WISCONSIN INSTITUTE FOR Citizenship & Civil Dialogue

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SUMMARY REPORT

DEVELOPING A HEALTH CARE CULTURAL BROKER PROGRAM
Insights from Hispanic/Latino and Hmong Communities in Central Wisconsin

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I would advise (health systems) to work with the Hmong and Hispanic communities to build a program or model that is actually helpful and that people will actually want to take advantage of. A cultural broker is not going to just be an interpreter, but a person to work on building trusting relationships between patients and the health care system.

The most important factor in developing a cultural broker program in northcentral Wisconsin is to gain the trust of members within the targeted communities. The cultural broker should be known in the community and be a trusted figure. Gaining trust is essential to establishing communication.

I hope that when this cultural broker model is in action, they are supported by the hospital and health care system. They will have a lot on their plate, and I hope that they have the necessary support and respect from their colleagues. They deserve to have a seat at the table when it comes to their patients and they deserve to offer ideas to make the program as successful as possible.

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SUMMARY OF KEY FINDINGS

In early 2025, the Wisconsin Institute for Public Policy and Service (WIPPS) Research Partners and the Medical College of Wisconsin – Central Wisconsin (MCW-CW) gathered information via one-on-one interviews with Hispanic/Latino and Hmong residents of Central Wisconsin about their experiences accessing and navigating area health care systems. Insights and feedback from these community members could help inform the development of a cultural broker program within a health care organization. Collaborators from the Hmong and Hispanic Communication Network (H2N), Healthy Opportunities for Latin Americans (HOLA), and Let's Talk-Marathon County provided expertise that was essential to including the voices of Hispanic/Latino and Hmong community members in this project. The project was funded with support from WIPPS and the Marshfield Clinic Health System, as well as with in-kind support from MCW-CW.

This report summarizes the key findings and highlights from 31 one-on-one interviews conducted with Hispanic/Latino and Hmong residents of Central Wisconsin. These individuals represent a range of perspectives based on different ages, family structures, employment situations, nationalities, and cultural backgrounds. A majority of the interviews (71%) were conducted in Spanish or Hmong. The interview feedback is supplemented with additional qualitative data gathered from two focus groups with 13 Hispanic/Latino and Hmong community health workers/health navigators and two deliberative dialogues with 15 Hispanic/Latino community members. In total, input from 59 individuals was collected and synthesized, resulting in a rich and extensive set of qualitative feedback that can help in the design of a cultural broker program that is responsive to the unique needs and challenges of Central Wisconsin's Hispanic/Latino and Hmong communities.

The structured interviews focused on several topics relevant to the development of a cultural broker program, including: (1) Barriers and challenges that Hispanic/Latino and Hmong residents face when accessing health care services in Central Wisconsin; (2) Communication and language barriers within health care settings, including feedback on interpretation services; (3) Cultural beliefs and practices that impact health care experiences; (4) Racial discrimination/bias in health care and how to build trust with Hispanic/Latino and Hmong communities; and (5) Key factors to consider when developing a cultural broker model. Highlights are summarized below and in Tables 1 and 2. An expanded discussion of these topics is included in subsequent sections of this report.[1]

- **Hispanic/Latino and Hmong residents reported that they face many unique barriers and challenges when accessing health care and when navigating health systems in Central Wisconsin. There was strong support for the development of a cultural broker program to address these barriers.** Feedback on key components to consider when developing a cultural broker program included:
  - Help patients overcome access to care barriers, improve health literacy, and assist them with navigating care within complex and often confusing health systems.
  - Address communication and language barriers and improve access to fluent, medically competent, high-quality, and cultrually-sensitive interpretation services, especially in-person interpretation.
  - Support patients' cultural beliefs and help them overcome cultrual barriers in health care systems; bridge gaps in providers' understanding of patients' cultural expectations and preferences.
  - Have a strong external community presence and establish a high level of community trust.

[1]A separate document includes the interview, discussion, and issue guides and notes from the focus groups and deliberative dialogues. See *Supplemental Appendices – Developing a Cultural Broker Program – Insights from Hispanic/Latino and Hmong Communities in Central Wisconsin*. The notes from the focus groups and deliberative dialogues provide additional detail on the topics summarized in this report. Readers are encouraged to refer to those notes for added perspectives from community health workers and health navigators, as well as from the Hispanic/Latino Let's Talk, Marathon County panelists who participated in the Spanish language deliberative dialogues.

- **Cultural brokers can help patients overcome barriers to accessing medical care. Language and cultural barriers, as well as costs and financial considerations, including a lack of affordable health insurance and fear of medical bills, were among the most significant barriers that Hispanic/Latino and Hmong community members indentified when asked about barriers to accessing health care.** Language barriers, including challenges accessing in-person interpretation, make it difficult for many Hispanic/Latino and Hmong community members to navigate health systems. Challenges include filling out forms for financial assistance and insurance, health histories and intake forms, and with scheduling appointments. These issues can cause some to avoid seeking care. These challenges are exacerbated by low health care literacy, limited understanding of health care systems, and limited awareness of resources. Many Hispanic/Latino participants also noted that their immigration status, including fear of deportation, made them reluctant to seek care or fill out forms. Other barriers cited include long wait times for appointments; lack of transportation; and difficulty taking time off work to assist family members with transportation and interpretationn needs.

- **Cultrual brokers can help patients address communication and language barriers that contribute to individuals avoiding health care systems. Language barriers may have negative impacts on the quality of health care and can create difficulties for patients in communicating medical concerns and in understanding treatment options. Participants noted that the accessibility and quality of interpretation can be improved across all areas of health systems, especially in-person interpretation.** Some expressed concerns about the fluency and familiarity with medical terminology of interpreters. Others prefer to have a family member act as their interpreter, but expressed concerns about their medical knowledge. Alternative interpretation methods such as telephone, iPad, or translation apps were generally viewed negatively. Some indicated that computer-based translation apps (like Google Tarnslate) should be avoided due to issues with grammar and sentence structures. Participants also noted examples of where medical terminology is not easily translated between languages.

- **Cultural brokers can help patients obtain culturally-sensitive care and can help resolve conflicts between patients' cultural beliefs, providers' expectations, and health care systems' policies.** Examples of areas where a cultural broker can help bridge cultural divides include: navigating cultural expectations regarding gender roles and family structures (ex. "machismo," patriarchal/patrilineal families, large family supports); cultural preferences for a provider of the same gender (ex. the concept of "modesty" in Hispanic/Latino cultures); diet/food, especially for Hmong women after child birth or gifts of food in Hispanic/Latino culture; and respect for alternative medicine practices, including preferences for using natural or herbal remedies before seeking care. A cultrual broker can help educate staff and providers to improve cultural awarenress, including the importance of religious/spirirual beliefs (ex. Hmong shamanism and healing rituals and Catholic faith practices for Hispanic/Latinos). Many echoed the need for culturally-sensitive, fluent, and competent interpreters in all areas of health care systems, including the need for awareness of regional or country-specific differences in terminology

- **Trust was identified as one of the most important components of a successful cultural program. Cultrual brokers can help increase Hispanic/Latino and Hmong community members' trust in their health care systems. Having an external community focus and building partnerships between the health system and the communities they serve provides a foundation of trust.** In addition to a strong community presence, health systems can earn trust by providing cultural training to staff on the history of the populations they are treating and by encouraging providers to attend community cultural and social events. Small gestures like greeting patients with a few words or phrases in their preferred language or by taking an interest in their patients' culture can have large impacts on building trust.

