CULTURAL AND LINGUISTIC CONSIDERATIONS FOR VISION CARE

CONSENSUS FROM ROUNDTABLE

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Introduction

With the changing face of the nation, more and more eyecare professionals are experiencing a culturally diverse patient base. Seeking to better understand how to overcome challenges to providing vision care to multicultural populations, Transitions Optical, Inc. hosted a roundtable discussion exploring cultural and linguistic considerations for vision care in Washington, D.C. on April 20, 2009.

The event featured an in-depth discussion on the CLAS (Culturally and Linguistically Appropriate Services) standards, which were developed by the Office of Minority Health of the U.S. Department of Health and Human Services to improve access to and quality of health care for minorities. While the CLAS standards are primarily directed toward health care organizations, they offer many lessons for the optical industry and can be used by individual providers to make their practices more culturally and linguistically accessible. The CLAS standards comprise four mandates, nine guidelines and one recommendation addressing in-language services, bilingual materials, staff training and conflict resolution.

During the roundtable, representatives from the Office of Minority Health, Kaiser Permanente and the National Multi-cultural Institute presented their experience with the CLAS standards and how other health care organizations have successfully incorporated them into practice. This was followed by presentations from eyecare professionals and educators on their experience meeting the unique eye care needs of specific demographics, including Asian Americans, African Americans and Hispanics. Presentations addressed the numerous challenges for these populations to receive quality vision care and vision wear, and referenced the high incidence of specific eye- and systemic- diseases paired with low awareness levels of the need for preventative care. Unique cultural characteristics and barriers to receiving adequate care were also addressed for each population.

Following the presentations, participants discussed and agreed that certain elements of the CLAS standards could serve as a helpful guide for eyecare professionals to better serve their culturally diverse patients. This included the development of in-language or multilingual resources and the use of interpreters during the exam process. Participants also identified the need for all eyecare professionals to become more "culturally aware" to determine who their patients are and their specific needs, and to learn how to better communicate with them. They also expressed the need for increased diversity among optical professionals and stressed the importance of introducing "cultural awareness" early on in the education process.

This consensus paper overviews the content presented during the roundtable and captures subsequent discussions. After reading this consensus paper, you will have a better understanding of:

1. **What the CLAS standards are and how they have been successfully applied by the general health care sector** (strategies shared by the Office of Minority Health, Kaiser Permanente and the National Multicultural Institute).

2. **The specific eye health- and communication-needs of culturally diverse patients, including Asian Americans, African Americans and Hispanics.**

3. **Strategies for promoting cultural competency within your own practice, using the CLAS standards as a guide** (based on roundtable discussion).

A Growing Need to Promote Cultural Competency

The demographic landscape is changing.

- By 2050, minorities will comprise more than half of the U.S. population.
- Hispanics currently make up 15 percent of the U.S. population. By 2050, this number will jump to 30 percent.
- Asian Americans and African Americans together comprise 19 percent of the population. By 2050, they will account for 25 percent.

Language barriers can be an issue.

- 49.6 million Americans (18.7 percent) speak a language other than English at home.
- 22.3 million Americans (8.4 percent) have limited English proficiency.

The CLAS Standards

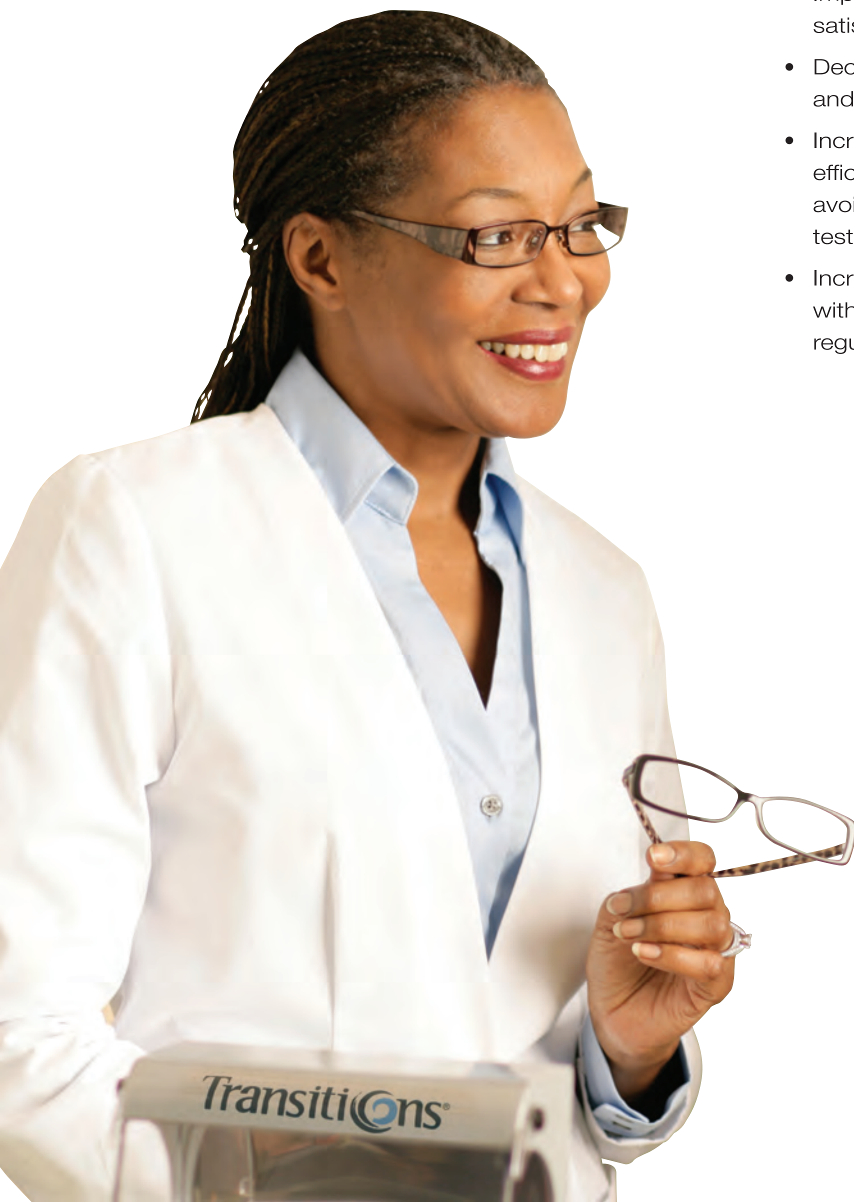
The CLAS (Culturally and Linguistically Appropriate Services) standards are national standards created by the Office of Minority Health. These standards serve as a roadmap for health care organizations to provide culturally competent services and improve access to and quality of health care for all minorities. The Office of Minority Health defines “culturally competent care” as providing services to people of all cultures, races, ethnic backgrounds and religions in a manner that respects the worth of the individual and preserves their dignity.

