Being Mindful *of* Cultural *and* Linguistic Diversity IN EVERYDAY PRACTICE

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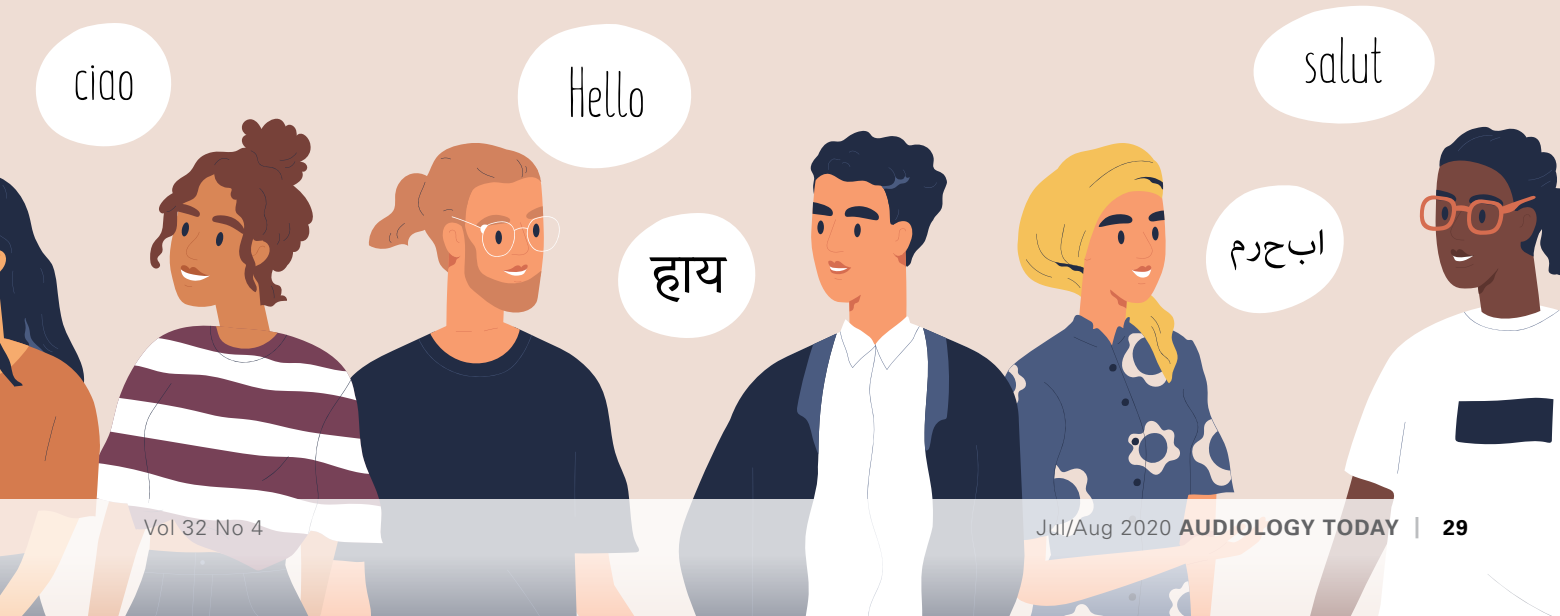
Audiologists, whether seasoned providers or new to the field, can advance our cultural competence by being mindful of the cultural and linguistic diversity of the patients we serve.



A culturally and linguistically diverse (CLD) patient is one who comes from a home environment where a language other than English is spoken and whose cultural values differ from mainstream culture. According to the Center of Immigration Studies, about one in five U.S. residents speak a language other than English at home (Camarota and Zeigler, 2015).

This article provides information about factors related to cultural and linguistic diversity as they relate to best hearing health-care practices. Cultural and linguistic competence suggests an ability by health-care providers and health-care organizations to understand and respond effectively to the cultural and linguistic needs brought by patients to the health-care encounter (HHS, 2000). Readers will benefit from the examples, resources, and recommendations for removing communication barriers when interacting with CLD patients.

A changing and increasingly diverse population in the United States has created challenges for providers to deliver culturally competent services while maintaining a high quality of care and improving hearing-health outcomes. Communication barriers, including language, can impact patient satisfaction, understanding, and quality of care.

To provide culturally competent and high-quality services, clinicians must strive to effectively communicate with all patients, including the CLD population and those vulnerable to low-health literacy. Increasing cultural competence and adhering to best-practice guidelines will decrease communication barriers and increase patient satisfaction. In turn, this improves the effectiveness of audiologists' services and achieves a positive patient–provider relationship. As clinicians, we need to strive to remove language and cultural barriers to provide excellence in hearing health care for all.

Best Practices for Using Interpreters

There are few health-care providers who are bilingual, leading many providers to rely on the patient's family members, clinic staff, or non-fluent health-care professionals for communication with the CLD population. These patients often feel less satisfied with their visit compared to a visit with those who have used professional interpreters. Moreover, using untrained interpreters is more likely to result in errors and poor outcomes (Juckett and Unger, 2014).

Participating with an interpreter for CLD patients is standard for most clinicians. Although using qualified interpreters and interpreting services is an important first step in creating a safe environment for CLD patients, there are best-practice techniques to consider (Rhodes et al, 2005).

- Avoid idioms, metaphors, colloquialism, or jargon. Phrases used by native English speakers such as "feeling blue" or "let's wrap up" may not translate effectively into another language.

- Review any professional vocabulary that could require an expanded explanation with the interpreter.

- Allow the interpreter enough time to interpret all messages.

- Look at and speak with the patient or caregiver(s), not the interpreter or phone.
- Ask the interpreter, patient, or caregiver(s) if he or she has any questions or needs clarifications.
- Defer from using a family member as an interpreter unless it is truly the only option.

Avoiding Microaggressions

Microaggressions are brief statements or behaviors that, intentionally or not, communicate a negative message about a non-dominant group, including the CLD population. The subtlety of these affronts is what makes them so harmful. FIGURE 1 includes examples of microaggressions and the messages they convey (Sue et al, 2007).

The challenge of avoiding microaggressions is that they are often disguised as banter. If you are the target of a microaggression, educate the offender by focusing on the comment itself instead of criticizing the person, especially if you believe no malice was intended.

When witnessing someone being the target of a microaggression, do not speak on their behalf, but offer support. Victims of microaggressions may be accused of being over-sensitive.

Finally, if you are identified as using a microaggression, listen to the offended party. Take the opportunity to turn an unfortunate incident into a learning opportunity to grow not only as a clinician, but as a person (Clay, 2017).

Health Literacy

Health literacy refers to understanding basic health information to make appropriate health-related decisions (U.S. Department

FIGURE 1. Examples of microaggressions and the messages they can convey.

MICROAGGRESSION	MESSAGE
"You speak good English." OR "No, where are you really from?"	You are a foreigner.
"You are so articulate."	It is unusual for someone of your race to be intelligent.
"When I look at you, I don't see color."	Denying a person of color's racial/ethnic experience.
"As a woman, I know what you go through as a racial minority."	Your racial oppression is no different than my gender oppression.
"Don't be shy. I want to hear what you think."	Encouraging assimilation to a dominant culture.

of Health and Human Services, 2010). About 36 percent of American adults have basic or below basic health literacy (Kutner et al, 2006).

Low health literacy is associated with several negative health outcomes, such as increased emergency room admissions (Griffey et al, 2014) and mortality (Peterson et al, 2011). Not all CLD patients have low health literacy, but vulnerable groups include non-native speakers of English and minority groups. Additionally, older adults, those with lower levels of education and income, and people with chronic diseases are also at risk.

Even though certain populations are more vulnerable to low health literacy, clinicians can be mindful of specific red flags with their patients, including the following:

- No questions asked
- Difficulty explaining their diagnosis or equipment
- Frequently missing appointments
- Becoming angry, demanding
- Being quiet, passive
- Clowning around, using humor
- Submitting incomplete registration forms
- Making excuses. For example, "I forgot my glasses. Can you read this to me?" or "Let me bring this home so I can discuss it with my children."

One way to support patients is to guide them to ask the right questions in their appointments.

The "Ask Me 3" program was developed by the Institute for Healthcare Improvement. The program encourages patients and families to ask three specific questions of their providers to better understand their health conditions:

- What is my main problem?
- What do I need to do?
- Why is it important for me to do this?

As part of a patient-centered approach, we need to effectively communicate with all patients. Clear patient–provider communication may encourage patients to take an active role in managing their overall health, and especially, their hearing health.

Recommendations for improving health literacy (AMA, 2007):

- State the most important information first and explain why that information is important.
- Confirm patient understanding by asking for a summary.
- Supplement conversations with written materials that focus on key information and include visuals, while keeping in mind that translated materials do not always increase health literacy.
- Avoid technical terminology and language.

- Speak in simple sentences and use active voice.
- Provide captions for all graphics, including step-by-step illustration guides.
- Use high-contrast paper and font color. Font size should also be large.

Providers can assess the readability of their clinical handouts by using measures available in Microsoft Word, such as the Flesch Reading Ease scale and the Flesh-Kincaid Grade Level.

Rudolph Flesch developed the Reading Ease scale with scores ranging from zero to 100 (Flesch, 1948). Lower scores (e.g., 0–40) indicate greater difficulty and higher scores (e.g., 80 and higher) indicate easier reading. Writers can achieve plain English with a minimum score of 60 (Flesch, 1979).

The Flesch-Kincaid Grade Level Formula measures the readability of a document based on the minimum educational level that the reader needs to understand the document (Stockmeyer, 2009). Cotugna and colleagues recommend a fifth- to sixth-grade reading level for patient-education materials (Cotugna et al, 2005). To use these features in Word, reference the following links:

MICROSOFT 2013

www.writeawriting.com/how-to-write/readability-statistics-word/

MICROSOFT 2016

www.officetooltips.com/word_2016/tips/viewing_document_and_readability_statistics.html

Conclusion

Audiologists, whether seasoned providers or new to the field, can advance our cultural competence by being mindful of the cultural and linguistic diversity of the patients we serve.

Implementing strategies such as embracing best practices when using an interpreter, avoiding microaggressions, and improving the readability of patient-education materials will enable audiologists to provide patient-centered care to CLD patients and those with low health literacy.

Being mindful of the cultural and linguistic diversity of the patients we serve and adjusting our practice strategies accordingly may decrease barriers to effective communication. This, in turn, may improve hearing health-care outcomes for all patients.

For more information about being mindful of cultural and linguistic diversity in everyday practice, including patient handouts, scan the following QR code.

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