



**BEYOND MEDICAL INTERPRETATION:
THE ROLE OF INTERPRETER CULTURAL MEDIATORS (ICMs)
In Building Bridges Between Ethnic Communities and Health Institutions**

Selecting, Training and Supporting Key Outreach Staff



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*Community House Calls:
A program to reduce barriers to health care for women and children*

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The Interpreter Cultural Mediator model takes inspiration from other health worker models developed over recent years, including the model described in Where There is No Doctor, and the Camp Health Aide Program, developed by the Midwest Migrant Health Information Office.



EXECUTIVE SUMMARY

The Interpreter Cultural Mediator model described in this manual has been developed through the joint efforts of Dr. Ellie Graham, Dr. Carey Jackson, and their colleagues at Harborview Medical Center (HMC) in Seattle, Washington. Called Community House Calls, the demonstration program was begun in January 1994 to decrease sociocultural barriers to care for non-English speaking ethnic populations receiving their care at Harborview Medical Center.

The Interpreter Cultural Mediator model incorporates timely integration of ethnographic and medical anthropological principles with current medical care practices and medical education goals. Key aspects of the model include:

- The use of Interpreter Cultural Mediators and Community Advisors as part of the health care team, allowing access to cultural information and cultural traditions that are in transition but that still strongly influence refugee families.
- Development of a structure that allows clinical and public health aspects of care to be addressed at the same time.
- Development of a vital role for interpreters, in which they provide culturally sensitive case management and follow-up, and educate providers, residents and medical students about the cultural issues surrounding their clients' care.
- Increased collaboration between the Departments of Internal Medicine and Pediatrics in the area of teaching residents and medical students about cross-cultural care.
- Development of EthnoMed, an electronic ethnic data base that allows ethnic communities to directly inform providers about their specific cultural beliefs, health care needs, and community resources.

If a medical anthropological approach to improving cross-cultural health care is at the philosophical center of the program's design, using a team approach is at the core in terms of program logistics. A well-integrated health care team comprised of professionals and paraprofessionals is key to a successful program. Team members include interpreter cultural mediators, community advisors, program coordinators, medical directors, other health providers, administrators, and social services professionals. Together, the team members create a case-management approach that is culturally appropriate, comprehensive, and that provides ample opportunity for two-way dialogue, education and mediation around issues that often pose great barriers to the practice of cross-cultural medicine.

This manual provides a basic overview of steps to take in order to develop an Interpreter Cultural Mediator program. To provide a realistic picture, we identify commonly encountered pitfalls, including cultural, political and personal issues that will inevitably come to the fore during program development. What cannot be completely chronicled are the specific difficulties program developers will encounter as they attempt to build an ICM program in their own area.

Any program runs into snags during development, and such difficulties are especially sensitive when a number of persons, with specific community agendas and ethnic backgrounds, attempt to work together.

Therefore, those who use this manual should know that "between the lines" are the misunderstandings and frustrations normal to any process that attempts to build bridges between lay and professional agendas. It is important to acknowledge and prepare for a great expenditure of time and emotional energy that will be required to negotiate and maintain productive working relationships with ethnic communities, case-managed families, Interpreter Cultural Mediators, and other team members. Efforts to improve communication do not always lead to satisfaction; on occasion, once an ambiguity is resolved and the respective parties understand one another, they will continue to disagree. Consequently, the success of a program like this requires program managers who anticipate such problems and are able to budget the time, energy, and good humor needed to sustain community involvement.

The Interpreter Cultural Mediator model has proven to be highly effective in generating two-way flow of information about health and social issues between clinics and their patient population. It allows patients greater access to culturally knowledgeable providers and access to health services in their own language; allows providers to receive more cultural and social feedback during interpreted patient encounters; and provides medical and pediatric residents with a more intense experience and exploration of cross-cultural health issues. The program encourages more appropriate use of medical services, decreasing inappropriate use of urgent and primary care services while increasing visits from patients who might otherwise not be seen.

INTRODUCTION: BEYOND MEDICAL INTERPRETATION *The Need for Cultural Mediation and Provider Training*

A tremendous need for adequate medical interpretation exists at urban and rural public hospitals and medical clinics throughout the United States. Clinics and hospitals that only 25 years ago served few non-English speakers now may see large numbers of non-English speaking refugees and other immigrants. At Harborview Medical Center in Seattle, for instance, health providers treat patients from over 70 different language groups with the help of an interpreter service that costs over \$600,000 per year. In spite of the frequency with which health providers treat non-English speaking patients, and the fact that skillful interpreters are involved, the results can be less than adequate. Most health providers do not receive training in the practice of cross-cultural medicine, nor do they have access to cultural information about their patients. And interpreters, skillful though they may be, cannot overcome important language and cultural barriers through limited, discrete interpretation sessions.

Medical interpretation is an inherently difficult task, even under the best circumstances. It is especially difficult when it is confined to brief, 15- to 30-minute sessions such as one typically encounters in a medical setting. Interpreters must constantly choose between various interpretive approaches, weighing the value of using literal, conceptual, or cultural equivalency in each situation. They are called upon to skillfully enhance the primary relationship between provider and patient; facilitate trust-building between patient and provider; and inform the provider when miscommunication occurs. All of these steps require a high level of skill and confidence.

The brevity of a typical medical visit can cause communication difficulties, even when provider and patient share the same language. When language and culture are worlds apart, or when there is trauma related to war or refugee experience, it becomes increasingly difficult for the interpreter to adequately communicate the patient's concerns, or for the provider to address the patient's health needs in an effective way. In such cases, medical interpretation is not enough. Both provider and patient need a more sophisticated approach to interpretation that involves an expanded understanding of the language and cultural beliefs that affect their communication. A more detailed understanding of the patient's family structure, health and cultural beliefs, and present situation is necessary before the provider can accurately address many health problems.

