Improving Compliance with Rehabilitation Treatment Recommendations Among the Latino/a Population of Caregivers and Clients

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ABSTRACT
This paper addresses what is currently known about language barriers in health care, ways in which language barriers affect health and health care, the usefulness of linguistic access service interventions. It is inevitable that health care providers must comply with federal and state requirements to ensure language access. However, published studies found that our health care system lacks the appropriate training of personnel for making resources available, trained interpreters, and translated medical literature tested for understanding in the patients native tongue language (Youdelman, 2008). The purpose of this research is to explain how cultural and language barriers impede effective health care outcomes from both the health care provider and patient. The role in available resources, trained interpreters, cultural competence, and utilization of available resources will be explored through a face to face pilot interview with 14 semi-structured survey questions. The results of the interview indicate that clinicians need to have increased awareness and knowledge of available resources in their facilities.
INTRODUCTION

Clear communication between physicians, clinicians, nurses and their patients is essential for the success of any health program intervention. In some cases, patients and health care professionals do not speak the same language. It has been reported that ineffective communication is a major risk factor to patient safety. In the year of 2005, the Joint Commission on Accreditation of Healthcare Organizations found that communication was the leading root cause of sentinel events in all categories (H &HN: Hospitals & Health Networks, 2006).

According to Faux (2004) current research suggests that patients sometimes cannot read, or they read very little in any language including in their native language. On occasion medical interpreters may be available to translate during the medical consultation. It is questionable as to what happens when the patient goes home and does not remember when or how to take a prescribed medication.

Year after year such situations arise on a daily basis for immigrants who do not speak the same language of their new country. Patients and their families are confused and frustrated but health care providers are bewildered by low compliance of their medical follow through. Although written instructions are issued to the patient, they are insufficient it the patient is illiterate.

Statement of Problem

Spanish speaking patients have been found to have poor compliance with medical treatment. In grand efforts to eliminate racial disparities in healthcare, ethnic and racial lines still exist. National and state-level surveys have found minorities are less likely to have a usual source of ongoing health care. Patients with limited proficiency with the
English language face great difficulties in understanding health information. Spanish speaking patients are often reluctant to recognize their health care needs and may not be aware of their rights to health care services. It is recognized that language barriers continue to compromise the quality of care within nursing and rehabilitation services.

Purpose Statement

The purpose of this study is to look at improving patient caregiver compliance for Spanish speakers with medical treatment recommendations. Patients with limited English proficiency will have a difficult time accessing health care and understanding health information. Recognizing that language barriers comprise the quality of care with health services for Spanish speaking patients, clinicians should consider utilizing trained professionals for interpreting and the use of tested translated written materials when assessing patients.

Research Questions

What are the protocols for utilizing effective communication tools in a medical setting with emphasis on Latino/a community of caregivers and patients? What needs to be in place for successful communication practices to occur?
THEORETICAL RATIONALE

There has been a current cultural competence movement that has haphazardly addressed linguistic issues, but no real penalties exist for culturally inept practices and policies (Suleiman, 2003). Spanish Speakers have protection from discrimination in federally funded human services under Title VI of the Civil Rights Act of 1964. This federal law directs each health care setting to implement a system that allows limited English proficient individuals (LEP) to have access to language assistance services. Keers-Sanchez (2003, pg 557) defines LEP individuals “cannot speak, read, write or understand the English language at a level that permits them to interact effectively with health care providers and social service agencies.”

Assumptions

An assumption of this research study is that despite continuous efforts to ensure that all patients receive equal quality care, the health care system perceptions are preventing LEP patients, particularly Spanish speaking, to have increase use and compliance with medical treatment. It is assumed that health care agencies will hire and benefit from trained interpreters. In addition, it is assumed that health care professionals comply with existing federal and state requirements. Lastly, it is assumed translated medical materials in the patient’s native language will increase understanding in which they are not always adequate.
Background and Need

The United States can no longer be classified as a strictly English-speaking population due to an increasingly diverse population. Immigrants often arrive to this country with significant health care needs and with limited knowledge of the language of their new country. With this language barrier it prevents these individuals from getting timely and appropriate health care, exacerbating existing conditions and precipitating new ones. Many clinical settings use qualified medical interpreters to help reduce the language barrier. Medical interpreters provide a passage across the language gap between health care providers and patients. Findings (Dysart-Gale, 2007) suggest that health care providers and interpreters experience difficulties in their collaboration that negatively impact health services to patients with limited English proficiency.

This research study is based on government collected data on health care utilization among Latinos. Recent census studies estimates that Latinos represent the largest growing ethnic group in the nation. However, studies have found that Latinos are least likely to utilize health care services. Past and current research has identified various potential barriers that prevent Latinos from obtaining medical care. Such barriers include language and cultural differences, limited health insurance, financial constraints and lack of transportation (Estrada, Trevino & Ray, 1990).

There has been a growing need for trained medical interpreters in public and institutional settings. Currently there is no federal or board certification of medical interpreters due to unresolved fundamental issues supporting obligatory certification programs. The National Council on Interpreting in Health Care drafted a collaborative code of ethics involving the codes of the major advocacy groups such as Department of
There are denotations, connotations, grammar, accents, and dialects in every language. The challenges in translation from various languages to English can significantly change the meaning of words or phrases due to subtle inflections in tone. According to Ayonrinde (2003), potential problems with interpretation include: inaccurate translation, the interpreter may be directive or provide unsolicited editorial input; the interpreter may lack the corresponding vocabulary in either language; body language may be misunderstood or missed; transference/counter-transference issues may be present in the communication; the patient may withhold taboo or embarrassing information from the interpreter or the interpreter may be unacceptable to the patient due to gender or ethnicity issues.

Good communication is the key to a well functioning physician-patient relationship. In emergencies it may be necessary to use any translator available. Many of the language barriers needs can be addressed and resolved if health providers utilize available resources that their facility or community provides or advocate for increased multilingual health care professionals for interpreter services. For this reason increasing the utilization of trained interpreters is very important in insuring misinformation regarding the patient’s health.
REVIEW OF THE LITERATURE
Many individuals who speak limited English already face language barriers when seeking health care. The review of literature focuses on the following four themes (1) laws and policies on language access (2); effectiveness of interpreters (3) cultural sensitivity in the bilingual health care setting; (4) translated medical materials. This outline provides the reader with an understanding with the perceived mismatches between the health care provider and patient regarding medical treatment.

Laws and Policies

There is an increasingly diverse population in the United States. In 1964, a federal law, Title VI, was mandated that would provide individuals with limited English proficiency guaranteed language access as a civil right and would be protected from discrimination in federally funded human services. Health providers must comply with Title VI of the Civil Rights Act of 1964, which ensures that federal money does not support providers who discriminate against race, color or ethnicity. Youdelman (2008) finds that non-English speaking patients are less likely to use primary and preventive care and are more likely using the emergency rooms. Once they are in the emergency room they are less likely to receive services compared to English-speaking patients.

All states have mandated regulations that clarify the federal requirements. State laws vary from being comprehensive in addressing specific health providers or patient population. Recent laws have begun focusing on cultural and language barriers affecting health care. The goals of these new recent laws are to increase the clinicians’ awareness of language access. So far, New Jersey, California and Washington have enacted requirements for physicians and clinicians.
All health providers must comply with Title VI of the Civil Rights Act of 1964, which ensures that federal money does not support providers who discriminate on the basis of race, color or nationality. The Supreme Court and Health and Human Services (HHS) have interpreted Title VI as a way to protect minorities who do not speak English well. In the year 2000 President William Clinton issued an Executive Order 13166 called Improving Access to Services for Persons with Limited English Proficiency (Grubs, Chen, Bindman, Vittinghoff & Fernandez, 2005). In the year 2001, President George Bush reaffirmed this new order requiring each federal agency to draft guidance tailored to recipients receiving federal funding (Youdelman, 2008). The HHS issued a final Guidance in August 2003 that added the standards for Culturally and Linguistically Appropriate Services (CLAS) in health care. This specifically mandates that health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all times and in a timely manner during.

All states have enacted regulations that clarify or broaden federal laws. Every state has at least two such laws, while twenty-two states have more twenty, and four states have more than seventy five. California is the only one with more than 100. Although many federal and state laws have been in effect for many years, many providers lack the knowledge of how to use them and how to provide language services (Youdelman, 2008).
Interpreters

Medical interpreters have been found to close the gap between the clinician and patient. However research findings report that practitioners and interpreters experience numerous difficulties in their collaboration that can result in negative outcomes. Dysart-Gale (2007), argues that these communication difficulties between the interpreter and health provider stem from unrealistic expectations about the nature of communication in the health care setting. Health institutions demand trained medical interpreters but at present there is no federal or board certification of medical interpreters. In this study, communication models were analyzed in interpreter practice.

Ayonrinde (2003) addresses the challenge of translation from languages in which subtle inflections in tone change the meaning of words and phrases. For example, In Chinese the pronunciation of the character for the number ‘four’ is similar to the character word death. Furthermore, translation is described as the ability to exchange words from one language to another while retaining the meaning. Ayonrinde adds that there are potential problems with interpretation such as the interpreter may be directive or provide unsolicited editorial input, the interpreter may lack the corresponding vocabulary in either language, non-verbal cues may be missed, certain topics are not discussed due to taboo information within the patient’s culture.

Cultural Sensitivity in the Bilingual Health Care Setting

According to Irvine, Roberts, Jones, Spencer, Baker and Williams, (2006) language barriers continue to compromise the quality of care within health care providers. They identify past research by highlighting nurses’ failure to resolve
communication difficulties, resulting in misinterpretation of information and advice, poor compliance to treatment regimen and limited psychological support. Therefore, appropriate language education for health care professionals is important to work effectively with clients with limited English proficiency. The aim of this study examined factors that influence clinicians in Welsh language. Consideration on how health care providers translate such perceptions into practice and explored the determinants of providing language choice in clinical practice was added to the study. Clinicians reported that by identifying with the individual through their preferred language they were able to facilitate a holistic and patient-centered approach to care.

Estrada, Trevino, and Ray (1990) address the issue that Mexican Americans have been found to make less use of health care. They found that past research has identified various barriers that impede access to obtaining medical care. Such barriers include language and cultural differences, lack of transportation, cost of health care and limited health insurance. The purpose of this study was to further examine the type of barriers to health care reported by Mexican Americans and determine which subgroups in a sociodemographic are most vulnerable to such barriers. Findings in their research concluded that language barriers is not the issue for minorities such as Mexican Americans to access appropriate healthcare it is more of a financial issue.

Male and Female Gender Roles among Latinos

Successful treatment outcomes require health providers to acknowledge and engage patients on values fundamental to their lives. Among the countless factors that influence adherence to treatment and medical decisions are family. The decision making may include their extended family to form a consensus on treatment plans. However,
Improving Medical Compliance Among Latinos

some patients may defer to a key member in the family to make important decisions and the practitioner must be prepared to determine the intensity of familial involvement.

The expectations for men, women and children are more explicit and rigid in Latino culture than in Anglo culture (Roll & Irwin, 2008). Role assignments and expectations are less defined in Anglo families. Decisions affecting the family are generally made jointly, by husbands and wives.

Within the Latino community, the husband is the designated head of the family and he is expected to make all of the significant decisions affecting the family. While the husband is the designated head of the family, the Latino wife has considerable power behind the scenes. She is mostly in charge of day to day of the household and disciplining their children. When they are unable to control their children’s behavior the father steps in.

Religious Views

Latino culture is essentially a Catholic culture. The Catholic faith is seen as an integral part of one’s identity. Religion may lead to disagreement over value systems or denial in forming a therapeutic relationship between therapist and patient. (Ayonrinde, 2003). The lack of sensitivity or awareness about the patient’s faith perceived as offensive. Many individuals believe that by praying and setting religious icons such as our Lady of Guadalupe may heal and clear their medical problems. Latinos have the attitude that if something happens to them it is okay because it is God’s will and accept everything with conviction (Sullivan, 2001)

Aranda (2008) focuses attention on examining the relationship among religious involvement, private prayer and depression in a clinical sample of 230 older U.S born and
immigrant Latinos residing in a large metropolitan city the United States. Latinos tend to have a very strong connection to their religious affiliation and practices. In attending religious services at least one time per week, majority report receiving a great deal of guidance in their daily lives from religion. Studies found a positive correlation between religious involvement and decreased depression within the Latino community.

View of Health Care

Many Latinos find the care system very difficult due to it increasing sophisticated technical diagnostic and treatment procedures. Confusion arises from the initial start of care of making appointments to understanding the complex life support consent forms printed in English. Past and current findings report that many Latinos are unable to effectively communicate with health care providers (Andrulis, 2003). Even when there are interpreter services available, it is not enough. For many, this limits their access and options to only utilizing clinics where Spanish is understood. This issue often results in their inability to get an appointment on time and often not attending to their medical problem.

It is believed by Latinos that racial discrimination and general lack of cultural sensitivity can lead to medical negligence. For example, in a focus group study conducted at the Midwest Bioethics Center, a participant felt that the reason her husband lost a limb was due to lack of care and because they were Mexican (Sullivan, 2001). Latinos tend to stress the importance of personal relationships rather than institutional relationships. They often prefer to be closer in space and have physical contact such as a hand on the shoulder from their health providers. If the health provider stands it customary distant 3 feet away from their Latino patient, it is perceived as disinterested
and uncaring. This situation can affect treatment compliance. Latino patients prefer a more directive approach and generally do not feel as comfortable to responding to open-ended questions (Antshel, 2002).

It is unfortunate that personal relationships conflict with today’s health care system trend of more productivity resulting in shorter visits. It is often times that the Latino patient has many questions and is confused about the treatment regimen resulting in poor compliance. Due to the clinicians and patient’s language barrier, questions and answers are rushed and not confirmed in a mutual understanding. This results in the Latino patient feeling confused and assumes that their health care provider did not care. Many Latinos believe the health care system is racist, negligent and lacks the cultural sensitivity. Fears of discrimination and negligence lead to some Latinos to turn to traditional Mexican healers (Sullivan, 2001).

Translated Medical Materials

It is imperative to have clear communication between physicians and patients in order to have positive outcomes in a medical intervention. In some cases there are communication barriers where the health provider and patient do not speak the same language. Faux (2004), finds that the low-literate patient with the use of specifically designed pictographs could facilitate comprehension and increase compliance with medication management. However research findings argue that not everyone shares the same interpretations of symbols. Houts, Witmer, Egeth, Loscalzo, and Zabora (2001) found that in their first previous study of utilization of pictographs there were three important limitations to that study: (1) the subjects were literate and perhaps it is easier to remember pictographs better than people with low literacy skills, (2) only short term
memory was tested and (3) a maximum of 50 instructions were shown in pictographs whereas some illnesses may be complex requiring hundreds of instructions. The aim of the second study is to address those limitations by investigating 4-week recall of 236 medical instructions accompanied by pictographs by people with low literacy skills.

The subjects in this study were 21 adult clients of an inner city job training program who had less than fifth grade reading skills. Of those subjects 67% percent were African American, 24% were Hispanic and 9% were Caucasian. Results presented a 85% mean correct recall of pictograph meanings immediately after instructions. The range was 63 to 99% shortly after training. After the 4 weeks of training it dropped to 71 % mean ranging from 33 to 94%. These findings indicate that people with low literacy skills can, with the help of pictographs recall massive amounts of medical information for significant periods of time. The Hispanic group English was their second language and low literacy was considered to have a different meaning. Therefore a Hispanic/non-Hispanic score was created for these analyses.

It is obvious that like prescription labels, written materials have to be easy to read and culturally appropriate. It is often the case that material developers do not pay attention to these aspects. Andrulis and Brach (2007, pg. S128 ) point out that creating foreign language materials in relation to their English counterparts; a process they refer to as transcreation, a translation of the information from the English version to ensure cultural concepts and language nuances are appropriate for the target audience.

Limitations/Gaps in the Literature

Current research suggests major flaws in the criteria used for classifying individuals as proficient interpreters in a clinical medical setting. There is limited
research on the appropriate testing methods and tools for translated medical materials and interpreters. Research lacks findings whether medical translated materials are appropriate in addressing native language, cultural sensitive and of various comprehension levels.

