The CATESOL Journal

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Meeting the Language Needs of Immigrant Health Professionals: An Innovative Approach

Immigrant health professionals in the US seeking to reenter or advance in health professions need more than English medical terminology to effectively communicate and succeed in the workplace. We have developed an extensive, integrated curriculum based on the identified needs of this diverse population that incorporates meaningful content, critical thinking, and personal and professional development throughout the learning experience. The English Health Train presents an exciting and successful new model of supporting immigrant health professionals to integrate into health careers in the US and, in turn, contribute to a more linguistically and culturally competent health-care workforce.

Background

Among the many challenges facing the health-care sector today is the lack of culturally and linguistically diverse health professionals. While racial and ethnic minorities make up about 33% of the population (U.S. Census, 2006), health professionals from underrepresented minorities make up less than 10% of the total number of physicians (Council on Graduate Medical Education, 2005) and roughly 17% of the total number of nurses (Dionne, Moore, Armstrong, & Martiniano, 2006). Immigrant health professionals, in particular, face substantial barriers to working in professional capacities in the health-care workforce commensurate with their training and experience from abroad.

The San Francisco Welcome Back Center (SFWBC) is the lead site of the California statewide Welcome Back Initiative, whose mission is to "build a bridge between the pool of internationally trained health workers living in the United States and the need for linguistically and culturally competent health services in underserved communities" (SFWBC, n.d.). Established in 2001 as a joint project between City College of San Francisco and San Francisco State University, the center's original purpose was to look within immigrant communities, identify internationally trained health professionals (ITHPs), ascertain if they were using their education and skills in the health sector, and learn

about the specific barriers they were facing to practicing their profession. With sister programs in Los Angeles, San Diego, and Boston, The Welcome Back Centers have collectively identified more than 7,500 ITHPs who were not integrated into their health-care fields at the time of their initial contact with the program.

The San Francisco Welcome Back Center offers case management, counseling services, and educational programs to assist these health professionals in overcoming such barriers so they might return to the health sector, thereby helping to increase the level of linguistic and cultural competence among California's health-care workforce.

First among the main barriers preventing these immigrants from entering health care in the US was acquiring a level of English language proficiency needed to function successfully in the health-care setting—along with compounding issues such as the lack of familiarity with the U.S. health-care system, available time, and financial issues. Even those Welcome Back participants who already had a basic command of the English language reported frustration with the amount of time it took them to further improve their English and the lack of affordable and accessible Intensive English Programs. It was evident that the available English as a Second Language options were not meeting the needs of ITHPs seeking rapid entry into the health sector and/or licensing in their professions.

To fill this gap, the San Francisco Welcome Back Center embarked on the process of developing and piloting a highly specialized, health-focused ESL curriculum. The project was named English Health Train (EHT), referring to the career track and steps required to reach one's goals in health care. The EHT curriculum was designed as an in-depth, yearlong program aimed at accelerating the employment readiness of ITHPs by focusing on the language, communication, and career-development skills needed by this population to enter and succeed in health careers in the US. The curriculum was designed to target both ITHPs who were working outside of the health-care sector as well as those who were working in health-care positions below their capacity or out of context with their experience and training.

Planning for the English Health Train Curriculum

Assessing the Needs of Target Learners

In the first phase of the EHT project, the curriculum team—made up of ESL, curriculum, and health-care specialists—developed a needs-assessment plan with three goals in mind:

- To determine the communication gaps of target learners, based on their current and desired performance in health-care settings;
- To develop a profile of target learners in terms of their current situations, career goals, and learning preferences; and
- To identify critical factors that may affect the long-term success of the new health-care curriculum.

The main informants for the data-collection process were the target learners

for such a program, immigrant health professionals enrolled at the San Francisco Welcome Back Center. In addition, health-care services administrators (particularly those who hire, train, and/or supervise health workers), project stakeholders (e.g., the EHT Advisory Committee), and educators and counselors of the targeted population (e.g., vocational ESL [VESL] teachers and educational case managers) were also key informants. Through a variety of methods—questionnaires, interviews, focus groups, and document review—valuable information about target-learner needs, workplace expectations, and the instructional context was gathered and used as the foundation for curriculum planning.

The main data-collection instrument used for both English learners and health-service administrators was a custom-designed questionnaire. The development of the two questionnaires was informed by a combination of sources, including: existing curriculum framework produced through a previously completed process of developing a curriculum (DACUM), outcomes from advisory and planning meetings, syllabi from other English for health-professional courses, and limited scholarly literature on similar programs (see Bosher & Smalkoski, 2002).

A total of 100 questionnaires were mailed to a random sample of ITHPs registered at the center. In addition, 18 questionnaires were distributed to students taking English for Health Professionals or Vocational English for Health Workers at a local community college. A total of 51 questionnaires were returned from respondents who, as a group, were themselves representative of the extremely diverse population that the center serves.

A total of 31 questionnaires were mailed to a random sample of local health-services administrators working in hospitals, community agencies, and educational institutions. The informants were experts responsible for recruiting, training, and orienting foreign-trained health professionals, as well as those in charge of day-to-day supervision. Such a group was chosen in order to gather information that would help the curriculum team better understand the workplace expectations and desired performance of health-care professionals—specifically foreign-trained professionals—in different health settings. A total of 11 questionnaires were returned from this group.