A representative from the Office of Minority Health who helped to create the CLAS standards was present at the roundtable and reviewed the reasons why the standards were created, how they are structured and what benefits organizations implementing them have seen.

The Office of Minority Health developed the 14 CLAS standards in 2000 and divided them into three sections: culturally competent care (standards 1-3), language access services (standards 4-7) and organizational supports (standards 8-14). While most of the standards are suggestions for improving care, the language access services are mandates for health care organizations receiving federal funding. The Office of Minority Health recommends that the principles of all of the standards be integrated throughout the organization and undertaken in partnership with the communities being served.

The CLAS standards have proven to be effective for many health care organizations, offering numerous benefits to providers. Using the CLAS standards can:

- Help providers facilitate the application of cross-cultural skills necessary to better serve culturally diverse patients.
- Facilitate access to care and the reduction of health disparities.
- Improve care and enhance patient satisfaction.
- Decrease malpractice risks and insurance costs.
- Increase operational efficiency (timely services, avoid duplication of tests, etc.).
- Increase compliance with state and federal regulations.



The Standards

The following section details the 14 CLAS standards and offers implementation strategies from the Office of Minority Health. During discussion, the standards were reviewed by participants to determine how they can be used within the optical industry. This consensus is reflected in the Key Discussion Points section of this paper.

CLAS Standards 1-3: *Culturally Competent Care*

The first three standards reflect the theme of culturally competent care and are **guidelines** that are recommended by the Office of Minority Health for adoption as mandates by federal, state and national accrediting agencies.

Standard 1
Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

Standard 2
Health care organizations should implement strategies to recruit, retain and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

Standard 3
Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

The Office of Minority Health recommends the following implementation strategies for the first three standards:

- Focus on behaviors of all staff members.
- Conduct a needs assessment for staff.
- Add cultural competency skill sets into job descriptions when hiring new staff members.
- Incorporate diversity into mission statements and strategic planning.
- Publicly recognize staff members for completing cultural competency training.

CLAS Standards 4-7: *Language Access Services*

Standards 4-7 reflect the theme of language access services and are **mandates**, or current federal requirements for all recipients of federal funds.

Standard 4
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 points of contact, in a timely manner during all hours of operation.

Standard 5
Health care organizations must provide to patients/consumers, in their preferred language, both verbal offers and written notices informing them of their right to receive language assistance services.

Standard 6
Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

Standard 7
Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

The Office of Minority Health recommends the following implementation strategies for CLAS standards 4-7:

- Take advantage of a bilingual staff, interpreters and telephone interpretation services.
- Market services available in non-English brochures and materials distributed to the public.
- Educate all staff members on what services are provided.
- Discourage use of family and friends as interpreters.
- Assess knowledge of medical terminology of interpreter/bilingual candidates.

CLAS Standards 8-14: *Organizational Supports*

The final seven standards fall into the category of organizational supports. While standards 8-13 are **guidelines**, standard 14 is a **recommendation** – or suggestion by the Office of Minority Health for voluntary adoption by health care organizations.

Standard 8
Health care organizations should develop, implement and promote a written strategic plan that outlines clear goals, policies, operational plans and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

Standard 9
Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments and outcomes-based evaluations.

Standard 10
Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity and spoken- and written- language are collected in health records, integrated into the organization's management information systems and periodically updated.

Standard 11
Health care organizations should maintain a current demographic, cultural and epidemiological profile of the community, as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

Standard 12
Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.

Standard 13
Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing and resolving cross-cultural conflicts or complaints by patients/consumers.

Standard 14
Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards, and to provide public notice in their communities about the availability of this information.

The Office of Minority Health recommends the following implementation strategies for CLAS standards 8-14:

- Integrate cultural competency principles into the strategic planning process.
- Conduct an organizational self-assessment.
- Conduct patient and community surveys (geo-mapping, knowing the community, etc.).
- Utilize available demographic data (Census and school enrollment data, etc.).
- Adapt in-take procedures to facilitate the collection of patient data (racial, ethnic and language data).
- Involve community representatives on advisory committees/boards.
- Attend community events/meetings to establish trust.
- Publish documents, newsletters, local media, etc., on your progress in promoting cultural and linguistic competence service delivery.

Additional Implementation Strategies

In individual presentations during the roundtable, representatives from Kaiser Permanente and the National Multicultural Institute shared their experiences with the CLAS standards, offering case studies and additional strategies for implementation. These illustrate different approaches that the optical industry can take in an effort to further provide culturally appropriate services to a growing base of diverse patients.

Kaiser Permanente

Kaiser Permanente is the largest nonprofit health plan in the United States, serving nearly 8.7 million members in nine states and the District of Columbia. Its organizational commitment to the provision of culturally and linguistically competent care is reflected in its extensive utilization of the CLAS standards.

Kaiser Permanente has relied on research to understand the unique needs of its customer base and guide the development of specific language services programs to address the needs of limited English patients and communities. For example, funding support from the California Endowment Grant enabled evaluation and advancement of innovative models and programs:

1. *The Interpreter Services Research Agenda* validated the importance of professionally trained and certified health care interpreters. The research led to the expansion and replication of the **Health Care Interpreter Certificate Program**[i], a college-level training program designed to provide quality accreditation standards for interpreters.
2. *The Translation Services Research Agenda* informed the need for a standardized translation process. It paved the way for the **National Standardized Quality Translation Initiative**[ii], a program designed to produce quality, affordable and accessible translated in-language materials.
3. *The Provider Linguistic Proficiency Research Agenda* reinforced the need for a qualified assessment of provider linguistic proficiency. The **Clinician Linguistic and Cultural Assessment Initiative**[iii] was developed to ensure adequate patient-provider language concordance in clinical care, reinforcing a standard level where the provider is expected to be able to communicate directly with the patient, independent of an interpreter.

Examples of Inaccurate Translations In the Field

Provided by Kaiser Permanente

Term	Misinterpreted Translation
Co-payment	Coping
Behavioral health workshop	Day program for lunatics
Nurse practitioner	Nurse in practice, nursing aid, physician's assistant
Literal Word-for-Word Translation Errors	
Safe sex	Sure sex (Spanish)
Patient	Sick person (Chinese)*

*A patient is not always someone who is sick.

National Multicultural Institute

The National Multicultural Institute is an organization that "trains the trainers" and has experience working with corporations, educational institutions, government agencies and non-profits in workforce diversity, human resource management, multicultural education and cross-cultural conflict resolution. The National Multicultural Institute also looks to the CLAS standards to help achieve its mission to build an inclusive society that is strengthened and empowered by its diversity.

The National Multicultural Institute offered several suggestions for providing quality care for diverse patients:

- Conduct an internal assessment of your organization to determine levels of cultural awareness and make sure staff is open to traditional approaches in health care.
- Conduct an ongoing evaluation of the services and programs your organization offers.
- Implement cultural and cross-cultural awareness programs.
- Carefully select tools and take advantage of resources, including human resources.
- Offer a bilingual staff and/or interpreter services.
- Take advantage of communication/mass media.

Two examples of the initiatives that the National Multicultural Institute has implemented in order to incorporate culturally and linguistically appropriate services into a variety of health-care settings are depicted in the following case studies.

CASE STUDY: Emergency Room Initiative

Provided by the National Multicultural Insitute

Background – A young Asian boy was brought in to the Emergency Room by his parents with a high temperature and chest congestion. Upon physical assessment, the nurse noticed red circles on his back and called in a social worker to talk to the parents, who did not speak much English. The nurse did not understand that "cupping," a traditional Asian practice in which cups are placed on the skin, had been used.

Interventions – To enhance an already existing hospital-wide program, individual departments were reviewed to determine needs and certain CLAS standards (1,3,13) were referenced. Focus groups were held and cultural-focused education programs were implemented.

Results – Following this education, the staff felt more confident in taking care of culturally diverse patients, having a better understanding of their customs and perceptions of care. Role-playing scenarios also helped the staff to identify possible human trafficking victims.

CASE STUDY: Hospital-Wide Cultural Awareness Program[iv]

Provided by the National Multicultural Insitute

Background – In August 2008, the Joint Commission began developing accreditation standards to help hospitals promote, facilitate and advance the provision of culturally competent, patient-centered care. Hospitals were encouraged to consider these recommendations and develop their own program for improving patient care and understanding.

Interventions – A Hospital Committee was formed with representation from all departments (CLAS 8) and a needs assessment of the community was implemented (CLAS 9). Additionally, a cultural diversity coordinator was appointed, reporting to the Human Resources department (CLAS 2,8). More than 2,000 employees were required to take a seven-month training program, in addition to a two-hour mandatory webinar and experiential educational session with employee evaluations (CLAS 3,9).

Results – More than 2,000 employees were trained and additional continuing education was developed. A grant was obtained to purchase interpreter computers for all patient units and areas, and a medical interpreter program was implemented (CLAS 4,6). Patient materials were developed in the five most common languages (CLAS 5,7), and cultural resources were provided for departments and patient care areas (CLAS 1). A community partnership was formed as a "neighborhood outreach" (CLAS 12,14) and a community benefit support group was created to continually identify the needs of the community (CLAS 11,14). Patient satisfaction surveys were given post discharge (CLAS 9), and employees were responsive to patient surveys on culturally appropriate care (CLAS 13).

Tips from the Office of Minority Health for achieving cultural competency within the optical sector.

Outline your cultural and linguistic goals
Put them in your policies and procedures
Train your staff
Integrate at every point of contact
Connect with the community
See the results

Understanding Diverse Populations

Following the presentations regarding the CLAS standards and strategies for their implementation, roundtable participants reviewed the unique characteristics and needs of the most representative minority groups in the U.S. to help determine specific strategies and tools needed to provide more culturally and linguistically sensitive eye care. Key attributes of Asian-American, African-American and Hispanic groups are reviewed in this paper.

Focus on Asian Americans

A Growing Demographic

Asian Americans represent the third largest minority population and second fastest-growing group. Today they make up approximately 5 percent of the U.S. population, numbering 15.5 million. By 2050, this number is expected to increase to 40.6 million, or 9 percent of the population.[v]

The Census Bureau defines the term "Asian" to include people of the Far East, Southeast Asia or the Indian subcontinent (Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam). The Chinese comprise the largest Asian group within the U.S. (3.6 million), followed by Filipinos (2.9 million), Asian Indians (2.7 million), Vietnamese (1.6 million), Koreans (1.5 million) and Japanese (1.2 million).[vi]

The majority of Asian Americans are foreign-born, with only 36 percent born in the U.S. However, this pattern differs when country of origin is taken into consideration. A majority of Japanese Americans and many Chinese Americans are U.S.-born, with many third or fourth generation.[vii]

Almost 90 percent of all Asian Americans come from just six countries – China, India, the Philippines, Vietnam, Korea and Japan – with immigrants from India representing the fastest-growing segment.[viii]

As their population continues to increase, the Asian-American buying power is also anticipated to grow significantly over the next several years from $509 billion in 2008 to $752 billion in 2013 – making it the second fastest-growing market to Hispanics.[ix] While Asian Americans are one-third of the size of the Hispanic population, they have half of their buying power.

Asian Americans also lead all race and ethnic groups with a median household income of over $66,000 in 2007, compared with just over $50,000 for the total population.[x]

Overall Health Issues

Asian Americans are affected by several overall health issues which can impact the eyes.

Diabetes

Diabetes is the fifth leading cause of death among Asian Americans between the ages of 45 and 64. Asian Americans are more likely to develop type 2 diabetes than the general population. Alarmingly, since Asian Americans are less likely to be obese, doctors are often late in diagnosing them as diabetic – reinforcing the eye exam as an important measure in preventative care.[xi]

While a patient may initially complain of problems such as blurred vision, over time, diabetes can lead to more serious problems such as diabetic retinopathy, cataract and glaucoma. Treatment is easier when problems are diagnosed early.

Because people with diabetes are more susceptible to heightened damage from ultraviolet (UV) radiation and can experience reduced contrast sensitivity and increased susceptibility to glare, the proper eyewear should be recommended. For example, photochromic lenses offer automatic UV protection while reducing glare.

Asian Americans report greater difficulty communicating with their health professionals.

Tuberculosis

Tuberculosis (TB) is one of the most serious problems facing Asian-American women and is 13 times more common among Asian populations.[xii] TB remains the world's leading infectious cause of death, and can also lead to a number of diseases throughout the body and the eye.[xiii] **Ocular tuberculosis** encompasses any infection by Mycobacterium tuberculosis, or one of three related mycobacteria species (bovis, africanum, microti) in, on or around the eye.[xiv]

Eye Health Issues

Asian Americans are at higher risk for a number of eye health issues.

Because of the shape of their eyes (narrow angles), Asian Americans are more likely to develop **angle-closure glaucoma**, which is caused by a rapid or sudden increase in pressure inside the eye.[xv] People of Japanese descent are also more prone to **low-tension glaucoma**.[xvi]

Myopia, or nearsightedness, is also more common among Asians.[xvii]

Eye Care Perceptions

In a study supported by the Vision Care Institute, nine out of 10 Asian Americans agreed that maintaining proper vision care is a priority. Despite this, more than one third do not believe they need an eye exam unless they are having a vision problem. The Asian-American population is also the least likely to believe that vision correction will greatly improve activities such as driving, work performance, reading performance and computer work.[xviii]

Additionally, Asian-American children are less likely to get their vision checked than African-American or Caucasian children.[xix] In a study supported by the Center for Disease Control, Asian-American children who did see an eyecare professional were more likely to be diagnosed with myopia than the general population (26 percent vs.18 percent).

These statistics reinforce a need to educate the Asian-American population on the importance of regular eye exams and sight-enhancing vision wear options.

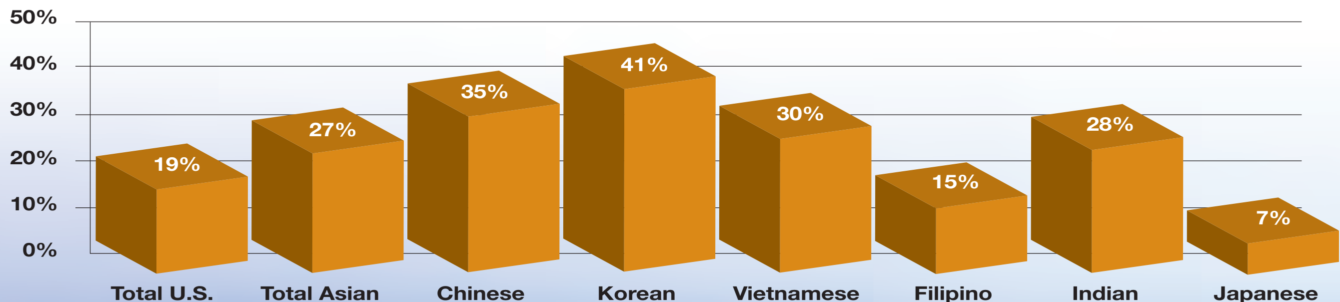
Language and Communication

Approximately 77 percent of Asian Americans speak a language other than English at home. Among the specific groups, the percentage of those who speak another language at home ranges from 47 percent for Japanese to 88 percent for Vietnamese.[xx] While the vast majority of Asian Americans speak English very well, they prefer in-language communication – especially the South Asian and Filipino groups.[xxii]

77 percent of Asian Americans speak a language other than English at home

Asian Americans tend to be highly nonverbal, exhibiting silence and timing of verbal exchanges, facial expressions and interpersonal space and body movement. Many may nod "yes" to be polite, even if they mean to say no.[xxiii] Additionally, some Asian women prefer not to face their physician eye-to-eye when discussing health matters, but instead prefer to sit beside the physician.[xxiv]

Percent of adults reporting one or more measure of poor communication*



Base: Adults with a health care visit in the past two years. Source: The Commonwealth Fund 2001 Health Care Quality Survey.
* Doctor didn't listen to everything, patient didn't understand fully, or patient had questions but didn't ask.

Cultural Values

Family

Family is the central focus of life for many Asian Americans. They tend to have larger households (2.7 people) than the national average (2.5 people), and more wage earners per household.[xxvi]

Education

Many Asian Americans believe that academic achievement is the greatest tribute to their parents and family.[xxvii] They are more educated than the average American and tend to hold more top-level jobs. In 2008, nearly half of all Asian Americans over the age of 25 had a bachelor's degree or higher, compared to 30 percent of non-Hispanic whites.[xviii] Because of this, they are stereotypically seen as a "model minority," or a hard-working, education-hungry, social ladder-climbing group. This puts pressure on other Asian Americans and does not take into account diverse income levels, education and assimilation.

Because of their higher income, Asian Americans tend to eat out more often and spend more on furniture, major appliances, clothing and personal care products and services. They also tend to spend more than the average U.S. household on shelter, education and transportation.[xxix]

Harmony

Harmony is the keynote of existence. Asian Americans seek harmony in social interaction, relying on their listener's ability to understand the speaker's intent. They are reluctant to criticize or contradict overtly, and have the ability to "read" others' genuine attitudes through nonverbal cues.[xxx]

Health Care Attitudes

Asian Americans, among other minorities, receive less adequate and less intensive health care than Caucasians. They are also more likely to try alternative methods of health care, including acupuncture and traditional healers.[xxxi] Because of their traditional approaches to health care, Asian Americans may not perceive the value or identify the purpose or necessity in obtaining care.

Asian Americans are also less likely than non-Hispanic whites to have health insurance coverage. This could be because they may view public assistance as a weakness.[xxxiii]

Cultural Virtues

Virtues among Asian Americans include **patience**, **perseverance**, **self-sacrifice**, **maintenance of inner strength**, **self-restraint** and **humility**.[xxxiv] The most popular religion among Asian Americans is no religion (27 percent), with eastern religions coming in second (21 percent).[xxxv]

Focus on African Americans

A Growing Demographic

African Americans make up the second largest and third fastest-growing minority in the United States. Today, the African-American population numbers 41.1 million, or roughly one in seven people. By 2050, this number is projected to increase to 65.7 million. Their projected growth through 2050 (71 percent) outpaces that of the general population (49 percent).[xxxvi]

Similar to the Hispanic and Asian-American populations, the African-American market opportunity is also increasing. It is anticipated that the African-American buying power will increase to a staggering $1.2 trillion in 2013 from $913 billion in 2008.[xxxvii] Additionally, it's important to recognize that women are more commonly the head of household and often control the purse strings.

By 2013, African-American buying power will increase to $1.2 trillion

Overall Health Issues

Diabetes

Diabetes affects 2.2 million African Americans, and prevalence is 70 percent higher than in non-Hispanic whites. Diabetes can lead to complications such as diabetic retinopathy, which can lead to vision loss over time. Approximately 60 percent of diabetes-related blindness can be prevented through early detection and treatment.[xxxviii]

African Americans are not only more likely to be diagnosed with diabetes, but are more likely to develop and die from its complications.[xxxix] For example, kidney failure is four times more common than in non-Hispanic whites[xl] and lower limb amputations are two-times more common.[xli] Frequency of diabetic retinopathy is also 50 percent higher.[xlii]

Hypertension

African American adults are 40 percent more likely to have high blood pressure than non-Hispanic whites, yet 10 percent less likely to have it under control.[xliii] In addition to causing serious heart and kidney problems, hypertension can affect the eyes and lead to hypertensive retinopathy, which causes blurry vision and eventually blindness.

HIV/AIDS

The prevalence of Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Virus (AIDS) is trending upward within the U.S. African-American population. Late-stage AIDS can lead to complications throughout the body, including the eyes. Cytomegalovirus retinitis occurs in one quarter of active AIDS patients, and can lead to retinal detachment and blindness within two to six months.[xliv]

Sickle Cell Disease

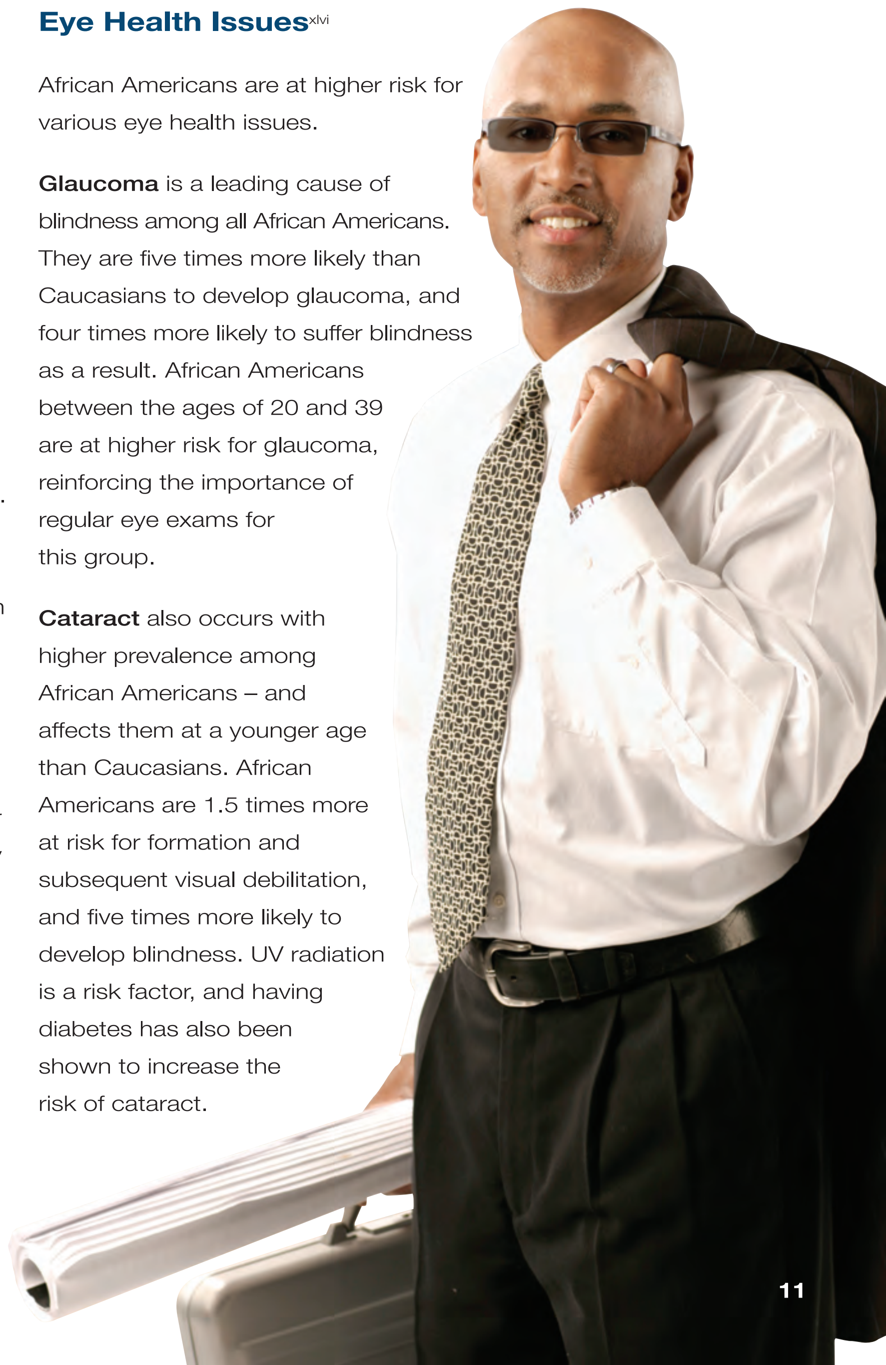
African Americans are especially prone to sickle cell disease. Roughly two million African Americans in the U.S. – or one in 12 – is a carrier of the sickle cell trait. When tiny blood vessels in the eye become blocked with sickle-shaped cells, vision problems and even blindness can result.[xlv]

Eye Health Issues[xlvi]

African Americans are at higher risk for various eye health issues.

Glaucoma is a leading cause of blindness among all African Americans. They are five times more likely than Caucasians to develop glaucoma, and four times more likely to suffer blindness as a result. African Americans between the ages of 20 and 39 are at higher risk for glaucoma, reinforcing the importance of regular eye exams for this group.

Cataract also occurs with higher prevalence among African Americans – and affects them at a younger age than Caucasians. African Americans are 1.5 times more at risk for formation and subsequent visual debilitation, and five times more likely to develop blindness. UV radiation is a risk factor, and having diabetes has also been shown to increase the risk of cataract.



Raising Awareness

There remains a need for education about the role that eye care and eyewear can play for African Americans. In a recent survey, four out of five African Americans agreed that they should get their eyes checked yearly – however, less than half had an eye exam within the past year.[xlvii]

There is also a need to educate African Americans on the importance of UV protection for the eyes. Only 7 percent of African Americans know that extended exposure to the sun can cause eye damage, which is lower than the awareness rate of the total population (9 percent).[xlviii]

Cultural Values

There are many common cultural values among the African-American population:[xlix]

- Assertiveness in communication
- Word-of-mouth communication
- Receptiveness to organizations that give back to the community
- Desire to see a positive image of their culture
- Reverence and care for elderly family members

African Americans are also likely to watch African-American media at home (81 percent) and are more than twice as likely to trust African-American media over the mainstream.[l]

Recommendations for Treating African-American Patients[li]

- Do not assume a financial ability to purchase.
- Do not assume a lack of understanding.
- Do not assume a level of education based on appearance, age, etc.
- Understand that the African-American demographic is a diverse group.
- Treat each patient like a person as opposed to an "African-American" person.

Barriers to Care

In a study conducted among elderly African-American consumers and eyecare professionals, several barriers to care were identified. While the eyecare professionals perceived potential barriers as (in order) *transportation, cost of eye care, trust* and *insurance*, the African-American participants perceived barriers as *transportation, trusting the doctor, communicating with the doctor* and *cost of eye care*. This study reinforces that – despite fewer to no language barriers – communication does play an important role in providing adequate care to the African-American population and needs to be addressed within the optical industry.[lii]

Other barriers to care may include economic factors, lack of access, lack of awareness of the need for screening, fear of results, spirituality, personal priorities and motivation.

It is also important to mention that African Americans make up a very small percentage of eyecare professionals within the United States. They comprise just 1.7 percent of optometrists and only 4 percent of physicians and surgeons, of which ophthalmologists comprise a small number.[liii]

Hispanics will comprise one-fourth of the nation over the next two decades

Focus on Hispanics

Additional, in-depth information about the Hispanic population can be found in the consensus paper, *Factors Impacting Vision Care and Vision Wear of Culturally Diverse Groups: Focus on Hispanics*, available through Transitions Optical Customer Service (800-848-1506).

A Growing Demographic

Hispanics represent the fastest-growing demographic group in the United States, and will comprise approximately one-fourth of the nation over the next two decades.[liv] While the Hispanic population is larger in states such as California and Texas, it is spreading across the country – meaning all eyecare professionals could soon be seeing an increase in the number of Hispanic patients, if they haven't already. In fact, eyecare professionals may even notice a difference in their patients' names. For the first time, Garcia and Rodriguez are among the top 10 most common surnames in the United States.[lv]

With this growth comes tremendous opportunity for eyecare professionals to grow their businesses. The buying power of Hispanic consumers was $863 billion in 2007 – a number that is expected to increase to $1 trillion by 2010.[lvi]

Eye- and Overall- Health Issues

There are several eye- and overall- health issues that affect the Hispanic population. Many overall health issues – including **diabetes** and **hypertension** – have implications for vision and can be detected through the eye, making regular, comprehensive eye exams critical. Hispanics are also at higher risk for many eye health issues, including **pterygia**, **macular degeneration**, **glaucoma** and **cataract**.

The Hispanic Culture

Hispanics may be first, second or third generation, with various levels of proficiency in English. While fluency is varied, 85 percent of Hispanics use at least some Spanish at home, work or school[lvii] – making a bilingual staff or use of bilingual materials an effective way for eyecare professionals to better communicate with their Hispanic patients and show respect for their culture.

In addition to language barriers, there are several other challenges to providing quality care – including low awareness levels of the importance for preventative eye care, lack of familiarity with the health care system and the ability to understand and fill out paperwork, and lack of access to health insurance. It is also important for eyecare professionals to keep in mind cultural values – such as the importance of family, respect for authority figures and their doctor, a desire for one-on-one relationships with their doctor and the importance of personal appearance.

During the roundtable, participants emphasized that Hispanic consumers have the potential to be very **loyal** to their eyecare professionals. If they are satisfied with their visit, they may recommend that particular practice or eyecare professional to their family members and friends. Hispanic consumers can also tend to be **cautious** – or wary of new experiences and in need of affirmation of outcomes. Because of this, it is helpful for the eyecare professional to explain a diagnosis, necessary treatment or products offered so that the patient and his or her family members understand.

Hispanics also tend to be **fashion-conscious** and **brand-aware**. For this reason, even if they are paying out of pocket for their lenses, they are likely to spend more on premium products or higher-performing lens options.

Know Your Hispanic Patients[lviii]

- 15% of Hispanics had an annual vision checkup in the past year.
- 62% of Hispanic patients tend to always be accompanied by a family member when visiting their eye doctor.
- 66% of Hispanics prefer to visit optical practices with a bilingual staff, even if they can communicate in English.
- 76% of Hispanic patients prefer a doctor who is spontaneous and personable vs. too formal.

Eye and Overall Health Issues Affecting Various Demographics

ISSUE	African American	Asian American	Hispanic
Overall Health			
Diabetes	Prevalence 70% higher than in non-Hispanic whites; more likely to develop and die from complications; can lead to diabetic retinopathy[lix]	5th leading cause of death among those 45-64; more likely to develop type 2 diabetes than general population; diagnosis more likely to be late, since they are less likely to be obese[lx]	10% of Hispanics have diabetes; 3 times rate of general population;[lxi] 95% have preventable, type 2 diabetes;[lxii] can lead to diabetic retinopathy
HIV/AIDS	Trending upward; cytomegalovirus occurs in 25% of AIDS patients and can lead to retinal detachment and blindness within 2-6 months[lxiii]	Though not as common among Asians (1% of AIDS cases in U.S.), the number of new cases diagnosed is increasing[lxiv]	Account for 19% of new AIDS diagnoses and people living with AIDS; 3 times the rate of Caucasians; 4th leading cause of death of those 35-44;[lxv] can lead to vision problems
Hypertension	40% more likely than non-Hispanic whites to have high blood pressure; 10% less likely to have it under control; can lead to hypertensive retinopathy[lxvi]	Higher levels among the Filipino population;[lxvii] can lead to hypertensive retinopathy	Affects 29% of Hispanics; can lead to hypertensive retinopathy[lxviii]
Sickle Cell Disease	1 in 12 is a carrier of the sickle cell trait in the U.S.; can lead to vision problems and blindness;[lxix] 1 in 600 born with sickle cell anemia[lxx]	While not as common as in African Americans, can affect this population[lxxi]	Affects 70,000 people in the U.S., primarily African American or Hispanic;[lxxii] can lead to vision problems and blindness; 1 in 1,000-1,400 born with sickle cell anemia[lxxiii]
Tuberculosis	Rates 8 times higher than in whites;[lxxiv] can lead to ocular tuberculosis	13 times more common among Asian populations; serious problem facing women; can lead to ocular tuberculosis[lxxv]	Rates 8 times higher than in whites;[lxxvi] can lead to ocular tuberculosis
Eye Health			
Cataract	1.5 times more at risk for formation and subsequent visual debilitation; 5 times more likely to develop blindness[lxxvii]	Affects the Asian population; prevalence of age-related cataract higher in Asians than Caucasians[lxxviii]	Leading cause of visual impairment; affects 1 in 5 Hispanic adults; 3 times more common in older Hispanics vs. whites and African Americans[lxxix]
Glaucoma	5 times more likely than whites to develop glaucoma; 4 times more likely to suffer blindness[lxxx]	More likely to develop angle-closure glaucoma;[lxxxi] Japanese more prone to low-tension glaucoma[lxxxii]	Open-angle glaucoma most common cause of blindness;[lxxxiii] affects 6% over 41, 12% over 80[lxxxiv]
Macular Degeneration	At lower risk, but risk factors such as smoking and UV radiation can still contribute to development[lxxxv]	Assumed to be at lower risk, but risk factors such as smoking and UV radiation can still contribute to development[lxxxvi]	10% of Hispanics at risk for developing advanced AMD; 1 in 4 have signs in both eyes[lxxxvii]
Myopia	Not as common among African Americans (6.6%);[lxxxviii] more prevalent in African-American preschoolers than Hispanic preschoolers[lxxxix]	More common among Asians; affects 78.5%[xc]	Affects 13.2% of Hispanics[xci]
Pterygia	Exposure to UV radiation is a risk factor	Exposure to UV radiation is a risk factor	Hispanics have higher incidence; exposure to UV radiation is a risk factor[xcii]

Key Discussion Points

Roundtable participants agreed strongly that, regardless of race or ethnicity, *quality* of communication with patients is key. All of the efforts of industry professionals to deliver the proper vision care and vision wear are in vain if patients misunderstand what is needed to care for their vision.

Yet, communication is not something that always comes naturally for eyecare professionals. While extensive investment is made in educating students in optical fields about the medical side to their jobs, "soft skills," such as communication, are less emphasized. Professionals will invest in the latest equipment to provide the best diagnostic care to patients, but may not invest in training staff to communicate appropriately so that patients understand what their diagnosis is, or what is expected of them. Additionally, since we are living in a digital age, participants also commented that in-person communication is becoming less natural for people – but should remain a priority.

The group agreed that achieving cultural competency is integral for successful communication. This is another area that does not come naturally for most professionals, because we are not in the habit of thinking about how our communications might be received outside our own level of understanding and points-of-view. The participants suggested that eyecare professionals need to step out of a traditional approach to care – thinking more broadly about what culture is, as well as the impact it has on communication techniques and the ability to provide adequate care. They agreed that cultural competency should spread beyond race and ethnicity to also encompass the needs of specific genders and age groups. As an example, participants discussed how children – regardless of race or ethnicity – have their own unique culture and communicate and learn in different ways.

It is important for eyecare professionals to recognize that these different cultures exist and that, within each culture, there may be different levels of patient understanding. It is also important to recognize that removing an obstacle – such as a language barrier – can be very complicated. While there are companies and organizations – such as the Office of Minority Health, Kaiser Permanente and the National Multicultural Institute – who remain dedicated to this task and have made much progress, there is still not complete and definitive agreement on the best approach. However, there is much that the optical industry can learn from looking at the methods taken by these groups.

Roundtable participants turned to the CLAS standards as a guide to begin exploring what efforts can be taken within the optical industry to improve overall care for minorities. The discussion then evolved into other ways in which the optical and health care sectors could work individually or together to promote culturally and linguistically appropriate vision care.

Using the CLAS Standards as a Guide

Participants agreed that several elements of the CLAS standards make sense for the optical sector and could serve as a guideline for eyecare professionals to achieve cultural competency and better serve their multicultural patient base. Some areas of consensus are below.

Interpreter Services (Referencing CLAS Standards 4 and 6)

The CLAS standards require that health care organizations receiving federal funding provide language assistance services – including interpreters – at no cost to a patient. During discussion, participants agreed that interpreters are helpful to have in the exam room and dispensary when language or education barriers are present. Because translations can be literal or figurative, interpreting can be difficult – even when the same language is spoken. For this reason, it is important for the doctor and interpreter to ensure they understand each other before communicating to the patient. This includes accurate translations of medical terms.

Participants identified and analyzed three options for eyecare professionals:

1. Using family members as interpreters

Participants identified many potential problems with using family members as interpreters, including filtering. Even though the interpreter may be relaying most of what the patient is saying, the same meaning or tone may not be entirely communicated. This could become an issue, particularly when more complicated explanations on topics such as diagnoses and recommended care need to be provided. Additionally, participants recognized that the eyecare professional cannot take for granted that the family member is not making assumptions on behalf of the patient.

Participants also reinforced that there may be some cases in which the patient would like specific information to remain private or the family member is not comfortable being an interpreter – especially when a more serious eye health or medical condition is present. The emotional impact of serving as an interpreter can also be a factor. For example, one participant shared her experience of being an interpreter for a parent, saying "I wanted to be a daughter, not an interpreter."

For these reasons, participants agreed that family members should not be used unless it is the specific request of the patient – and the family member is comfortable serving as the interpreter. In fact, the Office of Minority Health discourages this method. However, if family members are used, it is important that care is taken to ensure messages are accurately relayed and perceived. In some cases, participants acknowledged that using family members can be helpful in further validating whether the patient understands, or is simply agreeing with, the eyecare professional. Regardless, participants were in consensus that children should never be asked to serve as interpreters.

2. Using a professional interpreter

While the CLAS standards state that interpreter services should be provided to patients at no cost, this may not always be feasible for smaller organizations, such as individual eyecare practices. However, there are times when a patient may come to his or her appointment with a professional interpreter.

Professionally trained interpreters have the ability to explain matters, such as eye health issues and treatments, to patients beyond a literal translation. Using a professional interpreter can also allow for a more open dialogue between the eyecare professional and patient, where questions can be asked and more effectively answered.

To further ensure the promotion of cultural competency, professional interpreters employed by the health care sector often receive special training from organizations such as National Multicultural Institute or Kaiser Permanente. One method for eyecare professionals to obtain the services of professionally trained interpreters, on a case-by-case basis, could be through the use of telephone interpretation services, or a local interpreter services vendor.

Eyecare professionals should also recognize that a professional interpreter is not necessarily as emotionally connected to the patient as a family member or friend, allowing for neutrality. When using an interpreter – whether a professional or a family member – it is important to still acknowledge and address the patient.

3. Hiring a bilingual staff

There are many benefits to hiring a bilingual staff – especially if your practice is located in an area with residents who speak a language other than English. By hiring a bilingual staff, you are not only welcoming new, potential patients, but can help existing patients feel more comfortable during their appointment. It is important to recognize that even patients who speak English may prefer to have dialogue with someone who speaks their native language. These patients may also be more likely to recommend your services to family members or friends who do not speak English.

Upon hiring bilingual staff, it is recommended to assess their knowledge of medical terminology. Even with a bilingual staff, cultural and linguistic competency cannot be assumed and they may still need to undergo cultural sensitivity training.

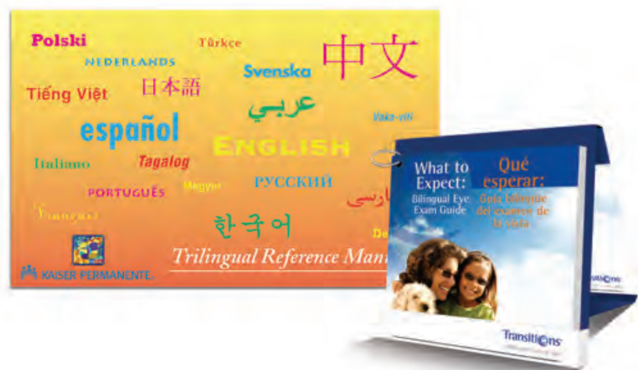
In-Language Materials (Referencing CLAS Standard 7)

One of the core mandates of the CLAS standards is making available in-language, easy-to-understand patient materials and signage. Participants agreed that **in-language or multilingual materials should be used** when language barriers are present, and can also be used to show a sign of respect for one's culture. Participants reviewed materials currently existing within the general health care and optical sectors – including a Trilingual Reference Manual, as an example from Kaiser Permanente, and Bilingual Eye Exam Guide and Pocket Card from Transitions Optical – and brainstormed ideas for additional resources.

While participants agreed that in-language materials are definitely of value, they acknowledged that different types of materials may work better for specific populations. For example, the Hispanic demographic may appreciate a "novella" concept, in which the information is relayed to the patient with a story-telling style, for materials such as video or brochure. Additionally, while some groups may prefer a material to be strictly in-language, others may prefer it to be bilingual. It is important that these cultural differences and preferences are taken into consideration before materials are developed.

Another key topic discussed was the *quality* of in-language and multilingual materials. Participants agreed that in order for these materials to be of true value, they **must be thoroughly reviewed to ensure all translations are accurate and communicating the right messages to patients**. Any staff using the materials should also be fully aware of the content and know what the patient is reading.

Because multiple learning styles and different levels of literacy and understanding exist within all cultures, it is important to **offer a variety of materials**. For example, while they may not be necessary or appropriate in all cases, visuals or pictograms can provide added benefit in communicating messages to patients.



Professional Education (Referencing CLAS Standard 3)

Providing culturally competent care goes beyond simply addressing language barriers. The first three CLAS standards provide guidelines for promoting culturally competent care, with the third standard specifically recommending that the staff receives training and education in culturally and linguistically appropriate service delivery.

Participants agreed that **education and training on providing culturally and linguistically appropriate services should be offered to staff members on an ongoing basis**. This could include general orientation, e-learning (webinars) or video education programs on how to better communicate with patients. For example, Transitions Optical offers an ABO-approved course for opticians on how to communicate and dispense to Hispanic patients, regardless of language or cultural barriers.

The **need to educate and raise cultural awareness among students** was also discussed. Participants stressed the importance of introducing cultural competency early on in the education process. Students should be exposed to the breadth of multicultural materials available throughout the educational curriculum so that they are more likely to use these materials in their own practice.

Increasing Diversity (Referencing CLAS Standard 2)

The second CLAS standard involves implementing strategies to recruit, retain and promote a culturally diverse staff and leadership. Tying in with this theme, participants expressed the **need for increased diversity among optical professionals**. For example, even though African Americans make up approximately 14 percent of the U.S. population, they comprise just 1.7 percent of optometrists.

Recruiting more minorities into the optical profession would be beneficial in helping to better meet the needs of specific populations. One roundtable participant referenced his experience working at the Inter-American University of Puerto Rico School of Optometry, saying that 80 percent of their students came from the U.S. mainlands with the intent of becoming bilingual practitioners. These students have become successful in their own practices – not only because they are culturally competent, but because they are fluent in Spanish as well.

What Optical Practices Can Do

Regardless of whether or not the CLAS standards are specifically used in practice, participants agreed that in order for culturally diverse patients to receive better eye care, the optical industry must become more "culturally aware." Some strategies for achieving cultural competency in practice are below.

1. **Know who your patients are**. Assess your patient base by determining what demographics you serve and identifying their specific needs.

2. **Be culturally sensitive**. Understand where your patients are coming from (culture, values, etc.) and avoid stereotyping patients based on perceptions. It is also important to recognize that ethnocentric background assumptions and stereotypes can be hard to overcome.

3. **Address language barriers**. Depending on your patient base, consider hiring a multilingual staff, using in-language point-of-sale and educational materials or employing a service of professional interpreters to be on-call via telephone.

4. **Offer translated versions of key materials or forms**.

5. **Provide regular cultural sensitivity training to your staff**. Reinforce that your practice's mission, or policy, is to provide the best eye care possible to all patients regardless of race or ethnicity – and provide your staff with the education and resources they need to do so.

6. **Make the effort**. Even if you do not speak the same language, your patients will appreciate your effort to better understand and meet their needs.

7. **Become involved**. Take on a leadership role within your practice by promoting cultural awareness among your staff, and encourage involvement during community fairs and local events.

8. **Remember that "it's not just a pair of eyes, it's a human being**." Treat all patients with respect and care, regardless of race or ethnicity, language spoken or age.

Additionally, participants emphasized the need for vision care to be a collaborative effort between the doctor and patient, in which there is an open line of communication during all steps of the exam. They also addressed the need to educate patients on how to be more proactive with their care. This is important because, in some cultures, the prevailing sentiment may be to not question the health professional, who is seen as an authority figure.

Conclusion

As the number of eyecare professionals experiencing a culturally-diverse patient base continues to increase, there remains an urgent need for education on how to provide culturally and linguistically appropriate vision care to these diverse groups. This roundtable was the first in what will hopefully be many steps forward in providing quality vision care to all patients, regardless of race or ethnicity.

While this education should start in the schools, it should also be incorporated into a practice's daily routine and reinforced to staff members through ongoing education and training. Because vision care is a collaborative effort between the eyecare professional and patient, the eyecare professional must encourage an open dialogue. Considering that eye- and overall- health are so closely connected, roundtable participants agreed that in order to provide the best overall care to patients, a greater line of communication needs to also exist between the general physician and eyecare professional.

Many elements of the CLAS standards can serve as a helpful guide for eyecare professionals to promote cultural competency within their own practices. Eyecare professionals can also leverage existing resources available from companies and organizations, such as staff training and education, or bilingual or in-language point-of-sale materials.

Finally, in order to better serve culturally diverse groups, it is important for eyecare professionals to recognize that there is a need to improve and tailor communication based on a patient's individual health needs, cultural values, language proficiency and educational background/level of understanding. While patients can be of any race or ethnicity, gender or age, it is important to remember that they are all people and should be treated with respect and compassion. By understanding the demographic make-up of their practice – and by becoming educated on the unique needs of specific groups – eyecare professionals can not only gain cultural competence, but can benefit from strong, lasting relationships with their patients.

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