AUDIOLOGY SERVICES IN DIVERSE COMMUNITIES

A Tool to Help Clinicians Working With Spanish-Speaking Patients and Families

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CONTENTS

PART II. LANGUAGE TOOL: CLINICAL ASSESSMENT AND COUNSELING MATERIALS IN ENGLISH AND SPANISH

FOREWORD

The field of Audiology emerged as a profession during the 1940s, in part, as a response to thousands of men and women returning from the various conflicts in World War II. Many of these returning veterans had developed noise-induced hearing loss and needed help. Although the care of hearing-impaired individuals preceded these events, it was the U.S. government's hearing rehabilitation programs that led to standardized procedures for aural rehabilitation and hearing aid fitting that set the stage for Audiology today. These days, Audiology is at the forefront of hearing health care. The entry level degree is the Doctorate of Audiology (AuD) and professionals who hold this degree are trained to assess and manage hearing and balance problems across the lifespan. Many aspiring Audiologists come from across the world to train in programs in the U.S. and many bring unique experiences from international efforts to address the hearing health care needs of children worldwide.

The advanced diagnostic techniques, rehabilitation strategies, hearing aid technologies, and cochlear implants have had an enormous impact on the lives of millions of people with hearing loss. However, there are still large gaps in both knowledge and access to high-quality hearing health care in both the U.S. and across the world. In the U.S., one area that has lagged significantly is in the test materials, procedures, and management of Spanish-speaking individuals. Population data, as recent as 2019, estimate that about 42 million people in the U.S. speak Spanish at home. An additional 11.6 million are bilingual (Spanish/English). Not surprisingly, Spanish is the most studied language in the U.S. outside of English. To put it in perspective, when monolingual and bilingual Spanish speakers are combined the U.S. has more Spanish speakers than Spain and more Spanish speakers than the entire population of Colombia. The statistics alone suggest that hearing health care management of this population is essential and needs to be prioritized. Untreated hearing loss in this population not only can degrade quality of life, but also has practical implications. In particular, children in our schools are both at a disadvantage at home and in school trying to manage two languages.

The first step to addressing this hearing health care need starts with Audiologists. There is a scarcity of bilingual Audiologists to begin to address this critical need and many Audiologists need additional training to work with the Spanish-speaking population and although language is a primary barrier, cultural barriers also exist. Latino and Hispanic individuals can be of any race, and come from many countries that have different customs. Spanish-speaking individuals also span the educational and socioeconomic spectrum. Being aware of the vast diversity within this population is essential in effective patient management. Moreover, the lack of well-normed test material, such as word recognition lists, presents direct practical challenges. None of these barriers are insurmountable, but the solution starts with individuals such as the ones reading this book, to begin to build true momentum to professional solutions aimed at improving access and care.

This book is aimed at providing that first step by providing tools and suggestions to make current care more effective and to lay the groundwork for the essential solutions of tomorrow. As a bilingual Audiologist myself, I share the hopeful view with the author that the future will hold better solutions to meet the needs of this population both here in the U.S. and abroad.

—Edward Lobarinas, PhD

PREFACE

Letter to Hearing Health Care Professionals

Dear Colleagues,

Whether you are taking a case history, instructing a patient on steps to perform a test, sharing or reviewing results, your efforts to communicate effectively with them will help that patient and their family understand their condition better. This, in turn, will help them comprehend and act on your recommendations. This book is designed to support those efforts.

Effective communication is a key element of culturally competent health services. Culturally competent services require constant development and training. As an audiologist working in the United States, I understand that hearing care providers do not always have access to professional interpreters despite best efforts, perhaps due to scheduling issues, appointment lengths, or clinic locations, among other reasons. This book aims to build on your knowledge, help you recognize barriers, and develop ideas to address those barriers, as well as provide you with a language tool to help you bridge communication barriers when working with Spanish-speaking patients and their families. It will be a helpful tool not only for audiologists but also for other members of the multidisciplinary team as well as interpreters working and supporting Spanish-speaking families through their hearing journey.

I hope this text becomes an easy-to-use resource in clinic or home visits and that it helps to decrease language barriers, even when working with interpreters, to improve patient-centered services, to create more culturally competent hearing services, and ultimately to increase patients' and families' understanding of the diagnosis and recommendations,

Thank you again for your interest in improving the care we provide to linguistic minority groups—in this case, Spanish-speaking families.