Table 1 – Interview Participants' Feedback on Factors Relevant to Developing a Cultural Broker Program
Overcome Barriers, Improve Health Literacy, and Navigate Health Systems **(see Table 2, Topic 1)**
▫ Help patients understand and navigate the financial aspects of their care, including insurance, coverage, costs, and billing; simplify the financial assistance application and process** ▫ Increase patients' understanding of the structure of U.S. health systems and what to expect during the health care experience (ex. reasons why certain tests may be ordered, procedures recommended, or medications prescribed) ▫ Help patients navigate within the health care system and resolve issues in order to improve the quality of care ▫ Improve cooperation between components of health care systems and streamline policies to facilitate better access to care (ex. simplify applications for financial assistance, intake forms, smooth referrals to specialists) ▫ Helping patients understand their rights, including access to interpreters, when to seek a second opinion, the right to disagree with a treatment recommendation, or to request a better explanation about their medical situation ▫ Follow up with patients after their appointments to ensure they understand their conditions and treatments ▫ Improve cooperation between the health system and others already working in the community to help Hispanic/Latino and Hmong residents access health care (community health workers and navigators)*
Address Communication/Language Barriers and Improve Interpretation Services **(see Table 2, Topic 2)**
▫ Provide education and training in cultural awareness for health system staff and providers at all levels ▫ Have strong communication/interpretation skills, including language fluency and medical terminology expertise ▫ Help patients access interpretation services and reduce administrative barriers to interpretation services** ▫ Use a wide variety of communication tools and resources to connect with patients in their preferred language** ▫ Help navigate situations between preferring a family member as an interpreter and health system policies ▫ Advocate for the patient when communication, language, or cultural barriers arise. Negotiate for a patient based upon their broader knowledge of the patient's situation. Explain practices and procedures that are confusing* ▫ Provide care with kindness, empathy, and with an emphasis on serving others
Support Cultural Beliefs and Practices and Overcome Cultural Barriers **(see Table 2, Topic 3)**
▫ Have a deep understanding of cultural norms, backgrounds, and lifestyles of Hispanic/Latino and Hmong patients (ex. the presence of large families during hospital stays, diet preferences, shamanism, rituals, etc.) ▫ Be adept at country-specific variations in cultural practices, language, and vocabulary (ex. awareness of regional cultural and language differences within Mexico or differences in Spanish across countries) ▫ Be a resource for the provider and the patient and help to resolve issues related to cultural gaps in understanding medical care** ▫ Bridge generational and familial differences within Hispanic/Latino and Hmong communities and health systems ▫ Help patients mediate between preferences for alternative medicine practices and traditional medical approaches ▫ Help health care systems be more sensitive to how religious beliefs and faith practices impact care expectations ▫ Increase awareness of the importance of preventive care, establishing a relationship with a provider, and the importance of seeking care before symptoms become severe*
Have a Strong External Presence and Build Community Trust **(see Table 2, Topic 4)**
▫ Establish trust and respect within the broader community and with patients as individuals ▫ Help address underlying distrust of Western medicine when it conflicts with the traditional medical practices and preferences for herbal medicine among Hispanic/Latino and Hmong cultures (esp. with Hmong elders) ▫ Ensure that the cultural broker service is free and accessible to community members; generate awareness ▫ Foster collaboration and partnerships between the health system and local community groups and organizations that are successful in improving health outcomes for patient populations (ex. H2N, HOLA, Wausau Free Clinic)* ▫ Collaborate with community-based efforts to provide medical care such as screenings and vaccine clinics in community and employer-based settings (ex. pop-cup clinics, diabetes screenings, vaccine clinics at farms)*

This feedback was based on interviews in February/March 2025 with 31 Hispanic/Latino and Hmong residents of Central Wisconsin. *This point was specifically identified by H2N focus group participants as being important to the development of a cultural broker program. See Appendix B in *Supplemental Appendices – Developing a Cultural Broker Program – Insights from Hispanic/Latino and Hmong Communities in Central Wisconsin* for summaries of the focus groups. **Feedback from participants in the Let's Talk, Marathon County deliberative dialogues with Hispanic/Latino residents of Marathon County also indicated strong support for this point. See Appendix C of the *Supplemental Appendices* report for notes summarizing the deliberative dialogues.

Table 2 - Summary of Key Themes from Interviews by Topic Area*
Topic 1 – *Barriers to Accessing and Navigating Medical Care for Hispanic/Latino and Hmong Residents*
▫ Costs and financial considerations, including lack of health insurance and the inability to afford insurance ▫ Difficulty filling out forms for insurance and financial assistance, and fear of medical bills due to language barriers ▫ Immigration status, including fear of deportation (concern expressed by Hispanic/Latino interview participants) ▫ Communication and language barriers, including challenges accessing in-person interpretation services ▫ Difficulty filling out paperwork, understanding mail from health care providers, and scheduling appointments ▫ Low health care literacy, limited understanding of health care systems, and limited awareness of resources ▫ Limited understanding or respect by health systems of cultural beliefs and traditions, which creates trust issues ▫ Long wait times for appointments and the ability to schedule timely appointments ▫ Lack of transportation; Hispanic/Latino participants further noted a fear of driving due a fear of police interactions ▫ Difficulty taking time off work to assist family members with transportation or interpretation needs
Topic 2 – *Communication and Language Barriers and Feedback on Interpretation Services*
▫ Language barriers can lead individuals to avoid care and can have negatives impacts on the quality of health care ▫ Language barriers create difficulties in communicating medical concerns and understanding treatment options ▫ Patients may lack understanding of their rights, including how to request an interpreter ▫ Having access to interpreters is important, but the accessibility and quality of interpretation can be improved ▫ Participants strongly prefer in-person interpreters and they are needed across more areas within health systems ▫ Some expressed concerns about the fluency and familiarity with medical terminology of interpreters ▫ Some patients have strong preferences for a male or female interpreter, especially for sensitive topics ▫ Some prefer to family members as an interpreter; others expressed concerns about lack of medical knowledge ▫ Alternative interpretation methods such as telephone, iPad, or translation apps. were generally viewed negatively ▫ Translated materials should be done by an actual person, not a computer (or Google Translate)
Topic 3 – *Difficulties Navigating Health Care Due to Cultural Beliefs and Practices*
▫ Conflicts between patients' cultural beliefs and providers' expectations ▫ Gender roles and family structures (ex. "machismo," patriarchal/patrilineal families, large family supports) ▫ Cultural preferences for a provider of the same gender; concept of "modesty" in Hispanic/Latino cultures ▫ Importance of diet/food, especially for Hmong women after child birth or gifts of food in Hispanic/Latino culture ▫ Respect for alternative medicine practices; natural or herbal remedies are preferred before seeking care ▫ Lack of preventive care; some avoid seeking care until serious symptoms arise (especially Hmong patients) ▫ Religious beliefs (ex. Hmong shamanism and healing rituals and Catholic faith practices for Hispanic/Latinos) ▫ Need for culturally-sensitive, fluent, and competent interpreters in all areas of health care systems ▫ Need for more training and cultural awareness for staff and providers ▫ Cultural reverence for physicians may lead some to not ask questions or feel as if they are a burden to the doctor
Topic 4 – *Feedback on How to Build Trust in Hispanic/Latino and Hmong Communities*
▫ Increase diversity of providers and staff; retain providers in order for patients to establish relationships ▫ Provide cultural training to staff on the history of the populations they are treating ▫ Encourage providers to attend community cultural and social events to gain a deeper cultural understanding ▫ Learn basic phrases and greetings and ask simple questions that may reveal some of the patient's culture ▫ Address language barriers and offer quality, in-person interpretation services ▫ Provide information, flyers, and other materials in multiple languages ▫ Improve communication, answer questions, and ensure patients understand their situations ▫ Treat patients with kindness and respect, even if there are cultural or language differences; spend adequate time ▫ Help patients navigate insurance, financial, and billing concerns, and the health care system more generally ▫ Address quality of care issues when they arise so as to avoid situations of mistrust

*These key themes were based on interviews in February/March 2025 with 31 Hispanic/Latino and Hmong residents of Central Wisconsin. Each topic is discussed in more detail in subsequent sections of this report. The themes that emerged from the interviews are also consistent with feedback from focus groups conducted with 13 H2N Hispanic/Latino and Hmong community health workers. See Appendix B in *Supplemental Appendices – Developing a Cultural Broker Program – Insights from Hispanic/Latino and Hmong Communities in Central Wisconsin* for summaries of the focus groups.

BACKGROUND AND OVERVIEW

A cultural broker in health care is a person who helps patients and their families navigate the health care system by bridging cultural gaps and language barriers. A cultural broker can help build trust between patients and providers; support patients in navigating the health care system; work within the health care systems to provide care and services that are mindful of a patient's cultural background and language; and educate staff and providers about the need for and importance of culturally appropriate care.

To inform the development of cultural broker programs within health care organizations, in early 2025, the Wisconsin Institute for Public Policy and Service (WIPPS) Research Partners and the Medical College of Wisconsin – Central Wisconsin (MCW-CW) gathered information via one-on-one interviews with Hispanic/Latino and Hmong residents of Central Wisconsin about their experiences accessing and navigating area health care systems. Collaborators from the Hmong and Hispanic Communication Network (H2N), Healthy Opportunities for Latin Americans (HOLA), and Let's Talk-Marathon County provided expertise that was essential to including the voices of Hispanic/Latino and Hmong community members in this project. The project was funded with support from WIPPS and the Marshfield Clinic Health System, as well as with in-kind support from MCW-CW.

The structured interviews focused on several topics relevant to the development of a cultural broker program, including: (1) Barriers and challenges that Hispanic/Latino and Hmong residents face when accessing health care services in Central Wisconsin; (2) Communication and language barriers within health care settings, including feedback on interpretation services; (3) Cultural beliefs and practices that impact health care experiences; (4) Racial discrimination/bias in health care and how to build trust with Hispanic/Latino and Hmong communities; and (5) Key factors to consider when developing a cultural broker model.

The original concept of cultural brokers and individuals serving as negotiators or navigators between two different factions has its roots in ancient cultures.[2] In the 1960s cultural brokering in health care settings started to gain traction to help bridge relationships between members of racially, ethnically and/or linguistically diverse communities, social service systems and health care providers. The role of a cultural broker is to serve as a bridge or intermediary between patients of different cultures and assist these patients as they navigate the complex landscape of health care systems and community resources[3]. While implementation of cultural brokers in health care in Wisconsin is limited, experiences of other health systems (such as M. Health Fairview in Minnesota) point to the importance of program components such as building trust within the community; support in navigating the health system; support in addressing social drivers of health; and working within the system to provide culturally and linguistically appropriate services to support better health outcomes.[4]

[2] https://nccc.georgetown.edu/culturalbroker/2_role/index.html

[3] See Jezewski, M. A. (1995). Evolution of a grounded theory: Conflict resolution through culture brokering. Advances in Nursing Science, 17(3), 14–30.

[4] See M. Health Fairview (2023, January 5). *Celebrating five years and counting of the M Health Fairview cultural brokers program — and improved access to care and resources for our neighbors.* Retrieved from: https://www.mhealthfairview.org/blog/cultural-brokers-program-celebrates-fifth-anniversary and https://www.minnpost.com/race-health-equity/2022/11/explaining-the-cultural-broker-role-and-how-they-are-helping-advance-health-equity-in-minnesota/?gad=1&gclid=EAIaIQobChMIiqOV_d3A_wIVcRWtBh0QpgyoEAAYAyAAEgJpOfD_BwE

OVERVIEW OF THE INTERVIEW METHODS

This project primarily used key informant interview methods to gather insights directly from Hispanic/Latino and Hmong community members about their personal experiences with health care in Central Wisconsin. During the interviews, participants were also encouraged to share insights about the experiences of family members. The interviews focused on several topics including: (1) Barriers and challenges that they or their family members have faced when accessing health care services in Central Wisconsin; (2) Communication and language barriers within health care settings, including feedback on interpretation services; (3) Cultural beliefs and practices that impact experiences with health care systems; (4) Racial discrimination/bias in health care and how to build trust in health care systems among Hispanic/Latino and Hmong communities; and (5) Feedback and suggestions on key factors to consider when developing a cultural broker model.

An interview guide was developed in order to structure the interviews. See Appendix A in the *Supplemental Appendices – Developing a Cultural Broker Program – Insights from Hispanic/Latino and Hmong Communities in Central Wisconsin* for the interview guide. By talking one-on-one with Hispanic/Latino and Hmong community members, we hoped to gather feedback that would be helpful to area health care systems and organizations seeking to improve health outcomes for patients through a cultural broker program.

Interviews were conducted by community health workers (CHWs) from the H2N Hispanic/Latino and Hmong teams, representatives of HOLA, and a medical student with the Medical College of Wisconsin. Targeted recruitment methods were used to identify interview participants. For example, the H2N community health workers have built relationships with many Hispanic/Latino and Hmong community members and they were able to reach out to these individuals to discuss their interest in participating in the project. Or they may have encountered a community member at an H2N event who they thought could offer an interesting perspective. The goal was a quality, in-depth interview, not just meeting a specific quota. The H2N community health workers and other interviewees were trusted to identify appropriate interview candidates. Interview participants were given a $50 gift card as a token of appreciation for their time.

CHWs looked for opportunities to complete interviews with community members from across the Central Wisconsin area and who may receive care from a variety of area health care organizations. We wanted to be sure to capture a range of experiences and perspectives, including those who may get care from area free clinics, as well as from local health systems.

The time, format, and location of the interview was selected at the discretion of the interviewer and the participant based on what was most convenient. Of the 31 interviews that were conducted, 13 were done in person, 13 were done using Zoom, three were done by telephone, and two were submitted in written format using the interview guide. All but two of the 14 interviews with Hispanic/Latino participants were conducted in Spanish[5]. Ten (10) of the 17 interviews with Hmong community members were conducted in English; seven were conducted in Hmong or "Hmong-lish."

Each interview was scheduled for 60 minutes in order to ensure adequate time to fully discuss all of the questions. The interviews were recorded on whatever device the interviewer preferred (telephone, laptop, Zoom). The participants were informed in advance that they would be recorded and offered consent. They were reassured that their participation would anonymous and comments and feedback would not be attributed to them by name in the summary reports.

[5] One (1) of the Spanish language interviews was conducted in a combination of Spanish and Portuguese.

After the interviews were completed, comprehensive notes were compiled in English. These notes were captured in an interview template which was then shared with the WIPPS analyst who was responsible for summarizing and synthesizing the qualitative responses. Responses were organized by topic area. Quotes and comments were compiled in order illustrate key themes and experiences.

When considering interview methods it is important to remember that interview methods are not intended to yield results or insights that are generalizable to a larger population (in this case, the population of Hispanic/Latino or Hmong residents of Central Wisconsin). Rather, interviews can be used to better understand the reasons underlying individual's perspectives or the range of perspectives on a given topic, or to provide insights about how a situation is perceived and experienced. The information shared in this report reflects the insights, feedback, and experiences of the participants with whom we spoke and should not be assumed to be representative of the views of all Hispanic/Latino and Hmong community members in Central Wisconsin.

Given the nature of the topics discussed and differences in individual experiences, there may be different voices and multiple views that need to be presented. Our goal in writing this report was to represent the range of views expressed by those who participated in the discussions. With the exception of specifying when a comment was made by "one participant," this interview report does not report the exact frequency or quantity with which comments or opinions were expressed.[6] The use of specific numeric references in an interview report can sometimes lead readers to inadvertently think about responses in terms of percentages (X percent of people think this; Y percent think that), which can then lead to false generalizations. Those kinds of characterizations are better suited for a methodology where a larger number of individuals are sampled, such as a survey.

For readability, convenience, and to improve the flow of the narrative, we sometimes use terminology such as "Interview participants reported…," or "Interview participants said…." These are shorthand references to the individuals who participated in the interviews and should not be interpreted as reflective of the views of all community members. Lastly, we may use terminology to convey the pervasiveness of a theme such as "many" or "most"; "some" or "several"; or "a few." How these characterizations are applied is largely at the discretion of the analyst/observer based on their review of responses across interviews. To minimize some of the inherent subjectivity, the characterizations of comments were reviewed by all of the individuals who conducted interviews as part of this project during an internal review phase. This additional review served as a "check" on the balance and completeness of the summary and to ensure that the report accurately reflected the discussions. Paraphrased quotes are included in order to illustrate the participants' responses. These have been edited for readability, but the respondent's intention is reflected in the comment.

The Medical College of Wisconsin – Central Wisconsin's Human Research Protections Program (MCW HRPP) reviewed the project protocols and interview procedures. From the provided information, the MWC HRPP determined that project met the criteria of an internal institutional quality improvement project and not human subjects' research.[7]

[6] One additional exception to this practice is included in the section of the report that asks about whether the participant had experienced racial discrimination. Notes typically indicated a "yes" or "no" answer when describing participants' experiences. We felt more comfortable counting responses and reporting percentages in this specific case.

[7] The project's MCW HRPP identification number is PRO00054306. Dr. Corina Norrbom and Anthony Lewis submitted the application for review.

INTERVIEW PARTICIPANT CHARACTERISTICS

As stated previously, we wanted to ensure that interviews were conducted with a broad group of participants reflecting a mix of gender and age distributions. Interview participants were also selected to be from separate households and families. As shown in Table 3, a total of 31 interviews were conducted and of these, 14 were with Hispanic/Latino community members and 17 were with Hmong community members.[8] Of the 14 Hispanic/Latino participants, six were male and eight were female. Eight (8) of the 14 Hispanic/Latino participants were in the 18 to 40 years old age range and three were in the 41 to 55 and 55 and older age ranges, respectively. Of the 17 Hmong participants, six were male and 11 were female. Ten (10) of the Hmong participants were in the 18 to 40 years old range; three were in the 41 to 55 years old range; and four were 55 or older. It was important to include a broad range of ages, especially since older populations (like Hmong elders) may face specific health care challenges that are different from a working-age population or from those with young children.

Table 3 - Number of Interviews by Participant Race/Ethnicity, Age, and Gender

	Hispanic/Latino			Hmong		
Age	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**
18-40	3	5	8	4	6	10
41-55	2	1	3	0	3	3
55+	1	2	3	2	2	4
Total	**6**	**8**	**14**	**6**	**11**	**17**

Table 4 illustrates that the Hispanic/Latino interview participants were from a range of countries and reflected different nationalities, including Brazil, Guatemala, Ecuador, El Salvador, and Mexico, with most (n=8) having familial and cultural ties to Mexico.

Table 4 - Countries Represented by Hispanic/Latino Interview Participants

	Mexico	Brazil	Guatemala	Ecuador	El Salvador	Total
Total	8	2	2	1	1	14

Table 5 reports the age and gender totals with all interviews combined. Of the 31 total interviews, 12 participants were male and 19 were female. The majority (n=18) were individuals in the 18 to 40 years old age range. Six (6) were in the 41 to 55 years old range and seven were above the age of 55.

Table 5 - Number of Interviews by Age and Gender – All Interviews Combined

Age	Male	Female	Total
18-40	7	11	18
41-55	2	4	6
55+	3	4	7
Total	**12**	**19**	**31**

One of the goals was to ensure that interview participants reflected a broad range of health care experiences from different area health care systems; in different emergency, outpatient, and inpatient clinical settings; and in a wide range of geographic locations. In other words, we did not want to capture only the experiences of those receiving care from one specific health system. Interview participants' comments indicated that they or

[8] Two (2) of the 31 interviews with Hmong community members were based on written, self-reported information that was submitted for the various questions in the interview guide.

their family had received care from a range of providers across Central Wisconsin, including Aspirus, Bridge Community Health Clinic, Family Health Center, Marshfield Clinic Health System, and the Wausau Free Clinic. Geographic experiences spanned the Marshfield, Stevens Point, Wausau, and Wisconsin Rapids communities, among others. Participants insurance status ranged from some having no coverage, to others receiving Medicare, Medicaid, and Badger Care. Some had private and/or employer-based insurance; some were self-pay.

ADDITIONAL QUALITATIVE INSIGHTS FROM FOCUS GROUPS AND DELIBERATIVE DIALOGUES

The information included in this report is supplemented and reinforced by additional insights gained from focus groups with H2N Hispanic/Latino and Hmong community health workers, as well as from deliberative dialogues conducted with Hispanic/Latino participants in the Let's Talk, Marathon County project. In addition to the interviews (n=31), including the focus group participants (n=13) and Let's Talk dialogue participants (n=15) allowed a total of 59 individuals to contribute and insights and feedback to this project.

The two one-hour focus groups were held in December 2024, prior to the conducting the one-on-one interviews. WIPPS held the focus group discussions with community health workers and navigators on the H2N Hispanic/Latino and Hmong teams. Eight (8) individuals participated in the H2N Hispanic/Latino team focus group and five participated in the Hmong team focus group. These focus groups were held virtually. A member of the WIPPS research team facilitated the discussion and summarized the feedback based on notes taken by a WIPPS intern and a Medical College of Wisconsin medical student observer. See Appendix B in *Supplemental Appendices – Developing a Cultural Broker Program – Insights from Hispanic/Latino and Hmong Communities in Central Wisconsin* for summaries of these focus groups.

These focus groups provided an important opportunity to learn more about the topics that would be covered in the interviews from the perspectives of those who work every day with members of the Hispanic/Latino and Hmong communities. The H2N team members have considerable familiarity with the challenges that Hispanic/Latino and Hmong community members face when accessing health care in Central Wisconsin. Given their experiences, this represented an opportunity to add further qualitative insight into the topic of developing a cultural broker program. Also, it allowed us to be sure that the community member interview guide would be focused on the right questions. It was reassuring that the themes and experiences of the 31 individuals that were interviewed were consistent with the themes that emerged from focus groups. In addition, focus group participants offered several unique insights based on their professional experiences that were not necessarily captured in the one-on-one interviews. These unique insights have been added to this report.

The Let's Talk, Marathon County deliberative dialogues offered yet another opportunity to include a third set of qualitative data from Hispanic/Latino residents of Marathon County. In December 2024, WIPPS conducted two in-person Spanish language dialogues on the topic of *How Do We Achieve a Healthy Community for All?* The dialogues were held in Wausau at the UW Stevens Point at Wausau campus. A total of 15 Hispanic/Latino individuals participated. All had limited English language proficiency and therefore the dialogues were conducted in Spanish by trained moderators. Moderator and observer notes taken during the Spanish language sessions were translated into English and were provided to the project team for inclusion in this report. The feedback from the Spanish language Let's Talk dialogues suggests that there was considerable support for many action items that could be fundamental components of a cultural broker program, including the need for assistance with navigating health care systems (including the financial aspects of health care); help with language barriers that impede access to quality care; increasing health literacy by connecting community members with information and resources in languages they understand; and helping to bridge cultural gaps between patients of different backgrounds and their health care providers. Appendix C of the *Supplemental Appendices* report includes summaries of the two Spanish language dialogues.

ORGANIZATION OF THE REPORT

The main focus of this report is to provide insights that are relevant to development of a cultural broker program. In the narrative sections that follow, we first summarize key findings and themes from the perspective of the interview participants that are relevant specifically to the development a cultural broker program. Participant feedback on developing a cultural broker program is organized into four main component areas:

- *Overcome Barriers, Improve Health Literacy, and Navigate Health Systems*
- *Address Communication/Language Barriers and Improve Interpretation Services*
- *Support Cultural Beliefs and Practices and Overcome Cultural Barriers*
- *Have a Strong External Presence and Build Community Trust*

Each of these cultural broker program component areas is subsequently addressed in more detail in specific topical sections. The topical sections include:

- *Topic 1 – Barriers to Accessing and Navigating Medical Care for Hispanic/Latino and Hmong Residents*
- *Topic 2 – Communication and Language Barriers and Feedback on Interpretation Services*
- *Topic 3 – Difficulties Navigating Health Care Due to Cultural Beliefs and Practices*
- *Topic 4 – Feedback on How to Build Trust in Hispanic/Latino and Hmong Communities*

Table 6 illustrates which topic-specific sections correspond to the cultural broker program component areas.

Table 6 – Organization of the Report by Topic Area

Cultural Broker Program Component Area*	Topical Discussion Area
Overcome Barriers, Improve Health Literacy, and Navigate Health Systems	Topic 1 – *Barriers to Accessing and Navigating Medical Care for Hispanic/Latino and Hmong Residents*
Address Communication/Language Barriers and Improve Interpretation Services	Topic 2 – *Communication and Language Barriers and Feedback on Interpretation Services*
Support Cultural Beliefs and Practices and Overcome Cultural Barriers	Topic 3 – *Difficulties Navigating Health Care Due to Cultural Beliefs and Practices*
Have a Strong External Presence and Build Community Trust	Topic 4 – *Feedback on How to Build Trust in Hispanic/Latino and Hmong Communities*

*Table 1 in the Summary of Key Findings provides a high-level overview of points related to each the cultural broker program component areas. Table 2 in Summary of Key Findings provides a high-level overview of themes in each topic area. Readers looking for a quick overview can refer back to these tables. Readers wanting more detailed explanations and supporting quotes can refer to the sections that follow in this report.

In each section of this report we include detailed quotes from the participants in order to share the unique voices of those who shared comments. Their quotes and comments were selected to illustrate the range of participants' experiences. Participants are not mentioned by name.

For the sake of brevity, a separate document was prepared with appendices with interview, discussion, and issue guides and notes from the focus groups and deliberative dialogues. See *Supplemental Appendices – Developing a Cultural Broker Program – Insights from Hispanic/Latino and Hmong Communities in Central Wisconsin*. The notes from the focus groups and deliberative dialogues provide additional detail on the topics summarized in this report and readers are encouraged to refer to those notes for added perspectives.

DEVELOPING A CULTURAL BROKER PROGRAM

Hispanic/Latino and Hmong community members were asked to provide feedback on the most important factors that, from their perspective, a health system should consider when developing a cultural broker program. This section illustrates the themes that emerged from the interview participants' responses.[9]

OVERCOME BARRIERS, IMPROVE HEALTH LITERACY, AND NAVIGATE HEALTH SYSTEMS

A cultural broker should play a key role in helping patients understand and navigate the financial aspects of their care, including costs, billing, and insurance. Multiple participants expressed the need for health care systems to have bilingual staff that are culturally sensitive, patient, and willing to explain to customers about health insurance options, including what is covered under the plans they have. From their perspective, the cultural broker needs to assist patients in applying for financial assistance, if needed, and they should have an understanding of what programs are available for patients who do not have insurance. In addition, they should help explain what the costs will be for those without insurance. One participant noted that, "It would be a great idea if there was someone who could explain how the hospital works, what the options are to get payment plans and know the charges up front." Another participant would like someone to explain to her what she and her family have access to and what they do not have access to due to their immigration status (in reference to insurance and payment options). Having financial and insurance information in Spanish would be appreciated.

Proactively help patients understand the structure of U.S. health care systems and what to expect during their health care experience. Help patients navigate the health care system and work to resolve issues in order to improve the quality of care. For example, have the cultural broker go to medical appointments and explain everything in simple language, including patient's rights. "This can help the patient understand everything and not just a few things." One participant would like a bilingual cultural broker to help her navigate the medical system and explain what she does not understand. She emphasizes that they need to be available when she needs them, for scheduling appointments, to help her in case of an emergency, or when she needs to get in contact with someone at the hospital. Another participant mentioned that he would also like a cultural broker to guide him through the health care system. One participant stated, "Have a Hmong person who works in these different departments reach out to Hmong patients to explain appointments and treatment versus just being told what to do by a doctor. This will help patients understand their illness and understand why the doctor is telling them to take certain steps. This will also help mitigate misinformation.**"**

Improve cooperation between components of health care systems and streamline policies to facilitate better access to care. [10] This includes simplifying applications for financial assistance, intake forms, and ensuring smooth referrals to specialists.

Help patients understand their rights. This would include helping patients understand their right to access an interpreter, to seek a second opinion, to consent to procedures or to disagree with a treatment recommendation, or to request a better explanation of their medical situation.

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[9] The themes that emerged from the interviews are consistent with feedback from focus groups conducted in December 2024 with 13 H2N Hispanic/Latino and Hmong community health workers. See Appendix B in *Supplemental Appendices – Developing a Cultural Broker Program – Insights from Hispanic/Latino and Hmong Communities in Central Wisconsin* for summaries of the focus group participants' feedback.

[10] In addition to themes consistent with the other points made here, H2N community health workers who participated in the focus group discussions noted that the cultural broker can help improve and foster cooperation between community health workers and health navigators who are already working with Hispanic/Latino or Hmong populations and area health systems.

Follow up with patients after their appointment to ensure that they understood their appointments. Ask patients if they were satisfied with their appointment. A cultural broker could help find solutions for problems or listen to patients' opinions and struggles. One participant suggested that, "A cultural broker should call patients and talk to them about their appointments. They can possibly help schedule three-way calls with a doctor or a nurse so that patients can get their questions answered and so that they can fully understand their health. Having this communication and clear instruction will help the patient feel more comfortable and trust their treatment plans. Hmong people can be reserved, so it can take a lot for them to share that they are feeling certain symptoms or are sick with something. A cultural broker could help them open up more."

ADDRESS LANGUAGE BARRIERS AND IMPROVE INTERPRETATION SERVICES

Provide education and cultural training to staff and providers at all levels on the history, cultural beliefs, and practices of the populations they are treating. A cultural broker can help providers have a deeper understanding of Hispanic/Latino and Hmong culture which in turn, can help providers better connect with their patients.

Have strong communication skills, fluency in language and interpretation, and strong familiarity with medical terminology. Help patients access interpretation services and reduce barriers to interpretation services. One participant noted, "Language is one of the fundamental factors to consider in a cultural broker program." Participants expressed a strong desire for "in-person" medical interpreters for patients to feel safe during the medical appointment**.** It is especially important that the interpreter speaks the language of the patient, not something similar. For example, "There is a difference in Spanish from Spain and Spanish from Latin America." Hmong staff need to be fluent in English and Hmong, not just have basic knowledge. The cultural broker "must be good a communicating, explaining and have a good command of the subject and know how to guide people according to their needs." In addition, a cultural broker must be bilingual and trained in medical terms, "not only the ones used in the U.S., but also culturally relevant terms too." Participants envisioned that a cultural broker could help with multiple things, beyond "just being an interpreter." They could be a resource to bridge the cultural gaps, provide information, and answer questions that often are not answered during a regular appointment.[11] As one participant noted, "This person should be sensitive to those that they work with, sensitive to families and individuals, and their cultures."

Use a wide variety of communication tools and resources to connect with patient populations in languages that patients can understand. Information should be inclusive and should be translated into different languages. Participants suggested that resources can also include classes to teach interpreting skills in order to increase the availability of interpreters. Several mentioned the importance of having a dedicated phone line for reaching the cultural broker and having a helpline that has people who are available to answer questions, provide information on different illnesses or prevalent diseases, etc. One participant suggested using social media platforms to connect with Hispanic/Latino communities, with messages in Spanish. Other suggestions included: videos about how health care works can be helpful to learn more about the services available to patients; health care clinics should participate in more community events; use community resources and organizations like HOLA to help Hispanics/Latinos learn more about topics like immigration rights; share

[11]In addition to themes consistent with the other points made here, H2N community health workers who participated in the focus group discussions noted that it is important for the cultural broker to advocate for the patient when communication, language, or cultural barriers arise and negotiate for a patient based upon their broader knowledge of the patient's situation. The cultural broker can explain practices and procedures that are confusing. This point is related to the cultural broker having an expanded role beyond interpretation. Per the focus group participants, interpreters are ethically limited to translating exactly what the doctor and patient are saying. Cultural brokers should be allowed to interpret and providing additional information from the patient's perspective.

information on the Spanish language podcast; and it would be useful to have flyers or informational booklets translated into Spanish explaining the services provided, costs, a guide with medical terminology in Spanish and English. One participant mentioned the need for more brochures that say things like "Attention! please read this!" and "have the 20 most important things an immigrant needs to know when they come to the U.S. for the first time. Provide this in Latino stores and bus stations should be great. One of those 20 things mentioned on the pamphlet should be about health insurance and how clinics and hospitals work here."

