the LEARN model

reappears, framing patient-provider dialogues or problem-solving exercises. Feedback is provided via audio examples of hospice providers engaging in the LEARN model with their patients. In the four remaining case studies, the learner applies variations of the LEARN model to resolve dilemmas arising from cultural differences between the provider and the patient. At critical decision points in each case study, learners are asked to consider what they would do in the situation and are encouraged to type their responses in text boxes. They then listen to brief audio demonstrations of the LEARN model and can compare their answers to the best-practice examples.

Hospice providers apply variations of the LEARN model to assess situations and plan interventions appropriate for the observed cultural preferences of the patient. The text boxes are intended to stimulate self-reflection and self-assessment, trigger thoughts about an upcoming topic, or promote problem solving. Interactive exercises throughout the case studies allow hospice providers to demonstrate skills they are learning, such as asking about explanatory models, conducting spiritual assessments, resolving ethical conflicts, and working with families whose values differ from their own. The interactive case studies present realistic EOL situations that require skills in cross-cultural communication rather than “trait list” knowledge of specific cultures.

Preliminary Evaluation of the Educational Intervention

This study was approved by the academic institution and the hospital system which included the hospice where the study took place, institutional review boards. Providers at a single hospice agency in the U.S. Pacific Northwest, with a daily census of approximately 330 patients, were recruited to participate in this study.

Procedure

A convenience sample of providers was recruited through an announcement that was delivered by the medical director at hospice staff meetings. Staff were informed that the complete Web-based training would take approximately 3 hours and that participants would attend one 90-minute focus group to provide feedback on the training. Participating staff were instructed to complete the training during non-work time, using their own computers. For the time they spent completing the Web-based training, providers received 3 Continuing Education credits.

Case studies were reviewed by three focus groups of hospice providers (N = 21 unduplicated providers; a description of the focus group members is presented in Table 1). Gender was not reported, as it could positively identify participants. Providers were given 1 week to review the complete Web-based training, which took approximately 3 hours. Focus groups were then scheduled, one per week over the next 3 weeks. The focus groups were conducted after the day shift concluded and were held in the hospice inpatient facility conference room. Each focus group was facilitated by the same 2 members of the research team. Each focus group lasted approximately 90 minutes. The focus groups were audio recorded and the recordings were then transcribed verbatim.

The first focus group (n = 6) included an in-depth discussion of the case study about the Hmong patient's beliefs about her illness and treatment expectations differing from the providers' beliefs. The second focus group (n = 7) reviewed the case study of the African American family who doesn't trust the provider's recommendations for care. These two case studies were selected for special attention because it was hypothesized that they would need the greatest adaptation to make them relevant to hospice. The third focus group (n = 8) reviewed all the case studies and the usability of the Web-based training.

Two open-ended questions were posed by the facilitators: “How could we improve the content of this course?” and “How could we improve your experience in this course?” Follow-up questions about the providers’ experience of the Web-based training included probes asking about the images, interactivity, audio quality, and video quality. During the discussion, the facilitators added pertinent probing questions based on issues raised in participants’ prior comments.

Analysis

Focus group results were analyzed using a topical data analysis technique (Sandelowski & Barroso, 2003). We used the Atlas/ti software program for data management and analysis of responses, developing an initial coding scheme and then augmenting the scheme with additional codes identified from the responses. The responses were independently coded by 2 investigators who met to discuss codes and differences in how the codes were applied. Discrepancies were resolved through discussion between the coders until they reached consensus. After the initial round of coding was completed, we generated reports on the broad domains of interest and then read the coded responses to identify the range of responses within each domain (Ayres, 2003). To assure the trustworthiness of our analysis, we shared our interpretations of the responses with the participants, obtained their feedback, and made adjustments in our summary to include their comments and recommendations.

Results

Themes related to improving content of the Web-based training

Overall Content—Participants in general, and particularly the social work participants, found the Web-based training helpful. As noted in the comments below, the curriculum was seen as realistic, but some of the nursing staff expressed a desire for more information and more complexity in the case studies.

“I am impressed with the depth and breadth of the curriculum” SW # 5

“good cases ... very realistic ... relevant to social work education” SW # 8

“you really did your homework ... the subject matter was well thought out” nurse # 4

“It was great to use such a good tutorial, and it’s exciting to think of other hospices using it” SW # 9

“cases ... lacked complexity that would make them more challenging” Nurse # 9

“I would like more detail ... links to other Web sites might be helpful” Nurse # 3

Discussing Hospice—Participants believed that even more emphasis should be placed on how to communicate core information about hospice services.

“this is a great opportunity to talk about quality of life vs. quantity of life” Nurse # 2

“allows natural end-of-life – not hastening or delaying” SW # 2

“perhaps you could include ... hospice doesn’t take away hope” Nurse # 10

“In hospice we care for the whole family, as it relates to the patient. This is especially true with patients of minority populations, where you can’t separate out patient from family.” SW # 3

As these quotes indicate, focus group participants felt that more information on how to introduce the underlying philosophy of hospice was needed in various cultural settings. Some participants felt that the message that hospice does not take away hope for continued life was especially important in culturally diverse settings.