Responses from both sets of questionnaires were tabulated and processed using the Statistical Program for the Social Sciences (SPSS). In addition, information gathered from interviews with other health-care experts, a focus group with a subset of target-learner respondents, and meetings with ESL educators and case managers working with this population was analyzed and incorporated into the findings about the language needs of ITHPs.

Linking Key Findings to the New Curriculum

In order to directly apply the information gathered from all groups of respondents to the curriculum-development process, emergent findings were linked to specific sets of recommendations that would then lay the foundation for curriculum design and content. These recommendations took into account both demographic information collected about the ITHPs (i.e., gender, country of origin, languages spoken, length of time in the US, former

health profession, and current employment) and respondent feedback from questionnaires on various issues related to immigrant health professionals' past, current, and desired situations. Furthermore, understanding the diverse cultural backgrounds of these target learners was critical to shaping a truly needs-based and learner-focused curriculum.

A sample of findings from the needs assessment, with respective curriculum-focused recommendations, appears below.

Profile of Target Learners	*Recommendation for Curriculum*
Wide variety of language and cultural backgrounds, with majority being Spanish and Chinese speakers	Course content should emphasize cross-cultural themes in health care, with case studies and examples from participants' own cultures; language-practice activities should incorporate intercultural communication strategies throughout.

Respondents were vastly diverse, representing 15 languages and 18 countries.

Profile of Target Learners	*Recommendation for Curriculum*
Majority has been living in US for less than 5 years or more than 10 years.	Curriculum team should gather more information about specific language needs and cultural-adjustment issues of more recent immigrants versus long-term residents in order to build into the curriculum strategies for success for both types of participants.

Respondents had been in the US anywhere from 2 months to 30 years, with the highest percentage in the 1-5–year range (62.9%), representing immigrant health professionals who are still in their initial period of cultural and linguistic adjustment. Interestingly, the next-highest group was not respondents in the midgroup (5-10 years in the US), but those who had been here for more than 10 years (27.3%), representing a different experience level in a new country and perhaps different motives and attitudes regarding English courses for health professionals. (See Table 1 in the next section.)

Profile of Target Learners	*Recommendation for Curriculum*
Most have already taken a wide variety of ESL classes, though only a few have taken English for health care.	New courses should be "marketed" as a very specialized, in-depth program focusing on successful communication skills for health care and directly linked to the participants' lives and current needs.

A large majority of respondents had taken ESL courses in the US, including in many key skill areas (e.g., listening/speaking, writing, grammar). Only 1 respondent had taken an English course specifically for health-care workers. Considering that the vast majority of respondents expressed interest in an

accelerated English for health professionals program, most do see themselves as already having a foundation in English. Significantly, 78.5% perceive their current level of proficiency to be intermediate or high-intermediate.

Profile of Target Learners	*Recommendation for Curriculum*
Mostly trained as doctors, nurses, and dentists	Course content and practical application of skills needs to be partly based on models from careers in these three areas while also integrating a wide variety of health-care careers, with strategies for linking their skills to a variety of career options.

Respondents held a variety of jobs in their countries of origin. Approximately 12 different health professions were mentioned, the most common being doctor or nurse with very similar percentages, followed by dentist and finally other professions (e.g., psychiatrist, pharmacist, physical therapist, and midwife).

Profile of Target Learners	*Recommendation for Curriculum*
Most are working outside their previous health professions in jobs well below their educational and skill level or are unemployed.	Curriculum should include in-depth components on exploring career options and job-search strategies based on the occupational outlook of health-care professions in California; a main program goal should be to increase participants' motivation and confidence to explore different options.

The extremely high number of currently unemployed respondents (almost half), combined with those who were working completely outside the health sector and holding jobs well below their educational and skill level (18%), represented a total of 66%. For example, these jobs included gardening, housekeeping, and construction. Those who were working in health care had taken jobs that did not match their level of expertise—for example, dentists working as dental assistants. Therefore, it was critical to note that in this representative group of ITHPs, 94% were outside their true professions in health care. Only 3 respondents (6%) occupied positions they had had in their countries of origin, and these were all in the nursing field. Another important finding was the fact that those trained as doctors had the highest rate of unemployment (66.6%) among all respondents.

Profile of Target Learners	*Recommendation for Curriculum*
Many are uncertain or unclear about their career goals in health care in the US.	The approach of the entire program should be one of ongoing career and professional development, with self-assessment incorporated throughout as a means of participants' setting attainable goals within the U.S. health-care system.

When asked about career goals, the most popular area of interest was in nursing (42%), including from those originally in other health professions. About a third (30%) of respondents were uncertain or vague about their goals within the US, providing answers such as "I don't know" or "something related to health care," primarily from doctors. In fact, all but 4 doctors expressed uncertainty about their career plans in the US or mentioned jobs that did not match their level of expertise (e.g., medical assistant).

Profile of Target Learners	*Recommendation for Curriculum*
Majority wants to take specialized courses in English for health professionals, including a 1-year program, but some are limited in the amount of time they can commit.	Curriculum team needs to balance participants' real-life situations with achieving objectives of 1-year program and plan courses that are accessible to as many interested ITHPs as possible.

Among potential participants in English for health professionals courses, interest in this type of program was extremely high, with relatively high interest (66.7%) in an accelerated 1-year program.

Profile of Target Learners	*Recommendation for Curriculum*
Most are likely to have access to a computer but do not necessarily regularly use it, including the Internet.	Computer skills (e.g., Internet research) should be incorporated into courses, with increasingly more advanced tasks, as a means of developing additional job skills in participants.

Although the majority of respondents had access to a computer at home (88.2%), a significantly smaller percentage (62.7%) used the Internet regularly. Such findings had important implications for the incorporation of computer- and Web-based activities in the curriculum.

Responses From Employers and Supervisors

Input from the surveyed health-service administrators provided an opportunity to compare perspectives of these decision makers with those of the learner population in terms of the communication needs of ITHPs and the role new courses might play in improving these skills. Results of the survey indicated that the perceptions of the former were quite similar to those of the latter in terms of what would further the success of ITHPs in the U.S. health-care system and culture. For example, health-expert respondents emphasized the importance of such workplace expectations as understanding work requirements, chain of command, accountability, and customer service skills. Such perceptions clearly matched responses from the target-learner survey in which immigrant health professionals recognized their need for understanding roles and responsibilities in a U.S. health-care setting.

The health experts highlighted the need for cross-cultural understanding among ITHPs, many of whom may not have been exposed to the diversity that exists in the US. This drove the curriculum to incorporate strategies for intercultural communication competence as a thread in all three courses, basing content more specifically on the cultures, experiences, similarities, and differences of the learner population for the new program.

Respondents also emphasized the need for ITHPs to learn communication skills such as assertiveness in interacting with supervisors, coworkers, and patients. They also placed a strong emphasis on the skills needed to handle difficult situations and resolve conflicts in terms of communication with both patients and other health professionals. One key implication for the curriculum planners was the need to incorporate a problem-solving approach throughout the courses in which case studies and dialogues involving common areas of conflict are critically analyzed and then the respective language practiced. Another major implication was to acknowledge the intercultural layers involved in the real-life practice of these communication skills and to integrate them into the curriculum.

Review of Existing Materials

A careful review of course materials written for and used in English for health professionals or medical English programs shed further light on the gap between the language needs of ITHPs and the ESL courses available to them. A clear pattern emerged of materials with a limited focus in several critical areas for this learner population: range of topics covered, diversity of health-care professions and cultures represented, applicability of communication strategies included, variety of health-care situations incorporated, and depth of cross-cultural issues addressed. In terms of common methods for language practice, heaviest attention was given to learning vocabulary, specifically medical terminology presented in traditional word lists with controlled exercises and limited contextualization.

Simple situational dialogues (e.g., between patient and medical receptionist or nurse and doctor) were clearly more prevalent as a basis for language practice than more challenging interactions or health-care issues. In addition, only rarely were direct links made between the learner's own health profession and topics presented. And very important, the overall language goals in most materials for this population focused more on *survival* in the health-care workplace than *achievement* or *advancement*. Given the profile of these target learners as highly educated and highly motivated, often with an extensive background in health care from their own countries (which often included the reading of medical texts in English), the mismatch between their real needs and the ESL courses and materials available to them was significant.

Developing the New Curriculum

Principles of Course Design

Based on the analysis of documented learner needs, the EHT team developed a curriculum plan establishing the goals, objectives, and sequence of learning through three semester-long courses making up the 1-year program.

In turn, the goals of the new curriculum led to the organization of the content into five main modules. At the end of the 1-year program, participants were expected to have improved communication skills in English based on their increased ability to:

1. Use strategies and skills for pursuing career goals in health care and making informed career choices. (Module 1)
2. Communicate effectively and appropriately with patients and families in health-care settings. (Module 2)
3. Communicate effectively and appropriately with other health-care professionals in health-care settings. (Module 3)
4. Understand systems, requirements, and issues in health care in the US and California. (Module 4)
5. Understand how cross-cultural beliefs, traditions, and behaviors affect everyday communication in health care. (Module 5)
6. Use strategies and skills for exploring their own ongoing professional development beyond the current program. (All Modules)

In developing the curriculum, special attention was given to identifying content areas and methodologies that were adaptable to different learning contexts and instructional modes. It was deemed critical that the learner-centered curriculum integrate a focus on career and professional development skills, as well as intercultural communication strategies, throughout the three courses. Using the integrated modular design, the team developed units and language activities that would provide students ongoing opportunities for meaningful practice in all language skills, critical thinking by comparing and analyzing health-care contexts and situations, and personalization based on their own cultures, health professions, and career goals.

In addition, emergent themes identified in the California statewide *Welcome Back Initiative Synthesis Report* (Fernández-Peña & Clayson, 2004), such as loss of professional identity, commitment to underserved communities, and flexible career pathways were also integrated throughout the curriculum in a variety of language-based ways to make the learning modules more relevant to the realities and needs of participants.

Flexible Curriculum Model

The completed curriculum consists of 40 8-hour units, based on five major themes/modules, as well as special project and assessment components. The three courses build directly on each other and develop learners' skills at an increasingly higher level (progressing from a low-intermediate to high-intermediate level of English proficiency) across thematic modules. (See Appendix A for the full EHT curriculum chart.)

The curriculum is designed in a way that can be implemented as a whole or in part since all modules and units are both linked and self-contained in terms of the objectives, topics, and skills covered in each. This structure clearly lends itself to delivery of the curriculum as semester courses, short courses, a series of theme-based workshops, or special one-day sessions. In addition, the

modular approach of EHT is also applicable to Web-based distance education for even broader access by different ITHPs. As a 1-year program, EHT offers the flexibility of course work that ranges 320-400 hours.

Types of Integrated Activities

All units in the curriculum consist of a variety of activities that help develop language and communication skills, prepare participants for everyday and challenging situations in health-care environments, and incorporate career-advancement strategies. Oral and written communication tasks include: listening exercises (interviews, conversations, lectures, etc.), case studies, role-plays, questionnaires, group discussions, presentations, and language-focus exercises (for examples see Appendix B). Weekly take-home assignments allow participants to practice health-care–focused reading and writing, vocabulary, and critical thinking. Out-of-class projects that engage student learning in media and community (e.g., Internet research, TV/video viewing, community research) appear at the end of all units.

Profile of the Pilot Group Learners

From January to December 2005, the complete EHT curriculum was piloted through the San Francisco Welcome Back Center. In the spring, summer, and fall semesters, three courses were delivered to the same core group of participants. The pilot aimed at evaluating the new materials and program as a whole in order to make needed improvements and prepare for the successful dissemination of the curriculum beyond the pilot phase.

The group of participants from the San Francisco Bay Area selected to participate in the 1-year pilot program was very diverse in terms of health professions, countries of origin, first languages, length of time in the US, and career goals.

Table 1
Profile of EHT Pilot Participants

Health professions	Nurse (11), physician (10), dentist/oral surgeon (5), lab technician (2), anesthesiologist (1), obstetrician (1), physical therapist (1)
Countries of origin	Mexico (9), China (5), Colombia (3), Peru (3), Russia (2), Moldova (2), Chile (1), Nicaragua (1), Dominican Republic (1), Indonesia (1), Burma (1), Yemen (1), Morocco (1)
First languages	Spanish, Mandarin, Cantonese, Russian, Indonesian, Burmese, Arabic
Length of time in US	2-18 months (10), 2-5 years (18), 10-12 years (3)

Career goals	Nursing, medicine, dentistry, allied health professions, alternative medicine, medical interpreting, medical research, and so on

The instructor selected for the pilot program had both a health-care background and ESL expertise—an ideal, though not necessarily a common, combination for such courses.

Findings From the Pilot Project

Participant Feedback

Through a rotation system in which a different group of participants completed an evaluation form for each unit, the participants provided feedback on the following aspects of the curriculum: relevance of content, interest of health-care topics and issues, variety of activities, language skills covered, level of student involvement, level of materials, effectiveness of project work, and overall quality.

Participants were most satisfied with *content relevance, level of interest of topics/issues*, and *out-of-class work. Different language skills* received the lowest ratings, perhaps because of participants' preference for additional, more traditional practice in grammar and pronunciation, as documented in their written comments.

> I think this program designed for health professionals is an excellent opportunity to learn the perspectives, the customs, and professional methodology followed in this country. I think it has helped me to develop myself in health care. Also, it has helped me to share opinions with health professionals from different careers and countries. In my opinion, this program is great; it's an incentive to see more people fighting for the same goal. (EHT pilot program participant from Mexico)

In terms of the qualitative comments that students made in their feedback forms and in the end-of-program focus group, several patterns emerged. All participants provided overwhelmingly positive feedback on the curriculum as a whole and verbally emphasized the relevance of the program for achieving their health-care goals. Many emphasized that they were confident they had improved significantly in their English proficiency and ability to explore different career options in the US. They also thought the graded level of the materials was appropriate for them. Participants particularly valued the group work, the exchange of ideas with other ITHPs, the variety of activities and skills, the out-of-class project work, and the cross-cultural emphasis throughout.

The most frequent suggestions for improvements focused on a need for more discrete language practice (grammar and pronunciation), the incorporation of more videos or on-site visits to exploit authentic health-care situations, more explicit instructions for the computer-based project work (including providing various options for each assignment), more Internet resources and Web sites, and more time allotted for units that cover less

familiar themes for participants (e.g., caring for disabled patients and online professional development).

Learning Outcomes

A variety of methods were used to measure the participants' learning outcomes in the individual courses and in the program as a whole. The assessment process included both formative and summative means, written and oral tasks, and teacher and participant (self-) assessment.

All 25 participants in the core group who completed the pilot program satisfactorily achieved the EHT objectives. All demonstrated an improvement in their proficiency in English communication and career-development skills, as evidenced in various measures of learning. Evaluation activities consisted of oral interviews, written exams, special projects, and self-assessments. Many demonstrated very significant gains in both oral and written skills, as high as 295% improvement, with an average of 99.5% for written and 55.8% for oral skills. The results of the summative assessment were supported by the consistently high scores participants received in their integrated skills project work, culminating in their final projects and portfolios. Following is a brief description of key evaluation activities conducted in the pilot program to measure learning.

Oral Interview. The pilot participants were individually interviewed at the start of the program and 1 year later, at the end of the program. Through a semistructured interview format with two interviewers, participants were asked a set of varying questions on personal, professional, and current health-care topics. An oral-skills rubric based on a 5-point scale was used, focusing on criteria such as linguistic accuracy and facility of expression. All interviewers observed a marked improvement not only in the quantitative scores for oral skills, but also in the quality and length of the responses by participants interviewed. Significantly, an increased level of confidence was evident in all participants, including those who had been shy and reticent to speak at the start of the program.

Written Test. A pretest and posttest were administered for each of the three courses. This timed written exercise consisted of a variety of graded tasks that focused on the communication and career-development skills covered in units and modules.

Project Work. The EHT course materials include a special out-of-class project at the end of each unit meant to provide participants with further communication-skills practice and research-skills development, as well as the opportunity to apply the unit content to their own health-care fields and goals. For example, the project for a unit on career pathways has students research and chart requirements on the Web for three relevant health professions they would like to pursue; a unit on communicating with patients has students observe effective questioning and interviewing techniques that are applicable to health-care situations; and a unit on communicating with coworkers has them do a self-assessment on their own assertiveness skills.

A project-based rubric was used to assess the participants' work and give them detailed feedback for ongoing improvement. The rubric indicators were based on various criteria: timeliness, completeness, relevance,

authenticity, accuracy, and professional presentation. Participants were also required to keep their best project work in an individual portfolio, which was periodically self-assessed and reviewed by peers and the instructor. These portfolios were displayed at the end of the pilot program as rich evidence of the significant progress participants had made during the course of the year. The majority of participants consistently produced high-quality projects based on careful, relevant research (primarily Web based) and preparation outside of class. Numerous projects relied on collaborative group work, which was usually begun in class.

The final project for the program, at the end of the third course, was a longer group presentation that integrated high-intermediate oral, written, and research skills. This project was also a culmination of several key themes in the curriculum, with a special focus on health-care disparities and underserved communities—including in their own ethnic communities. The quality of these final projects was particularly impressive, with such topics as "Diversity in Health Care Professions in California," "HIV/AIDS in the Latino Community," "Health Issues in the Russian Immigrant Community," and "Fertility and Family Planning in Ethnic Communities." Many groups presented their findings in professional graphs and charts, some using such tools as PowerPoint for the first time. Based on a 0-100% scale, and evaluated by three educators, the final group projects received scores ranging from 77% to 97%, with an average score of 90%.

Self-Assessment. Finally, assessment within EHT was carried out in partnership with learners as an "ongoing dialogue" rather than as a sequence of discrete events. Self-assessment tools were used to encourage learners to understand and analyze their own current and desired performance in English language skills for health care, to help them build a system and tools for documenting their professional skills and achievements in health care, and to promote self-evaluation as a means of defining, pursuing, and assessing their own communication and professional goals. (See Appendix C for sample self-assessment rubrics based on unit content.)

Unintended Outcomes

Even though a measurement of postprogram impact has not yet been tested, evidence emerged during the course of the pilot program demonstrating positive employment and educational outcomes for 22 of the 31 participants before the pilot phase was even completed. Of the 31 participants, 10 obtained jobs in health-care positions, while 8 entered a health-care training program, and 4 passed their licensing exams. It is critical to note here that *all* of these participants directly attributed such changes to the impact the EHT experience had on them.

> I gained a lot from the English Health Train program. I improved my English, I learned a lot about the health care workplace, but above all, I regained self-confidence. Now I know what I want to do. I have no doubt I can work in this country, pursue my education, and be successful. I think my classmates and friends feel the same way. We come from differ-

ent countries and cultures, but we all have the same goals: to work in the health care field, serve the whole community with our knowledge and skills, in spite of its diversity, and gain personal satisfaction. (EHT pilot program participant from Morocco)

Pilot participants consistently identified an increased "level of self-confidence" as a major outcome of participating in the EHT program, such as the confidence needed to explore new career options, interview for new jobs, enroll in new courses, and generally move closer to achieving their goals in the US. Although more difficult to quantify, this type of impact was continually mentioned in their feedback forms, personal stories, and many informal discussions. It was also a common theme in their testimonials at their graduation ceremony.

Another important unintended outcome worth noting was the strong community that developed among the participants in the program. They increasingly supported each other and celebrated each other's successes of all types. This was another theme that they commented on frequently in oral and written form throughout the evaluation process. In the final group meeting, several participants noted that because of this community, they would not recommend making EHT a fully Web-based or online program.

Challenges and Lessons Learned

The major challenges, and opportunities, that arose in developing and implementing the extensive new EHT curriculum included:

- The inherent challenge in meeting the needs of an extremely diverse population—taking into account their different cultural backgrounds, health-care professions, amount of time in the US, and language needs—in a 1-year program. The team needed to continually consider how the curriculum could be as accessible to as many ITHPs as possible yet maintain the quality and relevance of the program.
- The difficulty for the team in striking a balance between developing a far-reaching curriculum and not being overly ambitious. Each theme and unit topic opened up a wealth of possibilities, requiring intense analysis and negotiation by the team about where to "draw the line" without cutting a critical health-care issue short. Along these same lines, the range of evaluation and assessment methods piloted was extensive and rather ambitious. This, too, posed both challenges (e.g., for instructor and participants) and opportunities (e.g., to determine the most effective, learner-centered assessment plan for EHT).
- The challenge for the participants to accompany a very intensive program for the period of 1 year in terms of both attendance and motivation given their many other obligations. Fortunately, even though some attrition occurred, a core group maintained the momentum required and even ended the program with the same enthusiasm with which they started. However, this was a challenge to consider for further implementation of EHT and another reason the curriculum was based on a flexible modular design.

10 Critical Factors for Success

In reflecting upon the pilot program, the EHT team identified 10 special features of the curriculum that made this a meaningful learning experience and unique language curriculum for ITHPs in the US, each of which was a critical component to the success of the program.

1. Directly based on the identified needs of the ITHP population and reflects their diverse backgrounds and goals;
2. Provides meaningful practice in a wide range of language skills within an integrated curriculum—from active listening to critical-thinking skills;
3. Uses a content-based and task-based approach to merge relevant, up-to-date health-care content with intensive language practice;
4. Promotes self-development and self-assessment within a process of ongoing improvement for participants;
5. Builds a community among the participants in which they continually exchange experience, expertise, and support through varied activities and modes of interaction;
6. Assists participants in developing their own job-search and career-development strategies through personalized projects, such as professional portfolios;
7. Integrates cross-cultural issues and intercultural communication skills throughout, based on relevant scenarios, case studies, and diverse patient and health professional profiles;
8. Provides ongoing opportunities to analyze challenging and emerging issues in health care—such as at-risk populations, alternative health perspectives, and health disparities—within a meaningful language curriculum;
9. Takes into account the *whole* participant, beyond discrete language deficiencies, and aims at increasing the confidence ITHPs need to overcome educational and professional obstacles to achieving their goals in health care;
10. Creates a direct link with the Welcome Back mission by building into the curriculum opportunities for participants to explore diverse, underserved populations in the US and propose ways to better serve them.

Beyond the Pilot Year

Experience to Date

In 2006 the EHT program was approved by the curriculum committee at City College of San Francisco and has since become institutionalized into the ESL curriculum.

As word of EHT spread, the San Francisco Welcome Back Center began to receive many requests for the new curriculum and for guidance on how to implement it successfully. After the successful institutionalization at a local community college as three credit courses, the center embarked on the strategic dissemination of the new program to the many institutions serving the ITHP population that expressed interest in adopting EHT.

To ensure the appropriate and effective implementation of the curriculum at different sites with varied needs, a full 1-day orientation and training-of-trainers workshop was offered based solely on demand. To date, more than 50 educational institutions from throughout the US have been reached through these sessions. The audiences have consisted of educational administrators, program directors, ESL/VESL coordinators, curriculum planners, and instructors from ESL, nursing, health sciences, and health education departments. The extremely positive response to the extensive curriculum by all institutions involved further validated the need for a new approach to meeting the language needs of ITHPs.

An evaluation of long-term outcomes is now being planned to formally measure the impacts of the program on the participating immigrant health professionals. As the model is adapted and implemented in different institutional settings across the US, a plan to document the various iterations and applications of the curriculum is in progress for the purpose of identifying best-practices models for wider dissemination.

Conclusion

From everyone involved in the 1-year pilot of the new English language program for immigrant health professionals, there was overall consensus that the curriculum was unique and had the potential to fill a huge void that existed regarding the means available to help ITHPs overcome the language barriers they face in the US. The learning outcomes of the 1-year pilot program were impressive in all measures, both oral and written, summative and formative. Perhaps the most remarkable evidence of the program's success, however, were the unintended outcomes that occurred, from the health jobs attained before the end of the program to the high level of regained confidence directly attributed to EHT by the participants. Their own voices and stories provided the greatest rationale for sustaining, supporting, and expanding a program that brought these immigrant health professionals much closer to reaching their goals in the US, or that empowered them to explore new ones.

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References

Bosher, S., & Smalkoski, K. (2001). From needs analysis to curriculum development: Designing a course in health-care communication for immigrant students in the USA. *English for Specific Purposes, 21,* 59-79.

Council on Graduate Medical Education. (2005). *Minorities in medicine: An ethnic and cultural challenge for physician training.* Washington, DC: US Department of Health and Human Services, Health Resources and Services Administration.

Dionne, M., Moore, J., Armstrong, D., & Martiniano, R. (2006). *The United States health workforce profile.* Rensselaer, NY: Center for Health Workforce Studies, School of Public Health, SUNY Albany. Retrieved January 9, 2009, from http://chws.albany.edu/index.php?id=11,0,0,1,0,0

Fernández-Peña, J. R., & Clayson, Z. (2004). *Welcome Back Initiative synthesis report.* Unpublished report.

San Francisco Welcome Back Center. (n.d.). Mission statement. Retrieved January 9, 2009, from http://welcomebackinitiative.org/sf/about

U.S. Census Bureau. (2006). Nation's population one-third minority. *U.S. Census Bureau News.* Washington, DC: U.S. Department of Commerce. Retrieved January 12, 2009, from http://www.census.gov/Press-Release/www/releases/archives/population/006808.html

Appendix A
English Health Train Curriculum Plan

	MODULE 1 *Exploring Career Goals in Health Care*	MODULE 2 *Communicating with Patients and Families*	MODULE 3 *Communicating with Other Health Professionals*	MODULE 4 *Exploring Critical Issues in Health Care*	MODULE 5 *Intercultural Communication in Health Care*
COURSE A					
UNIT 1	Health Care Professions and Career Paths	The Patient-Health Professional Relationship	Interaction among Health Professionals	Understanding Health Care Systems	Culture and Communication in Health Care
UNIT 2	Requirements for Entry in Health Field	Gathering Patient Information	Using Medical Terminology Appropriately	Understanding Health Care Cultures and Sub-Cultures	Beliefs and Traditions about Health and Illness
UNIT 3	Job Search Skills	The Patient-Centered Interview	Assertive Communication with Co-Workers	Critical Health Issues in the U.S.	Cultural Diversity in Health Care
COURSE B					
UNIT 4	Job Application Process	Examining and Monitoring Patients	Professional and Social Communication	Healthy Lifestyles and Behaviors	Serving Multicultural Patients
UNIT 5	Job Interview Skills	Developing a Treatment Plan	Working Effectively on a Team	Alternative Health Perspectives	Working with Multicultural Health Professionals
COURSE C					
UNIT 6	Professional Behavior and Workplace Expectations	Medical Charting and Reporting	Supervising Health Professionals	Health Care for an Aging Population	Cultural Disparities in Health Care
UNIT 7	Work & Safety Issues for Health Professionals	Patients with Special Needs	Telephone and Electronic Communication	Legal & Ethical Issues in Health Care	Analyzing Needs of Cultural Communities
UNIT 8	Professional Development in Health Care	Handling Challenging Situations with Patients	Handling Challenging Situations with Co-Workers	Future Directions for Health and Health Professionals	Serving Underserved Communities

Appendix B
Sample Activities for the Classroom

MODULE 2 – Communicating with Patients & Families
UNIT 1 – The Patient - Health Professional Relationship

LESSON 2: THE RIGHTS OF PATIENTS AND FAMILIES

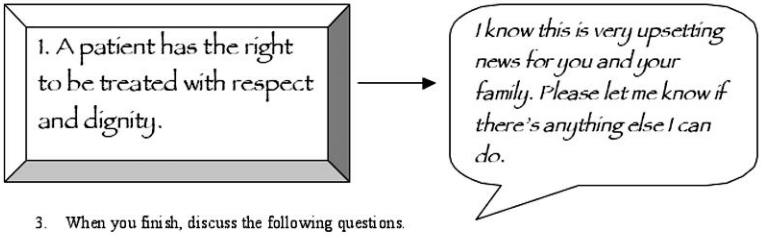
2B Matching: Understanding Patient Rights

Think About It We all have rights and responsibilities in our society, in our work, and in our families. What responsibilities does a patient have? What rights does a patient have?

Groups

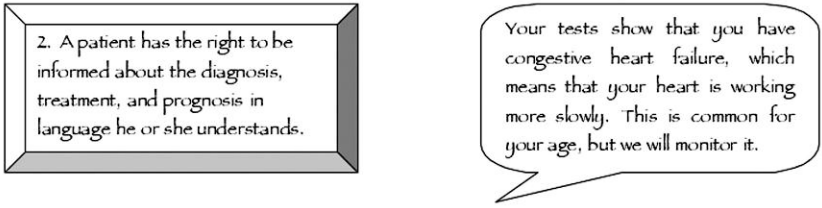
1. Your teacher will give each group two sets of cards:
   - **SET A** – Nine Patient Rights
   - **SET B** – Statements by health professionals to patients that show an understanding of these rights.
2. Match each patient right with the correct statement.

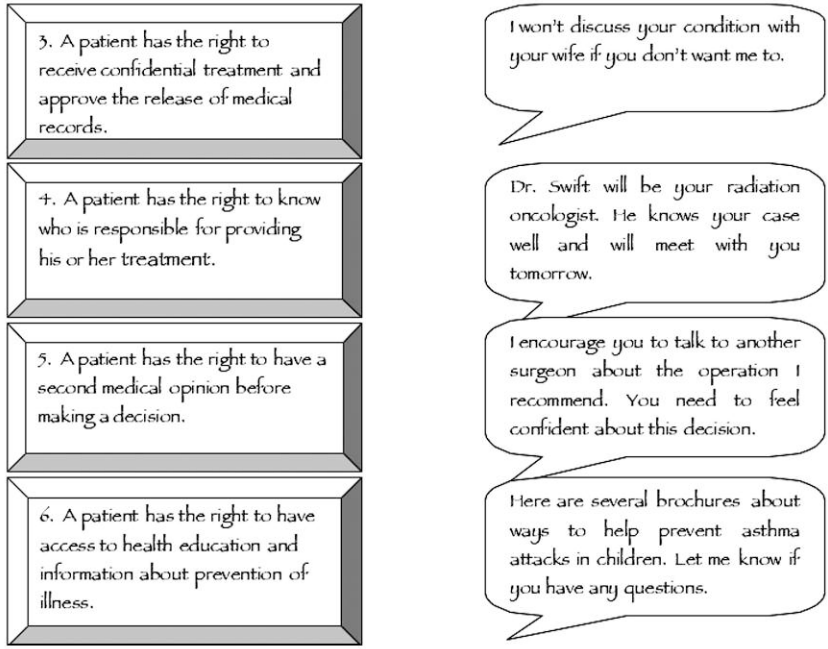
Example



3. When you finish, discuss the following questions.
   a. Do you think some patient rights are more important than others? Rank them from the most to the least important.
   b. Think of another example of what a health care professional might say for each Patient Right card in your profession.
   c. What *responsibilities* do patients have? List a few.
   d. How are these patient rights and responsibilities similar to or different from those in your country?

Patient Rights Cards





MODULE 4 – Exploring Critical Issues in Health Care
UNIT 5 – Alternative Health Perspectives

LESSON 1 – TYPES OF INTEGRATIVE MEDICINE

1A Find Someone Who: Personal Experiences

Think About It Is your attitude and approach to health care shaped more by your experience as a patient or as a health professional? Would you say your approach is mostly a biomedical, a popular, a folk or traditional, or an alternative one?