**Implications for Future Research**

This review highlights the need for further research into the continuing problem of the poor underrepresentation of poor and Spanish speaking patients in the health care system. There is lack of information on appropriate assessment tools to certify interpreters and translated materials. Significant research has been dedicated to poor outcomes and use of health care services among the Latino community. Findings yet lack to answer a more critical issue: what type of assessment should be used to certify interpreters as knowledgeable and use of translated materials as appropriate? There is a need to implement testing of translated materials in one’s own native language.

**Overall Significance of the Literature**

I found that sufficient research has been dedicated towards cultural awareness and lack of use of medical services among the Latino community. However, findings continue to lack evidence that current translated materials and certification programs for interpreters are appropriate.
PILOT STUDY: PROCEDURES

Sample and Site
The study takes place at a home care agency. The subject population consists of nurses, physical therapists, occupational therapists, speech therapists and social workers. This facility is a home care agency that provides health services in a home based setting to a wide variety of age groups, ethnicities and diagnosis. This site averages 5 patient Spanish speaking referrals a month for nursing and therapy care. There are 2 therapists that speak fluent German, 1 therapist is fluent in Italian, 1 therapist is fluent in Russian, 2 therapists that speak fluent Spanish and in addition the scheduler speaks fluent Spanish. Aside from providing services to Spanish speaking patients, this site also provides home health services to patients that speak Farsi, Chinese, Vietnamese, Cambodian, and Russian. The average for servicing this patient population is minimal, 1 or to patients every two months. This home care agency is a non profit organization.

Access and Permissions
The researcher is an occupational therapist who works with the subjects. The study includes a questionnaire survey consisting of 14 questions. Permission to proceed with the study was approved by the director of the program.

Data Gathering Strategies
The data gathered is qualitative. The study involves 14 survey questions as follows:

1. Please state your professional title.
2. Do you speak and or write in another language?
3. How often do you come across Spanish speaking only patients?
4. What are your outcome findings in meeting positive therapy outcomes with Spanish speaking clients?

5. From your perspective, what affects Spanish speaking patients to be compliant with your treatment regimen?

6. Do you have access to interpreter services? If so, how often do you use them?

7. How many certified interpreters do you have in your facility?

8. Have you ever utilized a non-certified individual such as son/daughter, janitor, neighbor, housekeeping etc. to translate medical information?

9. Do you have access to translated written materials for your recommended interventions?

10. Do you insure that the issued written instructions, health promotion brochures, computerized pictographs are understandable and acceptable across literacy, culture and language? If so, how? If not, why not?

11. Do you feel you are culturally competent?

12. Does your facility offer or provide you with integrated health literacy, cultural and linguistic training?

13. How important is to make cultural competency awareness mandatory as part of continuing education for medical professionals?


The study looks at the clinicians’ use of available resources, such as interpreter services, the quality of translated materials and cultural awareness in their clinical setting.
Data Analysis Approach

All data collected from this survey is used to determine to what extent health care providers are utilizing resources that are available to them in order to better communicate with their non-English speaking clients. It is my assumption that trained interpreter professionals and accessible translated materials improve compliance in medical treatment with Spanish speaking patients. In addition, data gathered is utilized to increase staff awareness of available resources that this agency provides for non-English speaking patients. Themes that are presented in this paper and reflect the assumptions that despite available resources agencies provide to staff members, clinicians are not efficiently utilizing the resources; and available resources such as translated written materials are often inadequate.

Ethical Standards

This study adheres to Ethical Standards in Human Subjects Research of the American Psychological Association (Publication Manual of the American Psychological Association, 200?). Additionally, the project was reviewed and approved by the Dominican University of California Institutional Review Board. Number 6058.
DISCUSSION

Summary of Major Findings

Interview

Current findings show that health care providers experience numerous difficulties when proving services to patients with limited English proficiency. Spanish speaking patients have been identified as having poor compliance in medical treatment. As a result it leads to damaging medical health outcomes such as difficulty stabilizing and preventing chronic illnesses reaching a rapid mortality state. In order to have a better understanding of these outcomes, I interviewed one expert in the field of home health care as to what is perceived to be impeding Spanish speaking patients to be compliant with treatment. The participant has over 10 years experience as an occupational therapist in community day treatment centers for traumatic brain injury, acute hospitals and home care settings for adult patient population with multiple diagnosis. The participant expressed great interest in the topic theme and openly shared her thoughts on further needs to address language barriers.

The initial interview was conducted in person with 14 guided questions utilizing a recorder the entire time. The participant’s responses led to 3 themes that were intriguing. These themes were identified as (1) lack of use of interpreter services (2) lack of cultural training (3) moderate volume service provider for Spanish speaking patients.

Lack of Use of Interpreter Services

In the first identified theme, it was alarming listening to the responses relating to access and use of interpreters. The respondent with a long pause stated “I often forget we
have a certified interpreter and do not think of calling her for her Spanish speaking interpreter services although I speak Spanish but it is limited”. When asked about other resources available, she added “We have Language Line which is a portable telephone with two receivers you take into the patients home and call an interpreter, I often thought about it but it is time consuming and cumbersome, I cannot recall when I last used it “. When the participant was asked about laws and regulations regarding interpreter use the respondent was unsure what they were. The respondent added “I always used a family member”. When asked about using translated written materials the respondent answered frankly “I never really had to use them, I usually just hand write my own but it is minimal”

*Lack of Cultural Training*

Secondly, the lack of cultural training was an added theme that led to further exploration. The participant’s belief is that the agency’s cultural training held once a year is brief and generic, including in her statement “I would like learn about various cultures such as on beliefs and views of medicine relating to their culture”. When asked to elaborate, the participant stated “there are many cultures who believe in restrictions with hot and cold foods when treating illness, restricted physical exercise after meals and a clinicians’ gender being problematic as some cultures it is taboo to have health care providers that are of opposite gender”. The participant added to their statement “I have some knowledge and training in other cultures because of my personal interest and experiences”. When the participant was asked if they felt culturally competent, there was a short pause, but stated “I would rate myself as a 6 from a scale from 1-10”.
**Moderate Volume Service**

Lastly, another theme that surfaced was that this agency provides home care services to Spanish speaking patients with the average of 5 patients a month for referrals. The participant averages 1-2 patients a month for occupational therapy services that are Spanish speaking. The respondent adds “This is only addressing my assigned area and discipline, I am aware that other clinicians work in the canal area in which there is a big Spanish speaking community area that we provide services for home care. This is not including physical therapy, nursing and other occupational therapist that average maybe 3-5 a month for this population”.

**Summary**

This interview was informative and insightful by the responses provided by the participant. It was bewildering to learn that this agency provides services to Spanish speaking patients but not enough resources and training for staff to utilize available resources. The interview took place at the participant’s work site office and there were minimal patient education resources in Spanish that were visually displayed.

This interview has added perspective on what needs to be added to my research project such a survey questions and continued literature reviews. By the participant’s responses it would be easy to assume that the problem would be resolved by increasing staff awareness with interpreter services. However, it would be interesting to compare findings at this facility with other facilities.

**Comparison of Findings to Existing Literature**

Current research suggests major flaws in the use of interpreters and the impact in our health care system. There is limited research on the appropriate testing methods and
tools for properly certifying an interpreter and testing the understanding of translated
medical information into a different language. In the current literature findings the type
of interpreter in studies may not be defined at all or the interpreters being studied may
be a mix of both ad hoc and trained. Research lacks findings whether there is over-
identification of Spanish speaking patients having poor medical compliance when in fact
it is a result of the clinician lacking knowledge of available language communication
resources.

Implications
This review highlights the need for further research into the continuing problem
of the use of interpreters and translated materials in a health care setting. There is a lack
of information on appropriate assessment tools. Significant research has been dedicated
to poor medical compliance within the Latino community and the law implications of
providing services for individuals with limited English proficiency. Findings yet lack to
answer a more critical issue what type of assessment should be used to license
interpreters and prevent health care providers from drawing incorrect conclusions from
poor medical assessment practices.
REFERENCES