"Cultural interpretation" or mediation provides a more comprehensive understanding of the patient because it addresses aspects of health care and culture of which the provider may be completely unaware. For example, some Southeast Asian patients may think the provider's directive to give their child oral rehydration fluids will cause their child to become even sicker. Unless the interpreter can explain this idea to the provider, the thought will probably go unexpressed, yet will certainly affect whether the child receives fluids. Oromo patients might be insulted by the offer of water, considering it as somehow reflecting their poverty. If the interpreter can explain the function of the rehydration fluids in a culturally understandable way, the Oromo patient will be more likely to use the rehydration solution, or at least work with the provider to find a mutually agreeable alternative. Many examples such as these can be found in any study of cross-cultural medicine.

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

In Seattle, the Community House Calls program has provided training and supervision to change the role of five interpreters to the more comprehensive position of Interpreter Cultural Mediator. Language groups served by the Seattle ICMs include Cambodian; Somali; Tigrinya-speaking peoples from Eritrea and Ethiopia; and Amharic and Oromiffa speaking peoples from Ethiopia. Clinic providers have expressed delight in having interpreters who work as direct outreach workers and cultural trainers.

The broadened role of ICM is connected to a broader view of case management, as well. The ICM model moves away from the traditional approach to case management, which tends to focus on weaknesses and deficits. Instead, the ICM model encourages participants to recognize the strengths and resources of the patient or family, and to engage in an integrated problem-solving effort, using the family and community strengths and resources as much as possible.

DEVELOPING AN INTERPRETER CULTURAL MEDIATOR (ICM) PROGRAM

Program Goals

The health care goals of the Interpreter Cultural Mediator model are established in recognition of the inherent difficulties that arise when health providers attempt to offer quality health care to a number of ethnically diverse populations, within a confined time frame and without adequate knowledge of the patients' languages, cultural backgrounds or current living situations. The following goals can be realistically achieved within the context of the ICM team approach as described in this manual.

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

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

Selecting a Focus

It is helpful to choose a focus around which the Interpreter Cultural Mediators can frame their work. Community House Calls initially chose a maternal-child focus, working primarily in the Refugee and Children's Clinics. The focus helped define training style and content, criteria for case-management referral, and other aspects of the program. As a program expands and additional community and public health foci are added, other clinics can be added, for example, the Women's and Geriatrics Clinics. In other settings, the model could operate out of a Family Practice Clinic.



The Oromo ICM (left) schedules an appointment for a House Calls patient.

The ICM Team

The Interpreter Cultural Mediator Program's success depends on using a team approach, involving the cast of players described below. Careful selection of ICMs, Community Advisors, and Program Coordinators is key, as well as identification of sympathetic and supportive community officials and health care professionals who can assist in promoting the program.

Interpreter Cultural Mediators

Interpreter Cultural Mediators are bicultural, and bilingual persons who are familiar enough with the biomedical and American cultures that they can act confidently within the health care system, be known and trusted by the institutions, and have influence with providers and clinic teams. Often the ICM has worked previously as an interpreter in a medical setting. The ICM's bicultural, bilingual background enables him or her to serve as a trusted contact for non-English speaking families from her ethnic community. (From now on we will refer to the ICM as "her," but male ICMs will play an important role in the program as well.) She helps families negotiate a complex and culturally unfamiliar health and social services process, and provides information to providers who need a better understanding about cultural practices, current community conditions and family issues. For a thorough understanding of the ICM's work-related responsibilities, please see the section entitled "ICM Responsibilities and Tasks: Discussion" (pp. 25-31) in this manual.

Interpreter Cultural Mediators are salaried employees, preferably full-time staff, of the institution for which they work, e.g., the public hospital, clinic, or other agency.

Community Advisors

While the ICMs straddle two worlds, that of the mainstream westernized medical world and their own ethnic communities, there remains an older generation in each ethnic community whose members are not bicultural or bilingual; rather, they retain their traditional health beliefs and continue to promote traditional forms of healing and problem solving. These elders are often influential in terms of specific health and ethical decisions made by their children and grandchildren. It is important to integrate their role and knowledge into the overall treatment plan for families being cared for at the primary care clinic, at least during the period in which the immigrant family is newly arrived and in transition, and ideally over time, in recognition of and with respect for the uniqueness and value of the culture itself.

Through working closely with local ethnic community associations, specific elders who are recognized as traditional caregivers or "natural helpers" are approached with the request that they consider serving as Community Advisor for their ethnic group. One person from each of the ethnic communities is chosen to act in this capacity. Following an initial orientation and training period in which these individuals explore their roles as cultural and community informants, Community Advisors begin to work with the Interpreter Cultural Mediators and hospital



The program coordinator for the East African communities (seated) works in clinic with Yodit Mengist, an ICM.

health personnel as part of the ICM team. Their responsibilities include talking to providers about cultural concepts of specific diseases such as asthma, training some of the case-managed families to contact the clinics and obtain pharmacy refills over the phone, and explaining to case-managed families how to call the primary care clinics and pharmacy, and how to make appointments. They have access to a manual which has been developed in each refugee language, which describes and explains the process of calling the clinic. Community Advisors also learn to explain to case-managed families how to use voice mail, which allows patients to leave messages in their native language. They provide information for cultural/community overviews that are used to train residents and staff and participate, on occasion, in developing health priorities for their own communities. They are very active in social activities in their communities, often working closely with several of the more isolated families, attempting to bring them into a fuller social connection with the larger community.

The Community Advisors receive a small honorarium for their time but are perceived as working for their communities rather than for the medical center. They work closely with the ICM, and meet monthly with one of the program faculty co-directors to review cultural issues.

Program Coordinators

Program Coordinators are also bicultural and bilingual members of one of the target ethnic populations. They are fluent in at least one of the key languages targeted by the ICM program, have advanced training and experience in a health care, social work or public health setting, and are experienced in working with at least one of the target populations.

The Program Coordinator's managerial role is essential to the effective implementation of the Interpreter Cultural Mediator program. Program Coordinators manage the ICMs' activities on a daily and weekly basis. They work with the program directors in coordinating selection and hiring of the Interpreter Cultural Mediators, supervise and provide technical support to the ICMs and coordinate the ICM's work with social workers and clinic support staff. They often are called upon to represent the program to both professional and community organizations, and participate in education and training sessions for both providers and community members. They coordinate Community Advisor training and monitor the CA's activities, coordinate continuing education for CAs and ICMs, coordinate activities and communication with ethnic community organizations, develop systems to facilitate the flow of information between clinics and with other institutions, schedule community meetings, educational activities, clinic conferences, program management meetings, and Advisory Board meetings.

Program Coordinators, like the Interpreter Cultural Mediators, are salaried employees of the medical center. See the section entitled "Supporting the ICM: the Role of the Program Coordinator" (pp. 37-39) for additional information about the Program Coordinator's responsibilities.



The medical directors and program coordinators strategize to coordinate changes in clinic policy.

Medical Directors

Physician directors of the program are instrumental in establishing legitimacy for ICMs within the clinic and larger teaching institution. In our model, these physicians have been medical directors of the primary care ambulatory clinics participating in the program. Their leadership has resulted in smooth integration of new health care team members into existing clinic settings. Their promotion of the program within the hospital and the medical school has resulted in adoption of the ICM model as both an essential service and important training experience.

Other Health Care Providers

Other health care providers participating in the Interpreter Cultural Mediator program include primary care physicians, residents, interns, public health nurses, mental health professionals, and social services providers who become involved with the case-managed families. Providers possess a varied level of experience working with patients from other cultural backgrounds, from fairly experienced to relatively inexperienced. According to recent research conducted at Harborview, however, even those providers with a fair amount of cross-cultural experience lack adequate preparation and skills to communicate fully with their non-English speaking patients, even with the help of interpreters. There remains a significant amount of cultural, social and family information that providers do not have access to, which makes it difficult to provide good care for their patients.

Through the ICM program, providers are able to more accurately address relevant health care issues facing the patient, and incorporate appropriate cultural knowledge into their treatment of patients.



Many educational activities take place in community centers and homes. Here a medical student (standing) is teaching health education to Ethiopian community members.

Ethnic Community Associations

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

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

Institutional Support

Many of the ICM program goals require the support of key administrators within the institution. Obtaining funding for program continuance and expansion, development of institutional innovations such as expanding the role of interpreters or developing a cross-cultural health curriculum for medical students and residents, and removal of institutional barriers that limit access to non-English speakers all require the enthusiastic support of key department heads, clinic administrators, administrators for nursing, ambulatory care and social work, as well as key front-line staff, including receptionists and charge nurses.

Social Services Institutions

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

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

Recruiting and Selecting ICMs

Recruiting and selecting persons for the position of Interpreter Cultural Mediator requires the use of routine human services/personnel activities, combined with a community-based approach that allows management to identify candidates who meet the specific, unique needs of each ethnic community. Advertisements for the position can be placed at the university, at the primary care clinics, medical center personnel office, local newspapers, agencies serving refugees and non-English speakers, and ethnic community association headquarters and newsletters. Posted ads in the community, formal presentation of the ICM program at ethnic community association meetings, and word of mouth are important avenues for recruiting ICMs.

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

Qualifications

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

ICM Summary Position Description

The following list of duties provides an overview of the Interpreter Cultural Mediator's responsibilities. More detailed discussion of the ICM's tasks and how the ICM interacts with other team members in the accomplishment of these tasks is found in "ICM Responsibilities and Tasks: Discussion (pp. 25-31)."

The Interpreter Cultural Mediator will:

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

Work Schedules

ICMs work every day, regardless of whether they have been hired as full-time or part-time employees. This is due to the nature of their job, the fact that the clinics are open daily, and that evening educational meetings must be scheduled not only with the ICMs in mind, but with the rest of the ICM team members in mind as well. The amount of work they do, the flexibility required of them, and the emotional intensity involved in case management all lead to our vigorous recommendation that the ICM be budgeted as a full-time employee.

A demanding schedule and intrusions into their private time makes ICM burn-out a very real possibility, and something that management needs to guard against. The ICMs need extra support and assistance in keeping their hours to a manageable number, and in protecting themselves from too many evening phone calls from clients. The flexibility of the position must at the same time be honored and maintained, because community life does not operate strictly on a 9-5 schedule.

Case-managed families request information and assistance on any number of issues, including locating furniture or finding cribs and clothing for a new baby. Cultural constraints make it difficult for many ICMs to say "no" to such requests, and they put great effort into helping families whenever they can. Although this sense of responsibility and community connection is one of the reasons the program is so successful, it also creates a situation where the ICMs become stressed and fatigued. Management should be aware that such requests will be common, and assist the ICMs in locating community resources that will make their response to such requests faster and easier.

