Achieving a More Minority-Friendly Practice

How successful is your practice at meeting the needs of diverse patients? These 10 tips can help you improve.

Amy Glenn-Vega, MBA, MHA, RHEd

Nineteen-year-old Esperanza Martinez Alfonso takes a seat in the lobby of the Family Medicine Clinic. She's pretty sure she's pregnant, and since moving to the United States from Mexico just six months ago, she's seen brightly colored signs written in her native language, telling expectant mothers to "See your doctor today! Get prenatal care for the health of your baby! It's never too early to start!" She's never been to see a doctor in her life and has no idea what to expect.

She searches the coffee table for a magazine. Everything is in English, so she folds her hands in her lap and looks around. The walls of the clinic are lined with posters of pregnant women, but none of them are Hispanic.

A receptionist pokes her head out from behind a sliding glass window and waves her hand at Esperanza. "Excuse me, miss. Do you have an appointment?" Esperanza is startled and can't understand what she's saying. She slowly approaches the receptionist. "No speak English," she quietly tells her.

"Oh," the receptionist replies. "Well, did you bring a translator with you?" Getting no response from Esperanza, the receptionist sighs and hands her a clipboard with several forms attached. "I still need you to fill these out," she says.

Esperanza takes the clipboard and returns to her seat to complete the forms, which are all in English. Luckily, she recognizes the first line ("last name"), but she doesn't know whether to put down her maternal last name or her paternal last name. The form only has space for one. She hesitantly approaches the receptionist again. "Do you have an insurance card?" the receptionist asks, speaking loudly and slowly. "Um … how do you people say it? Aseguranzas?"

Esperanza's eyes grow wide as the word is spoken. "No," she replies, "no aseguranzas." She's uninsured, but she's brought some cash. She has a few hundred-dollar bills from the last paycheck that Elidio, her boyfriend, cashed. She pulls the money out of her purse.

The receptionist shakes her head. "We can't make change for a hundred-dollar bill. Don't you have a credit card or a check?" she asks, motioning to her purse. Esperanza still doesn't understand a word that's being said and begins to wonder why the receptionist won't take the cash in her hand. "Maybe it's not enough," she worries.

KEY POINTS

- A practice that treats all patients the same regardless of ethnic or cultural background should not necessarily consider itself "minority friendly."
- Minority-friendly practices acknowledge and respect differences in patients' ethnic and cultural backgrounds and take these differences into account when caring for them.
- Steps a practice can take toward cultural competency include hiring a culturally diverse staff, providing forms and materials in different languages and making sure hours are accessible to minority populations.

The unfortunate reality

No one wants a patient to feel unwelcome in a practice, but that's exactly how some minority patients may feel in yours without your even realizing it. The receptionist in the previous example probably wasn't aware of

Amy Glenn-Vega is the director of allied and public health continuing education at Southern Regional Area Health Education Center in Fayetteville, N.C. In 2001, she received a national award from the Healthcare Educators Association for her book, Miguel's Story, *about Latin American patients assimilating into the North American medical culture. Conflicts of interest: none reported.*

Covered in *FPM* Quiz

Downloaded from the *Family Practice Management* Web site at www.aafp.org/fpm. Copyright © 2002 American Academy of Family Physicians. For the private, noncommercial use of one individual user of the Web site. All other rights reserved. Contact copyrights@aafp.org for copyright questions and/or permission requests.

SPEEDBAR®

Minority groups can be defined a variety of ways: by race, ethnicity, gender, nationality, culture, religion, age or sexual orientation.

Practices that want to attract or retain minority patients must do more than treat them just like everyone else.

The author's Cultural Competence Continuum can help you identify how well your practice currently meets the needs of minority patients.

The highest point on the continuum is "cultural proficiency"; however, few family practices have the resources to reach this level.

Esperanza's discomfort. She was merely treating Esperanza as she does every other patient, while trying to get her paperwork in order. But if Esperanza's experience with the doctor is anything like her experience in the waiting area, what are the chances she'll return?