I hope you find this book helpful!

Warm regards,
Alejandra Ullauri, AuD, MPH
Bilingual Board-Certified Audiologist

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There are many people I would like to express gratitude to for their help in making the idea for this book become a reality.

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This book is dedicated to all the health care professionals around the country helping bring health services to minorities and their communities. I find your efforts and dedication to help close the health disparity gap inspiring. Your fieldwork, presentations, papers, and discussions have enlightened my understanding, and they have brought immense hope that together we can improve so many lives. Thank you for leading the path.

INTRODUCTION

As the population of the United States becomes more diverse, health care professionals have a responsibility to embrace this transformation to better serve patients and their families. Today in many cities throughout the United States, audiologists work in diverse communities helping patients who come from different cultural and linguistic backgrounds. Audiologists' role in the care of older adults is now more important than ever as the field pushes for a public health approach to address hearing loss and its links to cognitive decline. As the ethnogeriatric population grows, audiologists need to redesign their service delivery models to meet the needs of this vulnerable population. Literature shows that culturally competent health services are needed to address the needs of minority populations experiencing health and health care disparities. Cultural competence in health care is a journey that requires ongoing self-reflection, constant learning, adaptation, and transformation to meet the always changing needs of minority patients who do not share the culture and language of the majority.

In the following chapters, readers will gain knowledge, skills, and tools that will equip them to continue this journey we call cultural competence in health care. Providers should expect

- an overview of cultural competence and its barriers, with a focus on audiological services and the Hispanic/Latino population;
- an evidence-based, cross-cultural approach to address those barriers; and
- a language tool to aid clinicians communicating and working with Spanish-speaking patients.

The Latino/Hispanic population is too diverse to be covered as one group. Therefore, as we embark on this topic, the reader should know that the purpose of this book is to give hearing care providers a tool to better serve a segment of the Latino/Hispanic population—Latino/Hispanic patients and their families who are monolingual (Spanish is their main language), with limited English proficiency and who may also experience limited health literacy. These families are more likely to experience health care disparities due to immigration status, insurance coverage, and socioeconomic background. In Chapter 3, we discuss the diversity found within the Latino/Hispanic population. It is important that clinicians embrace diversity while avoiding stereotyping.

The largest portion of this book is committed to the language tool designed to aid clinicians. This tool describes diagnostic tests, details instructions to the patient when performing a specific test, and provides clinicians with patient-education materials. It presents the same information in English on the left and Spanish on the right. This format facilitates consistency when conveying a message to a patient/family through an interpreter (who might or might not be certified), decreases the chance of error or misinterpretation, and helps ensure that the information provided by the audiologist is the same information received by the patient. In the language tool, the reader will find

- a description in English and Spanish of a hearing test, hearing device, or anatomical part;
- test instructions for patients;
- tips for the tester when testing Spanish-speaking patients;
- standardized tests and questionnaires (validated in Spanish); and
- a quick guide to find the proper audiology term in Spanish.

This language tool is an aid for communication between an English-speaking clinician/provider and

a Spanish-speaking patient. This tool may assist clinicians when they have limited or no access to professional interpreting services. This tool, by no means, should replace professional interpreters.

As we start navigating cultural competence in health care, one needs to understand how diverse populations interact with the health care system, what influences those interactions, the barriers they might face, and the possible ways to address and decrease those barriers. To discuss this broad topic, it is crucial that the reader has a clear grasp on the terminology surrounding these issues from the start. In the following sections, key concepts are described.

Culture

Culture is a pattern of learned beliefs and behaviors. It explains how we view and value the world. Culture is part of all of us (Napier et al., 2014), and it is influenced by socioeconomic status, religion, sexual orientation, and occupation. Hyter and Salas-Provance (2018) describe it as the way one person or a group of people experience life and engage in daily practices. They refer to culture as something that we learn and transmit socially; something that is present in our problem-solving behaviors, values systems, beliefs, symbols, attitudes, religion, artifacts, and communication. One key factor to highlight is that culture is not tied to any race, ethnicity, nationality, or religious affiliation (United Nations Educational, Scientific and Cultural Organization, 2001). Ting-Toomey and Chung (2012) describe culture as an iceberg. The peak of the iceberg represents what we see: traditions, religious rituals, art, and symbols. The underwater portion of the iceberg that we cannot see represents beliefs, perceptions, attitudes, and value systems. Culture is learned and influenced by the world that surrounds us.