Caseloads

Each Interpreter Cultural Mediator handles a panel of case-managed families that may range from 15 or 20 families to over 35 families per ICM. Most case-managed families are referred by clinic staff and social workers. A few referrals come from other organizations and the community itself. Case-managed families are defined as having complex or multiple social or medical needs and/or as being high utilizers of services.

Balancing Competing Demands

Home visits and clinic work are the two top priorities for the ICMs. However, demands housing, clothing, and other social services can detract from the time that the ICM spends in these two locations. It is a difficult task for the ICMs to balance the competing demands placed upon them by their job. ICMs must find their own balance; each accomplishes this through hands-on experience. The assistance of the directors and Program Coordinators, who provide frequent review, consultation, and mentoring, is important. The following percentages illustrate the range of time spent in various activities, as reported by the ICMs at Harborview Medical Center.

Interpreting and mediating in the clinic

The ICMs estimate that they spend 10%-80% of their time working in the clinic, with a majority reporting that they are in the clinic 60%-80% of the time.

Making home visits

The ICMs report spending 10%-80% of their time making home visits. The amount of time spent making home visits is basically the inverse of the time spent in the clinic; that is, the ICMs who spend 60% of their time in the clinic generally spend 20% of their time on home visits, and vice versa.

Assisting in seeking housing, shelter and household goods

The ICMs find themselves inundated with requests for assistance in finding household goods, such as baby clothes and cribs, as well as locating housing and shelter. They can easily spend 20% of their time on these activities, and report that they do not have enough time to keep up with all of the requests that their community members make. They recommend that they limit themselves to spending only 5% of their time in this category, but it is difficult to achieve this limit.

Other Activities

Paperwork, community meetings, provider teaching, supplies and other resource identification/distribution activities account for at least 10% of the ICM's time.

Data Collection and Record Keeping

As busy as the ICMs are, sitting down to write reports can be one of the last tasks they do. And since English is a second language for the ICMs, generating reports can be a somewhat daunting requirement. Therefore, using hand-held, palmtop computers and a software program designed to record the types of contacts made by ICMs has been a real boon to the program, and is highly recommended.

The ICMs keep their weekly calendars on their palmtop computers. They correct their calendars at the end of the day or week to detail what actually happened, and these logs are then down-loaded into a PC system which allows the program coordinators and directors to review the bigger picture in terms of productivity, planning and evaluation. Using the computer entries, program staff can develop ways to measure ICM productivity. Printouts of ICM contacts with case-managed families are also put into the medical records, providing written feedback for health providers.

The ICMs also do chart reviews, identifying preventive health steps for each child in the case-managed families. Eventually, they may enter the chart review into the database function of their palmtops, making it possible to observe whether improvements in preventive care are occurring over time.



The Tigrinya ICM (left) is recording patient data for her records.

ICM RESPONSIBILITIES AND TASKS: DISCUSSION

Job responsibilities by category include medical interpretation, cultural mediation, case management of families, training families to access care, educating providers about cross-cultural health issues, and providing community health education and outreach.

Medical Interpretation

One of the goals of the ICM Program is to decrease language barriers to health care. Most of the ICMs involved in the Community House Calls program actually worked as medical interpreters before to becoming Interpreter Cultural Mediators. As mentioned earlier, interpretation is not a simple task, and the quality of interpreted medical encounters can vary greatly. ICMs are provided with training that enables them to further develop and refine their interpretive skills. They also become the appointed interpreter for given patients, providing continuity of interpreter services to patients where previously interpretation was provided on a case-by-case basis only. The ICM is able to develop a more complete knowledge of the patient's medical history and cultural concerns, greatly improving the quality of the medical interpretation.



One of the medical directors and a Cambodian interpreter, work as a team to care for an elderly Cambodian woman.

Cultural Mediation/Culture Brokering

Another aspect of the ICM's role as interpreter is equally important: the role of cultural mediator or "culture broker." Along with medical interpretation, the ICM is responsible for interpreting the cultural and social circumstances that may impact care to the provider in the patient-interpreter-provider interaction. Since the ICM model provides for home visits as well as clinic visits, it is possible for the ICM to gain an excellent understanding of the patient's situation and health needs.

Often, the ICM will spend 10 or 20 hours with a family or patient over a period of weeks, allowing adequate time to understand the family's needs and problems. When the ICM shares this information with the provider, the provider is able to more fully comprehend the precise needs of the patient as well as the barriers that may prevent the patient from improving. For instance, in the case of a 4-year-old-boy with asthma, it was impossible for anyone to know how to reduce the child's frequent midnight visits to the emergency room, prior to the ICM's discovery that the child's mother did not know that the mold and mildew found in the house contributed to the child's asthma. Similarly, the mother did not appreciate the importance of properly cleaning the child's nebulizer. Following discussions with the ICM, as well as assistance in cleaning the equipment, removing mold, and covering the boy's mattress with a removable, washable cover, the child improved considerably and his emergency visits declined.

Educating Providers in Cross-Cultural Health Care

The ICM model for improving the health status of refugee and other non-English speaking patients focuses heavily on developing the provider's fund of knowledge in the areas of cross-cultural health care, interpreted medical encounters, and basic knowledge about the cultures encountered. This is accomplished through using the team approach, enlisting Interpreter Cultural Mediators, Community Advisors and the providers themselves in a provider training curriculum.

Several different types of provider training are available under the ICM model. The expanded role of culture broker enables the ICM to provide cultural information and to bring problems to the attention of the provider during clinic visits, something which interpreters often are unwilling or unable to do. Didactic training sessions are also provided to staff and trainees through special conferences and a core curriculum which has been developed to teach residents about cross-cultural health care. Home visits to case-managed families are yet another vehicle used by the ICM program to broaden the provider's understanding of cultural and social issues that impact the health care of patients from other cultures. Finally, through EthnoMed, the computerized data-base developed by the Community House Calls program, providers now have access to cultural and health information that enables them to further develop their fund of knowledge and make better treatment decisions for their patients from other cultures.

Provider training in the clinic

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



The Oromo ICM (in white dress) visits an Oromo family to assess their housing needs.



Family and community strengths are the key assets for many social problems resolved by the IMCs.

Case Management

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

In Seattle, clinic staff responded well to the introduction of the ICMs as case managers. Within only two months, the ICMs were case managing 58 families; by the end of the first year, a total of 127 families were being case-managed, with a total of 2,341 visits being logged. (See Appendix 1, ICM Case Management Activities, May-December, 1994.) Other case management activities performed by the ICMs included case conferences with medical staff and contacts with clients at other agencies.

Typical cases seen by ICMs

Typical problems requiring the use of ICMs include follow-up on specific medical problems such as diabetes, ear infections, asthma, infectious gastroenteritis, and tuberculosis; follow-up to remind families of appointments and to help them with referrals; interventions in cases of sexual abuse, parenting problems and domestic violence; assistance in situations where a parent has major mental health problems; and assistance in locating and maintaining a good housing situation.

Drawing upon the case-managed family's strengths

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

For example, the Oromo ICM in Seattle explored health club services and organized a group of women in her community to attend classes so that they could get regular exercise. The Tigrinya-speaking ICM has used the Tigrean women's organization to organize showers for expectant mothers and arranged for a mentally ill father to regularly visit the community center during the day to relieve stress on his wife and children. A cooking class for Cambodian women patients who live in a large housing project was organized by the Cambodian ICM and Program Coordinator. They have also started a support group for Cambodian youth and have developed the teen community advisor program. Working with a community group, the Amharic-speaking

ICM helped organize and conduct English as second language classes. The Somali ICM and CA have organized a Somali Women's Organization that meets monthly. As women who have been so isolated here in the United States begin to establish networks with other women of their own culture, they often find it easier to promote the health of their families.

Training Families to Access Health Care Services

ICM involvement both decreases and increases utilization of services. Utilization decreases with improved communication, especially around identification of social stresses that may manifest as medical symptoms or interfere with parents' ability to care for their children. Handling problems through triage on the phone also decreases utilization. On the other hand, persons who have untreated problems or had not received preventive care are more likely to be brought into the health system when an ICM is involved.

When Interpreter Cultural Mediators first begin working with case-managed families, the family members generally have a very little experience or ability in making phone calls to the clinic, setting up appointments, and handling other logistical steps. In order to improve the ability of families to access clinics independently, Program Coordinators and ICMs have developed a training program for the Community Advisors which allows the CAs to train the families themselves, with a minimum of ICM involvement. Scripts are being written in each target language that includes common questions asked by the reception staff (e.g., patient name, hospital number, sick or well visit, need for interpreter, and so forth). Over time, the Community Advisor trains family members, ideally two or more persons per family, to handle these calls without assistance. This training process is facilitated by the special AT&T telephone service being used by the Harborview Medical Center Refugee Clinic. A voice mail service is available in all of the targeted languages, making it possible for patients to access a specific voice mail recording and speak in their own language. Each ICM also has a voice mail box which allows patients to directly contact her in their native language.

The Community Advisors have started training some of the case-managed families in how to contact clinics and obtain pharmacy refills over the phone. Staff have developed a manual that explains how to call the primary care clinics and pharmacy, what information is needed and common terms used to make appointments. The manual is available in each of the targeted languages.

Community Health Education and Outreach/Support

The ICMs are responsible for providing broad health education to the target ethnic communities. They evaluate and assist in design of educational materials in cooperation with the program coordinators and directors. Community health education and outreach often take the form of identifying a need and locating a resource person to come into the community to address this need through special educational events. For instance, the ICMs have identified parenting classes as being an important health education activity which was not provided to most of the ethnic communities. The Program Coordinators have organized parenting classes for the communities; the ICMs encourage their case-managed families to attend the sessions and provide interpretation services during and afterwards. They also facilitate dialogue about the sessions to discern how helpful they are to the parents.

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



An ICM (right) explains to a House Calls patient how to make a clinic appointment.

TRAINING

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

Training Format

- I. Four to six weeks of intensive training comprised of the following elements:
 - A. Introduction to the role of the ICM
 - B. Didactic teaching sessions on a range of issues and services (see curriculum)
 - C. Role-playing in medical and cultural interpretation techniques
 - D. Role-playing in preparation for making home visits
 - E. Supervised home visit followed by debriefing
 - F. Contact with families in clinic setting prior to making home visits

II. Ongoing training in negotiating with social services and health providers on behalf of the case-managed families; presentation skills; medical terminology; and other inservice training that increases the effectiveness of the Interpreter Case Managers and assists them in conducting their duties confidently and skillfully.

Curriculum Overview

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

Goal 1: Understand the role of the Interpreter Cultural Mediator.

Curriculum:

- (1) An introduction to the ICM program
- (2) Description of ICM team members
- (3) Medical interpretation: definition, discussion, role-playing
- (4) Cultural mediation: definition, discussion, role-playing
- (5) Case Management: definition, techniques, role-playing
- (6) The ICM's role in the day-to-day care of case-managed families
- (7) The role of the Community Advisor (CA); how to support the CA

Goal 2: Understand the resources and roles of the health and social institutions in the local area, to enable the ICM to assist case-managed families appropriately.

Curriculum:

- (1) The clinic, hospital, medical center as workplace: understanding the ambulatory care network, inpatient services, radiology and other ancillary services
- (2) WIC resources and mission
- (3) Neighboring medical centers and clinics
- (4) Public health department clinics: TB clinic, refugee screening, public health nursing
- (5) Department of Social and Health Services: eligibility criteria for assistance, periodic reviews, responsibilities of the department and the patient
- (6) Mental health resources available to case-managed families
- (7) Child protective services
- (8) Housing authority and shelter resources: eligibility and availability
- (9) Child-care resources and services: eligibility and availability
- (10) Parenting training available to case-managed families
- (11) Domestic abuse/resources

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

Curriculum:

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

Goal 4: Understand the concepts of prevention.

Curriculum:

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

Goal 5: Understand pregnancy from the medical view.

Curriculum:

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

Goal 6: Know basic first-aid.

Curriculum:

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

Goal 7: Understand common conditions of childhood.

Curriculum:

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

Goal 8: Learn to review cases with medical staff.

Curriculum:

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

Orientation and Training Recommendations

We recommend that an initial four-to-six week orientation and training program be pursued, comprised of a fifty-fifty split between didactic training sessions and hands-on clinical experience. This recommendation is based on the feedback received from the Seattle ICMs, who reported that they had difficulty absorbing all of the information they received in their more intensive two-week orientation, comprised of eight-hour days in which specialists from health care and social services presented pertinent information. (The Seattle ICMs didn't begin working in the clinics until after they had participated in the didactic portion of their training.) The ICMs who were interviewed for this manual said that it would be easier for them to integrate the information they receive in the didactic sessions if they were working in the clinics at the same time.

Too much information, too fast, was the chief complaint of ICMs interviewed for this manual. Many of them made statements such as, "the most important thing is the working experience. If you are working (in the clinic), then you are able to use the information; you have something to hang it on." However, it is incumbent upon the curriculum developers to gather all of the pertinent information and make it available to the ICMs in a usable form, whether they are ready to use it or not.

It is likely that the orientation and initial training will leave new ICMs feeling somewhat drained, even using the format suggested above. Program managers can explain to the ICMs that they are not expected to remember everything they are exposed to during the initial training, and that they will have many opportunities to go over the information. The ICMs receive binders with all of the handouts and important pieces of information when they begin their training. They can refer to this resource later on, as they need it.

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

As the ICMs become familiar with a range of information about clinical and medical services, social services, housing, emergency shelter, WIC, schools, parenting classes, day care and other services which promote the health of families, they find themselves working closely with social workers and other non-medical professionals, interpreting for the families who are seeking help. Families can become rapidly dependent upon the ICMs to negotiate situations for them. To avoid fostering this kind of dependency, the ICMs are trained to be aware of this dynamic and to recognize it if it develops. The Program Coordinators help each ICM review the assets and skills of each family and look at ways to enhance the family's assets and skills.

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

Continuing Education

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

In addition to bi-weekly continuing education meetings, the ICMs meet bi-weekly for a group meeting where they review issues. They also meet, as a group, two hours per month with the Community Advisors; two hours per month in a community meeting; two hours per week in case reviews with the Program Coordinators; and one hour per month in clinic team meetings and teaching sessions. The ICMs receive additional training through participation in the health education sessions organized for the communities.

SUPPORTING THE ICM: THE ROLE OF THE PROGRAM COORDINATOR

As mentioned earlier, many of the logistical pieces of the ICM program require the daily supervision and planning responsibilities assigned to the Program Coordinator. Discussion of the specific duties of the Program Coordinator follows.

Supervising the ICMs

The Program Coordinator provides daily supervision and support of the ICMs, and intervenes and draws together the appropriate team members when an especially difficult case develops. Community House Calls originally wrote the Program Coordinator position as a half-time position. It has become clear that the Program Coordinator position is more demanding than originally envisioned and that it is necessarily a full-time position if more than three ICMs are involved. We recommend budgeting the Program Coordinator at .25 FTE per ICM supervised.

In addition to daily supervision of the ICMs and facilitation of the program generally, the Program Coordinator's responsibilities include the following duties:

Facilitating Caseload Management

The Program Coordinator assists the ICM in prioritizing work activities, triaging cases and identifying community resources and other forms of assistance and networking as needed. The Program Coordinator accompanies each ICM on several home visits each month.

Providing Individual and Group Training

The ICMs continue to receive two hours of individual and group training; the Program Coordinator is responsible for organizing and facilitating these sessions.

Evaluating ICMs and Promoting Their Professional Development

Working with the program directors, the Program Coordinator assists in evaluating the work of the ICMs. The Program Coordinator identifies ways to promote the ICM's skill building on the job, and searches for ways to develop the ICM's professional linkages with physicians, community leaders, and other professionals. Simple things that the Program Coordinator can do to support the ICMs include having business cards made for them.

Facilitating Community Relations

Any new program serving refugee populations is likely to encounter political conflicts that have been transplanted from the countries of origin. The politics of community work was an anticipated problem that has had many ramifications. The Program Coordinators, by the very nature of their position and responsibilities, become involved in the resolution of these problems. Occasionally, problems may not be resolved. Either way, this aspect of the Program Coordinator job is an important function, and can be emotionally laden for the coordinators. They will need support from their superiors in this area.

Each ethnic community will respond differently to issues as they arise, based upon its own traditions, goals, and history, political and social dramas played out in the countries of origin, and the dynamics of the newly established refugee community. The ICM team must be aware that these dynamics exist and consciously work with the team to discern how they affect the program. To a great extent, the specific dynamics will be discovered only in the process of working closely with the ICMs, CAs, and community leaders in each ethnic community.

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

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

Another somewhat different example of political conflict at the community level is seen in the example of professional medical interpreters who responded to the creation of the Interpreter Cultural Mediator position as a competing force in the medical center. As mentioned earlier, before the ICMs existed, interpreters were either salaried or contracted individuals with varying levels of training and skills. They provided interpretation only for discrete encounters between providers and clients, and had no responsibility beyond a specific clinical encounter. In contrast, the ICMs represent both the communities and the medical center and have clear roles in both places. This different approach potentially displaces some interpreters who have not been selected to work as ICMs.

In summary, the creation of the new job title and set of responsibilities brings with it a "ripple effect" throughout the community and institution into which the ICMs are inserted. The new position affects not only the case-managed families and ethnic communities, but the clinics, interpreter services, administration, social work, and other related ancillary services.

Facilitating ICM Adjustment to Position and Role

Another area in which the Program Coordinator's culturally sensitive and knowledgeable supervision is needed relates to Western notions of professionalism and accountability, and how these notions impact the ICMs. Punctuality, scheduling, limit setting, assertiveness, and record keeping and confidentiality are issues that are highly defined by cultural beliefs and practices. Conflicts can emerge in this area and need to be dealt with in a way which is helpful to the ICMs while preserving the functioning and credibility of the program.

The personal impact of the ICM program on the ICMs, their families, and their personal and emotional lives can cause stress. The ICMs' jobs have created increased responsibility, and often more responsibility than resources. Clinic and family expectations sometimes are unrealistic. The trials and traumas of the families the ICMs case manage can be the same traumas that they and their loved ones have faced. Close supervision, support, continuing education, and counseling services help the ICMs adjust to the pressures of their jobs.

OTHER SUPPORT ISSUES

Office, Telephone and Computer Space

The ICM needs a designated work space. Although the ICMs are out of the office making home visits or working in the clinic much of the time, they need a place to meet, receive messages, and do paperwork. Looking for available space on a daily basis detracts from the little time they have to complete this aspect of their work. We recommend that careful planning about location and cost of adequate office space and equipment be made early in the development of the program, in order to fully support the ICMs in their jobs.

Technological Tools: Palm-top Computer, Pagers and Voice Mail System

Palm-top computer

Using as much appropriate technology as possible will save lots of time and trouble down the road. The palm-top computer used by the ICMs is described earlier in this manual [see "Data Collective and Record-Keeping" (p.24)]. We can't recommend it more highly. In addition to the record-keeping function of the palm-top computer, the computer provides the ICMs with instant information about their patients, which is invaluable when someone calls unexpectedly about medication or other issues. The ICM needs only to refer to her palm-top computer to bring up the patient's profile, enabling her to answer questions quickly and easily. The computer is also a great time-management tool, and keeps the Program Coordinators, ICMs, and program directors in easy contact with one another. The palm-top computers have made the whole process of implementing the ICM program much easier than it was in the past. It has allowed Harborview Interpreter Services to document billing of ICM interpreter contacts, and made it possible to print out summaries of ICM contacts with families.

Pagers

Pagers are an easy way for the ICMs and Program Coordinators to stay in touch with one another, and for clients to reach their case manager. Even with a designated office and telephone message center, pagers are still recommended.

Voice Mail System

While the palm-top computer and pagers have made the ICMs' jobs easier and more efficient, the AT&T voice mail system used at Harborview Medical Center has made it easier for the clients themselves to gain access to health services. Two systems are available. Each ICM has voice mail, making it possible for clients to call the clinic in their native language.

Secretarial, Computer Programmer, Research Assistant Support

The amount of secretarial, computer programmer, and research assistant time required to implement Community House Calls in the first year was more extensive than originally projected. The Program Coordinator position was originally written to include research and evaluation responsibilities, but in fact, supervision and support of the ICMs requires all of the Program Coordinator's time. We recommend that additional FTEs be considered for research, evaluation, and secretarial support.

ON THE JOB: CASE EXAMPLES

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

Case One

A Tigryna speaking family from Tigray, Ethiopia arrived in the United States in 1991. Sometime after arriving, the father, age 51, developed severe mental dysfunction, including poor memory. He has a volatile temper. The etiology of the father's mental dysfunction is not clear. Both he and the mother had serologic evidence of syphilis but the father does not have neurosyphilis. His memory loss is so severe that it has affected everyday life in many ways. He cannot be left alone with his three children, two girls, ages 2 and 4, and a boy, age 12.

The family had lived in a rural area of Ethiopia before seeking asylum in the Sudan, where they lived for 12 years before relocating to the United States. The father gives a history of being imprisoned and tortured before fleeing Ethiopia. The mother, age 40, had no schooling. The father had 8 years of formal education, and previously worked as a farmer, farm laborer, and shopkeeper.

In Seattle, the family initially lived in emergency housing and had a great deal of trouble getting DSHS support in spite of the father's mental disability, in part due to the difficulty establishing a clear diagnosis. Due to the family's social problems and stress, the children have been closely followed by a nurse practitioner and social worker in HMC's Children's Clinic. The 2-year-old has recurrent ear infections and an iron deficiency. The 5-year-old has behavioral problems both at home and school.

The mother takes care of her husband around the clock. She is depressed and socially isolated. She is solely responsible for rearing her three children. This family was referred to the Interpreter Cultural Mediator by providers from both the Children's Clinic and Refugee Clinic.

Intervention Plan:

1. The primary care provider referred the father to a psychiatrist. He has been evaluated and is now on medication. He is also seeing a mental health counselor once a week.
2. The ICM has arranged with community members to take the father to the community center a few times a week. Getting out of the house helps both the father, who has a chance to be around other people, and the mother, who has time to do household chores and to have time for herself.

3. The ICM and the social worker made a home visit to assess the home environment. After the assessment, the ICM suggested that the mother and the daughter attend a parenting class together. At first the mother resisted the idea because she believed it was the daughter who needed help, not herself. The ICM worked with the mother to explain the reasons why both of them would benefit from attending the class, and how the whole family would benefit. The ICM and the social worker are now arranging a one-on-one parenting class for the mother and daughter. The ICM will interpret in the parenting session and give support to the family.
4. Arrangements have been made for the Community Advisor to visit the mother occasionally, to reduce the feeling of isolation which the mother experiences.
5. The ICM is working with the mother to link her to community resources. The mother is joining a women's organization, which has a strong social support network.

Case Two

An Amharic-speaking young couple, ages 22 and 23, reside in Seattle with their two children, ages 18 months and 8 months. The mother is expecting her third child by September, 1995.

The family was referred to the ICM because the two children were losing weight. The ICM made some home visits and became aware that the mother was very depressed. She had a hard time getting up in the morning because she could not fall asleep until four in the morning. When the children woke up a few hours later, she was tired and gave them a bottle rather than offering food. She did not seem to offer much food during the rest of the day, either. The father says he was willing to help out, but he is away from the home most of the day. He takes English as a second language class in the morning and spends the afternoon at the library.

The family has been closely followed by the Interpreter Cultural Mediator, along with the primary care provider, the Program Coordinator, and a public health nurse. Recently the mother came to the medical center with her 8-month-old child. He had a swelling on the left side of his head. The parents said that they did not know when and how the swelling occurred, but assumed he had fallen from the sofa or been hurt somehow while playing with his 18-month-old brother. The mother said she saw the swelling when she was combing his hair. She brought him to the clinic after four days, when the swelling did not go away. An X-ray was taken which showed the child had a skull fracture. Child protective services was involved in this situation as well as the Interpreter Cultural Mediator team.

Intervention plan:

1. The mother is enrolled in a parenting class with 10 other East African women. The ICM is attending the same class. The ICM will give culturally relevant feedback to the parenting instructor and coordinator at the end of the program, and will discuss parenting issues with the mother. The ICM encouraged the father to attend the class, too.
2. Full-time child care has been arranged for both children. Child Protective Services is paying for the child care. This gives the mother time to rest, take care of house work, and attend parenting and English as a second language classes.
3. The parenting class that the mother is involved in lasts 10 weeks. Following its completion, the mother will attend the "Born to Read" program offered to expectant mothers and mothers of children under 1 year of age. The class will cover prenatal care, nutrition, parenting, and basic survival skills. ICM team members will visit some of the sessions and give feedback to the instructor and program coordinator. The "Born to Read" class is part of an English as a second language curriculum. Community House Calls staff played an active role in the development of this program.
4. The ICM team recommended counseling for the couple. The team is working to connect the couple with an East African counselor who speaks the same language and understands their culture well.

Case Three

A 30-year-old Cambodian woman with six children, ages 3 months to 12 years, was referred by health providers at the Harborview Medical Center's Women's Clinic for case management. She and her husband have lived in the United States for 15 years; they are illiterate in both Cambodian and English.

Upon visiting the family's home, the ICM found that the 10-year-old son, who had a birth defect which had obstructed his bowel, had not been seen by a health provider in two years. A colostomy had been performed when the boy was about a year old, and a visiting nurse had followed up for some time, but follow-up had been discontinued by the family. The same child had a severe hearing loss and an undescended testicle that had never been corrected. Both of his hearing aids were broken, and he needed dental work. The mother had been seen at the clinic because she had given birth three months earlier. After her most recent pregnancy she had expressed interest in family planning. An appointment was made at the Women's Clinic to insert a Norplant but providers discovered she was pregnant already. The woman requested termination through home remedies, and when that failed, she requested an abortion.

The mother seemed to the ICM to be too overwhelmed with taking care of all six children to focus on her 10-year-old son's complicated health needs. The father has a history of domestic violence and alcohol abuse, had been in jail and had his driver's license temporarily suspended.

Medical coverage was also a problem for this family, as the parents moved between two different insurance providers, creating a number of bureaucratic paperwork difficulties.

Intervention plan:

1. After the woman decided to terminate her latest pregnancy, the ICM assisted her by locating a Cambodian interpreter who could attend the pre-abortion instruction appointment with her. It was difficult to find an interpreter at the private clinic where the woman went for the abortion; the patient arranged for one of her female friends who spoke Cambodian and English to accompany her.
2. The ICM made an appointment for the 10-year-old boy to see his primary care provider at Harborview Medical Center's Children's Clinic.
3. The 10-year-old's primary care provider at HMC referred the child to Children's Hospital for surgery follow-up and to see an audiologist. Unfortunately, insufficient medical coverage delayed the child being seen at Children's.
4. The ICM team is working with the family to clarify their medical coverage and ensure greater continuity of care.

Case Four

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

Intervention plan:

The ICM went out to the patient's home and noted that the child primarily drank milk and snacked on ice chips. She also found out that the mother wanted her 4-year-old son to go to Head Start, but that she did not know how to apply.

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

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