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HEALING HANDS

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Paso a Paso: Step by Step Toward Cultural Competence

Achieving cultural competence — the ability to communicate effectively across different linguistic and cultural traditions — is necessarily a gradual process. For clinicians, this requires close examination of health-related attitudes and beliefs — their clients' and their own. The following articles suggest some steps that homeless health care providers can take to begin the journey. To simplify this task while illustrating its complexity, we have chosen to focus on the clinical challenges presented by homeless persons whose primary language is Spanish, and how experienced clinicians are meeting them. Many of the lessons learned from these service providers are applicable to other cultural groups.

Communication barriers are among the most serious impediments to health care for residents of the United States whose native tongue is Spanish. The medical consequences of miscommunication can be catastrophic. In a memorable episode of a popular television series, a Hispanic woman with tuberculosis misinterpreted the written instructions on a bottle of pills that read, "take once daily." The patient took eleven pills at one time, with fatal consequences. In Spanish, "*once*" means "eleven."

> People of Spanish/Hispanic/Latino origin now comprise 12.5% of the total US population, over 23% of persons living in poverty, 17% of HCH clients, and approximately 11% of surveyed homeless service users nationwide.
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> *2000 Census; 2000 UDS; National Survey of Homeless Assistance Providers & Clients, 1996*

Miscommunication stems from misunderstanding. "Often clinicians don't understand what their Latino/Hispanic patients are saying, even if they speak the same language," observes **Ed Scully, MD**, of Greater Lawrence Family Health Center in Kingston, New Hampshire. Although most of his homeless patients are "Anglo," a significant number are from Puerto Rico, the Dominican Republic, Guatemala, or Colombia. Even bilingual(English-Spanish) clinic staff are challenged by the variety of dialects, linguistic idioms, health beliefs, and cultural values they encounter among these Spanish-speaking clients.

"Hispanic countries are not unicultural," **Linette Martinez, MD**, Homeless Coordinator at the Tom Waddell Health Center in San Francisco, reminds us. "It's very hard, even for a Spanish-speaking clinician, to gain insight into a patient's beliefs about health and health care." For example, it is more shameful for Latino males than for other homeless men to admit behaviors that increase their risk for HIV. Consequently, they don't seek screening as readily as other clients. "We see an unusual number of transgendered homeless patients from Latin America who are at huge risk for HIV," she says. Engaging them in HIV prevention and treatment requires skillful outreach. Martinez is also seeing a growing number of young, homeless men from remote areas of Mexico such as Chiapas, who have never seen a physician before. They speak a mixture of Spanish and their indigenous language. Martinez, who is Puerto Rican, has trouble understanding these patients.

"Essential to cultural competence is learning who your clients are and where they come from," declares **Edmundo Apodaca, LMSW** Albuquerque Health Care for the Homeless. Several cultures are represented among Spanish-speaking people in New Mexico — those whose Hispanic ancestors settled the northern part of the state generations ago; individuals of mixed Spanish, Mexican and Native American heritage; indigenous Mexicans and immigrants from Central or South America; a few Puerto Ricans; and Cuban refugees.

As a first-generation "Hispanic American," Apodaca admits that he is less fluent in Spanish than his immigrant parents. Explaining the process and rationale of behavioral health care to Spanish-speaking clients of diverse backgrounds is one of the greatest linguistic and

cultural challenges he faces. "The stigma against mental illness and substance abuse is present in both American and Hispanic cultures," he observes. "People fear disclosing their mental illness and don't understand what it is." Although some of his clients believe that mental illness is a result of divine providence or is caused by an external agent, only those from very isolated places without access to modern medicine believe in curses or evil spirits as sources of illness. Some traditional Native Americans still speak of "shape shifting" as an explanation of schizophrenia. Whatever their cultural background, his Spanish-speaking clients try to inform him as best they can what their problem is. Most come to the clinic expecting treatment, but many believe that substance abuse is best resolved through abstinence alone. "This isn't particularly effective for persons with heroin addiction," he says, which is "a big problem for clients from rural Mexico who try to cure themselves," usually without success.

"Customs of people from rural and urban areas differ," observes **Jenny McLaurin, MD, MPH**, who works for the Migrant Clinicians' Network and two rural health departments in North Carolina. She serves migrant farmworkers, many of them homeless, typically in rural areas where there aren't as many resources for people with different cultural and linguistic backgrounds. "Migrants tend to travel in groups with the same geographic origin," she says. In North Carolina, most farmworkers are Mexican, but some are from Guatemala, Honduras, and Puerto Rico. "Cultural origin influences patients' attitudes toward health care," agrees McLaurin. "For example, patients from Guatemala don't know the year or month of their child's birth, are used to home births, and are not as accepting of physicians."

Three categories of barriers contribute to the dissatisfaction of Latinos/Hispanics with health care providers and services, according to research cited by the National Council of La Raza:[6]

- **Availability:** long waits and inconvenient hours in health care settings, often requiring employed persons to miss work;
- **Accessibility:** lack of transportation, health insurance, and childcare; cost of services (especially specialty care and mental health services) and fear of deportation;
- **Acceptability:** few health care personnel who speak their language and understand their culture; lack of accurately translated health information, written at appropriate literacy levels, and containing concepts that reflect their cultural norms; failure to involve the family or cultural community in health promotion and disease prevention.

All of these obstacles seriously limit access to health care. Cultural competence of service providers is only one step in assuring that the health care needs of native Spanish speakers experiencing homelessness are met. ■

Balancing Traditional with Modern Healing

In general, people of Latino/Hispanic origin have a more holistic understanding of health and health care than is characteristic of Western medicine. They are more concerned about how the treatment of health problems will affect the emotional and spiritual well being of both the individual and the kinship group. Depending on their cultural and educational background, they may consult traditional healers, who are sensitive to these concerns, and use home remedies as an alternative or in addition to seeing medical professionals.[6]

Among the traditional healers preferred by native Spanish speakers are *curanderas* (who use herbs, teas, fetishes and prayers to cure a wide variety of illnesses), and *sobradores* (who repair dislocated joints, set bones, and provide massage therapy). It is important to acknowledge the patient's explanation of illness and preferred remedies, while ensuring that the treatment modalities used are compatible and do not endanger the client's health, according to homeless service providers. Cultural competence is key in achieving this sometimes delicate balance.

Jenny McLaurin, MD, MPH advises cooperating and collaborating with traditional healers. "If diabetic patients try to substitute herbs for insulin, find out what herbs they are using," she suggests. "If they are safe, let them take both herbs and insulin. If not, tell them why not."

> "In making a diagnosis, health care providers must understand the beliefs that shape a person's approach to health and illness. Knowledge of customs and healing traditions is indispensable to the design of treatment and interventions."
> *National Center for Cultural Competence*

Among Mexicans there is a common belief that injections are necessary to cure many illnesses, and there is widespread use of lay injectors who administer injections of vitamins and penicillin, reports McLaurin. "It is important to ask clients if they are getting injections or medications from anyone else," she says. Some clinicians invite traditional injectors to the clinic to educate them and their patients about the danger of transmitting HIV or hepatitis C with unsterilized needles. The best way to do this is through lay health educators (*promotoras*), she advises.

"Lay educators are used all over the world as an effective means of grassroots health education," explains McLaurin. *Promotoras* travel with the migrant community from Michigan to Texas, and help migrant workers recognize when they need primary health care. They partner with health clinics, often providing a valuable "bridge" between traditional health practices and Western medicine. Hispanic people turn to *promotoras* for advice. "Homeless advocates could be trained to perform that function," she suggests.

Edmundo Apodaca, LMSW always inquires of his clients what medicines and/or herbs they are taking, where they got them, and whether the treatment has been helpful. Then he explains that using herbs with prescribed medications could have an adverse effect, and informs their medical provider if they are seeing a *curandera* or *sobrador*, or using herbal remedies.

Uña de gato ("cat's claw") is an herb that is sometimes used to alleviate pain, diabetes, and inflammatory disorders, reports **Linette Martinez, MD**. She has found no evidence of its harmful effects, but if the chemical properties of medicinal herbs cannot be determined, she tries to persuade her patients not to use them with the medications she prescribes. "Respect your clients' beliefs, but inquire about them," advises Martinez.

"Ask, 'What do you think you have?' and 'What have you done about it?' Patients usually have a theory about what to do to relieve their discomfort. Listening with respect builds rapport." Her clients appreciate the fact that she is not dismissive of their ideas. They often bring her tea that is frequently used by Puerto Ricans "to cure nearly everything," as a thank you. ■

Building Rapport with Spanish-speaking Clients

Language and cultural barriers prevent many Spanish-speaking homeless people from seeking services. Confronting an unfamiliar health system and communicating their needs can be so daunting that they don't seek care except in an emergency. Undocumented immigrants are particularly hesitant to seek services, even when they are urgently needed, for fear of being deported. To alleviate these fears and build rapport with native Spanish-speakers, experienced clinicians recommend the following:

- **Demonstrate respect (*respeto*) by adhering to cultural norms related to age, gender, social position and authority.** Be more formal in addressing and interacting with adult clients. Don't use a child or someone of another gender as an interpreter. Be careful how you ask women questions. Asking a Latino/Hispanic woman where she spent the night (to determine homelessness) could be offensive. It suggests sexual promiscuity, which is taboo in her culture. Ask someone from the Spanish-speaking community how to phrase this question in the least offensive way.

- **Recognize the role of the family (*la familia*)** in making health care decisions. When a Hispanic family comes to the clinic, make all members feel welcome; this may be their only chance to see a health care provider. Ask who within the family influences health decisions for the patient. Ask how a given treatment or therapy would affect the family, and whether there are any concerns about it.

- **Invest in trained interpreters rather than relying on free interpretation services, lay people, or a family member** to interpret for your clients. If possible, hire a trained interpreter, provide training in interpretation skills for bilingual clinic staff, and educate providers about how best to utilize interpretive services. Even if you speak Spanish, know your linguistic limitations.

- **Listen to your clients; ask open-ended questions that don't require only a yes or no answer.** Ask questions that invite clients to share their perceptions of their health status and needs. For example, *"What do you think is causing this problem? What would you like for me to do? What kind of medicine do you prefer-an injection or oral medication? Who else helps you take care of your health and your children's health problems? Under what circumstances do you feel you should bring your child to the clinic?"*

WHAT EVERY HCH PROVIDER SHOULD KNOW

- "No person in the United States shall, on ground of race, color or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance." (*Title VI, Civil Rights Act, 1964*)
- Service delivery programs of the Health Resources and Services Administration are NOT required to verify the immigration and citizenship status of their patients. (*HRSA administrator, 8/8/98*)
- Coverage for emergency services is available to anyone who meets Medicaid financial and categorical requirements, regardless of immigration or insurance status. Applicants may not be denied emergency services based on failure to certify or document their citizenship or immigration status. (*OCR/HHS, 9/20/00*)
- Federally funded health centers provide health services to … all people who face barriers to accessing services because they have difficulty paying for services, [or] because they have language or cultural differences…. All health centers must provide services that enable patients to access health center services, such as outreach, transportation, and interpretive services. (*PIN 98-23: BPHC Program Expectations, 8/17/98*)
- All recipients of Federal funds from the U.S. Department of Health and Human Services must take steps to ensure that persons with limited English proficiency (LEP) can meaningfully access health and social services. All health organizations must:[4]
  - **Provide oral language assistance services**, including bilingual staff and interpretive services, **at no cost to LEP clients**;
  - **Provide verbal and written notice** to LEP persons in their preferred language **of the right to free language assistance**;
  - **Assure the competence of language assistance provided** to LEP patients by interpreters and bilingual staff; and
  - **Make available easily understood patient-related written materials** and post signage in the languages of groups commonly encountered or represented in the service area.

  (*OCR/HHS, 8/30/00; OMH/HHS, 3/01*)

- **Explain treatment options and medical procedures thoroughly, in a way that is understandable.** If you speak Spanish, speak slowly, so clients can understand and absorb what you are saying. Patients may not express disagreement or doubt about your medical instructions out of *respeto* for your authority. Ascertain whether they understand your instructions through careful questioning.

- **Be knowledgeable about your clients' legal options for health coverage and health care.** Be familiar with your state's eligibility requirements for public health coverage. It is against Federal law to require information about a client's immigration or citizenship status as a condition for providing emergency services. Documentation of immigration or citizenship status is required only of applicants for non-emergency Medicaid, SCHIP, TANF, or food stamps (*not* of family members who are not applying for benefits). Some clients may be able to change their immigration status by applying for asylum, which could enable them to qualify for Medicaid.

- **Involve the whole care team in the clinic visit, not just the medical provider.** Dedicating a block of time in the clinic schedule just for Spanish-speaking clients can help them to feel at ease in the health care setting and promote a sense of community. ■

SOURCES & RESOURCES

1. Agency for Healthcare Research Quality. *Mejorando la calidad de la atencion medica:* Spanish-Language Guide [for patients] to Getting Better Quality Health Care. AHRQ Publication No. 01–0032: ahrqpubs@ahrq.gov.
2. Aguirre-Molina, Marilyn, et al. *Health Issues in the Latino Community*. NY: Jossey-Bass Publishers, 2001; 528 pp.: *www.apha.org/media*; 301 893–1894.
3. Bureau of Primary Health Care/HRSA. *Cultural Competency: A Journey: www.bphc.hrsa.gov/*; 1-800-400-2742.
4. Center for Mental Health Services. *Cultural Competence Standards in Managed Care Mental Health Services: Four Underserved/Underrepresented Racial/Ethnic Groups,* 2000: *www.mentalhealth.org/publications/allpubs/SMA00-3457/intro.asp*.
5. Chase, Robert O. and Clarisa B. Medina de Chase. *An Introduction to Spanish for Health Care Workers*. New Haven, CT: Yale University Press, 1998; 239 pp.: *www.apha.org/media*; 301 893-1894.
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7. National Alliance for Hispanic Health. *A Primer for Cultural Proficiency: Towards Quality health Services for Hispanics*. Estrella Press, 2001: *www.hispanichealth.org/primer.pdf*.
8. National Alliance for Hispanic Health. *Quality Health Services for Hispanics: The Cultural Competency Component*. February 2001, 116 pp.: *www.ask.hrsa.gov/detail.cfm?id=PC00029*.
9. Office of Minority Health/HHS. *National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report*. Washington, D.C., March 2001: *www.omhrc.gov/OMH/Programs/2pgprograms/cultural4.htm*.
10. Schlosberg, Claudia L. *Immigrant Access to Health Benefits: A Resource Manual*. The Access Project and the National Health Law Program, 1999–2000; 114 pp: *www.accessproject.org/p_c.htm*.

Other helpful information available online:

Center for Cross-Cultural Health: *www.crosshealth.com/index.html*
Cross-Cultural Health Care Program: *www.xculture.org*
Diversity Rx: *http://diversityrx.org*
Ethnomed, Harborview Medical Center: *www.ethnomed.org*
Migrant Clinicians' Network: *www.migrantclinician.org*
National Center for Cultural Competence: *http://gucdc.georgetown.edu/nccc/*
Provider's Guide to Quality & Culture: *http://erc.msh.org*.
Su Familia: National Hispanic Family Health Helpline: 1-866-Su-Familia; *www.hispanichealth.org/helplines.htm*. ■

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P.O. Box 60427, Nashville, Tennessee 37206-0427 ~ For membership information, call (615) 226-2292 or visit www.nhchc.org.

HCH Clinicians' Network
P.O. Box 60427
Nashville, TN 37206-0427