Alzheimer’s Disease in Latino and African-American Cultures

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November marks the start of National Alzheimer’s disease Awareness Month. Many Americans dismiss the warning signs of Alzheimer's disease, believing that these symptoms are a normal part of aging. While age is a key risk factor for Alzheimer's disease in all racial and ethnic groups in the United States, it is significantly more prevalent among elderly African-Americans and Latinos than among non-Hispanic whites of the same age. African-American and Latino individuals also may show more severe symptoms when they are first diagnosed. These ethnic and racial differences in Alzheimer’s disease prevalence are not consistent from community to community and may result from such factors as less education, income, poorer diets or reduced access to health care. (National Institute on Aging)

Access and Diagnosis Considerations

For many Latino and African-American patients, limited language access services and a history of cultural insensitivity in healthcare settings have contributed to a general distrust of providers. Large numbers of elderly Latino patients, who are most at risk for Alzheimer’s, are first generation immigrants who are not necessarily comfortable or may not be fluent in the English language. In many care settings providers often use family members as interpreters. While this practice goes against the Standards of Practice for the medical interpretation profession, it also negatively impacts the interpersonal communication and exchange that is necessary to build trust between patients and providers. In addition, among adults with diabetes, high blood pressure, or heart disease (all potential risk factors for dementia), Latino’s are less likely to receive services to help monitor and control those conditions. Cultural biases in cognitive testing and inadequate translation of diagnostic tools also may skew diagnosis of dementia in Latinos.

Diagnosis and treatment of Alzheimer’s disease is of even greater concern for African-Americans, who are two times more likely to develop late-onset Alzheimer’s disease and are less likely to have a diagnosis of their condition, resulting in less time for treatment and limiting the effectiveness of treatments that depend upon early intervention. Also, African-Americans have a much higher rate of false-positive results. At the same time, there is substantial evidence of underreporting of dementia among African-Americans.

High Burden on Families

The strong cultural value of ‘family responsibility’ is one of the central tenets of both Latino and African-American cultures and often cognitive impairment and dementia is considered a normal part of aging that should be managed within the family. As a result, many Latino and African-American families tend to shoulder a lot of the responsibility to care for elders. Family members, particularly daughters and other female relatives, provide a disproportionate share of care to family members with the disease. Latino and African-American patients are less likely to be placed in long term care facilities and are more likely to live with relatives. Families need information, help and support to sustain their roles as caregivers. When care is provided outside of the family, families need reassurance that the family member with dementia is getting treatments that may help lessen the burden of the disease. These services should be provided in a way that reinforces family values and overcomes cultural barriers to service. Understanding these differences is critical to providing the most effective interventions to minimize Alzheimer’s disease risk for Latinos and other minorities.
Case Study: American Sign Language

Two patients, a husband and wife, both of whom are deaf were brought to the Emergency Room (ER) after sustaining injuries from a car collision. Recognizing that both patients are deaf, the provider attempted to communicate through the use of written notes. The wife has a vision impairment and is unable to read the note or understand what is being asked of her. The wife’s shirt and bra is cut off to facilitate examination. The wife reported that she felt violated when her clothing was cut off. The wife’s mother, who has limited knowledge of sign language, is used to interpret critical medical information. A medical interpreter is never called even after repeated requests from the patient and family.

Solution

Medical interpreters should be requested the moment a patient with Limited English Proficiency (LEP) presents in the clinic/ER. Written notes are not effective methods of communication for deaf patients since English is their second language. Many may not understand the grammatical structure of the English language. Family members should not be used to convey medical information since many may not possess the language skills and/or understand medical terminology to provide medical interpretation and may add/delete relevant information. MUSC provides American Sign Language Interpreters for face-to-face interpretations 24/7/365. The in-house team is available 8:00 a.m. to 5:00 p.m. daily. After 5:00 p.m. and on weekends, in-person American Sign language interpretation is available through a contractual relationship with Charleston Interpreting Services (CIS). Also, video remote interpretation is available. The equipment is stored in the Security Offices at the Main Hospital and Ashley River Tower (ART).

Q&A CORNER

Each issue of the newsletter will feature a Q&A section. The first person to respond with the correct answer to all questions will be recognized in a future edition.

1. In-person medical interpretation services for patients who speak Spanish is available 24/7/365 at MUSC Health. True/False
2. To request an in-person medical interpreter for patients who speak Spanish or for patients who are deaf/hard of hearing, who need an American Sign Language interpreter, care team members should do which of the following:
   A. Send an email request to Interpretation Services
   B. Submit a request via Service-Hub
   C. Call the operator

Email answers to: interpreterservices@musc.edu
Subject: Cultural Spotlight - Q&A

MEET THE MEDICAL INTERPRETATION TEAM

Introducing ……Beatrice Sanguino

Name one interesting thing about you? I am a mom. My compassion and love for people are the things that motivate me. I recently relocated to Charleston from Chicago.

How many years have you been an interpreter at MUSC Health? Even though I have only been at MUSC for 9 months, I have vast experience interpreting in the health care industry. I have over 9 years of experience as a medical interpreter.

What do you like most about interpreting? “I became an interpreter because I love helping others. Not only do I like to interpret but I enjoy being an advocate for those in need. It is great to know that at the end of the day, I have made a difference in someone’s life.”

Next Issue: January/February 2017

HOW TO ACCESS INTERPRETATION SERVICES AT MUSC

PATIENTS WHO SPEAK SPANISH

- In-person medical interpretation, 24/7/365
- Use Service-Hub to request an interpreter. (MUHA Intranet)
- Conference calls – extension 2-4595
- Telephonic Interpretation—24/7/365

ALL LANGUAGES - Telephonic Interpretation Services

- Available 24/7/365, over 200 languages
- Call 1-855-305-0998
- Request language, including any dialects. Can schedule a time for a phone interpreter for uncommon dialects.

PATIENTS WHO ARE DEAF OR HARD OF HEARING

- In-house Medical Interpretation is Available Mondays through Fridays, 8:00 am – 5:00pm
- In-Person Interpretation (After-Hours/Weekends) - Contact Charleston Interpreting Services at 678-446-7780
- Video Remote Interpretation - (ASL), Available 24/7/365 – Equipment is stored in Security Offices at ART and Main Hospital

ALWAYS DOCUMENT THAT INTERPRETATION SERVICES WAS USED.. IF IT ISN'T DOCUMENTED, IT WASN'T DONE!!!