Provide care with kindness, empathy, and with an emphasis on serving others. A cultural broker should have strong communication skills and interact with kindness and patience. According to one participant, "One of the main characteristics of a cultural broker is service. The first gift of service is the ability to engage with people." Others emphasized the need to be empathetic and to listen to patients' problems as they help them navigate through the system.

SUPPORT CULTURAL BELIEFS AND PRACTICES AND OVERCOME CULTURAL BARRIERS

Have a deep understanding of cultural norms and how cultural backgrounds and lifestyles impact patients' expectations about their health care, including awareness of country-specific variations in cultural practices, traditions, vocabulary, language, etc. Several participants noted the importance of understanding that there are significant differences in culture based upon nationality. For example, Mexican culture is different from Columbian culture and even within Mexico, there are regional cultural differences. Cultural brokers need to trained in country-specific cultural practices and country-specific vocabulary. Ideally, a cultural broker should be from the community that they are serving so that they are intimately familiar with both the language and the cultural traditions of that population. One participant noted, "cultural brokers need to be open-minded and try to understand each person as an individual as well as a part of a specific community." She also thinks that cultural brokers should be trained not only in interpretation, but how to communicate with different cultures.

Be a resource to both the doctor and the patient to bridge and resolve cultural gaps in understanding medical care. For example, if the doctor has questions or concerns, or they do not seem to understand why the patient refuses to go through certain treatments, the cultural broker could help explain and mediate the patient's perspective. On the other hand, the cultural broker could also help the patient trust the doctor and the procedures. Several participants mentioned this idea of having a dedicated unit, service, or hotline for patients from different cultural backgrounds to access. One described this as follows: "I think having a specific unit where you can call and ask questions would be really helpful. This unit could answer financial questions, treatment questions, but also give different options to patients. This unit could also be a lending ear where they listen to patient concerns and reassure them that the health care system and providers are doing their best to help."

Bridge generational and familial differences within Hispanic/Latino and Hmong communities and health systems. Several participants noted that there are differences between first generation Hispanics/Latinos who were born in a different country and those who were born in the U.S. Being aware of all these generational differences "is important to ensuring they receive the highest quality health care possible." Within the Hmong community, it was noted that elder Hmong community "is not good at taking their medication." This is because "their mindset is that taking medication would cure a disease, whereas when the doctor prescribed medication it may be to control the illness and make the patient manage day-to-day. But the doctor does not necessarily communicate that medication is to control the illness and instead they say that 'taking the medication will make you better.' So when patients take the medication and their illness is not resolved, they are more likely to not take it. This may be even more magnified if they hear other community members tell them that taking medications leads to kidney failures and dialysis." A cultural broker can help providers understand these nuances.

Understand the important role that alternative medicine may play in how a Hispanic/Latino or Hmong patient experiences their health care. The cultural broker can help patients mediate between alternative medicine practices and traditional medical approaches. For example**,** many Hispanic/Latino and Hmong patients want to use herbal medicines as complimentary to advice from their doctor. For example, if a patient has a dry throat and a doctor recommends drinking water, the Hmong patient knows an herbal tea could dampen ("noo") the dry throat. One participant who recently had surgery found that one specific doctor was more culturally sensitive to her needs. This doctor thought about how warm water is something that Hmong people often request and believe in. The doctor also told nurses to give the participant a Southeast Asian diet. She was comforting, and this stood out because other providers had not shown this knowledge or care for cultural needs. Some Hispanic/Latino and Hmong community members may prefer to try herbal remedies before seeking care. A cultural broker can help educate providers about these cultural preferences and practices.

Help health care systems and providers be more sensitive to how religious beliefs and faith practices impact patients' health care expectations. For example, participants expressed that a cultural broker should understand the traditional health care system and the Hmong faith so they can help resolve any issues between these two perspectives. Many Hmong use cultural practices such as "ua neeb" (traditional shaman ceremonies), herbal medicines, and have diet preferences. Multiple participants felt that hospitals should allow shamanistic rituals to be performed in their facilities for patients that believe in traditional healing methods. From their perspective, this would be considered similar to some of the rites of the Catholic church which are currently permitted in hospitals. One participant stated that "health systems should recognize the Hmong religion." Others emphasized identifying key figures within the Hmong community to serve as points of contact for cultural brokers. For example, the shaman is an important figure in the Hmong community and has significant influence among members of that community who believe in shamanistic healing. A shaman could be useful in facilitating communication between the medical system and Hmong patients. Hispanic/Latino patients may also rely heavily on their faith when dealing with stress or anxiety related to their care.

HAVE A STRONG EXTERNAL PRESENCE AND BUILD COMMUNITY TRUST

Establish trust and respect within the broader community[12], as well as with individual patients. One participant stated, "The most important factor in developing a cultural broker program in northcentral Wisconsin is to gain the trust of members within the targeted communities. The cultural broker should be known in the community and be a trusted figure. Gaining trust is essential to establishing communication." Many interview participant reinforced that "it is imperative that the cultural broker be present in the community and participate in community events." One participant mentioned his fear of being deported if he goes to a clinic. He expressed that cultural brokers should be someone they can trust and ask questions about how to be safe when going for an appointment. Another shared that the cultural broker should be "deeply engrained" in the Hmong community and should be able to connect with both the young and older generation of Hmong people. "They should be understanding of where both come from because they are so different, and they should be a trustworthy and knowledgeable individual." Any cultural broker program should maintain good communication with members of the community that it is targeting and encourage feedback from both patients and community leaders to ensure that the program is being effective in meeting its objectives. One participant stated that it is important that the services of the cultural broker are free. "If it is not free, people will not accept this service."

[12] In addition to themes consistent with the other points made here, H2N community health workers who participated in the focus group discussions also stressed the importance of having a cultural broker who can foster collaboration and partnerships between the health system and local community groups and organizations that are successful in improving health outcomes for patient populations (ex. H2N, HOLA, Wausau Free Clinic). In addition, they recommended that the cultural broker could help the health system collaborate with community-based efforts to provide medical care such as screenings and vaccine clinics in community and employer-based settings (ex. pop-cup clinics, diabetes screenings, vaccine clinics at farms).

ILLUSTRATIVE COMMENTS

You need to understand the regions from Mexico to understand our culture.

It is important for the doctor to know that it is a very common thing for us Mexicans to give food to someone for which we are grateful, I know and understand that the doctors have no obligation to receive it, but for us it means a lot, is a way in which we express our gratitude and it would be good for doctors to understand where we are coming from. I take tamales to my doctor, and he is from India, and I know that is hard for him to understand why we are doing this.

I understand that doctors here have not studied homeopathy or didn't get homemade medicinal recipes from their grandmas, but they have to make an effort to understand our cultural practices.

Cultural training program for doctors and nurses to go through and learn about our traditions and ways of life...diversifying food choices would be beneficial.

Some patients are hesitant to take drugs because of cultural differences and traditions. They believe in using herbal medicines, so there is sometimes a clash with traditional medicines when they go to see their doctor.

The provider's interested in my parent's culture and personal life help to build a connection with them even though they do not share the same culture and language.

The older Hmong generation still practices Shamanism and a lot of traditional medicine. It is a clash between eastern and western medicine.

As people we each belong to different race and follow different religion. If we are a certain people then we will follow that religion. I'd like the health system to recognize the Hmong religion.