Whole Class Survey the class about their experience with alternative medicine.

1. Read the statements in the *Find Someone Who* chart below.
2. Walk around the classroom and ask different classmates about their experiences.
3. When a classmate answers "Yes" to a question, write his/her name next to that idea.

Find Someone Who. . .		Name
1.	…has been to a chiropractor for a back problem.	
2.	…knows a lot about acupuncture.	
3.	…has prescribed herbs to a patient.	
4.	…meditates regularly.	
5.	…knows a homeopath very well.	
6.	…has studied massage therapy.	
7.	…can teach the class a few qigong movements.	
8.	…knows what CAM means.	
9.	…can list a few preventive methods for the common cold.	
10.	…would like to study integrative medicine.	

Whole Class Use the results of your survey to find out more about your classmates. For each item, take turns asking classmates who answered "Yes" a few more questions.

Example *Why did you try this? What were the results?*

MODULE 5 – Intercultural Communication in Health Care
UNIT 2 – Beliefs and Traditions about Health and Illness

LESSON 2 – COMMUNICATING ACROSS CULTURES

2A Case Studies: Cross-Cultural Situations

Think About It In health care, communication between people from different cultures can be affected by many factors. Four of these factors are listed below. Can you think of an example of each (e.g. *hand gestures* for non-verbal communication)?

A Language
B Non-Verbal Communication
C Beliefs about Health
D Family Traditions

Whole Class Read the situation below. Which factor(s) caused the problem? Write the correct letter(s) in the box.

CASE 1 ☐

Juan and Teresa Rodriguez are from Mexico. They take their 10-year-old son, Carlitos, to see the pediatrician. Juan's brother, Miguel, gives them a ride. The receptionist gives them several forms and Miguel begins to fill them out. When the nurse asks them to go see the doctor, all family members go in. Dr. Kline, the pediatrician, is surprised to see so many people in his office. He smiles at Carlitos and tries to talk to him and ask him questions. But the adults interrupt to tell the doctor about the problem. Carlitos is very quiet. Dr. Kline looks at the forms and sees that most of the information is missing. He feels frustrated because he wants to know how Carlitos feels and understand the case better.

Pairs Discuss the questions below.

1. What was the problem?
   - Why did everyone go into the doctor's office?
   - Why didn't Carlitos answer the questions?
   - Why was Dr. Kline frustrated?
2. How could the problem be resolved?
   - What could the doctor do to improve communication with the family?
   - What could he say to the family?
3. Have you ever had a similar experience?
   - As a patient? As a health care professional?
   - How did you feel? What did you do?

MODULE 5 – Intercultural Communication in Health Care
UNIT 7 - PROJECT WORK

Planning Research: Current Information on Disparities

On Your Own You will research the current situation regarding health disparities in the U.S. for a specific ethnic or racial community of patients or health professionals.

1. What do you want to find out more about? Check one or more areas below and fill in more specific information, if needed. (You can refer to Module 5, Unit 3 for common groups in the U.S.)

   - ❑ ethnic/racial group _____
   - ❑ type of patients _____
   - ❑ type of health professionals _____
   - ❑ type of health condition _____
   - ❑ type of treatment _____
   - ❑ geographic area _____

2. What is your research topic? Combine the elements above and write your topic.

   Example *Diabetes in the Mexican population in California*

   Your Topic _____

3. Why are you interested in this topic? Write your rationale below.

4. Walk around the classroom and find classmates who have the same or a similar topic as yours. Briefly discuss the rationale for each of your choices.

Groups Form new groups based on similar topics and common interests in exploring health disparities in specific communities. Your group will work together on the final project for Module 5.

Appendix C
Participant Self-Assessment Rubric

Outcome 1: Uses strategies and skills for pursuing career goals in health care and making informed career choices.

Indicator	Basic ***Need to develop skills & confidence in this area***	Developing ***Making some progress and have begun to acquire skills & confidence***	Proficient ***Skills and confidence have developed significantly***	Advanced ***Highly proficient level of skills and fully confident***
• I am aware of different career choices in health care in the U.S. and ways to research these.				
• I know about the U.S. educational requirements for health care professions.				
• I know about the duties and responsibilities of health care professions in the U.S.				
• I use various strategies and resources to find job openings in the U.S.				
• I can plan the steps of successfully searching for a job in the U.S.				
• I know how to fill out job applications appropriately and describe my experience, skills, and career goals.				

Outcome 5: Understands how cross-cultural beliefs, traditions, and behaviors impact everyday communication in health care.

Indicator	Basic ***Needs to develop skills & confidence in this area***	Developing ***Making some progress and has begun to acquire skills & confidence***	Proficient ***Skills and confidence have developed significantly***	Advanced ***Highly proficient level of skills and fully confident***
• I am aware of cultural factors that affect communication in health care situations in the U.S.				
• I can ask appropriate questions to learn about patients' cultures, values, and beliefs.				
• I am aware of my own cultural values and beliefs, as well as mainstream American values, and how these can affect interactions with patients.				
• I can identify different cultural beliefs about health and illness and related healing practices.				
• I am aware of cultural diversity in California and the U.S. and how this affects health care.				
• I am aware of different types of bias and discrimination that can affect health care for diverse populations.				