Cultural Competence

Cross and colleagues (1989) define cultural competence as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations" (p. 13). They refer to culture as an integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, and values. Culture is part of racial, ethnic, religious, or social groups. And "the word competence is used because it implies having the capacity to function effectively" (p. 13). Today, this definition continues to be widely accepted in health care. The National Center for Cultural Competence at Georgetown University Center for Child and Human Development (2003) defines culturally competent organizations as those that value diversity, conduct self-assessment, manage the dynamics of diversity, acquire and promote cultural knowledge, and adapt to the diversity and cultural contexts of the communities they serve. These factors allow them to work effectively across different cultures within their communities.

In the literature, readers will find terminology such as cultural sensitivity, cultural respect, and diversity management used interchangeably to describe cultural competence (McCalman et al., 2017).

Cultural Safety

Curtis and colleagues (2019) recommend the term cultural safety instead of cultural competence. In their view, (1) cultural safety "requires health care professionals and their associated health care organizations to examine themselves and the potential impact of their own culture on clinical interactions and health care service delivery" (p. 13). (2) Cultural safety is based on health care professionals and health care organizations acknowledging their own biases, attitudes, assumptions, stereotypes, and prejudices that may affect the quality of care they provide. This acknowledgment results in "critical consciousness," which leads to ongoing self-reflection and self-awareness, providing a door for accountability. (3) Cultural safety is about providing culturally safe care, and it aims to achieve health equity. Cultural safety requires stakeholders to make an impact and reduce bias within the workforce and work environment.

Readers will find the term cultural competence used throughout this book, as it is the term most often used in the literature. However, readers are encouraged to further discuss cultural safety as a better term to use in the context of health and health care disparities experienced by minority groups.

Cultural safety may better describe the impact of culture in accessing and receiving health services in a safe manner.

Limited English Proficiency

The Office for Civil Rights (2002) describes individuals with low English proficiency as "individuals who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English."

Latino Versus Hispanic

Federal agencies are required to report on two ethnicities—Hispanic or Latino and Not Hispanic or Latino—as mandated by the U.S. Office of Management and Budget (OMB): "OMB defines 'Hispanic or Latino' as a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race" (U.S. Census Bureau, 2020). However, nongovernment definitions make two distinctions between the two terms as used in the United States. The term Latino refers to people from Latin American ancestry and heritage who speak Spanish and Portuguese. The term Hispanic refers to people who speak Spanish, and have Spanish or Latin American heritage. In this book, we will use mostly the term Latino/Hispanic as defined by the U.S. Census Bureau.

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Chapter 5

CLINICAL HISTORY FOR PEDIATRIC AND ADULT CASES

The following clinical history forms aim to provide the clinician with a detailed overview of the patient's case from the start. Although the clinical history may seem long, it is designed to cover most questions in detail. The clinician has an exact version in English to understand the patient's Spanish version. The clinical history can be read by the patient or verbally presented by the interpreter.

Adult Clinical History

Patient Name: DOB: Date:

What is your main concern?	☐ Hearing loss ☐ Tinnitus ☐ Dizziness
How long have you had it?	☐ Less than 3 months ☐ 1 year ☐ 2–5 years ☐ More than 5 years ☐ Since birth or early childhood
Have you seen a primary care physician? Name:	☐ Yes, in the last 6 months ☐ I do not have one

Please respond with YES or NO Also tell me if it applies to BOTH ears or to only one	Yes/No	Both Ears	Right Ear	Left Ear
Do you have hearing difficulties?				
Has your hearing changed suddenly in the past 3 months?				
Do you have tinnitus or ringing in your ears?				
Do you have dizziness, balance issues?				
Do you have ear pain?				
Have you had ear surgery?				
Have you had an ear infection?				
Do you have discharge in your ears?				
Have you worn or do you wear hearing aids?				
Do you have a hearing implant?				

	Yes	No	If yes, please describe
If you have dizziness, Have you ever fallen? Is it triggered by changing positions? Does the room spin around? Does it last hours? Have you received treatment for it?			 How many times? Standing up, turning in bed, other?

continues on p. 88

Historia Clínica—Adultos

Nombre del paciente Fecha de nacimiento: Fecha:

¿Cuál es la razón principal de su visita?	☐ Pérdida de la audición ☐ Acúfeno o zumbido en los oídos ☐ Mareos o problemas de equilibrio
¿Cuánto tiempo ha tenido este problema?	☐ Menos de 3 meses ☐ 1 año ☐ Entre 2 y 5 años ☐ Más de 5 años ☐ Desde el nacimiento o desde la infancia
¿Ha visitado a su médico familiar? Nombre del médico:	☐ Si, en los últimos 6 meses ☐ No tengo médico familiar al momento

Por favor conteste estas preguntas con SI o NO Por favor también marque si la respuesta se refiere a ambos oídos, o solo a uno.	SI / NO	Ambos Oídos	Oído Derecho	Oído Izquierdo
¿Tiene dificultad al escuchar?				
¿Ha sufrido un deterioro brusco o repentino de la audición en los últimos 3 meses?				
¿Tiene acúfeno o zumbido en los oídos?				
¿Tiene problemas de equilibrio o mareos?				
¿Tiene dolor de oído?				
¿Ha tenido alguna una cirugía u operación de oído?				
¿Ha tenido alguna infección de oído?				
¿Tiene algún tipo de supuración en los oídos?				
¿Ha usado alguna vez audífonos o prótesis auditivas?				
¿Tiene algún tipo de implante de oído?				

	SI	NO	Por favor describa su respuesta
Si Ud. ha tenido mareos / pérdida de equilibrio ¿Alguna vez se ha caído? ¿Cree que los mareos se presentan cuando cambia de posición? ¿Le parece que la habitación gira a su alrededor? ¿El mareo dura horas? ¿Ha recibido algún tipo de tratamiento?			¿Cuándo fue el último mareo? ¿Cuántas veces? ¿Al pararse, o dares la vuelta en la cama?

continues on p. 89

continued from p. 86

	Yes	No	If yes, please describe
If you have tinnitus, Is it bothersome? Is it a constant noise? Is it a pulsatile noise?			
Do you know the cause of your hearing loss?			
Any family members with a hearing loss?			
Have you been exposed to loud noises?			Hunting/shooting Power tools Factory machinery Music
Have you hit your head in an accident or have you had a concussion?			
Do you have diabetes?			
Do you have heart disease?			
Do you have high blood pressure?			
Do you have neurological problems?			Depression Dementia Alzheimer's Parkinson's Stroke Other:
Do you have kidney disease?			
Have you had viral or bacterial infections?			Meningitis Mumps Measles HIV Syphilis Malaria Other:
Do you have arthritis?			
Have you been treated for cancer?			Type?
Have you had head or neck radiation therapy?			
Do you have vision problems?			
Do you take any medications?			Name and dose:

continued from p. 87

	SI	NO	Por favor describa su respuesta
¿Si tiene zumbido o acúfeno, este le molesta? ¿Es su acufeno un ruido constante? ¿O es un sonido pulsátil?			
¿Conoce la causa de su pérdida auditiva?			
¿Alguien en su familia tiene una pérdida de audición?			
¿Ha estado expuesto o expuesta a ruidos fuertes?			Disparos/casería Herramientas de trabajo Maquinaria de fabricación Música
¿Ha sufrido algún tipo de golpes a la cabeza?			
¿Tiene diabetes?			
¿Tiene problemas cardiacos?			
¿Tiene presión arterial alta?			
¿Tiene problemas neurológicos?			Depresión Demencia Alzheimer's Parkinson's Accidente cerebrovascular Otro:
¿Tiene algún problema o enfermedad renal?			
¿Ha tenido alguna infección bacteriana o viral?			Meningitis Paperas Sarampión VIH Sífilis Malaria Otra:
¿Tiene artritis?			
¿Ha recibido tratamiento para cáncer?			¿Tipo?
¿Ha recibido radiación en el área del cuello o la cabeza?			
¿Tiene problemas visuales?			
¿Toma medicamentos?			Por favor enliste sus medicamentos y las dosis: