“Culturally Appropriate Practice in Appalachia (focus on Case Management): Country Rounds Take Me Home”
Central/South Central Appalachian Region
The Appalachian culture is one that is exclusive and characterized as being:

- personalistic
- pluralistic
- valuing family and interpersonal relationships
- having strong spiritual values
- being hard working
- proud
- going to great lengths to not offend others (Hicks & Ambrose, 2004)

It is a closed community that has a higher incidence of overall health issues, including mental health and substance abuse disorders in comparison to the rest of the nation (Appalachian Regional Commission, 2018).

There is limited information available to assist health care/mental health professionals in the Appalachia area to develop culturally competent approaches to more effectively address the needs of the Appalachian culture.
Importance of Cultural Competency

For case managers/counselors who dedicate themselves to working with the Appalachian culture, it is imperative to “recognize the significance of understanding the unique value system and worldview” of the Appalachian people (Russ, 2010).

Culturally competent case managers, counselors and mental health professionals must understand the values and beliefs of the Appalachian people when entering a counseling relationship with them, that is if the goal is for treatment to be effective and successful (Keller & Helton, 2010).

The Appalachian people have been referred to as “the forgotten people and are often overlooked in multicultural counseling” (Salyers & Ritchie, 2006).
Importance of Cultural Competency

Research supports the need for more culturally competent health care professionals in the Appalachian region for the purpose of effectively addressing the mental health needs of the Appalachian culture.

To address the health care related issues of the people of Appalachia, case management professionals must develop a culturally appropriate approach to treatment.

Cultural competence is obtaining cultural information and then applying that knowledge to better understand the person.

The ability to adapt to different cultural beliefs and practices requires flexibility as well as a respect of the viewpoints of others.

Cultural competence means to really listen to the person and to spend time learning about the client’s beliefs related to their health care issues and treatment.

To provide culturally competent case management activities, case managers need to know and understand culturally influenced behaviors (Ahmad, 2011).
In the Appalachian culture, “individualism, self-reliance and pride are perhaps the most obvious values” (Salyers & Ritchie, 2006). The sense of pride value is one that means a feeling of not wanting to be burdensome to others. This culture can be viewed as stubborn.

The people of this culture want “to do everything for themselves, find their own way and suffer through hardships alone even when in great need” (Salyers & Ritchie, 2006).

The Appalachian value of self-reliance may be stronger than the desire for help. “A person from the Appalachian culture may be more sensitive than others to situations when there is a need to seek assistance, and they more than likely will interpret this as humiliating” (Salyers & Ritchie, 2006). This presentation may create the appearance that the Appalachian person is defensive and uninterested with offered help; even when the need for assistance is obvious. This can cause the health care professionals to feel frustrated and confused (Salyers & Ritchie, 2006).
It is common for the Appalachian culture to turn to the religion and faith based community for mental health assistance. “Religious involvement is an important means of handling stress” among the Appalachian people and time is taken to participate in religious activities to request supernatural help in healing (Keefe, 2005).

Regarding health care in general, the religious and spiritual world view is an important, almost vital component of the Appalachian value system. When Appalachians need assistance, they tend to first turn to their family and then to the local church (Russ, 2010).
In the provision of providing case management type of services, it is important to explore how the Appalachian cultural factors, values, and beliefs can alienate the Appalachian people from participating in case management activities.

The people in Central Appalachia are more likely to perceive “institutions, social agencies and professional helping agents with fear and suspicion” (Keefe, 2005).

Due to the nature of interactions with “outsiders” and authorities, the Appalachian people have learned to approach those in help professions with caution, this includes doctors, therapists/counselors, and social workers. This caution is even more of an issue if the helper is not a native Appalachian. Those “outsiders” are viewed as different and untrustworthy by the culture (Keefe, 2005).

In the Appalachia area, “institutions and agencies are not only viewed as cold and bureaucratic, but they often are staffed and/or administered by outsiders who are culturally insensitive to the people and region” (Keefe, 2005).

The Appalachian people will not participate in case management activities if they do not feel they are being respected.

Regarding mental health, rather than seek professional mental health care, the Appalachian people typically turn to other sources of help with any mental health related issues. The primary source of support for this culture is the family. Appalachia is a “kin-based society and relatives are relied upon for advice and emotional support” (Keefe, 2005).

Within the Appalachian culture, extended family also provides stability, support, and security.
Appalachia has some of the nation's highest rates of life-limiting chronic diseases, including heart disease, cancer and diabetes. According to data from the Centers for Disease Control and Prevention, residents of many Appalachian counties are three times more likely to die from diabetes-related causes than someone living in other counties in the same state, or in most other parts of the United States.

The causes of increased physical health issues in the Appalachian region are noted to be multifactorial, such as poverty, education and access to care. A collaborative approach that includes subject matter experts from different specialties with professionals and organizations that are currently working within the Appalachian community will assist in us reaching more effective solutions.

Appalachia mixes several ingredients of poor health: doctor shortages and access-to-care problems; stressful, unhealthy lifestyles; low education levels; and insidious poverty.
Creating a culture of health in Appalachia

**Mortality**

**Heart Disease Deaths:**
- Appalachian Tennessee’s heart disease mortality rate is 21 percent higher than the national rate and the same as the rate in non-Appalachian Tennessee.

**Cancer Deaths:**
- Appalachian Tennessee’s cancer mortality rate is 14 percent higher than the national rate and the same as the rate in non-Appalachian Tennessee.

**Chronic Obstructive Pulmonary Disease Deaths:**
- Appalachian Tennessee’s COPD mortality rate is 38 percent higher than the national rate and 20 percent higher than the rate in non-Appalachian Tennessee.

