2013 WEBINAR SERIES
STATE OF THE SCIENCE

Dementia Evaluation and Management among Diverse Older Adults and their Families

Sponsored by Stanford Geriatric Education Center in conjunction with American Geriatrics Society, California Area Health Education Centers, & Community Health Partnership

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“Using Interpreters with Dementia Patients and Their Families”

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I have no financial relationships to disclose and I will not discuss off label use and/or investigational use in my presentation.

About the Presenter

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Dr. Roche completed medical school in Dublin, Ireland and then worked in Australia for 2 years before completing her fellowship in the University of Colorado Health Sciences Center. She is an Associate Professor at UT Southwestern at Dallas, Fellowship Director and Medical Director of UT Home Health Agency.

Her interests include Ethnogeriatrics and Quality Improvement. She currently serves on the American Geriatrics Society Ethnogeriatrics Committee and also the AGS Ethics and Program Directors Committees
Dementia Among Diverse Ethnicities

- Alzheimer’s disease affects approximately 30 million people worldwide
- Prevalence may be higher in non-hispanic groups
- Minorities receive delayed diagnosis or inadequate treatment
- Biological factors partially explain the disparity, e.g. genetics and cardiovascular disease

Dementia Among Diverse Ethnicities

Cultural Factors

- Perception of normal aging
- Lack of access
- Trust issues
- Screening biases, testing used
- Communication concerns
Dementia Among Diverse Ethnicities

- Hispanics appear to present with more severe clinical features
- Yet they live longer
- Inadequate treatment in African American population
- Address the disparities of care

Goals and Objectives

- Be aware of the disparity of care in minorities
- Understand the cultural factors from the patient and caregiver perspective
- Be aware of cultural issues when using screening tools for dementia
- Educate the interprofessional team members
- Skill: learn how to effectively use an interpreter
Case

Mr. Wang is a 78-year-old Chinese gentleman who is brought to clinic by his wife and his son as a new patient. Mr. Wang and his wife speak primarily Mandarin and only a few phrases of English. His son John is fluent in English and accompanies him to clinic.

History

- A Mandarin interpreter is not available, but your clinic has access to video interpretation services, so you set this up for the encounter. Although you address the patient, the wife and son do most of the talking. They say Mr. Wang is “just not himself lately.” When asked directly, the patient says he has been feeling fine but does admit to some memory problems.
- Review of systems is otherwise negative.
Past Medical History

- HTN, well-controlled
- Atrial fibrillation, rate-controlled, on anticoagulation
- Past surgical history: Bilateral cataract surgery five years ago.
- Medications: HCTZ, metoprolol, warfarin. No known drug allergies.
- Family history: father died of colon cancer aged 73, mother had diabetes and died aged 80 of “natural causes.” Brother, sister, and children are all healthy.

Social History

- Mr. Wang was born and raised in China. Completed 10 yrs. of education. Worked in a factory for 52 yrs. Moved to US 10 yrs. ago with his son, who is a university professor.
- He lives in a suburban house with his wife, son, daughter-in-law, and 2 grandchildren. He has 2 other children who live in the area.
- He was active in the newcomer outreach program at the Chinese community center; he enjoyed cooking for weekly family gatherings. However, for 12 months he has attended community functions less frequently and no longer cooks; he spends most of his time now in his recliner watching TV.
- No history of tobacco, alcohol or illicit drug use.
Functional Status

- Independent in his ADLs.
- His wife and son have gradually taken over his IADLs, including shopping, preparing meals, and handling finances; he never did laundry. He still helps with light housework and uses the telephone. He drove mostly short distances to the community center and grocery store; he stopped several months ago.
- He is steady on his feet and continues to walk a mile a day with his wife in the evenings. No falls.
- He denies any feelings of sadness or depression. He still enjoys listening to his recordings of Chinese opera.

Physical exam

- Vital signs are normal
- Exam is unremarkable, with no focal neurological deficits
Cognitive Testing

- Based on this history, you would like to perform cognitive testing on Mr. Wang.

- **Q: What methods or tests might be appropriate?**
  - **Mini-cog**
  - Standard MOCA, communicated to the patient via interpreter
  - **Other**

Case

- **Q: What aspects of a patient’s background contribute to his or her “culture”?** *Select all that apply.*

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- **A:** All of the above encompass a patient’s culture. Some are easy to identify, while others such as beliefs about health, illness, and death are less obvious but may significantly influence a person’s perceptions and behavior. Culture has a significant impact on an individual’s interactions with the healthcare system, as we will explore with Mr. Wang.
Cognitive testing

- Minorities and culturally diverse patients tend to perform poorly on cognitive screening tools
- Avoid inappropriately diagnosing dementia
- Address the language barrier first
- Patients with limited English may answer incorrectly due to miscommunication rather than cognitive impairment
- Do not use tests written in English for English speakers
- Do not administer an English tool via a translator

Cognitive testing

- Education level is important in all cognitive assessments
- Higher levels of education improve performance
- Education adjustments may not account for poor performance in minority groups in which the test was not validated
Cognitive testing

- Even patients who are fluent in English as their second language may perform worse on an English language test, as language skills for a second language are impaired early in cognitive decline.

Cognitive testing

- Consider the patient’s cultural references and background
- Current events may not test a patient’s distant memory if it is not relevant to him or her.
- Also, in stories e.g. SLUMS, change the names and occupations of the characters to make them more culturally appropriate.
- Patients who are fluent in English as their second language may perform worse on an English language test, as language skills for a second language are impaired early in cognitive decline.
Cognitive testing

- Cognitive assessments e.g. MMSE, MOCA translated, modified, validated in many languages.
- For Mr. Wang, a Chinese MMSE or MoCA if a Mandarin interpreter is available who has been trained to administer the test appropriately.
- The MoCA: different languages, including several versions of Chinese [www.mocatest.org](http://www.mocatest.org).
- A live interpreter may be difficult to arrange.

Cognitive testing

- Administer a cognitive assessment aiming for being “culture-free”
- Shorter in length, with less emphasis on language or education-based skills
- Mini-Cog (clock drawing with three-item recall)
- Time and Change Test (telling time from a clock and making change with money)
- More equivalent performance across cultures and can be useful screening tools
Diagnosis

- With the video translator, you administer the Mini-Cog to Mr. Wang.
- Recall 1/3 items; clock shows poor executive function
- You explain he has early stage dementia, most likely Alzheimer’s
- They request a medication. You discuss the risks/benefits of acetylcholinesterases. They continue to request a medication so you recommend a trial of donepezil

Diagnosis

- You send them home with resources from Alz. Assoc. and the contact information for an active local support group
- Note in the chart to have the video interpreter system available for visits
Follow up

- Patient and his family return for follow-up 3 months later. You inquire about the medication; the prescription was never filled.
- You ask if they have found the support group helpful; they never made the contact.
- When you ask why, the wife replies that after reading the book with their son, they do not believe that the patient has this disease.

Case

- Rather than explaining why you think the patient has AD, better to promote patient rapport and family communication by eliciting the patient’s beliefs about his illness.
- Once you understand that, you can identify discrepancies, address misunderstandings, and negotiate a treatment plan.
- A good strategy for eliciting the patient’s perspective is Kleinman’s explanatory model of illness.
Case

- Kleinman *et al*: list of questions to elicit the patient’s understanding of their condition.
- What do you think caused your problem?
- Why do you think it started when it did?
- What do you think your sickness does to you? How does it work?
- How severe is your sickness? Will it have a short or a long course?
- What kind of treatment do you think you should receive?
- What are the most important results you hope to receive from this treatment?
- What are the chief problems your illness has caused for you?
- What do you fear most about your illness?

Case

- Using some of Kleinman’s questions, you ask Mr. Wang about his understanding of his memory problems. He wife says he believes that he has memory problems now because when he was a small child, he was involved in a house fire where his stepsister sustained severe burns and he did nothing to help her. They appreciate you providing him with resources and medicine, but as Alzheimer’s disease is not the cause of his memory problems, they did not think they would help.
Skill: Using an Interpreter Effectively

After presentation, attendees should be able to:

- appreciate the various elements of interaction that interpreters manage throughout bilingual conversations
- explain specific things providers can do/avoid doing to better facilitate communication with patient-families when working with an interpreter

Language Interpretation Standards

Legal
- CLAS
  - National Standards on Culturally and Linguistically Appropriate Services (CLAS)
  - Based on Title VI of the Civil Rights Act of 1964
  - Americans with Disabilities Act of 1990, Title 42

Professional
- CHIA: California Healthcare Interpreting Association
- SOMI: The Society of Medical Interpreters
- IMIA: International Medical Interpreters Association
CLAS Standards

Health Care Organizations must:
• **Offer and provide language services**, including bilingual staff and interpreter services, to patients at no cost
• **Provide written notices** in the preferred language and inform patients of their rights to language services
• **Assure competence** of interpreters and bilingual staff
• **Make available patient-related materials** and post signage in the languages of the commonly encountered groups in service area

Census Data

• More than 55 million persons speak a language other than English at home
• 24.5 million persons described speaking English less than very well
• 2010 50.5 million Hispanics in the US, 16% of the total population grew by 43% from 2000
• Asian alone population grew by 43%, to 14.7 million

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Medical interpreter

- Cultural competence includes linguistic competence
- Language is inclusive of culture and culture is encoded in language

Medical interpreter

Linguistic competence
- Capacity of an organization and its personnel to communicate effectively and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities

HRSA 2005
Medical interpreter

- Probably never been told how to use a medical interpreter
- Those who have Limited English Proficiency (LEP)
- Health Literacy
- Nearly half of all American adults—some 90 million people have difficulty understanding and using health information

Health literacy

- Reading
- Writing
- Listening
- Speaking
- Knowledge of Health Concepts/arithmetic
- Even well educated people with strong reading and writing skills may have trouble understanding a medical form or doctor’s instructions re a medication or procedure

HRSA 2005
Language

- Spanish
- English
- Grammar
- Terminology
- Intonation
- Pauses
- Silence
- Conventions of Politeness
- Cues
- Gaze
- Laughter

Concept of health, healthcare & medical treatment

NCIHC Values: Code of Ethics & Standards of Practice

- Accuracy
- Confidentiality
- Impartiality
- Respect
- Cultural Awareness
- Role Boundaries
- Professionalism
- Professional Development
- Advocacy
Modes of Interpreting

- Consecutive Interpreting
- Simultaneous Interpreting
- Sight Translation
- Others:
  - Summarization
  - Expansion
  - Document Translation

Complexity factors

- Types of Interpreting
- Communicative Goals
- Role Expectations
- Contextual Elements: Environmental, Interpersonal, Paralinguistic, Intrapersonal
Training protocols

- Conduct a short pre-session briefing
- Use 3rd person
- Maintain confidentiality
- Convey everything that is said
- Maintain impartiality
- Assist with closing the consultation/check for understanding
- Sight translate some documents if necessary

Types of Interpreter Roles

- Conduit
- Clarifier
- Culture Broker
- Advocate
  - Flow manager
  - Pace minder
  - Comprehension monitor
  - Gatekeeper

Dean, R., Pollard, R., 2005.
Before you go in

- Interpreters generally appreciate a short briefing of the topic to be discussed before you walk into the room
- Discuss logistics, known issues and the goals of the encounter
- Refrain from telling the interpreter “this is going to be quick”

In the Room

- Introductions are good manners. Take the time to introduce everyone in the room

  **Physical positioning** Triangular positioning
  
  Are you towering over someone?
  Are you blocking the room’s only exit?
  Be able to see and be aware of non-verbal response?
  Does the interpreter have visual access to all parties?
In the Room

• Overlapping talk is one of the hardest situations for interpreters to manage (information loss, lack of concentration, frustration with expectations)
• Eye contact with patients/families
  not the interpreter
• Direct eye contact-or not -a cultural norm
• Calm intent attitude is usually very helpful
• Lack of eye contact while listening by Asian patients can mean respect and concentration and not disrespect

In the Room

• Single questions, short phrasing
• Chopping up the information you deliver into tiny phrases may make it much harder for patients to absorb
• Complete your sentence before turning to the interpreter. Finish “If...but” clauses so the interpreter knows where you’re headed
• Give and get feedback from the interpreter and ask for questions
• Address patient families directly; they may actually understand you
When working with interpreters

• When Limited English Proficiency patients repeatedly nod with a subtle nervousness it may mean they are listening intently but they have no idea what is being said

Trust one’s senses: if the responses seem inadequately translated, they probably are

Time management: time efficient without rushing the patient

When working with interpreters

• All parties involved share responsibility for results of an interpreted discussion

• Rapport is really important for hard conversations…often, relationship is more important than focusing on one’s clinical role at first. Show your concern for family members, etc.

• Difficulties of idioms

• Avoid taxing the interpreter with: “I don’t know how you’re going to say that in Spanish…”
Medical interpreter

- Non-verbal Communication in the Interpreted Encounter
- Body language and non-verbal behavior are key
- 60% of rapport is the result of non-verbal language

Medical interpreter

- Warm and polite physical touch is considered a sign of empathy by many international patients
- However Muslims, Orthodox Jews, Chinese and some other Asian cultures specifically may not want any physical contact
- A smile when a patient is talking about a problem may be considered sarcastic by both cultures
Interpreters should avoid

- Remaining alone with the patient/family
- Providing healthcare/practicing medicine
- Translating documents unless qualified
- Take the side of the clinician or patient/family

If I speak a little Spanish, do I need to call an interpreter?

Seek out the most qualified person available

- Trained Interpreter
- Other Spanish-speaking medical staff
- A Language Line Interpreter
- Avoid asking patients/children to interpret for you
- Avoid asking family members, friends to interpret
- You MAY be the most appropriate person to communicate with patient/family…

Avoid practicing your language skills at the expense of the patient/family
• **References:**

Final Question
Thank You for Participating!

Reminder: Please complete our short survey.
We appreciate your feedback.

NOTE: Continuing Education Participants must complete a final survey in order to receive CEU/CME credit