Things that stuck out would be understanding my background or our Hmong culture and our beliefs and values. And just wanting the doctors and nurses to be sensitive to our needs and to our beliefs.

My parents believe in alternative medicine, but they will not tell the doctor when asked if they are using any medications at home. Hmong patients see their doctor as an authority figure and feel like they are wasting his time if they ask questions.

The overall Hmong community is afraid of going to the hospital. The youth understand the process, but elders do not. It would be good to give an overview of the appointment and what to expect at the appointment. For example, explain if lab is possible in the appointment, x-rays, shots, or other things are going to be involved. The health care team is familiar with the process, but the patients are not. They may go in thinking it's just an examination, but it turns into other things. These types of experiences scare the patient and make them not want to return or see a doctor. The overview of what to expect in the hospital would ease the anxiety.

The direct phone line (to access the cultural broker) is important because I need help and don't know how to navigate the automated messages. And if I can't reach a person and schedule an appointment with my family doctor, then I have no choice but to go to the walk-in clinic. And the walk-in clinics providers are temporary and not permanent providers that follow my health. Lastly, when there isn't a Hmong staff to assist us with paperwork, this can be stressful.

It would be nice to have Hmong people work in those fields and have someone reach out to patients and ask if they understood their appointments or their visits.

It means being a service-oriented person, being willing to explain things because we do not know much about how the health care systems works in this country. (She gave the example of having an insurance card for her child but not knowing what it is for and what is covered under that plan.)

They need to be committed to helping the Hispanic community with their needs, from making appointments to teaching us things that we need to know about the health care system.

Cultural brokers should be empathetic and trained in mental health problems.

Well, it should be a very friendly person when it comes to answering all your questions, a person, as I said, able to explain everything that is needed or what a person has to take with them when they go to the doctor, what you have to do, what you don't have to do.

The cultural broker has to become a trusted figure in the community in order for this to work.

When I see another Latino, we can instantly know what each other has been through. There is no need to explain who we are or what we believe in. That is why a cultural broker needs to be of that culture.

I would recommend that they find someone who is deeply engrained in the Hmong society, and the Hmong culture that knows a lot about it. And that has ties to both the youth and the elders. Finding the right person that everybody in the community can trust...someone that would know a lot about and be able to communicate with both the elders and understand where the youth are coming from too. That's going to be important. Because the youth are so different from the elders. You know, because we grew up in different environments, got exposed to different things. And someone who just wants to, to see the, you know, like our Hmong population and society grow and flourish.

The most important factors in my opinion are to choose a qualified, caring individual to be a cultural broker. This person needs to be strong-minded and willing to listen to patient concerns and needs. They need to not only be able to advocate for the patient, but also the doctor. If a patient refuses treatment, a cultural broker could help build that trust with the patient to get a procedure done. They can compromise with the patient and help the patient feel in control of their health. I would advise (health care organizations) to work with the Hmong and Hispanic communities to build a program or model that is actually helpful and that people will actually want to take advantage of. A cultural broker is not going to just be an interpreter, but a person to work on building trustful relationships between Hmong patients and the health care system. I also think the cultural broker should also have follow-up calls or appointments with patients. This can help ensure that the patient is feeling supported and it also allows them to ask questions and share concerns with someone directly connected to the hospital. With all of these in mind, I also hope that when this cultural broker model is in action, they are supported by the hospital/health care system. They will have a lot on their plate, and I hope that they have the necessary support and respect from their colleagues. They deserve to have a seat at the table when it comes to their patients and they deserve to offer ideas to make the program as successful as possible.

TOPIC 1 – BARRIERS TO ACCESSING MEDICAL CARE

Interview participants were asked to think generally about their experiences with health care in the Central Wisconsin area and to share feedback on the most significant challenges or problems that they or their family members have faced when seeking medical care. By understanding the barriers faced by Hispanic/Latino and Hmong community members, a cultural broker program can be responsive to the specific needs of these populations.

COST AND FINANCIAL BARRIERS

Costs and financial considerations, including lack of health insurance, the inability to afford insurance and understand coverage, difficulty filling out forms for insurance or financial assistance, and fear of medical bills were among the most prevalent barriers that Hispanic/Latino and Hmong community members cited when asked about challenges they faced when accessing medical care in Central Wisconsin.[13] Not having health insurance and not being able to afford health insurance and medical care in general was a top concern of many of the interview participants. One participant noted that he "struggles to pay for services." He would like to be able to have some sort of medical insurance and is not opposed to paying for it, but he has been told it is not a possibility with his immigration status. He has had to make payment plans many times to pay for medical bills, sometimes taking him up to a year to pay the sum back. Some access the Wausau Free Clinic or other free clinics for some kinds of care; in one case, the cost of insurance was too high so they stopped paying for health insurance and decided to use the Wausau Free Clinic instead.

Some interview participants avoid seeking medical care due to fear of the medical bill. Uncertainty about the costs of care can deter some who may need health care services from seeking care. One participant expressed that she avoids going to the doctor when she feels sick and she self-medicates because she is worried about possible medical bills. A participant mentioned that he has not been feeling well lately and he is thinking about going back to the Bridge Clinic, but the uncertainty and not knowing what to expect in terms of costs keeps him from making an appointment. Another participant noted that he always worries about how he is going to pay for care. Yet another participant stated, "My parents would go to the doctors, see the bills, go through many labs and appointments, and not feel or see any improvements in their health. Therefore, they just rely on herbal medicines and prefer not to waste time or money going to see the doctor."

[13] Participants in the Hispanic/Latino community health worker focus group had very specific feedback about the financial assistance process. In addition to language barriers, there may be opportunities to improve this process. For example, Hispanic/Latino families often cannot provide the documentation required for financial assistance, such as a paystub documenting employment or a bank account. Some employers do not want to provide the forms needed to apply for financial aid. Thus, the financial aid application will be incomplete and cannot be processed. Patients who do not file taxes are given additional forms to submit which they do not understand and cannot complete. Failure to submit these additional forms also causes applications to be rejected. Other concerns relate to identify verification. For example, many Hispanic/Latino immigrants may be working under a different name which does not match the name on their identification card. This makes them ineligible for financial assistance. Readers of this report may wish to refer to the notes for the Hispanic/Latino focus groups for more insights on these concerns. See Appendix B in *Supplemental Appendices – Developing a Cultural Broker Program – Insights from Hispanic/Latino and Hmong Communities in Central Wisconsin* for a summary of the Hispanic/Latino community health worker focus groups. In addition, Hispanic/Latino participants in the Let's Talk, Marathon County deliberative dialogues on the topic of *How Do We Achieve a Healthy Community for All?* also strongly supported the need for assistance with navigating health care systems, including the financial aspects of health care. See Appendix C of the *Supplemental Appendices* report referenced above.

While some seek care at free clinics, costs can be a barrier to seeking follow-up or specialty care. One example was given by an individual who received initial care at the Bridge Clinic, but was then referred to a specialist for additional care. He was able to apply for financial assistance that helped cover the initial exam, but once he was referred to the specialist, he needed to pay out-of-pocket because he lacked insurance. He went for the exam and realized that it was impossible for him to pay for the treatment when he was told that the cost of the treatment was $4,000 and he needed to pay $2,000 up front. The clinic did not offer a payment plan. He also mentioned that if they would have offered him a four- or six-month payment plan, he could have afforded to get treated.

Some participants avoid taking prescribed medications due to cost concerns. For example, one participant noted that some of the medications she has been prescribed were not covered by insurance and she was not able to afford them. This resulted in not taking or stopping taking the medications that she needed due to costs.

Fear and anxiety were expressed by several participants when discussing financial aspects of health care. One participant noted that members of her family only seek medical care when absolutely necessary because of the fear of expensive medical bills. She would encounter situations where individuals would say, "How much is this going to cost?" or "I cannot afford that today" or "Can I hold off on doing that?". The anxiety surrounding the costs of medical care contributed to delaying or failing to pursue recommended treatment.