Minorities make up a growing percentage of patients in many medical practices today. Practices that want to attract or retain these patients must do more than treat them "just like everyone else." What can you do? Unfortunately, there's no recipe that will help you appeal to every cultural segment. However, a good place to start is to take a cultural self-assessment to determine what your practice is doing well and where it needs to improve.

> **No one wants a patient to feel unwelcome in a practice, but that's exactly how some minority patients may feel in yours.**

How is your practice doing?

The Cultural Competence Continuum below is a quick tool for determining how well your practice currently meets the needs of its minority patients. The continuum is composed of six scenarios that reflect different stages of development toward cultural competency. Which of the following six stages best describes *your* practice?

1. Cultural destructiveness. In this stage, a practice or organization has policies and procedures that are obstacles to a certain cultural group. For example, a women's clinic is only open twice a week from 8 a.m. to 10 a.m. The clinic is conveniently located between two large textile mills, which employ the majority of the women in the community. But the women in the mills very rarely go to the clinic for routine and preventive health care because the two-hour time slot is too narrow. The women ending the night shift need time to go home, shower, change clothes and eat breakfast before a doctor's appointment. And the women beginning the day shift can't afford to go in late to work after an 8 a.m. appointment.

2. Cultural incapacity. In this stage, a practice or organization lacks the ability to help minority patients and communities. A bias toward certain cultural groups may or may not exist. For example, many health care facilities in the South and along the East Coast care for increasing numbers of Latin Americans. However, many of these facilities lack qualified interpreters and translators to facilitate communication between non-English-speaking patients and staff. This may be because of a lack of funding to hire interpreters and translators, or a lack of qualified people to fill those roles. Regardless, the practice has inadequate resources to meet the special needs of a particular cultural segment.

3. Cultural blindness. In this stage, a practice or organization is unbiased in their interactions with patients and treats everyone the same, regardless of race or ethnicity. The harm here is assuming that what works best for the dominant culture will also work for everyone else. For example, in an office providing obstetric care, it's common to see posters, booklets and flyers depicting the typical patient as a twenty-something Caucasian woman accompanied by a loving husband. With enough exposure to these images, patients like Esperanza may receive the message that they are not welcome.

4. Cultural pre-competence. In this stage, a practice or organization recognizes its limitations in serving a particular cultural segment and begins to take steps to improve care for this population. For example, administrators may revamp budgets to designate funding for cultural initiatives. Health care professionals may investigate cultural initiatives at other practices and consider interventions that might be effective in their own practices.

5. Cultural competence. In this stage, a practice or organization accepts and respects cultural differences, assesses its knowledge of culture and seeks to expand cultural resources. Culturally competent practices are willing and able to adapt existing models of service to better serve the

WHO IS A MINORITY?

While we often think of minority groups in terms of race or ethnicity, they can also be defined by gender, nationality, culture, religion, age or sexual orientation. The "minority population" can vary greatly by region, state, city, town or community. In fact, the minority population of one community can easily be the majority population in another.

needs of minority populations. They recruit culturally diverse employees and routinely provide cultural diversity training to staff. They are constantly assessing the quality of service they provide to minority cultures and are always striving to improve delivery of care to these patients.

6. Cultural proficiency. This is an advanced stage of cultural competence in which the esteem for a culture spills outside the clinic walls and into the community. Culturally proficient physicians and their practices support cultural initiatives in the community. They may lobby for minority-friendly legislation or make charitable contributions of money or services to cultural interventions. They are recognized as models for others who are striving to attain cultural competency.

Although cultural proficiency is the highest point on the continuum, few family practices have the resources to be this proactive. Most practices should aim for cultural competence (stage 5).

Where does your practice currently fall on this continuum? Knowing this will give you a better idea of where you need to go to make your practice more "minority friendly." Here are 10 practical suggestions to help you get there.

"WHAT DID HE SAY?"

Most physicians realize that using interpreters (for the spoken word) and translators (for the written word) when caring for patients with limited English proficiency helps reduce the chance of adverse outcomes. But because of the cost and limited access to qualified interpreters and translators, physicians often assume that "something is better than nothing" and use family members, friends of the patient or bilingual staff members as substitutes.

The main problem with using family, friends and especially children for bilingual communication is that physicians have no way of knowing whether messages are being conveyed accurately. Often, a friend or family member will filter the information instead of transmitting the words exactly as they are spoken. Also, because most people are unfamiliar with medical terminology, they are not capable of conveying the technical explanations that physicians need to give to patients. Furthermore, a patient's confidentiality may be violated when a friend or family member is invited into the exam room to provide interpretation.

If you don't have access to a qualified interpreter, a bilingual staff member is a better alternative than the patient's friends or family members. Most are already familiar with medical terminology and will uphold the patient's right to confidentiality. Ideally, the staff member should have some sort of formal training in interpretation. He or she should also be able to demonstrate proficiency in the language pair being interpreted, preferably through a written and verbal examination. The American Translators Association (www.atanet.org) offers accreditation services as well as a database of over 4,000 accredited translators and interpreters searchable by geographic area.

10 ways to improve

The following strategies can be applied to virtually any practice or health care organization to enhance relationships with patients of culturally or ethnically diverse backgrounds.

> Nothing helps break down the perceived barriers between "us" and "them" like knowing that "one of us" is also "one of them."

1. Recruit and hire minority physicians and staff. Nothing helps break down the perceived barriers between "us" and "them" like the comfort of knowing that "one of us" is also "one of them." Minority patients may have more trust and confidence in a practice that employs someone who can relate to and understand them.

2. Provide interpretation and translation services. Physicians are required under Title VI of the 1964 Civil Rights Act to provide interpreters for patients who have limited English proficiency (LEP). Ideally, physicians should have access to an accredited interpreter knowledgeable about medical terminology (see the box above). But because qualified translators are costly and difficult to find, you may want to consider a service such as Language Line (www.languageline.com), CyraCom (www.cyracom.net) or Online Interpreters (www.onlineinterpreters.com) that provides interpretation over the phone. Costs vary, but generally run between $2 and $3 per minute. Interpreters receive formal training and some are familiar with medical terminology.

You may also want to consider adding a bilingual option to your phone service for

SPEEDBAR®

Instead, the author recommends striving for "cultural competence."

In this stage, practices respect cultural differences and are willing and able to adapt existing services to better suit the needs of diverse patient populations.

For example, the author recommends practices hire minority physicians and staff and provide interpretation and translation services.

Because qualified interpreters are often difficult to find and very costly, the author suggests companies that provide services by phone.

SPEEDBAR®

Prices for phone interpretation vary, but generally run about $2 to $3 per minute.

Interpreters receive formal training and some are familiar with medical terminology.

Using friends or family for interpretation should be avoided since physicians will have no way of knowing if messages are being conveyed accurately.

Also, avoid using computer translation software for material given to patients. The translation is often too literal, introducing inaccuracies.

LEP patients calling your office, and you should have all essential forms and other written patient materials translated into languages you commonly encounter. Don't forget about signs around your office and in your parking lot. Translation services can often be found in your local telephone directory or by contacting a local chapter of the American Translators Association (www.atanet.org). When contacting a translator, inquire about fees and turnaround times up front. In addition, ask to see samples of their work and have these samples reviewed by patients in your practice and by a health care professional who is fluent in the language being translated. Ask people reviewing the samples whether the translation is accurate, tasteful and culturally appropriate.

The importance of using a qualified translator for written information cannot be stressed enough. Translation is an art form, requiring a human touch. Do not rely on computer translation software for information given to patients, as the translation is often too literal, creating inaccuracies.

3. Choose patient education materials carefully. Use booklets, videos and other educational materials that portray people with diverse backgrounds. Stocking waiting rooms and exam rooms with magazines, videos and other materials in non-English languages also contributes to a minority-friendly atmosphere.

4. Offer accessible hours. It is common for families new to the United States to have only one car, which is in use during the day by the family's wage earner. This makes transportation to the doctor's office during work hours difficult. Offering some evening and weekend hours improves their access to care and enables the whole family to take part in a patient's health care, a value strongly held in Hispanic culture, among others.

5. Do your cultural research. Did you know that many people from the Middle East prefer to shake the right hand when meeting someone? (They consider the left hand unclean.) Or that some Hispanic women want to ask their husbands' permission before accepting medication or making an important decision about their health care? Or that Lumbee Indians prefer to be close to the ground as they near death?

A candid conversation with your patient about his or her culture is one of the best learning tools available to you. Books, magazines and other publications about minority groups may also provide valuable insight into cultural beliefs, values and practices. The Internet is another excellent resource on cultural diversity, but keep in mind that much of the information on the Web is unmonitored and uncensored and not all of it is valid. A good place to start your Web research is at www.webofculture.com.

A candid conversation with your patient about his or her culture is one of the best learning tools available to you.

6. Participate in cultural diversity training. Take advantage of workshops, lectures, seminars and conferences in your community to learn about diverse cultural backgrounds. Encourage staff to participate in cultural diversity training as well. One way is to hire a trainer to come to your practice. Before any training session, ask for an agenda or an outline of the course and talk to the trainer about what you hope to achieve. Different trainers take different approaches to cultural diversity education, and the content of the program may be vastly different from your expectations.

7. Recognize special events and observances. One February, a physician posted the words "Celebrate Black History Month" on the marquee in front of her office. Over the next few weeks she saw more than 50 new patients, many of whom were black. Another physician observed January 6 – "The Day of the Three Kings" in Puerto Rico – by giving pocket calendars to all of his Puerto Rican patients. Other physicians send cards for Christmas, Kwanza and Hanukkah to patients they know have special ties to these holidays. Patients often interpret these gestures as signs of respect and esteem for their ethnic and racial identities.

8. Use good communication skills. Use the communication skills you use with other patients: Clarify, prioritize, paraphrase and summarize what the patient says. But with minority patients, you must pay even greater attention to non-verbal communication. For example, respect for authority is a strongly held value in many cultures, and some patients may say they understand and agree with your orders even if they do not. Never assume anything. Ask about everything.

9. Take advantage of resources for minority health initiatives. The Office of Minority Health Resource Center maintains a comprehensive database of funding resources for minority health initiatives. It's available online at www.omhrc.gov. This Web site also links to the Office of Minority Health's Resource Persons Network (RPN). The RPN is a unique coalition of professionals from a wide variety of health, research and academic backgrounds who volunteer their services to community-based organizations and health professionals active in minority health initiatives. RPN professionals can provide assistance with the development of projects and programs, review and critique grant applications, serve as speakers or panelists at minority health conferences or workshops, and provide technical assistance to minority health initiatives. (RPN may also be reached at 800-444-6472.)

Your state's Office of Minority Health can often provide you with resources for local funding, training and conference schedules, and free or low-cost patient education materials. Pharmaceutical companies are another excellent resource for free, high-quality educational materials targeted to specific minority populations.

10. Remember what we have in common. All human beings have universal needs that cross racial, ethnic and cultural barriers. We all want to be valued, understood and treated with genuine compassion and respect. Such needs are the common culture and language of the human race. To realize this and to incorporate these ideals into practice is the most important step toward achieving cultural competency.

Building bridges

The challenge to bring about radical improvements in minority health is massive, if not overwhelming. But it is not impossible. The first step for physicians is to gain an awareness and an understanding of barriers to health care for minorities. Next is assessing how well their practice delivers care to culturally or ethnically diverse populations, followed by identifying potential areas for improvement. The last step is putting solutions into practice. FPM

Send comments to fpmedit@aafp.org.

SPEEDBAR®

All human beings have universal needs that cross racial, ethnic and cultural barriers, such as being understood, valued and treated with respect.

These needs are the common culture and language of the human race.