**Injury Deaths:**
- Appalachian Tennessee’s injury mortality rate is 48 percent higher than the national rate and 16 percent higher than the rate in non-Appalachian Tennessee.

**Stroke Deaths:**
- Appalachian Tennessee’s stroke mortality rate is 18 percent higher than the national rate and 9 percent lower than the rate in non-Appalachian Tennessee.

**Diabetes Deaths:**
- Appalachian Tennessee’s diabetes mortality rate is 18 percent higher than the national rate and 1 percent higher than the rate in non-Appalachian Tennessee.

**Years of Potential Life Lost:**
- Appalachian Tennessee’s YPLL rate is 39 percent higher than the national rate and 13 percent higher than the rate in non-Appalachian Tennessee.

**Morbidity**

**Physically Unhealthy Days:**
- The average adult in Appalachian Tennessee reports feeling mentally unhealthy 31 percent more often than the average American and 7 percent more often than the average adult in non-Appalachian Tennessee.
### Strategies for Successful Engagement

#### Building Rapport
- “meeting people where they are”
- Face to Face interactions verses telephonic

#### Unconditional Positive Regard
- No judgement
- Being aware of one’s own bias

#### Motivational Interviewing:
- An effective Clinical Approach to help people make changes
- Upholds four principles- expressing empathy, and avoiding arguing; developing discrepancy, rolling with resistance and supporting self- efficacy
- Client-Centered and Collaborative (Miller and Rollnick, 2009)
- Directive style of engagement
- Evokes change from the client by exploring and resolving ambivalence
Stages of Change

- **Pre-Contemplation**
  - In denial
  - Unwilling
  - Disinterested
  - “Ignorance is bliss”

- **Contemplation**
  - Ambivalent
  - Uncertain
  - Indecisive
  - Conflicted

- **Preparation**
  - Experimenting with small changes
  - Gathering information
  - Ready to move forward

- **Active**
  - Engaging in modified behavior
  - Measuring successes

- **Maintenance**
  - Maintaining new behaviors
  - Avoiding relapse
  - Building confidence

- **Termination**
  - Zero temptation
  - Problematic behavior no longer exists

**Relapse**

- The rule, not the exception
- Reverting back to unhealthy behavior
- Commonly prevents exiting to Termination
- Most do not revolve endlessly or regress back to beginning

Spiraling forward or backward can happen at any point in the cycle.
People can regress into relapse(s), and they can also learn and progress out of them.
Motivational Interviewing Resources

Motivational Interviewing (MI) Basics

The underlying “spirit” (or philosophy) of MI is even more important than the skills. While you are an expert in health care, your client is an expert in his or her own life.

**SPIRIT OF MI: CAPE**

- **C**ommitment
- **P**artnership
- **A**ccommodation
- **E**vovation

**PRINCIPLES OF MI: RULE**

- **R**educing the “fighting reflex”: The urge to “fix” the client. Arguing for change can have a paradoxical effect.
- **U**nderestimate your client: The client’s reasons for change are most important because these will most likely trigger behavior change.
- **L**isten to your client: MI involves as much listening as informing.
- **E**mpower your client: Convey hope around the possibility of change and support patients’ choices and autonomy in change goals.

**FOUNDATIONAL SKILLS IN MOTIVATIONAL INTERVIEWING: OARS**

- **O**pen-ended questions encourage elaboration.
- **A**ffirmations: Promote optimism and acknowledge the client’s expertise, efforts, and experience of change. Affirmations are not about the practitioner’s approval of the client.
- **R**eflections: The skill of accurate empathy:
  - simple reflections: paraphrase, repeat the content.
  - complex reflections: reflect what the client has said as well as what he or she is experiencing (but has not yet verbalized [the meaning beneath the client’s words]).
- **S**ummaries: The best are succinct and highlight elements that keep the client moving forward. The goal is to help the client organize his or her experience.
Mr. Gonzales experiences heart failure following a heart attack two years ago. His wife nags him to take his blood pressure medication, but he feels fine without it. He watches his weight and fluid retention, which he believes is enough. Plus, he just doesn’t feel motivated to do much more. Mrs. Gonzales worries about him and asks you for assistance in getting Mr. Gonzales to take all his medicine as prescribed. How can you help?

<table>
<thead>
<tr>
<th>What Not To Do</th>
<th>What to do/consider ?</th>
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<tbody>
<tr>
<td>Blame or judge- you remember your heart failure meds- is there a reason that it’s harder to remember bp meds??</td>
<td>Acknowledge and build on successes/ explore strategies for success</td>
</tr>
<tr>
<td>Overlook cultural beliefs/ expect- Many people believe taking meds is a sign of weakness, that is not true</td>
<td>Consider impact of culture- ask where do you get your strength to make difficult changes</td>
</tr>
<tr>
<td>Try to persuade the patient</td>
<td>Understand how family dynamics impact behavior and choices- ask how does your family support you in taking care of your health</td>
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<tr>
<td>Employ the ‘fix it’ approach- I want you to take all your medicine so that you don’t have a heart attack</td>
<td>Create dissonance to foster internal motivation- what’s important to you? How would taking your BP meds help you reach your goals?</td>
</tr>
<tr>
<td>Diagnose the patient- you seem depressed, have you talked to your doctor?</td>
<td>Consider undiagnosed dep- ask what do you think about talking with your doctor about sadness and lack of energy?</td>
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</tbody>
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Amerigroup Case Management Program

Making a referral:
hcmref@Amerigroup.com
Referral Mailbox: 615-882-8212
Member Services Website: https://www.myamerigroup.com/tn/home.html
Provider Services Website: https://providers.amerigroup.com/Pages/Home.aspx

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Let’s identify some barriers and opportunities to address healthcare needs in this region of the State: