A Primer for Cultural Proficiency: Towards Quality Health Services for Hispanics

Includes Presidential Executive Order for Improving Access to Services for Persons with Limited English Proficiency

ESTRELLA PRESS

The National Alliance for Hispanic Health is the oldest and largest network of Hispanic health and human service providers serving over 10 million Hispanic consumers throughout the U.S. Since 1973 we have grown from a small coalition of visionary mental health providers to a large, dynamic, and strong group of organizations and individuals. Our mission is to improve the health and well-being of Hispanics in the United States. Our dedicated staff of 30 professionals are solely focused on Hispanic health.

Our constituents are our members, the consumers served by our members, and the greater society that benefits from the health and well-being of Hispanics. As the nation's action forum for Hispanic health and well-being, together with our members we strive to:

- Inform and mobilize consumers.
- Support health and human service providers in the delivery of quality care.
- Improve the science base for accurate decision making.
- Promote appropriate use of technology.
- Insure accountability and advocate on behalf of Hispanics.

Since we were created we represent all Hispanic groups, do not accept funds from tobacco or alcohol companies, and are dedicated to community-based solutions. Our members are organizations (e.g., community based organizations, provider organizations, government agencies, national organizations, colleges and universities, and for-profit corporations) as well as individuals.

A Primer for Cultural Proficiency:

Towards Quality Health Services for Hispanics

Includes Presidential Executive Order for Improving Access to Services for Persons with Limited English Proficiency

Estrella Press

Authored and produced by The National Alliance for Hispanic Health, Washington, DC, with support from the Health Resources and Services Administration and the Office of Minority Health of the United States Department of Health and Human Services. The opinions expressed herein are solely those of the contributors and do not necessarily reflect the policy or position of the funding sources or the Alliance Board of Directors or membership. An older version of this document was edited and published by the United States Department of Health and Human Services in September 2000.

Printed in the United States of America, 2001

Library of Congress Card Number: 00-111673

ISBN: 0-933084-07-2

Table of Contents

Foreword v

Introduction: A Better Understanding 1

I. The Basics

Chapter One: Culture – What it is, How it Works 3

Chapter Two: The Continuum of Working Across Cultures 7

Chapter Three: On Language 15

Chapter Four: Getting to Know the Culture 23

II. About Hispanics

Chapter Five: History of Hispanics in the United States 31

Chapter Six: Hispanic Health Status 37

III. Implementation

Chapter Seven: Role of Community-based Organizations 55

Chapter Eight: Intervention 61

Conclusions 67

Endnotes 73

Appendix One: Presidential Executive Order 79

Foreword

In 1985, the National Alliance for Hispanic Health (the Alliance) began Proyecto Informar™, an initiative to improve communications between health care providers and their patients. This effort involved all of the major health professional organizations and helped to popularize the concept of cultural competence. As a result of this pioneering work, today there are numerous organizations that have taken cultural competence as their mission if not their mandate.

During the past fifteen years of the implementation of Proyecto Informar™, we have learned many lessons. One is that competence is not enough. Delivering quality care is more than being competent in the practice of a narrow set of skills. That is only a starting point. Delivering quality health services to Hispanics is about being proficient in the art of listening and communicating with patients from a variety of backgrounds; understanding that health occurs in a holistic environment; incorporating an understanding of a person's unique family, work, spiritual, and physical environment into health services; and, ensuring that the institutional structures of health services act to encourage rather than discourage access to care.

As you will see on page 8 of this book, the continuum of cultural competency starts with services that are hostile to different cultures (cultural destructiveness) and ends at the point at which culture is held in high esteem (cultural proficiency). For many years, training and policy efforts have focused on seeking cultural competency, the step before cultural proficiency. We seek to move the discussion towards cultural proficiency. This primer reflects our understanding that cultural proficiency is critical to quality care. It brings together our cumulative and evolving experience with the art and science of cultural proficiency. As there can be no "cookbook" for cultural proficiency we have struggled to minimize stereotypes and generalizations, while creating a framework that can be used by providers either at the individual or organizational level.

To support the application of the lessons in this book, there is a companion workbook for health providers. Taken together, these documents represent an important resource for training and application of new skills in the art of culturally proficient health services delivery.

This primer is being released as new attention is being focused on cultural proficiency with the issuance of a Presidential Executive Order, "Improving Access to Services for Persons with Limited English Proficiency." The President's Executive Order is a critical step in solidifying efforts to improve communication with patients. However, we also need research that includes diverse groups, consumers that are active participants in their role in the new health care systems, reimbursement standards that acknowledge the importance of patient-provider interactions, and technology that is used for the benefit of the patient rather than the convenience of the provider. There is much to be done.

We are glad that we have begun the journey towards cultural proficiency and we welcome the opportunity to work with you to build a healthier Nation.

Jane L. Delgado, Ph.D., M.S.
President and CEO
The National Alliance for Hispanic Health

Introduction – A Better Understanding

Delivering Quality Health Care to Hispanics *¡Si se puede!* – Yes we can!

Providing patients with quality health care and helping people to change risky behavior patterns and understand the benefits of healthy living are all hallmarks of the kind of good practices health care professionals in the United States strive to achieve. Unfortunately, practitioners also face many unique obstacles to the level of care they would like to deliver. Some of these obstacles involve cultural misunderstandings and miscommunications with patient populations whose languages, experiences, and backgrounds are different from those of their providers.

While most health care providers consider themselves competent, we hope this primer helps all providers move the field towards proficiency. This primer is designed to help health care professionals and systems better understand, and more effectively respond to the growing needs of over 35 million Hispanics in the United States. It should facilitate greater access to, and utilization of, health and human services for this patient population, as well as provide useful suggestions on improving one-to-one provider-patient interactions. The primer is a distillation of information health care providers may need to assure delivery of the best possible care to Hispanic clients in a variety of clinical, prevention, and social service settings.

The primer is a distillation of information health care providers may need to assure delivery of the best possible care to Hispanic clients in a variety of clinical, prevention, and social service settings.

Perhaps nowhere are cultural differences more sharply drawn than in our approaches and definitions of health and healthy living. Culture is what we live every day and what we bring with us to our workplace which is why Dr. Arthur Kleinman, Harvard psychiatrist and anthropologist believes every encounter between a health care provider and a patient is a cross-cultural experience.[1] By deepening our understanding of culture we can begin to strengthen the promise of high-quality primary health care that is accessible, effective, and cost efficient for all of our patient populations.

Culture is what we live every day and what we bring with us to our workplace.

Unlike certain animals, human beings are not hardwired with a complex set of behavior patterns and instincts that allow us to function successfully from birth, and so we have to learn how to survive our varied environments and pass these acquired lessons down through the generations by means of language, both verbal and symbolic. In the sociological sense this learned language is the culture, the way of life, of human society.

...human beings...pass these acquired lessons down through the generations by means of language, both verbal and symbolic.

Material culture includes the artifacts we create from stone tools to Mayan pyramids, from cave paintings to telecommunications satellites and the internet. Non-material culture is the common behaviors, thoughts, actions, customs, and beliefs that bind a racial, ethnic, religious, or social group within society. In Mexican culture for example the celebration of the Feast of the Virgin of Guadalupe is rooted not only in Catholic religious tradition but in Pre-Columbian customs and transcends geographic borders.

Non-material culture is the common behaviors, thoughts, actions, customs, and beliefs that bind a racial, ethnic, religious or social group within society

Beyond unique examples like this one, anthropologist George Murdock has listed a number of cultural universals. These include: athletic sports, bodily adornment, cooking, cooperative labor, courtship, dancing, dream interpretation, family feasting, folklore, food taboos, funeral ceremonies, games, gift-giving, incest taboos, laws, music, myths, sexual restrictions, toilet-training, tool-making, religion, and of course medicine.[2] Every society recognizes its healers or health

I. The Basics

Chapter One: Culture – What it is, How it W orks

Every society recognizes its healers or health car providers as central to the functioning of human civilization, ...

care providers as central to the functioning of human civilization, but few previous societies have been as culturally diverse as ours, offering both a challenge and opportunity to those who would, as their chosen vocation, cure and comfort the afflicted.

...as certain as the existence of cultural universals, is the opposing tendency of every human society to develop ethnocentrism

One challenge to understanding culture is the simple recognition that, as certain as the existence of cultural universals, is the opposing tendency of every human society to develop ethnocentrism – to judge other cultures by the standards of one's own, and beyond that to see one's own standards as the true universal and the other culture in a negative way. The tendency towards ethnocentrism also may lead us to deny the reality that most cultures are in truth highly adaptive and likely to borrow from one another. This is certainly notable within the western hemisphere where one can see the extent to which mainstream U.S. and Hispanic cultures have long benefited and been enriched by an ongoing exchange and intermingling of cultural standards, icons, symbols, and habits both within and outside of the United States' border.

"Mainstream" U.S. culture itself is going through a continuous renewal generated by Hispanic and other cultures that contribute to the mosaic of daily life in the United States.

"Mainstream" U.S. culture itself is going through a continuous renewal generated by Hispanic and other cultures that contribute to the mosaic of daily life in the United States. A typical American diet today consists of a variety of foods from hamburgers to tacos, sushi to pupusas, middle eastern kabobs to paella, to black beans and rice.

Of course if we were a more homogeneous society, medicine and social service work might be easier in that we could use a single all-inclusive model for health care delivery. Then again, in a simpler society our work would not be as exciting nor as challenging.

As a society based on laws and principles rather than religion, "blood," race or ethnicity, the United States has one of the most fluid complex and democratic cultures in the world rich in diversity. It is, quite simply, a culture and society that recreates itself with each new

wave of migration and immigration, technological change, and social progress. On the other hand, it is also a political culture that periodically generates fear of the "other," of the so-called stranger among us. Historically we've seen bias and backlash emerge with each new wave of ethnic immigration that's been added to the weave of our cultural tapestry. Today, 9% of the U.S. population was born in another country.[3]

...the United States has one of the most fluid complex and democratic cultures in the world.

Of course each new wave of immigration brings with it its own unique culture, questions, and problems. With the latest Hispanic immigrants comes the question of self-definition, issues of class structure, especially in light of a larger, more stable Hispanic population already living in the United States.

Of course each new wave of immigration brings with it its own unique culture, questions, and problems.

The term "Hispanic" didn't come into wide usage until the 1970s and '80s. In the 50's and 60's Hispanics tended to organize around their own national identities as Mexicans and Mexican Americans, Puerto Ricans, Cuban Americans, Central Americans, and South Americans. By the early 1970's new groups formed that brought together Hispanic subgroups to coalesce into a more unified voice around numerous social, civil, and political causes. "We wanted all Spanish-speaking people involved. That was it. We weren't going to be isolated anymore," recalls one group's founder.[4] Today, most national Hispanic organizations even those formed representing the interests of one Hispanic subgroup work to strengthen the role of all Hispanics.

To understand Hispanic culture one first has to come to a more basic understanding of what it is that constitutes a culture. What are the often ephemeral constructs of language, values, experiences and conditions that make for unique "peoples" and cultures, and how can an understanding of these assist health care providers to better understand the needs of Hispanic patients or clients as well as those of other emerging ethnic groups.

To understand Hispanic culture one first has to come to a more basic understanding of what it is that constitutes a culture.

As health care providers we should appreciate the key role culture plays in our ability to influence behavior in a patient population or other group we seek to influence. We cannot afford to let cultural barriers limit our ability to meet the needs of our patients, or reduce their opportunity to benefit from the services we can provide.

We cannot afford to let cultural barriers limit our ability to meet the needs of our patients, or reduce their opportunity to benefit from the services we can provide.

Some reasons for the need to incorporate culture into health care at the individual patient-provider level as well as the system level are:

There are many reasons for incorporating cultural factors into health care.

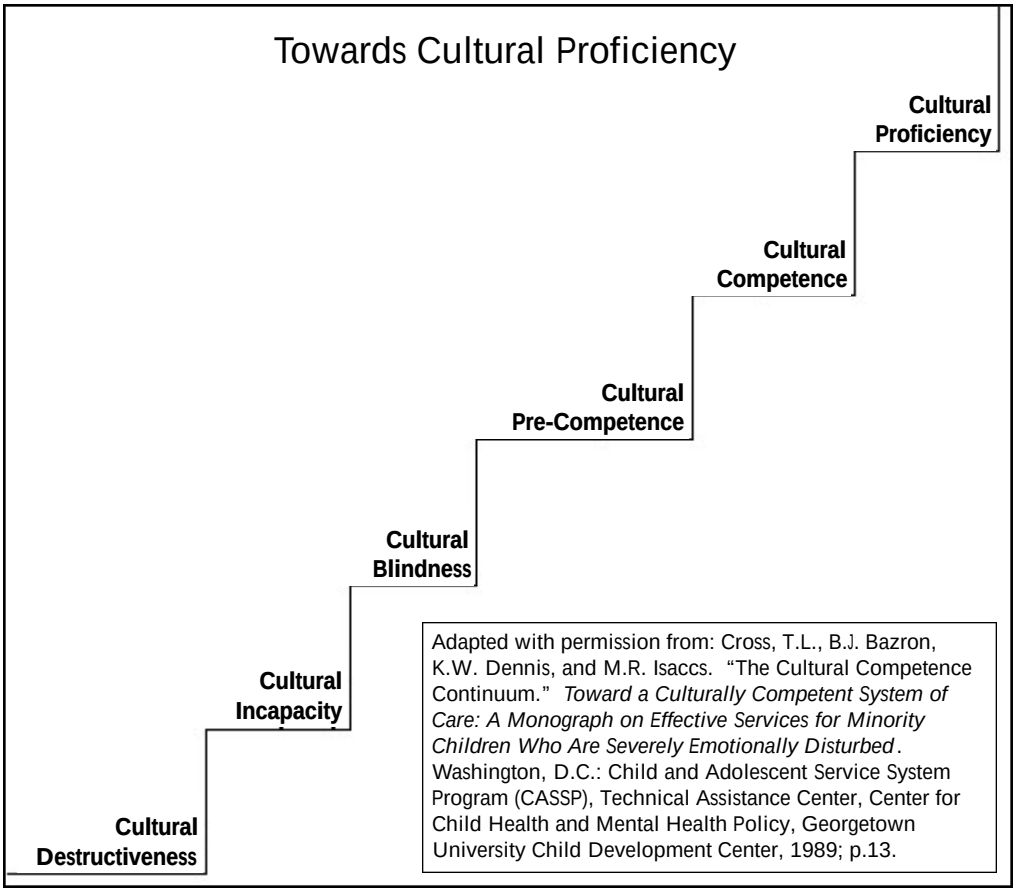
- perception of illness, disease, causal factors, and treatment varies by culture;
- diverse belief systems exist related to health, healing, and wellness;
- culture influences help seeking behaviors and attitudes toward health care providers;
- individual preferences and culture affect traditional and non-traditional approaches to health care;
- communications between patient and health care provider must be clear;
- patients have personal experiences of biases within health care systems; and,
- health care providers from culturally and linguistically diverse groups are under-represented in the current service delivery system.[5]

I. The Basics

Chapter Two: The Continuum of Working Across Cultur es

..."cultur," .. implies patterns of human behavior including thoughts, actions, customs, values, and beliefs that can bind a racial, ethnic, religious or social group within a society

The word "culture," as stated earlier, implies patterns of human behavior including thoughts, actions, customs, values, and beliefs that can bind a racial, ethnic, religious or social group within a society. These behaviors are learned early in infancy. Unfortunately, while "culture" changes and is adaptive, it is challenging for individuals to recognize and change their own cultural practices.[6]



There is within our various institutions, including the health care system, a continuum that ranges from cultural destructiveness to cultural proficiency. This six-part continuum, as defined by researchers at Georgetown University's Child Development Center, is a progression from cultural destructiveness, to cultural incapacity, to blindness, to pre-competence, to competence, and finally, to cultural proficiency. Understanding this continuum may help the individual provider assess and improve their own workplace or institutional setting.

The most negative end of the continuum, **cultural destr uctiveness** , is represented by attitudes, policies, and practices that are destructive to cultures and the individuals within these cultures. A system which adheres to a destructive extreme assumes that one race or culture is superior and should eradicate "lesser" cultures because of their perceived subhuman condition. Bigotry coupled with vast power allows the dominant group to disenfranchise, control, exploit, or systematically destroy the less powerful population.

*...**cultural destructiveness**... policies, and practices that are destructive to cultures and the individuals within these cultures.*

The most extreme examples of cultural destructiveness involve programs, agencies, and institutions that actively participate in purposeful attacks on another culture, and dehumanize their clients from different racial and ethnic groups.

Historically, some health and social service agencies have been involved in services that have denied patients access to care. Among the most infamous example is the Tuskeegee experiments in which poor black men with syphilis were observed but not treated for a number of years by white medical personnel interested in studying the progression of the disease. The consequences of this experiment left a legacy of distrust of government research programs among African Americans.

The term cultural destructiveness can also be applied to instances in which people's trust has been betrayed by neglecting to fully inform them of medical risks and benefits, an approach that can also have grave legal consequences. One such example occurred in a 1989-1991 study conducted by the Centers for Disease Control and Prevention, Kaiser Permanente, and the Los Angeles County Department of Health Services during a measles outbreak. In this instance, Kaiser-members, mainly Hispanic and Non-Hispanic black parents, were asked if they would allow their infants to take part in a study designed to compare the effectiveness of different measles vaccines. The parents, however, were never informed that one of the vaccines used was an experimental vaccine and not licensed for sale in the United States. Therefore, these parents made the decision to be included in the study without being fully aware of the risks involved.

Cultural Incapacity.. agencies do not intentionally seek to be culturally destructive but rather have no capacity to help clients from other cultures.

Cultural Incapacity occurs when agencies do not intentionally seek to be culturally destructive but rather have no capacity to help clients from other cultures. The system remains extremely biased, believes in the superiority of the dominant group, and assumes a paternal posture towards "lesser" groups.

A private hospital in which it may not have been unusual for a sick or injured Hispanic person to be turned away from an emergency room and directed to the nearest public hospital is an example of cultural incapacity.

Such agencies may act in a negative manner by enforcing policies which deny services to people and maintain stereotypes. Such agencies are often characterized by ignorance and an unrealistic fear of people who are different.

One example of cultural incapacity was described in a study published in the *Journal of the American Medical Association*. This retrospective study found that Hispanics who were treated for certain

bone fractures at the UCLA Emergency Medicine Center were twice as likely as non-Hispanic whites to receive no pain medication. The precise reason for this was not specified, but the investigators identified failure on the part of hospital staff to recognize pain in Hispanic patients as a possible reason for the discrepancy.

Cultural blindness , the predominant system in place today, involves agencies and organizations providing services with the express philosophy of being unbiased. They function with the belief that color or culture makes no difference and that all people are the same.

Cultural blindness, the predominant system in place today, involves agencies and organizations providing services with the express philosophy of being unbiased.

Culturally-blind agencies are characterized by the belief that all helping approaches traditionally used are universally applicable. If the system works as it should, all people —regardless of race or culture— will be served with equal effectiveness. This view reflects a well-intended philosophy. The consequences of such a belief, however, can often camouflage the reality of ethnocentrism, making services so ethnocentric as to render them useless to all but the most assimilated people from other cultures. A simple example of cultural blindness was the light tan bandage that for years was sold as "flesh colored." It was, but only if you were a fair-skinned person.

Culturally-blind agencies... reflects a well-intended philosophy: however, the consequences of such a belief can often camouflage the reality of ethnocentrism ...

Culturally-blind agencies suffer from a deficit of information and often lack the avenues through which they can obtain needed information. While these agencies often view themselves as unbiased and responsive to the needs of diverse communities, their ability to effectively serve diverse patient populations may in fact be severely limited.

As agencies move toward the positive end of the scale they reach a position called **Cultural Pre-Competence** . This term implies movement towards reaching out to other cultures. The pre-competent agency realizes its weaknesses in serving some communities and attempts to improve some aspect of its services to specific populations.

***Cultural Pre-Competence**..implies movement towards reaching out to other cultures.*

Pre-competent agencies are characterized by the desire to deliver high-quality, cost-effective services, and a commitment to civil rights.

Such agencies experiment with hiring staff who reflect a different culture, exploring how to reach underserved populations in their service areas, offering training for their workers on cultural sensitivity, conducting needs assessments concerning racial and ethnic communities, and recruiting diverse individuals for their boards of directors or advisory committees. Efforts at culturally diverse hiring and recruitment at the nation's medical schools in the 1970s are an example of this initial stage of cultural understanding. Pre-competent agencies are characterized by the desire to deliver high-quality, cost-effective services, and a commitment to civil rights. They respond to the needs of racial/ethnic communities for improved services by asking, "What can we do?"

One danger at this level, however, is a false sense of either accomplishment or of failure that prevents the agency from moving forward along the continuum. An agency may believe that the accomplishment of one goal or activity fulfills its obligation, or conversely, it may undertake an activity that fails and become demoralized and reluctant to make another attempt at improving its health care delivery to the targeted community.

***Culturally competent** agencies are characterized by acceptance of and respect for difference, continuing self-assessment regarding culture, careful attention to the dynamics of differences, continuous expansion of cultural knowledge and resources, and adaptations of service models.*

Culturally competent agencies are characterized by acceptance of and respect for difference, continuing self-assessment regarding culture, careful attention to the dynamics of differences, continuous expansion of cultural knowledge and resources, and adaptations of service models in order to better meet the needs of different racial and/or ethnic groups. Such agencies recognize and value groups as distinctly different from one another and as having numerous subgroups, each with important cultural characteristics.

Culturally competent agencies work to hire unbiased employees and seek advice and consultation from their clients. These agencies seek staff who represent the racial and ethnic communities being served and whose self-analysis of their role has left them committed to their

community and capable of negotiating a diverse and multicultural world. These agencies also provide support for staff to become comfortable working in cross-cultural situations. Further, culturally competent agencies understand the interplay between policy and practice, and are committed to policies that enhance services to a diverse clientele.

The most positive end of the scale is **cultural proficiency** . This culmination point on the continuum is characterized by holding culture in high esteem. Culturally proficient providers and systems seek to do more than provide unbiased care as they value the positive role culture can play in a person's health and well-being.

cultural proficiency..is characterized by holding culture in high esteem.

Culturally proficient agencies seek to add to the knowledge base of culturally-competent practices by conducting original research, developing new therapeutic approaches based on culture, and publishing and disseminating the results of their research and demonstration projects. Such agencies are expansive, advocating for cultural proficiency throughout the health care system and for improved relations between cultures throughout society. They are role-models at both an institutional and patient-provider level and can offer the health care provider useful examples of how to close cultural gaps and improve your service delivery, even if you don't speak the same language as your patient.

Chapter Three: On Language

¡Si puedes leer esto, ya vas por buen camino!
("If you can read this you're headed in the right dir ection!")

According to an article in JAMA, "The physician-patient relationship is built through communication and the effective use of language. Along with clinical reasoning, observations, and nonverbal cues, skillful use of language endows the [physician-patient] history with its clinical power and establishes the medical interview as the clinician's most powerful tool."[8]

"The physician-patient relationship is built through communication and the effective use of language."

It may seem to be stating the obvious, that health care providers who do not speak the same language as their patients are going to have difficulty diagnosing and treating their patients' conditions. Still this reality has to be faced and dealt with by the growing numbers of health care professionals who care for America's multi-ethnic, multi-racial, and increasingly multilingual society.

...health care providers who do not speak the same language as their patients are going to have difficulty diagnosing and treating their patients...

Growing numbers of Americans are proficient in two or more languages or at least have chosen to study a language other than English. In addition, there are some 32 million Americans who speak a language other than English at home. According to the Census Bureau, at least 14% of the nation's population now speaks a language other than English in their home. In major cities including New York, Los Angeles, Miami, Honolulu, Newark and El Paso, Texas, the figure is over 40%. Some 7 million persons in the United States do not speak English well, or at all.

...at least 14% of the nation's population now speaks a language other than English in their home.

Spanish is the main "other language" spoken in the United States. A majority of Hispanics in the United States are bilingual and likely to retain their Spanish language skills as their communities are replenished with new Spanish speaking immigrants. Although only 31.5% of Hispanics were born outside the United States and the Commonwealth of Puerto Rico, 77% report Spanish as their primary language and the language they speak at home.

Spanish, as stated earlier, is the second most common language in the United States, and the language of over half of the nation's non-English speakers.[9]

Spanish...is the language of over half of the nation's non-English speakers.

I. The Basics
Chapter Three: On Language

Interfacing with Hispanics, appreciation of the Spanish language, and the different accents, idioms and meanings within different Spanish-speaking sub-groups, is crucial to becoming culturally proficient. In addition, direct translations of English into other languages without a cultural awareness of the meaning, idioms, slang usage and various contexts in which those languages are used, can lead to confusion and miscommunication. A humorous example involved an insecticide ad that ran in the 1980s. Recognizing the value of the growing Hispanic market, the company promoted its product in Spanish-language ads as guaranteed to kill "*bichos*" What they didn't realize is that while *bichos*means bugs or insects in Mexico, in Puerto Rico it's understood to refer to the penis. Needless to say, they didn't have a lot of sales in San Juan. Similarly GM's Spanish language ads for the Chevy Nova were received with great hilarity by their target audience. The company hadn't considered that in Spanish "*No va*" means "It doesn't go."

...having a language-concordant physician resulted in better outcomes for well-being and functioning.

In a health setting language differences can have some very deleterious effects. In one study "The Effects of Ethnicity and Language on Medical Outcomes of Patients with Hypertension or Diabetes," Dr. Pérez-Stable et. al. found that for Spanish-speaking patients, having a language-concordant physician resulted in better outcomes for well-being and functioning. Monolingual Spanish-speaking patients were more likely to ask more questions and had a better understanding with physicians who also spoke Spanish.[10]

The communications difficulties associated with language differences have also made for some new legal arguments.

The communications difficulties associated with language differences have also made for some new legal arguments. Legal advocates for Hispanic and other limited English proficient (LEP) people seeking full and quality access to health care, education and other resources have traditionally worked to advance their cause using Title VI of the Civil Rights Act of 1964. That act states, "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".[11]

Executive Order to assist providers in fulfilling their responsibilities to persons with limited English proficiency (LEP), pursuant to Title VI of the Civil Rights Act of 1964 [see appendix 1]

In August 2000 President Clinton issued an Executive Order to assist providers in fulfilling their responsibilities to persons with limited English proficiency (LEP), pursuant to Title VI of the Civil Rights Act of 1964 [see appendix 1]. To support this Executive Order, the Department of Health and Human Services issued a Title VI policy guidance which emphasized that "in order to avoid discrimination against LEP persons, health and social service providers must take adequate steps to ensure that such persons receive the language assistance necessary to afford them meaningful access to their services, free of charge." The policy guidance specifically addresses the lack of language assistance capability among many providers that has resulted in barriers to meaningful access for LEP individuals. The policy guidance also stresses the dangers of using untrained interpreters, particularly those that the client brings with him or her.

This is critically important with issues of informed consent. The Joint Commission on Accreditation of Hospitals explains the doctrine of informed consent this way: "The patient has the right to reasonable informed participation in decisions involving his health care. To the degree possible, this should be based on a clear, concise explanation of his condition and of all proposed technical procedures, including the possibilities of any risk of mortality or serious side effects, problems related to recuperation, and probability of success. The patient should not be subjected to any procedure without his voluntary, competent, and understanding consent or the consent of his legally authorized representative."[12]

Providers should also appreciate that in addition to being a medical necessity, serious efforts to accommodate limited English proficient (LEP) patients also makes good business sense.

Unfortunately it is not possible to get a thorough patient history or give information to the patient required for informed consent when the patient and his or her health care provider do not speak the same language. But solutions can be found. Providers should also appreciate that in addition to being a medical necessity, serious efforts to accommodate limited English proficient (LEP) patients also makes good business sense.

A Kaiser Permanente Journal report found that, "communication failures between patient and physician are a significant factor in a patient's decision to sue..."[13] and a more recent review of Harvard University-affiliated health care institutions, employees, and physicians found that "12% of their total claims involved communication failure as the key risk management issue."[14]

...concept of linguistic accommodation in clinical and human service settings, even without the impetus of law, is easy to support as a common sense approach, smart business, and ethically responsible.

Of course, the concept of linguistic accommodation in clinical and human service settings, even without the impetus of law, is easy to support as a common sense approach, smart business, and ethically responsible. It's the development of practical means for realizing this accommodation that poses a challenge to health care professionals. In interviews conducted with experts in the field of addressing language barriers in health care settings, six approaches were identified to bridge the gap of cultural and linguistic barriers for effective health service delivery.[15]

Having identified these approaches, an in-depth assessment of health care facilities was conducted to determine to what extent they were using these existing approaches to address language barriers, and to gather advice from them on ways to improve their communication with non-English speaking clients.[16] The assessment focused on 80 health care facilities serving 15 communities with significant Hispanic populations. Of the 80 health care facilities surveyed, 78 percent had a stated policy of hiring bilingual/bicultural professional staff; 43 percent used a language bank; 26 percent encouraged language training; 23 percent hired trained interpreters; 16 percent used phone-based interpretation; and, 13 percent used written translations.

Six Approaches for Bridging Language Barriers

Each method and key aspects are listed below in order from most effective to least effective.

(1) Bilingual/Bicultural Professional Staff

- Recruit and retain bilingual/bicultural staff at all levels of the organization.
- Provide significant additional compensation for bilingual ability.

(2) Interpreters

- Establish minimum standards for interpreter training, competency, and other continuing education efforts.
- Make a concerted effort to increase and foster medical interpreter training.
- Provide courses designed to train providers to work with interpreters.
- Reimburse for interpreter services.
- Allow providers more time with patient when using interpreters.

(3) Language Skills Training for Existing Staff

- Support the development of bilingual skills for all staff members.
- Establish clear goals and realistic expectations for Spanish language courses.
- Offer classes in conversational and medical Spanish to all staff.
- Utilize training programs that have a demonstrated track record.

WARNING: Do not use non-health staff who are bilingual/bicultural as interpreters.

Six Approaches for Bridging Language Barriers (most to least effective)

(1) Bilingual/Bicultural Professional Staff

(2) Interpreters

(3) Language Skills Training for Existing Staff

(4) Internal Language Banks (only as a backup)

(5) Phone-Based Interpreter Services (emergency back-up)

(6) Written Translations (emergency stop-gap)

(4) Internal Language Banks (Only as a back-up measure)

- Hire supervisors to oversee and assess the language and interpretation capabilities of language bank members, to provide minimal interpreter training, and to regularly assess the quality of the language bank program.
- List interpretation as a secondary responsibility of language bank members so that supervisors of these staff members understand why they may spend time away from their regular duties.
- Compensate language bank members who do a significant amount of interpretation.

(5) Phone-Based Interpreter Services (Emergency back-up measur e for brief follow-up questions only.)

- Inform health care providers that phone-based interpreters may not be proficient in medical terminology.
- Use simple or common terms when using phone interpreters.

(6) Written Translations (Emergency stop-gap measure and in simple conversational use only, never as the sole means of communication)

- Develop mechanisms to promote the sharing of bilingual written materials, such as consent forms and patient education pamphlets.

Use of "cultural mediators" is also recommended

Antonia M. Villarruel Ph.D., an assistant professor at the University of Michigan School of Nursing recommends a seventh approach to overcoming language barriers through the use of "cultural mediators." "Cultural mediators form part of the health care team, working closely with medical and nursing staff," she writes. "In addition to medical interpreting, the cultural mediator interprets the cultural and social circumstances that may affect care. This enables providers to gain a more comprehensive understanding of patients' needs, and to negotiate culturally appropriate plans of care."[17]

Language of course, is only one part of understanding culture.

While the use of hand held portable devices will make translation more accessible, issues of accuracy and the clinical relationship are still to be worked out. Providers who follow approaches outlined above can qualitatively improve their ability to interact effectively with patients/clients whose dominant language is one other than English. But language, of course, is only one part of understanding culture.

In working with Hispanic patients language can be such an obvious barrier, challenge, and point of identity that it can sometimes obscure other critical more subtle aspects of cross-cultural understanding. There are certain cultural nuances or unwritten rules that govern social interactions. These unstated rules can impact the way in which individuals perceive, seek, and receive services. These essential cultural aspects can involve interactions as simple as conversational gambits and spatial (physical space) relationships, along with larger institutional issues such as family visiting hours, patient education, and measuring individual responses to pain. Being aware and understanding the cultural context for these interactions can be a tremendous asset to you as a health care professional, and in your ability to deliver effective care.

...language can be such an obvious barrier, challenge, and point of identity that it can sometimes obscure other more subtle aspects of cross-cultural understanding. There are certain cultural nuances or unwritten rules that govern social interactions.

"We're a touching people. If you're more than a handshake distance from your customer or patient you're too far," says a Mexican American pharmacist and state legislator who has conducted cultural proficiency trainings for her colleagues. "Touching, how you make eye contact, the subtle things all count," she explains. "Diet is another example. Back in the early 1980s I'd try and help my patients adjust their diet to their medications. But the American Diabetes Association at the time had nothing on the Latino diet. They had a mainstream diet plan, and a supplement on a Jewish diet, but nothing my Hispanic patients in their 60s and 70s could use. They weren't about to start eating brussels sprouts and cod for the first time in their lives. One older woman I remember looked at the material and asked me - '*¿Qué es un bagel?*(What's a bagel?)."[18]

"Touching, how you make eye contact, the subtle things all count."

Common cultural characteristics for Hispanics in the United States include: family, *respeto* or respect, *personalismo*, and *confianza*. This chapter will give a brief description of each these cultural concepts. It is important to note that there will always be individual variation from any cultural norm.

...there will always be individual variation from any cultural norm.

La Familia

A good starting place for any discussion of Hispanic culture is with la familia, the family

A good starting place for any discussion of Hispanic culture is with *la familia*, the family. Traditionally, Hispanics include many people in their extended families, not only parents and siblings, but grandparents, aunts, uncles, cousins and *compadres*, close friends and godparents (*padrinos*) of the family's children. When ill or injured, Hispanic people frequently consult with other family members and often ask them to come along to medical visits. Hispanic extended families and the support role they play for patients may run counter to certain institutional rules, such as hospital policies that limit patients to two visitors. In the interest of effective care, such policies may need to be reexamined to allow for more direct involvement of the supportive family network.

Hispanic families also traditionally emphasize interdependence over independence, and cooperation over competition

Hispanic families also traditionally emphasize interdependence over independence, and cooperation over competition, and are therefore far more likely to be involved in the treatment and decision-making process for a patient. This level of involvement may not always be possible. Migration and separation from family may stress the values of young immigrant workers or couples newly arrived in the United States. Similarly, teenagers who quickly acculturate to the United States and the manners of their peers may demand to be treated as individuals and show signs of typical adolescent conflict with their parents and other relatives who maintain traditional values and customs. Because such stresses to family functioning may have significant health implications, it is important for the health care provider to be aware of these issues.

Respeto

Respeto dictates appropriate deferential behavior towards others based on age, sex, social position, economic status, and authority

For Hispanics the intimate confines of extended families, close-knit Hispanic communities, and traditional networks are mediated by *respeto* (respect). *Respeto* dictates appropriate deferential behavior towards others based on age, sex, social position, economic status, and authority. Older adults expect respect from youngsters, women from men, men from women, adults from children, teachers from students, employers from employees, and so on.

Health providers, by virtue of their healing abilities, education, and training are afforded a high level of *respeto* as authority figures. As a general rule Hispanic patients tend to look forward to what the health care provider has to say and will value their direction and services.

As a general rule Hispanic patients tend to look forward to what the health care provider has to say and will value their direction and services.

One way some Hispanics show respect is to avoid eye contact with authority figures. This respectful behavior should not be misinterpreted as a sign of disinterest. At the same time the health care provider is expected to look directly at the patient, even when communicating through an interpreter.

Respeto implies a mutual and reciprocal deference. The Hispanic adult patient expects the provider to treat him/her with returned respect and may terminate treatment if they perceive that that respect is not being shown.

Respeto implies a mutual and reciprocal deference.

Along with good health care practices such as providing the patient with information about the examination, diagnosis, and treatment; listening to the patient's' concerns; and, taking their individual needs into consideration while planning treatment, there are some additional steps you as a health care provider can take to assure the respect of your Hispanic patients.

- If you're a younger provider, even though you will be awarded respect as an authority figure, you should be more formal in your interactions with older Hispanic patients. Formality should not be taken to mean coldness or distance, but rather politeness. It is polite to address Hispanic adults as *Señor* (Mr.), *Don* (Sir), *Señora* (Mrs.), or *Doña* (Madam).

...you should be more formal in your interactions with older Hispanic patients.

- Even if you do not speak Spanish, greeting a patient with "*Buenos dias*" (good morning) or "*Buenas tardes*" (good afternoon) suggests that you have respect for the Spanish language. These few words become an important cue to people about your positive attitudes

A few words spoken in Spanish may become an important cue to people about your positive attitudes towards them.

towards them as too often Hispanics sense hostility and disdain for their limited use or lack of English. If you speak some Spanish, it is important to remember to always use the formal *usted* (you) until such a time as the patient explicitly suggests the use of the informal *tú (you)*.

- Encourage the asking of questions. Out of a sense of *respeto* (respect) many Hispanic patients tend to avoid disagreeing or expressing doubts to their health care provider in relation to the treatment they are receiving. They may even be reluctant to ask questions or admit they are confused about their medical instructions or treatment. Associated with this is a cultural taboo against expressing negative feelings directly. This taboo may manifest itself in a patient's withholding information, not following treatment orders, or terminating medical care.

Health providers, as authority figures, need to take seriously the responsibility and *respeto* conferred on them by many Hispanic patients. They need to explain all medical procedures and treatments thoroughly, and to ascertain through careful questioning whether the patient has fully understood the explanations and instructions he/she has received.

Personalismo
Personal rather than institutional relationships are important.

Hispanics tend to stress the importance of *personalismo*- personal rather than institutional relationships, which is why so many Hispanics continue to rely on community-based organizations and clinics for their primary care. Hispanics expect health providers to be warm, friendly, and personal, and to take an active interest in the patient's life. For example a health provider, even one with a limited time schedule for patient visits, might greet *Señora* Díaz with, "*Buenos Días, Señora Díaz*. How are you doing today? How did your daughter's graduation go?" Such a greeting implies *personalismo*, conveying to the patient that the provider is interested in her as a person and will help put the patient at ease before an exam or medical procedure.

When asked in focus groups where they received their medical care, the majority of Hispanics responded by naming their personal health care provider rather than their HMO or other health care institution. Hispanic loyalty to the individual provider also has significant implications for continuity of care. If a health care professional leaves a health center for another in close proximity, their Hispanic patients are likely to follow him/her to the new setting. If the health professional leaves the area however, their Hispanic patients may frequently stop treatment, unless the provider has made introductions to the new health care provider and established a transitional relationship between them based on *personalismo*

Hispanic loyalty to the individual provider also has significant implications for continuity of care.

Unfortunately, *personalismo* tends to conflict with the health system's trend towards managed care and away from individualized practices and long-term provider/patient relationships. It is a loss many in the health care system are feeling.

The Hispanic patient's desire for closeness to their health care provider is more than the content of their verbal exchanges; it also has to do with physical space. When interacting with others Hispanics typically prefer being closer to each other in space than non-Hispanic whites do. When non-Hispanic providers place themselves at their customary two feet or more distance away from their Hispanic patients, they may be perceived as not only physically distant but wrongly be thought of as uninterested and detached. Such perceptions can be overcome by sitting closer, leaning forward, giving a comforting pat on the shoulder, or other gestures that indicate an interest in the patient.

Overall, Hispanics tend to be highly attuned to non-verbal messages.

Overall, Hispanics tend to be highly attuned to others' non-verbal messages. Non-Spanish speaking providers should be particularly sensitive to this tendency when establishing a relationship with patients who speak only Spanish. Over time, by respecting the patient's culture and showing personal interest, a health care provider can expect to win their *confianza* (trust). When there is *confianza*

Confianza
...a health care provider can expect to win their confianza (trust).

Hispanics will value the time they spend talking with their health care providers and believe what they say because *confianza* means that the provider will have their best interests at heart.

...the provider who is able to establish a bond of trust, of confianza, with his or her Hispanic patient will find a profound improvement in the quality of care-giving and willingness of the patient to take wellness and risk-reduction advice to heart.

Unfortunately *confianza* is increasingly difficult to achieve these days due to the dramatic changes occurring in the health care system, i.e., long-term provider-patient relationships are less common, physicians and others are limited in the amount of time they can spend with each patient, and HMOs and other institutions reduce their coverage and treatment of the poor. And yet despite these and other obstacles, the provider who is able to establish a bond of trust, *confianza*, with his or her Hispanic patient will find a profound improvement in the quality of care-giving and willingness of the patient to take wellness and risk-reduction advice to heart. Having won *confianza* from your patients you may also find yourself coming to appreciate the Hispanic view of health. Remember that with *confianza* there is compliance.

Integrated Health – body, mind, and spirit

While today's health care professionals work within the structures of mainstream medicine, providing separate physical and mental health care, Hispanic culture tends to view health from a more synergistic point of view. This view is expressed as the continuum of body, mind, and *espíritu* (spirit).

Within the last century, health and illness have been approached through a variety of treatments, each with its own philosophical base. Some have been based on empirical science (mainstream medicine), some believe disorders linked to the musculoskeletal system can be corrected by physical manipulations (osteopathy), some developed treatments based on the belief that minute doses of drugs that mimic diseases can be used to treat diseases (homeopathy). Still other approaches continue to base states of health on a purely spiritual belief system (Christian Science). In addition there is an extensive practice of traditional medicine carried out by *curanderas*, *espiritistas*, or healers

within the Hispanic community. In urbanized *barrios* this tradition has been carried on in part by Hispanic pharmacists, familiar with both traditional treatments like *té de manzanilla*(chamomile tea) as well as placing a strong value on the use of modern prescription medicines such as antibiotics. In recent years there has also been a dramatic increase of interest on the part of mainstream medicine in researching and identifying many of the healing properties and pharmaceutical potentials of traditional medicines.

In recent years there has also been a dramatic increase of interest on the part of mainstream medicine in researching and identifying many of the healing properties and pharmaceutical potentials of traditional medicines.

Webster's New University Dictionary defines Synergy as, "1. The action of two or more organisms to achieve an effect of which each is individually incapable." and "2. The theological doctrine that regeneration is effected by a combination of human will and divine grace." The Hispanic view of the mind, body, spirit continuum is a very synergistic one, but also quite practical.

Combining respect for the benefits of mainstream medicine, tradition and traditional healing, along with a strong religious component from their daily lives (over 77% of Hispanics in the United States are Catholic), Hispanic patients may bring quite a broad definition of health to the clinical or diagnostic setting. Respecting and understanding this view can prove beneficial both in treating and communicating with the patient, as well as useful for all health care professionals.[19]

Hispanic patients may bring quite a broad definition of health to the clinical or diagnostic setting.

II. About Hispanics

Chapter Five: History of Hispanics in the United States

Or why the City by the Bay is not called Saint Francis.

For Hispanics in the United States history is a confluence of national and social narratives that have only recently merged into a powerful river of common understanding.

In 1453 Constantinople fell to the Ottoman Turks, cutting off Europe's silk and spice trade with India and Asia. Thirty-nine years later an Italian named Cristóbal Colón, or Christopher Columbus, sailing west for the Queen of Spain first reached the New World thinking he had found a new route to the orient.[20] His first landfalls included Juana (Cuba) and the island of Hispaniola (the Dominican Republic and Haiti) whose natural wonders so amazed him he declared his eyes "would never tire of beholding so much beauty, and the songs of the birds large and small."[21] Having recorded their first impressions of North America's natural wonders the early discoverers quickly set about in search of gold and other objects of value. The Conquistadors were committed to expansion of the Spanish empire and recovery of treasure for the crown. Spanish Catholic missions soon followed with the goal of winning new religious converts. Colonial administrators began spreading Spanish culture from Mexico across Central and South America.

Spanish settlement... came early...Florida in 1565...1598 Don Juan de Oñate colonized New Mexico.

Spanish settlement of North America came early and included the first permanent European settlement of the New World at St. Augustine, Florida in 1565. In 1598 Don Juan de Oñate colonized New Mexico.

...immigration to the United States may be linked not only to the economic opportunities... but also to U.S. military actions...

Yet almost all Hispanic immigration to the United States may be linked not only to the economic opportunities that would attract European and Asian immigrants, but also to U.S. military actions linked to policies of Manifest Destiny (that declared the United States' "God-given right" to all North American territory) and the Monroe Doctrine (which declared United States hegemony over Mexico, Central and South America and warned European powers not to intervene there). From the Spanish American War that brought Cuba

and Puerto Rico under U.S. administration in 1898, to various actions in the Dominican Republic, Nicaragua, Honduras and other parts of Central America, waves of immigration followed on war, rebellion, and occupation. This process has continued as recently as the 1980s, when large numbers of Guatemalans, Nicaraguans, and Salvadorans fled to the United States to escape civil wars.

Mexican Americans: "So far from God, so close to the United States," has been a saying in Mexico for generations, reflecting the often turbulent relationship between the two nations. Continuing through the 1800's Spain extended its dominance over the bulk of what is now the United States, across California and the Southwest. Eventually the goal of the church to convert the indigenous inhabitants would lead to conversions and intermarriage and the survival of large numbers of mestizo, or mixed blood people. Today the California mission system lives on in the names of its early settlements that evolved into towns and cities: San Diego, Los Angeles, Santa Barbara, San Luis Obispo, Monterey, San Jose, and San Francisco.

For Mexicans living in the areas annexed by the Treaty, the border had crossed them adding new language and cultural obstacles that still exist today

Mexicans and Mexican Americans make up over 58% of the U.S. Hispanic population.

In 1821, Mexico fought to win its independence from Spain. Mexico lost half its northern territory to the United States following the Mexican American war through the Treaty of Guadalupe Hidalgo (1848). For Mexicans living in the areas annexed by the Treaty (all or part of the states of AZ, CA, CO, NV, NM, TX, UT, and WY), the border had crossed them adding new language and cultural obstacles that still exist today. With close family and community ties remaining on both sides of the frontier, Mexican migration to and from the United States has continued largely uninterrupted since the Treaty of Guadalupe Hidalgo. Today Mexicans and Mexican Americans make up over 58% of the U.S. Hispanic population and include at least two million seasonal migratory workers who spend part of the year in the United States and part in their native Mexico.[22]

Puerto Ricans: The second largest Hispanic group (about 19%) in the United States with some 3 million people living on the U.S. mainland and 3.9 million more living on the island.[23] Borinquén (the islanders' name for Puerto Rico) was discovered by Columbus in 1492 and conquered by Juan Ponce de León in 1508. The Taino and Arawak Indians who lived there were quickly killed off through violence, starvation, and forced labor. Yoruba African slaves were then brought to the island to work the sugar cane fields. They eventually won their freedom, intermarried, and incorporated their culture and beliefs into the island life.

In 1815 a second wave of Spanish settlers known as the "Real Cédula de Gracias" were encouraged to emigrate to Puerto Rico in order to "whiten" its population. Instead, by defining themselves as a new elite, they exacerbated tensions between islanders and their colonial administrators. In 1897 Puerto Rican nationalists declared themselves independent from Spain. A year later United States forces landed in Puerto Rico, Cuba, and the Philippines during the Spanish-American War. But unlike in Cuba and the Philippines, the United States never gave up its claim on Puerto Rico. In 1917 Puerto Ricans were made United States citizens under the Jones Act and eligible males were required to enlist in the military. In 1952 Puerto Rico was declared a Commonwealth of the United States.

In 1917 Puerto Ricans were made United States citizens under the Jones Act and eligible males were required to enlist in the military.

Economic underdevelopment on the island, the United States' expanding post-war industrial base, and job opportunities led to the migration of close to a million Puerto Ricans to the mainland between 1945 and 1965. Large Puerto Rican communities were established in New York, other parts of the Northeast, and Chicago. Half a century later people on the mainland continue to maintain close links with their families at home through the Puerto Rican "air bridge" of regular flights between the mainland and Puerto Rico. At the same time the cultural, political, medical, and social needs of Puerto Ricans on the mainland and on the island have tended to diverge over time, although key social agencies like New York's Puerto Rican Family Institute try to bridge that gap by maintaining service centers in both locales.

Cuban Americans comprise about 4% of the Hispanic population in the United States.

Cuban Americans: Cuban Americans comprise about 4% of the Hispanic population in the United States.[24] Even though they have a higher level of education and income compared to other Hispanic subgroups, the median income of Cuban Americans is less than that of non-Hispanic whites. Cuba, only 90 miles from Key West, Florida was visited by Columbus in 1492 and colonized by Spain in 1511 during which all the native people were killed. The largest island in the West Indies, Cuba, and its capitol port Havana, became a major shipping and transportation hub, as well as a key to the trade in rum, sugar, cod, and slaves. Its population was also a mix of European settlers and African slave laborers.

Even before the Spanish-American War of 1898, Cubans began emigrating to the U.S. In 1902, four years after annexing Cuba in the Spanish-American War, the U.S. granted it independence. However the U.S. maintained a major influence in Cuba over the next fifty years as it became a popular resort destination. The Cuban Revolution of 1959 that overthrew the regime of Fulgencio Batista and brought Fidel Castro to power drove some half a million upper and middle-class refugees to south Florida. Since then, Cubans fleeing the Castro regime continue to arrive.

Central Americans have immigrated to the United States, often in search of refuge from violence created by civil wars and other conflicts including economic instability created by civil war

Central Americans: Since its early settlement, Central America has had a history of turmoil. The economies of Central American countries tend to be unstable because of their dependence on a few agricultural export crops such as coffee, sugar, bananas, and cotton owned by a very small segment of society. Because of the political and economic struggles that the nations of this region have endured, many Central Americans have immigrated to the United States, often in search of refuge from violence created by civil wars and other conflicts including economic instability created by civil war. Central Americans have settled in different parts of the country. Salvadorans have settled mainly in Los Angeles and Washington D.C.; Guatemalans in Los Angeles, San Francisco, and Houston; and Nicaraguans in San Francisco and Miami. Many suffer from post traumatic stress problems, relating to their countries' civil wars.

Dominicans: Discovered by Columbus in 1492, the island of Hispaniola later divided following a slave rebellion and the establishment of the independent nation of Haiti. The remaining eastern two-thirds of the island would eventually become the Dominican Republic, a predominantly agricultural Spanish-speaking nation with thick rain forests and spectacular mountain ranges. Since the U.S. invasion of the Dominican Republic in 1965 during a period of civil unrest, over half a million Dominicans and their descendants have settled in the United States, with 70% of them located in New York City and adjacent parts of New Jersey.

...over half a million Dominicans and their descendants have settled in the United States...70% of them located in New York City and adjacent parts of New Jersey

South Americans: Several hundred thousand Colombians have also settled in the U.S., mainly in Florida and New York. Smaller numbers of Hispanics have come to the United States from Venezuela, Ecuador, and other Latin American nations. Although there are various reasons for South American immigration to the United States, two key causes include political instability in certain instances and the search for economic opportunity or prosperity in others.

...South American immigration...two key causes include political instability in certain instances and the search for economic opportunity or prosperity in others.

The history of Hispanics in the United States clearly indicates that in dealing with Hispanic populations in a medical or social service context, one must recognize the tremendous range of historical experiences that exists among the various sub-groups. Each nationality has its own historical perspective that affects how they view themselves within the context of living in the United States and how the U.S. has treated them. In fact, differences among subgroups may be related to how they entered the U.S., i.e., as legal immigrants, legal refugees, undocumented workers, or as a result of war.

Understanding the unique and unexpected health profile of the Hispanic patient population you ser ve.

While one can't be expected to memorize all the data that is provided in this chapter, there are three key points worth remembering in dealing with the issue of Hispanic health status:

Key Facts

- Hispanics have lower mortality rates than the overall population but are at greater risk for a number of chronic illnesses and diseases. Neither mortality nor "excess death" is an accurate measure of health for this population.

Neither mortality nor "excess death" is an accurate measure of health for this population.

- Hispanic populations exhibit a number of positive health indicators in terms of diet; low levels of smoking and illicit drug use; and, a strong family structure. However, with acculturation these positive indicators tend to deteriorate. Positive aspects of traditional cultures need to be reinforced.

Positive aspects of traditional cultures need to be reinforced.

- Although there are differences among Hispanic groups, there are important similarities.

Hispanics, as outlined earlier, share a range of sociocultural characteristics, as well as national, experiential, and in some instances genetic make-up, that can impact their health status within the United States. Certain cultural factors, such as a more traditional diet and lower rates of smoking among women impact favorably on their health status, while others, such as low immunization rates linked to low-economic status and fear of authority among new immigrants, have negative consequences. Unfortunately acculturation among new immigrants and their children seems to weaken positive health habits and lead to the adoption of negative ones from U.S. culture (such as smoking, alcohol use, and early sexual activity).

Unfortunately acculturation among new immigrants and their children seems to weaken positive health habits and lead to the adoption of negative ones from U.S. culture.

...it was not until 1989 that the U.S. National Model Death Certificate collected data on Hispanics.

For decades when researchers, health professionals, politicians and policy-makers addressed minority health, they were usually referring only to issues and statistics dealing with African-American health profiles and then extrapolating from these to other communities. The major reason for this was that it was not until 1989 that the U.S. National Model Death Certificate collected data on Hispanics. This lack of data prevented the emergence of an authentic Hispanic health profile. As data became more available in the 1990's, a Hispanic health profile emerged which showed that despite lower income, less education, and less access to health Hispanics have a longer life expectancy than non-Hispanic whites. This ran counter to the prevailing models of health.[25]

Mortality and Morbidity

In 1985 the Report of the Task Force on Black and Minority Health of the U.S. Department of Health and Human Services, attempted to outline the disparities in health status existing between the non-Hispanic white population and the rest of the population. However, it remained difficult to ascertain the actual differences in health status among "minority" populations due to the fact that although mortality data were available for blacks, Asian/Pacific Islanders, Native Americans and whites, it was still not available for Hispanics.

Even today the organization of reliable and accessible data on Hispanic mortality and morbidity lags behind that for other racial and ethnic groups.

Even today the organization of reliable and accessible data on Hispanic mortality and morbidity lags behind that for other racial and ethnic groups. Nonetheless certain trends and statistical health profiles have become clear, with the mortality rates for Hispanics proving counter-intuitive to the traditional view that the lower economic status and educational attainment of "minorities" dooms them to a higher rate of mortality.

Despite having a lower income, Hispanics live longer than non-Hispanic whites. Hispanics have an average life-expectancy of 75.1

years for men and 82.6 years for women.[26] As a result, for the Hispanic community the issues of morbidity rather than mortality are of greatest concern. These issues include lifestyle and behaviors affecting health, environmental factors such as exposure to pesticides, unclean air and polluted water, and the ongoing need for more effective use of existing health services. Many of these morbidity factors also play a significant role in Hispanic mortality rates.

Despite having a lower income Hispanics live longer than non-Hispanic whites.

The top ten leading causes (1998) of death for Hispanics of all age groups are:

1. Heart disease,
2. Malignant neoplasms,
3. Accidents and adverse effects,
4. Cerebrovascular diseases,
5. Diabetes mellitus,
6. Pneumonia and influenza,
7. Homicide and legal intervention,
8. Chronic liver disease and cirrhosis,
9. Chronic obstruction and pulmonary diseases, and,
10. Certain conditions originating in the prenatal period.[27]

The top two leading causes of death are the same for the Hispanic and for the non-Hispanic white population: heart disease and cancer

The top two leading causes of death are the same for the Hispanic and for the non-Hispanic white population: heart disease and cancer. However, for Hispanics these two causes account for 45% of deaths, whereas they accounted for 55% of all deaths among non-Hispanic whites in 1998.[28]

Of the ten leading causes of death for the Hispanic population, two, "Homicide and legal intervention," and "Certain conditions originating in the prenatal period," also reflect differences in age composition between Hispanics and other groups. The Hispanic community is marked by its youthfulness. Its median age is 26.6 years, compared to 38.6 years for the non-Hispanic white population.[29]

Because the Hispanic population has a greater proportion of young persons, it also has a larger proportion of deaths due to causes that are more prevalent at younger ages, such as male violence. Some key mortality differences are:

- Chronic liver disease is a leading cause of death for Hispanics, but not for non-Hispanic whites;
- Diabetes mellitus ranks higher for Hispanic populations as a cause of death than for non-Hispanic whites;
- HIV infection for Hispanics aged 1-4 and 15-24 years is the 9th leading cause of death, but is not a leading cause of death for non-Hispanic whites in those age groups; and,
- Homicide and legal intervention consistently ranks higher for Hispanics than for non-Hispanic whites for age groups between 15-24 years and 25-44 years.[30]

Looking at some of the major health problems facing Hispanics today including HIV/AIDS, diabetes, coronary heart disease, stroke, and depression, it is easy to see how lifestyle and health behaviors can significantly impact on Hispanics' health status. For example, improper diet, smoking, and excessive alcohol consumption are known to increase the risks for diabetes and cardiovascular disease.

Smoking

The relationship between smoking and various cancers, heart disease, and respiratory disorders has been clearly established. For the past twenty years there has also been a steady decline in the number of Hispanics who smoke tobacco. By 1998 only 18.9% of Hispanics smoked tobacco compared to 26.5% of non-Hispanic blacks and 25.9% of non-Hispanic whites.[31]

While Hispanic adults have the lowest rates of smoking, Hispanic eighth graders now have the highest rates of smoking among all their peers. A recent survey found that 50.6% of Hispanic eighth graders had reported smoking within the previous 30 days compared to 47.9% of non-Hispanic whites and 41.7% of non-Hispanic blacks.[32]

Hispanic eighth graders now have the highest rates of smoking among all their peers.

In addition, a recent survey in San Francisco found that while only 15% of first-generation immigrant Hispanic women reported smoking, 23% of second-generation Hispanic women smoked. This was consistent with other findings showing that as Hispanic women acculturate to the United States they tend to give up a number of their healthier habits such as not smoking and good nutrition.[33]

In addition, a recent survey in San Francisco found that while only 15% of first-generation immigrant Hispanic women reported smoking, 23% of second-generation Hispanic women smoked.

Diet

Diet has been shown to affect several cancers, diabetes, and heart disease. The Hispanic diet is high in fiber, relies on vegetable rather than animal proteins, and includes few dairy products and leafy green vegetables. In cattle producing countries however, diets tend to include a greater amount of animal protein. Recent studies also indicate that Mexican American women report a higher intake of vitamins A, C, folic acid, and calcium than do non-Hispanic white women. Again, however, these positive indicators tend to decline with U.S. acculturated second generation Mexican American women whose dietary intake is the same as that for non-Hispanic white women.[34]

The Hispanic diet is high in fiber, relies on vegetable rather than animal proteins, and includes few dairy products and leafy green vegetables.

Reflecting differences among Hispanic sub-groups, there are findings of both positive and negative nutritional indicators for Hispanic children. While the mean iron intake of Cuban American and Puerto Rican children meet the recommended level for iron, Mexican American infants are below the recommended level. The majority of Mexican American children also consume less than the recommended servings of fruits and vegetables, including fruits and vegetables with high vitamin A and C content. Also, after age 5, the majority of Mexican American children consume less than the recommended daily servings of milk.[35]

Although Hispanic women are regarded as coming from a breast-feeding culture, their nursing rates begin to decline as they acculturate to the United States.

In terms of mother's milk, according to 1990 statistics 52% of Hispanic women breast-fed their infants compared to 59% of non-Hispanic white women and 26% of non-Hispanic black women. Although Hispanic women are regarded as coming from a breast-feeding culture, their nursing rates begin to decline as they acculturate to the United States. In addition, bottle-feeding ad campaigns conducted in Puerto Rico and throughout Latin America by corporations that produce baby formula have also led to a steady decline in breast-feeding in these areas.[36]

Cholesterol

...cholesterol levels for Hispanics are similar to those reported for non-Hispanic whites and non-Hispanic blacks....

Linked to diet and nutrition, cholesterol levels for Hispanics are similar to those reported for non-Hispanic whites and non-Hispanic blacks. For all Hispanics, cholesterol levels gradually increase with age. Hispanics with high cholesterol levels tend to be less aware of their situation than their non-Hispanic white counterparts.[37]

...as Hispanic immigrants and other groups adapt to the dominant culture's diet their serum cholesterol levels begin to rise.

The traditional Hispanic diet includes a carbohydrate staple (such as rice or corn tortillas) with beans, which together provide a balanced source of protein without cholesterol. However, as Hispanic immigrants and other groups adapt to the dominant culture's diet their serum cholesterol levels begin to rise.

Weight and Exercise

Less than half (42%) of all adults in the United States are at a healthy weight. The rates are lowest for Mexican Americans at 30% compared to 43% of non-Hispanic white and 34% of non-Hispanic black adults. Data for other Hispanic population groups besides Mexican Americans are not currently available.[38]

Despite evidence linking regular physical activity to a range of health benefits, millions of United States adults remain essentially

sedentary, a fact which has generated the descriptive title of "TV couch potatoes" (or with the advent of the internet, "mouse potatoes"). Researchers report that men are more likely than women to participate in physical activity. Also Hispanics are less likely to exercise with 41.0% of Hispanic adults reporting no leisure time physical activity compared to 26.7% of non-Hispanic whites. A CDC study of high school students found that adolescent males are about twice as likely as adolescent females to report engaging in vigorous physical activity.[39]

While many Hispanics work in occupations requiring heavy manual labor, many of these activities do not contribute to aerobic fitness. A heart study conducted in San Antonio, Texas, found that Mexican Americans engaged in aerobic exercise less often than any other group.

While many Hispanics work in occupations requiring heavy manual labor, many of these activities do not contribute to aerobic fitness.

Alcohol and Substance Abuse

Another lifestyle issue facing the Hispanic community is excessive alcohol use that can, over time, cause serious medical problems, as well as increase the more immediate risk of accidents and violence. Alcohol appears to be the major drug of use among Hispanics with more than half (58.5%) reporting that they had used alcohol in the past year. Rates of heavy alcohol use (five or more drinks per occasion on five or more days in the past 30 days) are higher among Mexican Americans (6.9%) than among non-Hispanic whites (5.3%) or non-Hispanic blacks (4.7%).[40]

Furthermore, data indicate that rates of alcohol use increase with acculturation among all U.S. Hispanic groups. This trend is particularly evident among Hispanic women. Hispanic males are more likely to have used alcohol in the past year (68.3%) than Hispanic females (48.4%). However, data are now showing that lower rates of drinking among females are not evident among Hispanic youth. Among 12-17 year olds, 18.8% of Hispanic males report alcohol use in the past month compared to 19.1% of Hispanic females.[41]

...data indicate that rates of alcohol use increase with acculturation among all U.S. Hispanic groups.

Overall, 26.6% of Hispanics report ever having used an illicit drug including marijuana in their lifetime, compared to 33.2% of non-Hispanic blacks and 38.2% of non-Hispanic whites. Hispanics are also less likely to report having used illicit drugs during the past year (10.5%), compared to 10.4% of non-Hispanic whites and 13.0% of non-Hispanic blacks. However, the percentage of Hispanics reporting cocaine use within the past month (1.3%) is the same as that of non-Hispanic blacks and almost twice as high as that of non-Hispanic whites (0.5%). Hispanics are less likely to have used crack cocaine in the past year, however (0.7%), than blacks (1.3%) but more likely than whites (0.3%). Inhalants represent a particular threat for Hispanic adolescents: 5.6% of Hispanics age 12-17 report they've used inhalants, compared to 7.2% of white youth and 2.1% of black youth.[42]

Violence and Unintentional Injuries

Self-inflicted and unintentional injuries and death as well as violent homicides also have a disproportionate impact on youthful Hispanic groups and individuals.

Hispanic high-school students are more likely to have made at least one suicide attempt (12.8%), compared to their non-Hispanic black (7.3%) and non-Hispanic white (6.7%) peers.

Studies find that Hispanic high-school students are more likely to have made at least one suicide attempt (12.8%), compared to their non-Hispanic black (7.3%) and non-Hispanic white (6.7%) peers. Even more disturbing, Hispanic female high-school students are significantly more likely to have made at least one suicide attempt in the previous year (18.9%), than their non-Hispanic black (7.5%) or non-Hispanic white (9.0%) peers. Rates for female students are higher than for male students across all racial and ethnic categories.[43]

Violence is another increasing challenge to the health and well-being of Hispanic youth. The percentage of deaths from homicide and legal intervention is almost five times greater for Hispanic adolescents and young adults (28.0%) than that of their non-Hispanic white peers (5.8%).

Twenty-two percent of Hispanic high-school students now report they fear physical and violent attacks when going to and from school.[44]

Accidents are the third leading cause of death among Hispanics, accounting for 8.3% of all Hispanic deaths, but only the sixth leading cause among non-Hispanic whites at 3.9%. For children accidents and adverse effects are the leading cause of death for all groups. For Hispanic children, the rate of accidental deaths (11.0 per 100,000 persons under the age of 4) is similar to that for non-Hispanic white children (11.4) and lower than that for non-Hispanic black children (21.8). When examining accidental death rates due to motor vehicle accidents, the death rate for Hispanic children is also higher than that for non-Hispanic white children.[45] Two contributing factors that have been noted: Hispanic children are less likely to use seat belts or to be placed in child safety seats than their white counterparts, and Hispanic adults are over-represented in the number of arrests for drunk driving.

When examining accidental death rates due to motor vehicle accidents, the death rate for Mexican American children is higher than that for non-Hispanic white children.

Environment

In addition to lifestyle and behaviors, health status is significantly impacted by our surrounding environment. Most of the major environmental laws in place today, the Clean Air Act, Clean Water Act, Community Right to Know Law, etc. have as their objective the protection of our public health and yet very few Hispanics are aware of them. This is unfortunate as Hispanics in the United States face the highest rates of exposure to pollution and toxic substances. Hispanics are the group most likely to live in areas failing to meet air quality standards according to the EPA, with 80% living in areas that fail to meet at least one National Ambient Air Quality Standard (as compared to 65% of blacks and 57% of whites). 18.5% of Hispanics are exposed to the nation's worst air pollution (as opposed to 9.2% of blacks and 6% of whites).[46] Studies indicate that Puerto Rican children are also more than three times as likely as non-Hispanic white children to suffer from active asthma.[47]

Hispanics in the United States face the highest rates of exposure to pollution and toxic substances.

Mercury is highly toxic to humans. Unfortunately it is sometimes used by Hispanics as a folk medicine or spiritual agent.

In addition, Hispanics are more than two times as likely as blacks or whites to live in areas with either elevated levels of particulate matter or in areas with high levels of lead in the outdoor air. Another source of lead exposure for children is derived from swallowing nonfood items such as chips of paint containing lead, inhaling of lead dust and hand to mouth contamination. House renovations, folk medicines, and cosmetics are others sources of environmental lead exposure. Mercury, commonly known as "quicksilver" or *Azogue* (in Spanish) is highly toxic to humans even in minute amounts. Unfortunately, it is sometimes used by Hispanics as a folk medicine or spiritual agent. *Azogue* is frequently sold in *botánicas* - small stores that carry religious and cultural products. *Azogue* is sold in 3-5 ounce capsules. Believed to possess spiritual power it is sometimes burned as an incense, or in a candle, or sprinkled about the home.

Hispanics are also more likely than other groups to live in EPA non-attainment areas for ozone and carbon monoxide in the air

Hispanics are also more likely than other groups to live in EPA non-attainment areas for ozone and carbon monoxide in the air. Indoor air pollution agents include asbestos, carbon monoxide and second-hand or environmental tobacco smoke (ETS). According to the National Health Interview Survey, 44.3% of Hispanic pre-school children have been exposed to tobacco smoke.

The importance of safe drinking water to health can hardly be emphasized enough. Eighty-two percent of public health officials polled rated it the most important or a very important factor in increasing life expectancy and quality of life. Water quality issues are impacted not only by water sources, but also delivery systems including municipal pipes and household plumbing.

In urban areas low-income Hispanics are more likely to rent older homes and apartments which may contain antiquated lead plumbing (and wall paint).

In urban areas low-income Hispanics are more likely to rent older homes and apartments which may contain antiquated lead plumbing (and wall paint). Additionally biological contamination of urban water systems is getting more notice since outbreaks of cryptosporidum were reported in Milwaukee, Washington D.C. and other cities. Both

industrial and biological contamination of water is also a persistent problem along the United States - Mexico border particularly in *colonias*. In six Texas counties there are about 842 *colonias*(low-income subdivisions outside municipal boundaries) with some 200,000 Mexican and Mexican American residents. Only three *colonias* (less than 1%) have public sewage disposal systems. As a result water supplies often become contaminated with bacteria and viruses. The EPA reports that "outbreaks of dysentery and hepatitis A are commonplace in the *colonias*"

Hispanics are 71% of all seasonal agricultural workers and 95% of all migrant farmworkers.

Of the billion pounds of pesticides used annually in the United States 80% is used in agriculture. Hispanics are 71% of all seasonal agricultural workers and 95% of all migrant farmworkers. This is cause for great concern among public health professionals serving Hispanic patients and clients. Exposure to agrochemicals has been associated with a variety of cancers, particularly hemopoietic cancers; acute and chronic neurotoxicity; lung damage; chemical burns; infant methemoglobinemia; immunologic abnormalities; and, adverse reproductive and developmental effects. It's been reported that prolonged exposure to pesticides is responsible for an estimated 1,000 deaths and 313,000 illnesses annually among agricultural workers in the United States. Among young Mexican American farmworkers interviewed in New York state 48% reported working in fields with pesticides, and 36% reported being sprayed with pesticides while working in fields and orchards.[48] Thus health professionals working with Hispanic patients in rural communities should be familiar with the signs, symptoms and long term impacts of various pesticide and other agro-chemical exposures.

...health professionals working with Hispanic patients in rural communities should be familiar with the signs, symptoms and long term impacts of various pesticide and other agro-chemical exposures.

Biological and chemical contamination of water supplies in migrant labor camps is another widely reported, although not well documented problem. One study found that 43% of water supplies at state-licensed migrant camps in nine Michigan counties contained nitrates. Migrant labor camps in California have also been cited by the EPA for having excessive levels of nitrates and coliform bacteria in their drinking water.

Hispanics are over-represented in the electronics sector as laborers and assemblers, and in the oil and petrochemical industry.

Occupational exposure to chemicals is also widespread in the Hispanic community. Many Hispanics work in settings in which the risk of exposure to a variety of chemicals, gases, and other toxic substances is very high. Hispanics predominate in the migrant and seasonal agricultural workforce, and are also over-represented in the electronics sector as laborers and assemblers, and in the oil and petrochemical industry.

Key Areas of Concern

Community-based Hispanic health and human services groups throughout the United States and Puerto Rico have come to identify certain key health issues that are having major impacts on Hispanic health such as AIDS and HIV; cancer; coronary heart disease; stroke; hypertension; diabetes; environmental health; mental health; and, tuberculosis. These are areas that could be of particular interest if you are a health care provider working with a Hispanic patient population.

AIDS and HIV

The annual incidence rate of AIDS for Hispanic adult men is 3.2 times that and for Hispanic women 6.1 times that of non Hispanic white adult men and women.

The annual incidence rate of AIDS for Hispanic adult men is 3.2 times that and for Hispanic women 6.1 times that of non Hispanic white adult men and women.[49] In 1999 33.5% of the nearly 105,000 reported AIDS cases among Hispanics adults were due to injected drug use. Men having sex with men accounted for more than one-third of all reported cases (39.0%). Men who had sex with men and injected drugs was included at 5.1%. Among Hispanic women reported with AIDS, injected drug use accounted for 43.6%, while 53.1% got infected through heterosexual contact.[50]

Cancer

Malignant neoplasms are the second leading cause of death in the United States among both Hispanics and non-Hispanic whites. The cancer mortality rate for Hispanics is 64.6 per 100,000 persons compared to a rate of 230.1 for non-Hispanic whites and 185.3 for non-Hispanic blacks. Hispanics have a lower incidence and mortality rate for the four most prevalent cancer sites: prostate, breast (female), lung and bronchus, and colon/rectum. However, rates of stomach cancer are higher for Hispanics than for whites. Furthermore, the cervical cancer incidence rate for Hispanics (15.8 per 100,000 women) is higher than that for black women (11.8) and more than twice that for white women (7.1).[51]

Malignant neoplasms are the second leading cause of death in the United States among both Hispanics and non-Hispanic whites.

Coronary Heart Disease, Stroke, and Hypertension

Diseases of the heart were the leading cause of death among Hispanics in 1998. Still, according to the National Center for Health Statistics the death rate for diseases of the heart is lower for Hispanics (81.3 deaths per 100,000), than for whites (311.7) or blacks (236.7).[52] This lower rate of heart disease is surprising since Hispanics have a higher prevalence of conditions that increase their risk for coronary heart disease, including obesity and diabetes.

Diseases of the heart were the leading cause of death among Hispanics in 1998.

Cerebrovascular disease (stroke) is the fourth leading cause of death among Hispanics, accounting for 5.7% of all Hispanic deaths. It is the third leading cause of death among non-Hispanic whites, accounting for 6.9% of all deaths.[53] Since diabetes and obesity are associated risk factors for stroke and related diseases, Hispanics might be expected to face a higher stroke rate than non-Hispanic whites. In fact the opposite is true. If there is some sort of genetic "protective factor" prevalent in Hispanics, future research may be able to isolate and identify this mechanism, and use it to lower rates of cerebrovascular disease for other communities.

This lower rate of heart disease is surprising since Hispanics have a higher prevalence of conditions that increase their risk for coronary heart disease, including obesity and diabetes.

Hispanic men are more likely to have undiagnosed, untreated, or uncontrolled hypertension than the national average

Hypertension affects 25.2% of Mexican American males and 22.0% of Mexican American females.[54] Hispanic men are more likely to have undiagnosed, untreated, or uncontrolled hypertension than the national average. Hispanic females are more likely than Hispanic men to be aware of their condition, although fewer receive treatment for it, and very few have it controlled. In a report out of New York City it was found that 10% of Dominicans and 12% of Puerto Ricans sampled were hypertensive. The study also found that 9% of non-Black Hispanics were found to be hypertensive, compared to 12% of Black Hispanics.[55]

Diabetes

Puerto Ricans and Mexican Americans are about twice as likely to be afflicted by diabetes as are non-Hispanic whites.

Non-insulin dependent diabetes (Type II diabetes) is a major health problem among Hispanics, especially Puerto Ricans and Mexican Americans, who are about twice as likely to be afflicted by it as non-Hispanic whites. Data show the incidence of diabetes to be 26.1% for Puerto Ricans, 23.9% for Mexican Americans, and 15.8% for Cuban Americans, compared to 12% for non-Hispanic whites and 19.3% for non-Hispanic blacks for individuals aged 45-74.[56]

This higher rate of diabetes is correlated with the higher prevalence of obesity among Mexican American women, but overweight Hispanic women are still more likely to have diabetes than overweight non-Hispanic women. Another risk factor was assumed to be genetic as the incidence of non-insulin diabetes appears to be highest in Mexican Americans with substantial Indian heritage. However it is difficult to support this, given the higher prevalence of diabetes affecting Puerto Ricans who do not have this genetic inheritance.

Environmental Health

The environmental health status of Hispanic communities is poor, and is a major source of health problems. Among Hispanics there is a higher risk of exposures to: ambient air pollution; worker exposure to chemicals in industry; indoor pollution; and, pollutants in drinking water. In terms of exposure Hispanics consistently face the worst exposure levels, or levels that represent significant threats to health. Health practitioners should consider environmental sources in diagnosing and treating a variety of conditions affecting Hispanic patients and clients. Both the Agency for Toxic Substances and Disease Registry (ATSDR) and the EPA produce toxicological profiles that can assist you in diagnosing illnesses related to an environmental risk or toxic exposure.

Both the Agency for Toxic Substances and Disease Registry (ATSDR) and the EPA produce toxicological profiles that can assist you in diagnosing illnesses related to an environmental risk or toxic exposure.

Mental Health

Hispanics have the highest rates of depression. Additionally Hispanics are identified as a high-risk group for anxiety and substance abuse. Of course people in transition often experience feelings of irritability, anxiety, helplessness, and despair. They may mourn the loss of family, friends, language, and culturally determined values and attitudes. These reactions are not signs of individual pathology, but rather normal responses to the often disruptive process of change. Sources of stress include: life in a society that does not support their culture and way of life; having to cope with low-incomes and poor housing; experiencing suspicion and distrust regarding their legal status; and, experiencing exploitation and mistreatment from both individuals and institutions in the workplace and other settings.

Hispanics have the highest rates of depression.

Such stress had been assumed to increase the risk for somatic and functional illness, depression, organic disease, and interpersonal problems. In September of 1998 the Archives of Psychiatry published an article (Vega, et al) which provided compelling data that Mexican

Mexican born U.S. residents had less mental illness than Mexican Americans.

born U.S. residents had less mental illness than Mexican Americans. This was contrary to the years of myth that Hispanic immigrants would suffer more mental illness than Hispanics born in the U.S. as a result of post-traumatic stress disorders resulting from wars and other violent events in their countries of origin, and hostile attitudes towards Hispanic immigrants.

...immigrant children who hold fast to their parents' ethnic communities may do better than those who assimilate rapidly...

The evidence indicates that higher levels of acculturation and birth in the United States are associated with higher incidence of phobia, alcohol abuse, drug dependence, and anti-social behavior such as gang membership. Sociologist Herbert Gans argues that immigrant children who hold fast to their parents' ethnic communities may do better than those who assimilate rapidly and adopt the American culture that they see all around them, including cynical attitudes towards school and rejection of low-wage employment opportunities.[57]

...chances for downward mobility and anti-social behavior are greatest for second generation immigrant youth living in close proximity to other American minorities who are poor to start with, ...

Johns Hopkins University professor Alejandro Pertes finds that the chances for downward mobility and anti-social behavior are greatest for second generation immigrant youth living in close proximity to other American minorities who are poor to start with, and who are themselves victims of racial and ethnic discrimination.[58]

Severe psychiatric disorders among Hispanics are sometimes diagnosed incorrectly, when practitioners are unaware of prevalent cultural beliefs and practices, and when they use psychological tests that have not been standardized for bilingual populations.

Tuberculosis

Approximately 10 to 15 million Americans are infected with mycobacterial tuberculosis (TB). In the United States the number of cases of active TB increased over 20% between 1985 and 1992 with a disproportionate rise among racial and ethnic minorities. In 1998, the rate of new tuberculosis cases per 100,000 persons was 13.6 for

Hispanics compared to 2.3 for non-Hispanic whites and 17.8 for non-Hispanic blacks. The risk of contracting TB among Hispanics is approximately six times the risk among non-Hispanic whites. Among Hispanics TB is most prevalent in young adults, ages 25-44. Evidence suggests that the HIV epidemic is in part responsible for the recent increases in tuberculosis among Hispanics in this age group. TB may also be a particularly significant problem for migrant workers. Screening of 214 Hispanic migrant workers in Virginia in the 1980s found that over a quarter had tuberculosis infection, and were at significant risk of developing the clinically active disease.[59]

Among Hispanics TB is most prevalent in young adults, ages 25-44.

Much of what we know about Hispanic health is not only new but contrary to existing models of health. Consequently, it is crucial to determine the specific needs of each Hispanic population you are serving before developing educational or clinical approaches to treatment. It is also very important to re-evaluate approaches at regular intervals to assure quality of care.

III. Implementation
Chapter Seven: Role of Community-based Organizations
The best way to reach the Hispanic community is to work with existing organizations.

Community-based organizations....provide a significant point of entry...

Even beyond the barriers of language and culture, attempts to work with Hispanic communities may profoundly challenge health providers in varied and unexpected ways. Strategies for bringing new health models, education and access to individuals within community settings are an essential but largely overlooked component of the health care system in the United States. Community-based organizations within Hispanics neighborhoods, *barrios*, *colonias*, and other ethnic communities provide a significant point of entry and opportunity to expand outreach efforts.

...a network of hundreds of local community-based organizations have emerged in almost every Hispanic community in America.

While the health care system has established some links to historically black colleges and universities and through health-education programs, to African-American churches, limited relationships exist with the Hispanic community. In fact the Hispanic community has a completely different institutional structure when it comes to issues of health and health services, a structure with little organic or historical connection to mainstream providers. In America's neighborhoods there are Hispanic community-based organizations that have emerged. For the past 30 years, these organizations have acted as frontline advocates for and providers of Hispanic health care and social services

Many of these organizations, and hundreds of others like them, trace their origins to the political upheavals of the late 1960s and early '70s, when Hispanics began to assert themselves in bold, confrontational demonstrations linked to anti-Vietnam war protests, civil rights, and demands for economic justice. Among the highlights of the period were the emergence of César Chávez and the United Farm Workers Union that organized in the West with a focus on work-related issues. In the east, there was the emergence of the Puerto Rican Young Lords in New York with a focus on meeting community-based needs.[60] Interestingly, one of their first actions was the seizure of Lincoln Hospital in Harlem to demand that it become more responsive to the health needs of the Hispanic community. Equally interesting

was the fact that, even in the context of highly polarized times, the New York public hospital system's response was not to call in the police, but to agree to some early, tentative steps towards becoming culturally proficient and more responsive to the Hispanic population that it served.

...community-based health and social service organizations have established histories of providing linguistically and culturally credible services within their own communities.

Still, to a large extent the community-based health and social service organizations that grew out of this period of upheaval were and still are a product of community frustration at being denied access to mainstream health services or resources. Born out of community struggles, they remain governed by community boards and have established histories of providing linguistically and culturally credible services within their own communities. It is this national infrastructure and network that is the most appropriate and sensible entry point for designing and implementing health outreach programs for Hispanic communities. The following case studies and key concepts are relevant to other situations.

Case Study: In 1996, in New Mexico, Youth Development Inc. (YDI) was able to move a youth outreach program from a gym-based after-school setting to its own community training center, a converted 2,000 square foot residential house in the south valley section of Albuquerque. Since many of the twenty-five 9-12-year-old students YDI worked with each year were "latch-key" kids (children who returned home from school while their parents were still at work), the organization was able to utilize this house as a training facility for home safety and nutrition. Along with basic instruction on safety hazards such as exposed electrical plugs, they also instructed the children, many of whom already cooked for themselves and their younger brothers and sisters, on how to safely prepare healthy and nutritious Hispanic meals. Along with showing them videos on nutrition and health, and providing recipes, YDI staff and a volunteer chef also gave them hands-on cooking instructions in the center's kitchen. The effectiveness of the program was confirmed when a number of the kids' parents began asking for and receiving instructions on how to prepare these healthy Hispanic recipes.[61]

Case Study: In Miami, the Little Havana Activities and Nutrition Centers of Dade County, Inc (LHANC) created a health clinic to complement senior adult day care, nutrition, and social services. Through a capital grant request to the City of Miami under its Community Development Funding and private fundraising efforts from the Board of Directors, LHANC was able to build a clinic next to its Little Havana neighborhood center. The agency recruited a staff that is bilingual, lives in or has connections to the community, and who have an understanding of Hispanic health issues. LHANC supports their clinic staff with culturally proficient professional education programs and patient materials. The physical proximity of the clinic to the LHANC Little Havana activities center allows the clinic staff to have a regular connection to their clients. Reminders for office visits are made through adult day care program staff, healthy eating lessons are facilitated through the nutrition program, physical activity is incorporated into daily center dances and other recreational events, and insurance issues are facilitated through the LHANC social work staff. In addition, the co-location of a child day care center has opened opportunities for adult volunteering and intergenerational activities creating a truly holistic circle of health and well-being in Little Havana.

Case Study: In Los Angeles, the Multicultural Area Health Education Center (MAHEC) took youth on a field trip to Kaiser Permanente's Sunset Hospital in Hollywood. There they learned about health care issues, saw how a hospital works and met with physicians, nurses, a physical therapist, and other health care professionals. After the tour they all expressed their desire to work in health care. After a similar tour of the UCLA campus all the youngsters announced they wanted to be college students and health care providers. They were told they could do both. As a result of Kaiser Permanente's participation in this project MAHEC was granted funds to provide childhood immunization services, and began to consider other ways in which it, as a health care institution, could participate in preventative and outreach role-modeling opportunities for Hispanic and other youths from underserved communities.[62]

Case Study: The National Hispanic Prenatal Hotline (NHPH) (1-800-504-7081) provides information on over 3,000 community-based organizations to Hispanic consumers interested in information about pregnancy and prenatal care and needing referral to local prenatal care services. Hotline promotion is conducted primarily through Spanish-language media, including radio, television, newspapers and magazines, and by public service announcements and interviews highlighting the services provided by the hotline. NHPH is staffed by bicultural, bilingual information specialists who use the language the caller feels most comfortable speaking. The information provided, both verbal and written (educational materials mailed, without cost to the consumer) is individualized to the callers needs.[63]

Lessons Learned from Community-based Organizations

Confianza...takes time and evidence of significant long term commitment.

1. To earn *confianza* in a targeted community find out who is respected in the community. Ask your patients, your staff, business owners, clergy, members of the media, teachers who are the respected leaders and agencies that serve the community's needs. This takes time and evidence of significant long term commitment.

...listen to the community's agenda...

2. Remember the value of *personalismo* Go to local leaders and ask for their opinions about what people in the community need the most. Ask them who is already helping with that, and what outreach resources are available. Ask for advice about who you should work with in the community. Don't assert your agenda, instead listen to the community's agenda - what people are asking for - and assign your priorities based on their needs.

3. Providers and systems must demonstrate a capacity and willingness to allow community priorities to guide them. They must earn the community's trust or *confianza*, reach into the community through existing, respected groups; select culturally relevant media and/or materials to convey their messages; and, target whole families with understanding and respect.

4. Health outreach, promotion, and treatment programs should also target the specific community or Hispanic sub group they seek to serve. Spanish-language signs, educational materials, and videotapes don't work as well when they're simply translated directly from English. They have to be developed specifically for the target population. The person(s) developing the materials should be familiar with the language, literacy level, and culture of a specific target group and should have the materials reviewed by members of the target audience. Providers must be open receivers and listeners of "culture" and its dynamics in the delivery of health care.

...outreach programs must demonstrate a capacity and willingness to allow community priorities to guide them.

5. *Respeto* dictates appropriate deferential behavior toward others on the basis of age, sex, social position, economic status, and authority. The provider enters into a reciprocal interaction when treating an Hispanic patient. If a patient feels that the provider has violated the rules of *respeto*, the patient may terminate treatment. Younger providers, even though they will be awarded *respeto* as authority figures, are expected to be especially formal in their interactions with older patients. Formality is a sign of respect, but should not be confused with emotional distance.

Spanish-language signs, educational materials, and videotapes don't work as well when they're simply translated directly from English.

III. Implementation
Chapter Eight: Inter vention
The great risk is in not making the ef fort.

The purpose of intervention is ultimately to change the cultural and environmental norms that suppa:r unhealthy behaviors.

The purpose of any intervention is ultimately to improve health by changing the cultural and environmental norms that support unhealthy behaviors. It is within a community context that unhealthy patterns are developed, maintained, and promoted. Thus, while we want to prevent the abuse behavior itself, this can only be accomplished if the often deep cultural and social norms and values associated with the use and abuse are identified and addressed. Thus, when we plan or organize for health promotion, what we are really doing is attempting to change culture. However, it is not possible to change a culture if one is not familiar with the rules of that culture, how it functions, and how one must function within that culture.

Prevention of risky behaviors is the most effective and most difficult task that you as a health care professional can help the Hispanic community to accomplish. In the article "Cultural and Linguistic Competence in Substance Abuse Prevention for U.S. Latinos," Dr. Juana Mora points out that, "In the last decade, local Latino groups and organizations throughout the country have launched community efforts to reduce substance abuse in their neighborhoods, but community groups need the support of larger, public institutions in order to have long-term success."[66]

Hispanics have tended to receive fewer benefits from prevention and treatment programs due to lack of access and understanding.

Over the years, professionals in the field have understood that for best results, treatment and prevention strategies must be tailored to specific groups and populations. Still, despite such efforts, cultural and economic factors have significantly limited Hispanic participation in behavior-based prevention programs. Whether discussing health-maintenance activities such as prenatal and pediatric check-ups, inoculations, and adult physicals, or mainstream media and outreach campaigns aimed at high-risk behaviors including smoking, abuse of alcohol, illicit drug use, and exposure to HIV/AIDS, Hispanics have tended to receive fewer benefits from prevention and treatment programs due to lack of access and understanding.

Hispanic parents want culturally appropriate services; bilingual/bicultural health clinic staff; trust; and, materials in Spanish.

One troubling example of failure is the fact that Hispanics suffer from low immunization rates, and are the group least likely to see a physician. A national immunization project *Vacunas desde la cuna* conducted focus groups to determine why Hispanic parents were less likely than other parents to have their children immunized. Responses included:

- Lack of culturally appropriate immunization services.
- Scarcity of adequate bilingual/bicultural health clinic staff.
- Lack of trust, having reservations about the confidentiality of health clinics, particularly in relation to immigration authorities, and thus, being reluctant to use them.
- Seldom, or never, finding materials available in languages other than English.

For some Hispanics, the lack of health insurance is the major and overwhelming barrier to health care access and utilization.

For some Hispanics, the lack of health insurance is the major and overwhelming barrier to health care access and utilization (Hispanics are the racial/ethnic group least likely to be insured). With more than a third of the Hispanic population uninsured, the idea of seeing a health care provider for preventive health purposes can be seen as a financially unattainable dream.[64]

Case Study: In 1995 the Puerto Rican Family Institute (PRFI) of New York applied to a foundation grant for the establishment of a pediatric health clinic in the Bushwick section of Brooklyn. This program provided preventive health care services to children ages 9-12. Working with a pediatrician from Brooklyn's Wycoff hospital, and a part-time outreach worker, the project provided physicals and immunizations for hundreds of children, along with referrals, progress reports, and escort services for children needing blood work and other medical follow-up. While the clinic's mission was to provide preventive care to children, because of its bilingual, bicultural benefits and easy access within the community, many parents and other family members also

began to use it as their "one-stop shop," health care provider.

PRFI's response was to try and develop an effective referral system to help reconnect families with the health care system and educate them on the importance of long-term preventative health care action.

The Clinic also provided crucial lifesaving interventions for the children of undocumented workers and others who might have fallen through the cracks in the health care system had the clinic not been there. One example involved a 12-year-old girl who had recently arrived from Mexico who was diagnosed with acute Lupus and referred to treatment. Another instance was a 10-year-old boy, suffering possible brain damage from a traffic accident that took place while he was being illegally transported from Mexico to New York. He was also provided long-term medical treatment as a result of a clinic diagnosis.

By providing a people-friendly environment with offerings from coffee and snacks for parents, to lollipops and stickers for their young patients, to children's books, art supplies and health educational videos in the waiting room, PRFI created a model of an informal community based bilingual/bicultural health care facility.

With the end of its foundation funding in 1998, PRFI was able to negotiate with Wycoff Hospital for the establishment of a five-day a week pediatric satellite clinic to be based within PRFI. This reflected a recognition by Wycoff, a mainstream health care provider, that working on prevention programs with a culturally proficient community-based organization could provide benefits for the patient population, while at the same time providing economic benefit to the hospital in the form of reduced costs.[65]

III. Implementation

Chapter Eight: Inter vention

Programs are most successful when they emphasize the connection between the individual, the family, and the community

Programs are most successful when they emphasize the connection between the individual, the family, and the community. The importance of establishing a relationship of trust with community leaders and institutions in order to assess and create effective strategies cannot be overemphasized. Important questions to ask yourself are:

Is your outreach through existing Hispanic groups?
Do you work with select influential media?
Do you develop culturally relevant materials?
Do you target the whole family with your messages?

Simply assuring that something is in Spanish will not ensure that the message will be delivered.

Culturally relevant materials, as stated earlier, must be relevant to the specific Hispanic subgroup targeted with a message or program. Simply assuring that something is in Spanish will not ensure that the message will be delivered. A health video, for example, produced for a government agency by a non-Hispanic production company used a Mexican cast in a border setting and was found to be useless as an educational tool for Puerto Ricans, Dominicans and Central Americans in other parts of the country. By contrast, videos produced by Hispanic organizations, have used a range of actors who speak "broadcast" Spanish and cannot be easily identified with any single Hispanic sub-group.

Along with awareness of the wide diversity that exists within the Hispanic culture, health care professionals also need to learn about the particular groups they work with. For example a number of national Hispanic advocacy organizations that receive grants and funding from the tobacco industry are not the right organizations to approach for an anti-tobacco or health promotion campaign.

Spanish language print and broadcast media by contrast have proven far more willing to run and even help produce health oriented public service announcements than has the mainstream English language media. These free ads have ranged in content from smoking

reduction, cancer, radon, and prenatal information messages, to instructions on how to receive free check-ups, child-car seats, and home fire detectors. Still, available resources such as these within low-income and underserved Hispanic communities remain limited so that providing services requires imagination, cooperation, and creativity.

...resources...remain limited...providing services requires imagination, cooperation, and creativity

Conclusions

"You have to establish a relationship of trust with patients if you want to practice healing."

Hispanics are now being exposed to healthy living models that no longer see hospitals as a place where you go to die. At the same time, new service models are being developed that respond to the need for quality treatment for Hispanic patients and clients. Of course, only when mainstream institutions including major managed care programs, public and private hospitals, clinics and nursing facilities fully integrate into their systems culturally proficient approaches to patient care will Hispanics and other populations in the United States feel confident they can receive the best care possible. A number of major institutions have already transitioned to this new service model, including Harbor View Medical Center in Seattle, Washington and Thomason Hospital in El Paso, Texas. Often providing these kinds of culturally proficient services proves to be both low-cost and high-benefit from a care-delivery as well as from a financial point of view.

...providing these kinds of culturally proficient services proves to be both low-cost and high-benefit from a care-delivery as well as from a financial point of view

Case Study: Harbor View provides transportation (including ambulance ride-alongs when advisable) for family care givers of patients, particularly migrant workers from the eastern part of the state, where the injury or illness of one family member can be highly disruptive to the lives of others. Harbor View has also provided expanded in-hospital visitation and living opportunities, including translation and social service help in locating housing, clothing, laundry and other needed services for the dislocated care-giver as well as the patient. Along with a family approach in case management, all in-patient staff are given cultural proficiency training for their Hispanic, Southeast Asian, and other patient populations. In addition, there are cross-cultural rounds conducted at the hospital every month, involving speakers and presentations from different community-based groups. Those rounds are open to staff, faculty and community members to attend. Recently, Harbor View, working with St. James Catholic Church, also initiated an on-site English as a Second Language program for interested patients and their family members.[66]

Conclusions

Case Study: Thomason, a public hospital with 335 beds and 1400 employees in El Paso, Texas has an 80% bilingual, bicultural staff serving a patient population that is 94% Hispanic. The main focus for patient care, as well as professional relationships is *respeto* (respect) according to hospital CEO Pete Duarte. "You have to establish a relationship of trust with patients if you want to practice healing," he explains.[74] This translates to a range of culturally adjusted service relationships, from allowing families to spend the night with their in-patient relatives and providing them access to clergy, staff psychiatrists or other comforts they might seek, to on-going contractual agreements between the hospital and community-based health care and social service agencies that help patients resolve problems that go beyond their immediate medical condition but may contribute to it. These problems may include risk-taking behaviors, lack of employment, poor housing, or nutritional shortfalls. To promote its holistic approach to service, the hospital has developed a motivational CARE program. The C stands for Community and recognizes the hospital's role in helping to make the surrounding community a better place for families to live in and prosper, the A stands for Accountability not only for the health care dollars they administer but also to the shared values of the community they are a part of, the R stands for Respect and Dignity, "the most important Research and Development program we have in terms of healing," according to Duarte, and the E is for Excellence of service and care-delivery, a standard expected of every staff member regardless of their position. "It goes back to the basics of who we are as human beings," Duarte explains. "We have to get beyond the cultural stereotypes of the media and recognize that all our patients are human beings. We all come from the same place and have the same dreams for our families and our future, and we have to base our actions as health care professionals on trying to provide the best possible vision of healing in the very sacred places where we do our work".[67]

Despite the benefits many Hispanics have gained from risk-reduction, outreach and prevention efforts, reinforcement of positive cultural traits, and clinical treatment, Hispanics remain the United States population least likely to have access to a regular source of health care service and most likely to underutilize available health care services due to cultural barriers.

Hispanic adults are the group least likely to see a physician.

Access to health services, particularly those relating to chronic and disabling conditions is of prime importance to Hispanic adults. However, Hispanic adults are the group least likely to see a physician. Analyses of the 1998 National Health Interview Survey, found that 24.0% of Hispanics reported not seeing a physician in the past twelve months, compared to 14.2% of non-Hispanic whites and 16.5% of non-Hispanic blacks. According to the National Ambulatory Medical Care Survey, the number of physician visits per year for persons 45 to 64 years old was 4.8 for Mexican Americans, Cuban Americans, as well as for Puerto Ricans, compared to 5.6 for non-Hispanic blacks and 6.5 for non-Hispanic whites.[68]

For many Hispanics, health insurance is another major barrier to service, if not the major barrier to health care utilization. As noted earlier Hispanics are the racial/ethnic group least likely to be insured.

Nearly half of working adult Hispanics do not have job-related health insurance.

The lack of insurance in the Hispanic community is tied in part to a lack of health insurance in the workplace. Nearly one half (45.1%) of working adult Hispanics do not have job-related health insurance, compared to about a third (34%) of working adult blacks and a quarter (22.6%) of working adult whites.[69]

Unfortunately even when Hispanic patients have medical insurance and do seek medical services, they often must contend with a health care system that is not responsive to their needs. For example, a study of UCLA Emergency Medicine Center patients with long-bone fractures found that Hispanics were twice as likely as non-Hispanic white

Conclusions

...a study of UCLA Emergency Medicine Center... went on to find that ethnicity - not language, gender, or insurance status, was the main predicator for inadequate pain relief.

patients to be denied adequate pain medication (analgesia) in the emergency room. The study went on to find that ethnicity - not language, gender, or insurance status, was the main predicator for inadequate pain relief. The importance of cultural proficiency in improving Hispanic access to and service in health care settings seems to be key to making progress in this area.[70]

Hispanics today comprise 13% of the U.S. population, only 4.3% of physicians, and less than 3% of registered nurses are Hispanic.

The growth in numbers of Hispanic health professionals has also not kept pace with the recent growth of the Hispanic population as a whole. While Hispanics today comprise 13% of the U.S. population, only 4.3% of physicians, and less than 3% of registered nurses are Hispanic.[71] By 2050, Hispanics could make up 25% of the population according to the Census Bureau. Will Hispanics be equally well represented in the health and social service professions? While this is an important question in terms of social equity, an equally important question is whether Hispanics will be able to receive culturally proficient care and service from their health-care providers regardless of who those providers are?

...one-third of Hispanic, adolescent women who make their first gynecological visit do so for a pregnancy test compared with one-tenth of non-Hispanic women.

On a cultural level you may encounter a definitional problem about who is a health care provider and what that person or system does. In traditional Hispanic culture physicians, nurses and other health care professionals are seen as authority figures to be visited when one is sick. The idea of going to a doctor when one is feeling well may strike some Hispanics as odd (or if uninsured, an unaffordable luxury). One result is that Hispanics with high cholesterol levels have been found to be less aware of their situation than their non-Hispanic white counterparts. That is also why one-third of Hispanic, adolescent women who make their first gynecological visit do so for a pregnancy test compared with one-tenth of non-Hispanic women.

Since Hispanic women tend to look forward to pregnancy as a natural part of life, they do not see it as an illness or a medical condition. Therefore, they are less likely to visit a health care provider once they have confirmed they are pregnant. Consequently, Hispanic mothers are more than three times as likely as non-Hispanic white mothers to have late or no prenatal care, (approximately 30% receive no prenatal care). Although the infant mortality rate for Hispanic mothers (6.0 per 1,000 live births) is the same as that of non-Hispanic white mothers (6.0 per 1,000 live births), there is no question that the benefits Hispanic mothers derive from traditional Hispanic diets, family-support, etc. could be greatly supplemented and improved upon by regular prenatal check-ups with a health care professional.

The challenges and opportunities remain for all of us. Health professionals and systems must continue to adjust to a more multi-ethnic, multi-racial society in order to meet the needs of their patients and clients. A provider must always be aware of and respect the uniqueness of the patient. The desire of health care professionals and systems to work with community-based organizations and develop more effective ways of serving Hispanic and other patients' needs will create the kind of American health care system we all want.

Endnotes

1 Rachel Kreier, Crossing the Cultural Divide, American Medical News, Jan. 25, 1999.

2 Ian Robertson, Sociology, Wirth Publications, Unit 2 -The Individual, Culture and Society, Pg. 72.

3 Roberto Suro, Strangers Among Us, Alfred A. Knopf, 1998, Pg. 23.

4 Quote from Dr. Juan Ramos, in pamphlet "Connections - The Story of COSSMHO and its 25 Years of Connecting Communities and Creating Change", COSSMHO, 1998.

5 Elena Cohen, Goode T.D., Rationale for Cultural Competence in Primary health Care. Policy Brief 1, National Center for Cultural Competence, Winter, 1999.

6 Cross, TL, BJ Bazron, KW Dennis, and MR Isaacs. "The Cultural Competence Continuum" Toward a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed. Washington, DC: Child and Adolescent Service System Program (CASSP) Technical Assistance Center, Center for Child Health and Mental Health Policy, Georgetown University Child Development Center, 1989; P13 In: Proyecto Informar: Trainer's Manual. National Coalition of Hispanic Health and Human Services Organizations (COSSMHO), 1998. P134.

7 Todd K., Samara N., Hoffman J., Ethnicity as a Risk Factor for Inadequate Emergency Department Analgesia. JAMA March 24/31, 1993. Vol. 269, No.12.

8 Woloshin, S., Bickell, N., Shwartz, L., Gany, F., Welch, G. "Language Barriers in Medicine in the United States." JAMA, March 1, 1995.

9 U.S. Bureau of the Census. "Population Projections of the United States by Age, Sex, Race and Hispanic Origin: 1995-2050." *Current Population Reports* P25-1130, February 1996.

Endnotes

10 Eliseo J. Pérez-Stable, MD, Anna Nápoles-Springer, MPH, and José M. Miramontes, MD, "The Effects of Ethnicity and Language on Medical Outcomes of Patients with Hypertension or Diabetes" Medical Care, Volume 35, Number 12, pp1212-1219.

11 Civil Rights Act of 1964, 42 U.S.C. Sec. 2000d (1988).

12 The Joint Commission on Accreditation of Hospitals, Accreditation Manual for Hospitals as cited by Rafael Metzger, "Legal Issues in Care Delivery to Hispanics: Civil Rights and Professional Competence," A Paper prepared for COSSMHO's Cultural Competence Series Project, April 1998.

13 Teresa M. Kielhorn, JD, LLM, "Reducing Risk by Improving Communication", Permanente Journal Home Page, Kaiser Permanente Home Page (www.kpnw.org), Summer, 1997.

14 Id., citing K. Nakajima and D. Bidaillon, Communication issues in the managed care environment, 17 FORUM 6-9 (1996).

15 COSSMHO, "Navigating Language Differences," Proyecto Informar Trainers Manual, COSSMHO, Pages 107-123, 1998.

16 Ibid.

17 Antonia M. Villarruel, Ph.D., FAAN, Carmen J. Portillo Ph.D., RN, Pamela Kane BSN, RN "Linguistic Competency: Implications for Nursing Practice. A paper prepared for COSSMHO's Cultural Competency Series Project, March 1998.

18 From interview conducted with Texas State Senator and pharmacist Leticia Van de Putte for "Connections - The Story of COSSMHO and its 25 Years of Connecting Communities and Creating Change", COSSMHO, 1998.

19 Jane L. Delgado, Ph.D., ¡Salud! A Latina's Guide to Total Health - Body, Mind, and Spirit. Harper Collins, 1997.

20 Ilan Stavans, The Hispanic Condition, Harper-Collins, 1995, Pg. 27.

21 David Helvarg, The War Against the Greens, Sierra Club Books, 1997, Pg. 44.

22 US Bureau of the Census. "Population by Age, Hispanic Origin and Race, and Sex: March 1999," 2000.
23 US Bureau of the Census. "Estimates of the Population of Puerto Rico Municipos, July 1, 1999," 2000.
24 US Bureau of the Census. "Population by Age, Hispanic Origin and Race, and Sex: March 1999," 2000.
25 US Bureau of the Census. "Population Projections of the United States..." in Current Population Reports P25-1130, Feb. 1996.
26 US Bureau of the Census. Current Population Reports P25-1130, Feb. 1966.
27 National Center for Health Statistics. "National Vital Statistics Reports; Deaths: Final Data for 1998," Update, Aug. 2000.
28 Delivering Preventive Health Care to Hispanics, Page 30.
29 US Bureau of the Census. "Resident Population Estimates of the United States by Sex, Race, and Hispanic Origin," Nov. 2000.
30 Delivering Preventive Health Care to Hispanics, Page 30.
31 US Department of Health and Human Services, "Tobacco Use Among US Racial/Ethnic Minority Groups: A report to the Surgeon General." Office of Smoking or Health, 1998.
32 National Institute of Drug Abuse, "National Survey Results on Drug Use from the Monitoring the Future Study, 1975-1998, Volume 1: Secondary School Students." Monitoring the Future Study, 1999.
33 "Hispanic Youth Target Big Tobacco." National Alliance for Hispanic Health, 2000.
34 Delivering Preventive Health Care to Hispanics, Pages 32-33.
35 Delivering Preventive Health Care to Hispanics, Page 33.
36 Ibid.
37 Delivering Preventive Health Care to Hispanics, Page 34.
38 National Center for Health Statistics. National Health and Nutrition Examination Survey (NHANES), 1999.
39 Delivering Preventive Healthcare to Hispanics, Page 35.

Endnotes

40 Substance Abuse and Mental Health Services Administration. National Household Survey on Drug Abuse: 1991-1993, 1998.

41 Substance Abuse and Mental Health Services Administration. National Household Survey on Drug Abuse: Main Findings 1998, March 2000.

42 Ibid.

43 CDC. "Youth Risk Behavior Surveillance- United States, 1999." CDC Surveillance Summaries, June 9, 2000.

44 National Center for Health Statistics. "National Vital Statistics Reports; Deaths: Final Data for 1998," Update, Aug. 2000.

45 Ibid.

46 Wernette and Nieves, 1991. "Minorities and Air Pollution: A Preliminary Geographic Demographic Analysis." Presented at Socioeconomic Research Analysis Conference, June 27-8, 1991.

47 Delivering Preventive Healthcare to Hispanics, Page 39.

48 Delivering Preventive Healthcare to Hispanics, Pages 44-45.

49 Centers for Disease Control "HIV/AIDS Surveillance Report, 1999 special data run" 2000.

50 Ibid.

51 Wingo et al. "Annual report to the nation on the status of cancer, 1973-1996." Journal of the National Cancer Institute, 1999; 91:675-690.

52 National Center for Health Statistics. "National Vital Statistics Reports; Deaths: Final Data for 1998," Update, Aug. 2000.

53 Ibid.

54 CDC, National Center for Health Statistics, Division of Health Examination Statistics. Special data run, 2000.

55 Delivering Preventive Healthcare to Hispanics, Pages 48-49.

56 National Institute of Diabetes and Digestive Kidney Diseases. "Diabetes in Hispanic Americans." NIH publication No. 98-3265. April 1999.

57 Robert Suro, Strangers Among Us, Alfred A. Knopf, 1998, Pg. 51.

58 Ibid., Pg. 51.

59 Delivering Preventive Healthcare to Hispanics, Pages 52-53.

60 Ilan Stavans, The Hispanic Condition, Harper-Collins, 1995, Pg. 79-82, and other historic sources.

61 "Project HEAL - Responding to Community Needs from within the Community," COSSMHO, 1998.

62 Both the Chicago and Los Angeles examples are reported in "Project HEAL - Responding to Community Needs From Within the Community," COSSMHO, 1998.

63 Prenatal Hotline Celebrates First Birthday, The COSSMHO Reporter, Vol. 23, No. 2 March, 1998-June, 1998, Page 10, and additional interviews.

64 US Bureau of the Census. "Health Insurance Coverage: 1996." Current Population Reports, P60-2199, Sept. 1997.

65 "Project HEAL - Responding to Community Needs from Within the Community," COSSMHO, 1998.

66 From interview with Mamae Teklemariam, Community Health Services, Harbor View Medical Center, conducted for COSSMHO, July, 1998.

67 From interview with Pete Duarte, CEO Thomason Hospital, El Paso, Texas, conducted for COSSMHO, July, 1998.

68 National Center for Health Statistics. "Health United States 1990."

69 Agency for Health Care Policy and Research. "Health Insurance Status of Workers and Their Families: 1996."

70 Knox H. Todd, M.D., Nigel Samaroo; Jerome R. Hoffman, M.D. "Ethnicity as a Risk Factor for Inadequate Emergency Department Analgesia." JAMA, March 24-31, 1993, Volume 269.

71 US Bureau of the Census. "Employed Civilians, by Occupation, Sex, Race, and Hispanic Origin: 1995." Current Population Reports, Section 13 Labor Force Employment and Earnings.

Federal Register
Vol. 65, No. 159
Wednesday, August 16, 2000

Presidential Documents

Title 3—

The President

Executive Order 13166 of August 11, 2000

Improving Access to Services for Persons With Limited English Proficiency

By the authority vested in me as President by the Constitution and the laws of the United States of America, and to improve access to federally conducted and federally assisted programs and activities for persons who, as a result of national origin, are limited in their English proficiency (LEP), it is hereby ordered as follows:

Section 1. *Goals.*

The Federal Government provides and funds an array of services that can be made accessible to otherwise eligible persons who are not proficient in the English language. The Federal Government is committed to improving the accessibility of these services to eligible LEP persons, a goal that reinforces its equally important commitment to promoting programs and activities designed to help individuals learn English. To this end, each Federal agency shall examine the services it provides and develop and implement a system by which LEP persons can meaningfully access those services consistent with, and without unduly burdening, the fundamental mission of the agency. Each Federal agency shall also work to ensure that recipients of Federal financial assistance (recipients) provide meaningful access to their LEP applicants and beneficiaries. To assist the agencies with this endeavor, the Department of Justice has today issued a general guidance document (LEP Guidance), which sets forth the compliance standards that recipients must follow to ensure that the programs and activities they normally provide in English are accessible to LEP persons and thus do not discriminate on the basis of national origin in violation of title VI of the Civil Rights Act of 1964, as amended, and its implementing regulations. As described in the LEP Guidance, recipients must take reasonable steps to ensure meaningful access to their programs and activities by LEP persons.

Sec. 2. *Federally Conducted Programs and Activities.*

Each Federal agency shall prepare a plan to improve access to its federally conducted programs and activities by eligible LEP persons. Each plan shall be consistent with the standards set forth in the LEP Guidance, and shall include the steps the agency will take to ensure that eligible LEP persons can meaningfully access the agency's programs and activities. Agencies shall develop and begin to implement these plans within 120 days of the date of this order, and shall send copies of their plans to the Department of Justice, which shall serve as the central repository of the agencies' plans.

Sec. 3. *Federally Assisted Programs and Activities.*

Each agency providing Federal financial assistance shall draft title VI guidance specifically tailored to its recipients that is consistent with the LEP Guidance issued by the Department of Justice. This agency-specific guidance shall detail how the general standards established in the LEP Guidance will be applied to the agency's recipients. The agency-specific guidance shall take into account the types of services provided by the recipients, the individuals served by the recipients, and other factors set out in the LEP Guidance. Agencies that already have developed title VI guidance that the Department of Justice determines is consistent with the LEP Guidance shall examine their existing guidance, as well as their programs and activities, to determine if additional guidance is necessary to comply with this order. The Department of Justice shall consult with the agencies in creating their guidance and, within 120 days of the date of this order,

Appendix One
Presidential Executive Or der

each agency shall submit its specific guidance to the Department of Justice for review and approval. Following approval by the Department of Justice, each agency shall publish its guidance document in the **Federal Register** for public comment.

Sec. 4. *Consultations.*

In carrying out this order, agencies shall ensure that stakeholders, such as LEP persons and their representative organizations, recipients, and other appropriate individuals or entities, have an adequate opportunity to provide input. Agencies will evaluate the particular needs of the LEP persons they and their recipients serve and the burdens of compliance on the agency and its recipients. This input from stakeholders will assist the agencies in developing an approach to ensuring meaningful access by LEP persons that is practical and effective, fiscally responsible, responsive to the particular circumstances of each agency, and can be readily implemented.

Sec. 5. *Judicial Review.*

This order is intended only to improve the internal management of the executive branch and does not create any right or benefit, substantive or procedural, enforceable at law or equity by a party against the United States, its agencies, its officers or employees, or any person.

William J Clinton

THE WHITE HOUSE,
August 11, 2000.

[FR Doc. 00–20938
Filed 8–15–00; 8:45 am]
Billing code 3195–01–P

1501 Sixteenth Street, NW • Washington, DC 20036-1401
Tel: 202-387-5000 • Web: www.hispanichealth.org

Printed on recycled paper

ISBN: 0-933084-07-2