Coping with Communication Mistakes—One issue that was mentioned for improvement by focus group participants was how to address communication breakdowns, or errors by the health care provider, in communicating with families and patients from other cultures.

“we white Westerners tend to assume a first-name basis with patients and families. It’s so important to ask how they would like to be addressed” SW # 3

“... learning how to recover from a situation in which you have already blown it” Nurse # 8

“give case example of stupid, ignorant statements that we (white Westerners) always make” SW # 3

Participants in each focus group expressed positive feelings about the general direction of the Web-based training, in that the curriculum focused on showing helpful examples of communication between culturally diverse providers and patients. However, the participants also wanted the training to include examples of providers who make communication errors, and then demonstrate how these errors could be addressed.

Using Interpreters—One area of the curriculum that garnered several comments in focus groups was the use of interpreters in clinical settings.

“need to include how to use a medical interpreter” SW # 5

“important to suggest NOT using family members as interpreters when there are medical issues that need to be explained ... family members may not be able to accurately explain medical terms ... and possible disease progression” Nurse # 10

“add a section on the challenges that arise when there are language barriers” SW # 6

“how do you respond when a family says that they don’t want a professional interpreter because the community is so small and privacy becomes an issue?” SW # 3

“how do you work with an interpreter who seems to be interjecting themselves into the discussion ... maybe because the interpreter knows the patient?” Nurse # 2

“how might you go about setting up an effective and efficient discussion when an interpreter is used?” Clergy # 1

As these quotes suggest, using interpreters when providing care to patients who do not speak English can be fraught with several issues that providers have to address. Focus group participants were particularly concerned about the dynamics of using interpreters from the family or community, because of attendant confidentiality and communication issues.

Expanding the context for decision making—Focus group participants also noted that the training could be strengthened by expanding who is included such as extended family when discussing decisions. Participants suggested attending to issues of spirituality and paying attention to family belief systems when in culturally diverse settings.

“asking if he (the patient) want to discuss his spiritual beliefs” Clergy # 1

“including healer medicine man or woman who he’d like to include in his ... decision making process” SW # 7

“including any extended family who would like to be involved with ... decision making process” SW # 3

“people are entitled to make poor decisions” Nurse # 6

Themes Related to Improving the Experience of the Web-Based Training

In addition to the content topics mentioned above, the participants also commented on the process of the Web-based aspect of the training. Comments focused on the functionality, presentation, and navigation of the Web-based training, and on the use of medical jargon.

Functionality

“do overs ... the ability get feedback and to try an exercise again [was valuable]” SW # 7

“very user-friendly format” SW # 5

“being able to stop and make dinner then come back when the kids were in bed” SW # 1

Presentation

“use of pictures, audio, and feedback was great and it kept it from becoming boring” Nurse # 11

“I think bullet points could be used to improve readability” Nurse # 4

“eliminate or reduce text boxes...they [text boxes] are not helpful” SW # 3

Navigation

“clear directions, good examples, and situations that are all relevant to hospice” Nurse # 2

“the graphics and ease going through the program were excellent” Nurse # 10

“have all the text visible on one page so scroll bars do not need to be used to see the rest of the text” SW # 2

“have forward and back arrows at the top and the bottom of the page” Nurse # 6

Medical Jargon

“Focus still on MD-treatment” SW # 1

“keep explanation of treatment options simple ... so patients can understand” Nurse # 5

Comments on the Web-based design tended to focus on positive evaluations of the design, including the ease of use, and the advantages of having the audio and video components within the program. Overall, participants had only minor suggestions for revising the Web-based training to make it more user-friendly.

Discussion

The Web-based *Culture & End-of-Life* educational intervention used in this study is unique in that it is not culturally specific, but rather focuses on cultural difference as a general concept and focuses on assessment of issues that might stand in the way of effective

communication. A number of studies in the past have addressed issues of cross-cultural communication; however, most have focused on a specific cultural group, requiring empirical knowledge of specific cultures rather than an understanding of cultural difference on a more general level (Crawley, 2005). What is not available today is a cost- and time-efficient educational intervention that addresses the need for cultural competence education among hospice providers. The Web-based design of this training provides an innovative approach to the problem of time- and cost-effective cross-cultural communication education.

Based on the qualitative results of this study, hospice providers found the *Culture & End-of-Life* Web-based training to be an engaging and effective learning method. Focus group participants made many suggestions that will be useful in refining and expanding *Culture & End-of-Life*. For example, future versions should include content on working with interpreters. Other suggestions included adding more content on traditional, culture-specific therapies and information on how to incorporate these complementary therapies into hospice care.

During the Web-based training, the participating hospice providers were actively engaged in forming and answering questions about the new knowledge with which they were confronted. This is the educational goal of interactive software programs. Cognitive engagement occurs when the learner is encouraged to reflect on what has been presented and articulate the connections that are being formed in personal thinking. This level of engagement happens, for example, in the problem-solving exercises that demand the participating providers apply acquired knowledge to new situations presented in the case studies. Feedback confirming or disproving the hospice provider's solution or conclusions further contributes to the active acquisition of knowledge in the learning process.

Limitations

We present here a rationale, description, and preliminary evaluation of a Web-based, cross-cultural communication training. The current evaluation is limited in that it was based on a small sample of hospice providers from a single urban hospice agency. Findings from this study may not apply in rural hospice agencies. Nonetheless, the study does identify key factors that appear to influence the applicability and use of the Web-based *Culture & End-of-Life* educational intervention among hospice social workers. These findings require validation in further research.

The focus group methodology is limited in its ability to produce quantitative assessment of acceptability and effectiveness. However, the focus group methodology provides in-depth information about the hospice providers' responses to the case studies. Future studies should assess the outcomes of this intervention, including the acquisition of knowledge through the Web-based training, the effectiveness of a Web-based training versus in-person training, and how this educational training translates to changing clinical practice and affecting patient and family outcomes.

The focus group participants were predominantly white, and as such, were able to provide important feedback regarding how white providers viewed this form of training. Future work could also consider and evaluate the dynamics that emerge when providers of color work with both patients of color and patients from the dominant culture (i.e., white patients).

A limitation to Web-based training is the need for Internet access. However, 2009 estimates indicate that 70% of homes in the United States have Internet access (U.S. Department of Commerce, 2010), and this number continues to grow. For those who do not have Internet access in the home, most public libraries have computers available with Internet access, bringing the number of U.S. adults over 18 having Internet access up to 91%.

Implications and Conclusions

Social work educational standards (Council on Social Work Education, 2008) and ethics (National Association of Social Workers, 2001) require a focus on the ways in which cultural differences affect both provision of services and patient/family outcomes. As a member of the interdisciplinary team in EOL care, social workers have an important role in providing culturally relevant services to patients and families, and providing information to other team members about the role of culture in patient/family interactions. Accessible educational interventions that improve clinical skills and that can be translated to other team members are important tools in these efforts.

Better congruence between social work approaches and patient-specific needs can result in more-effective treatment, closer adherence to medical regimens, improved quality of life for patients and families, and, eventually, lower overall health care costs. Unfortunately, proven mechanisms to produce the desired competence coherently, consistently, and in a cost-effective way are not yet widely available. The Web-based educational intervention described here will contribute to filling this critical gap for hospice providers.

Specific next steps include testing *Culture & End-of Life* in a randomized control trial at four different hospice setting to evaluate its effects on quality of communication assessed by family caregivers. Future research is also needed to expand and refine the *Culture & End-of Life* Web-based training, offer it to a larger sample in a controlled trial design, and evaluate its effects on patient outcomes and costs of care. Such research would provide evidence of the effects of Web-based educational interventions for hospice care providers, and in particular for social workers involved in EOL care.

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Appendix A

Screenshots from *Culture & End-of-Life*

The Cultural Engagement Chart				
	Practitioner's view		Patient's view	
Cultural Engagement Chart	Step 1. Read the questions and type what you know at this point in the text boxes.		Step 2. Click the audio button in each box to hear Mr. Penn answer the questions. Then type his views in the text boxes.	
	Illness or health problem What are the patient's health problems? What has the patient been told?
	Cause(s) or etiologies What are the causes of each health problem?
	Treatment goals & concerns What has been done for these problems? What is the plan for helping the patient?

Figure 1.
Applying LEARN

Trust or trustworthiness

You realize that people who have experienced discrimination, historically or currently, may mistrust the health care system. But what can you do about it when providing care to African American patients like Mr. James. Type your answer in the textbox below.

I can:

Feedback

Trust or trustworthiness

You realize that people who have experienced discrimination, historically or currently, may mistrust the health care system. But what can you do about it when providing care to African American patients like Mr. James. Type your answer in the textbox below.

I can: Acknowledge the history of racism in this country, voice empathy, and assure them that we will provide the best possible care for there loved one.]

Feedback

Trust or trustworthiness

You realize that people who have experienced discrimination, historically or currently, may mistrust the health care system. But what can you do about it when providing care to African American patients like Mr. James. Type your answer in the textbox below.

I can: Acknowledge the history of racism in this country, voice empathy, and assure them that we will provide the best possible care for there loved one.]

Feedback

Increasing your trustworthiness

The question is not what can you do to increase the patient's or family's trust, but rather what can you do to increase your trustworthiness? The suggestions on the following page will help you demonstrate your trustworthiness (Crawley, 2002 and 2004).

Figure 2.
Receiving feedback

Figure 3.
Patient as teacher

Figure 4.
Learner interface example

Table 1

Sample Characteristics of Focus Groups (N = 21)

	Sample
Educational level	
Completed some college	1
Completed college	8
Completed graduate school	12
Profession	
Social work	9
Nurse	11
Clergy	1
Self-identified racial/ethnic group	
White	19
African American	0
American Indian	1
Asian	1
Hispanic	1
Prior cultural competence training	
Yes	11
No	10
Age	42 ± 5
Years of hospice experience	5 ± 3