IMMIGRATION STATUS

Immigration status is a significant concern expressed by members of Hispanic/Latino communities. Fear causes many to delay or avoid seeking medical care since they are unsure if interacting with a health care system might make them vulnerable to deportation. Some Hispanic/Latino patients are hesitant to seek medical care because of immigration status. They are frequently reluctant to sign standard medical forms for this reason, even though the forms are designed only to obtain medically relevant information and do not inquire about immigration status. Fear of deportation can be a significant impediment to seeking medical treatment for members of the Hispanic/Latino community, even for those who have immigrated to this country legally. This can result in these patients only seeking care when it is absolutely necessary because of a dire medical condition. One participant noted that he is afraid of using his real name at clinics. He understands that if he does not, they cannot create a medical record, but he is afraid that they are going to share the information with immigration.

COMMUNICATION AND LANGUAGE BARRIERS

Communication and language barriers, including limited English proficiency, were noted as among the most significant barriers that Hispanic/Latino and Hmong community face when accessing medical care in Central Wisconsin. Language barriers can discourage individuals from seeking needed care and can make navigating the health care process more difficult. Interpreting services may not always accurately reflect the patient's concerns, leading to quality-of-care concerns and increasing distrust of medical providers. Many participants expressed that they or their family members were reluctant to call and schedule medical appointments because they lacked confidence in being able to communicate; others may not understand how to navigate the automated telephone prompts in English. Another participant's parents do not speak fluent English. She observed them avoiding or deferring medical treatment because of the language barrier. They were reluctant to seek care for minor problems and preferred to deal with a condition as best they could, hoping that it would eventually resolve itself.

Participants described instances of having difficulty filling out paperwork or receiving mail from the health care provider. One participant noted that he always has to find someone bilingual to help him with paperwork and sometimes people are not available. He mentioned an occasion where he needed to fill out a financial application form and had to wait for an hour for help. Another noted difficulty filling out the initial patient intake papers. "The demographic form is easy to complete but the health history for myself and my family is hard to read since it's in English. We don't have Hmong terminologies because we never encounter anyone with this disease. For example, cancer has so many types and I'm not familiar with the types. It's very difficult without interpreting assistance. I've only completed this form with the assistance of an interpreter."

Language barriers may result in incomplete histories or misunderstandings about the problem. One participant observed that physicians may fail to obtain a full and accurate history from the patient when there are language barriers. Others noted problems with interpreting services which discourages them from seeking care. For example, even when there are interpreters present to help, sometimes they do not possess the appropriate clinical/medical vocabulary and knowledge. One participant believes that it is very important to have qualified interpreters and that they have appropriate training support. Another participant commented that "the medical interpreter that was serving at the time of the appointment probably did not interpret correctly or in a way to keep me calm on the process. There was an occasion when the doctor needed to alert the interpreter that she was not interpreting correctly." Several Hmong interview participants noted that a lot of medical terminology cannot be translated to Hmong, so this causes issues when interpretation is needed.

LOW HEALTH LITERACY

A lack of health care literacy (and literacy in general), as well as limited awareness of available health care and community resources, are barriers to accessing medical care. Lack of understanding of how the health care system works in the U.S. is a barrier to accessing health care. One participant noted, "What I need is an assistance program to help illiterate people like me. The people who have never been to school before. In the past I always needed an interpreter and have been in person. In-person interpreting was replaced with iPad interpreting. Another participant noted, "There have been instances where the diagnosis is confusing to me. For example, there was a time when I felt fine but a doctor has referred me to get a lab, x-ray, or mammogram done. I don't have a problem following a doctor's referral after getting an annual physical examination, but I don't fully believe the doctor and the referrals."[14]

CULTRUAL BARRIERS

Cultural beliefs, practices, and traditions (including gender roles, family hierarchy, etc.) can negatively affect access to health care. One participant stated that she often observes a "cultural disconnect" between Hispanic/Latino patients and the health care providers. She wants medical providers to be more understanding of a patient's background, beliefs, or medical values and to be sensitive to these cultural aspects. She noted that an important cultural belief affecting Hispanic/Latino women is the concept of "modesty." The participant described a situation involving a woman who needed an emergency C-section. The woman did not speak English. She was wheeled into the operating room and the staff pulled up her gown, exposing the lower half of her body. They began to prep her with disinfectant solution because of the need for a sterile field. The woman was

[14] Let's Talk, Marathon County dialogue participants strongly supported expanding programs that assist Hispanic/Latino community members with navigating health care systems, including financial aspects of medical care, and for increasing awareness of health navigation and other health-related resources in Hispanic/Latino churches, schools, grocery stores, etc. Participants in one of the dialogues reinforced the importance of having access to an individual that speaks their language and can help them understand how the health care system works. From their perspective, the Hispanic/Latino community needs more education on how to access information and navigate the system, including more information about what resources are available and how to access them.

extremely embarrassed to be exposed in in this way front of numerous strangers. In addition to these kinds of situations, providers need to be aware of patriarchal dynamics within the family and how it influences medical treatment. Other cultural practices related to diet, alternative and herbal medicines, and religious/spiritual beliefs are other challenges to how Hispanic/Latino and Hmong community members experience their health care.

SCHEDULING CHALLENGES AND WAIT TIMES

Wait times for appointments and the ability to schedule timely appointments were noted as areas of concern by many interview participants. One participant noted that "the wait time is really stressful and is a barrier. It can take weeks to months to schedule appointments and is inconvenient." Another commented that she would have to "book (appointments fort her children) about six months ahead of time, which is a long time for an appointment." Being able to schedule appointments at times that are needed is a concern.

TRANSPORTATION

Lack of transportation to providers is significant barrier to accessing medical care for Hispanic/Latino and Hmong community members. Transportation is an especially "critical issue" for many Hispanics/Latinos. Some do not have cars and face extreme cold when getting around. In addition, past experiences with the police create fear and mistrust. As a result, many avoid driving even if they are able to do it. One participant noted, "Regarding transportation, it's sometimes a problem if you don't have a car, or you don't drive because you don't have a license and you're afraid of getting stopped by the police and getting ticketed." It can be a challenge to rely on friends or family members to take them to medical appointments. Another participant mentioned that he does not feel comfortable driving to medical appointments during the winter, especially not having a driver's license or resident status. Now more than ever, he fears having an accident and being questioned by the police. This sentiment was echoed by another participant who noted that neither he or his wife has a driver's license due to their immigration status. He is afraid of driving to the hospital and being stopped by the police. He said that he would like a free transportation service to medical appointments. Many Hmong elders rely on family members to take them to appointments. One noted, "The biggest barrier is I don't know how to drive. I wait for my husband or my children. I also wait for my relatives. It takes a lot of me calling around. Sometimes I can't find a ride and I miss my appointments too."

ECONOMIC AND FAMILY CONSIDERATIONS

Personal, work, and family considerations, including difficulties taking time off work or the inability find child care present challenges. Sometimes it is hard for participants to get to an appointment because of work situations. Several interview participants noted that undocumented people fear going to the doctor because they fear losing their jobs. Another participant mentioned that it is hard to find someone who can take care of her children if she or her husband needs medical care and the other is working. Whenever she needs to go to an appointment, she has to take time off from work and it takes away from her PTO and vacation hours. This can be stressful because if there are a series of appointments, she has to take off multiple hours.

ILLUSTRATIVE COMMENTS

Right now I don't make enough money to cover a medical or dental appointment, so I have to think twice before going to the doctor.

When I feel sick, I just try to take a pill and that's it. (Regarding not having medical insurance and the cost of going to the doctor)

Costs and billing can be very unexpected, especially when there are labs, referrals, and medication. It is stressful not knowing what can be charged or what the bill will look like even when just following doctor instructions.

The cost of medical care is one of the reasons patients avoid going to the doctor. They try to avoid medical bills because they cannot afford it. They tend to pick and choose what kind of care they can get, so that causes delay of care.

I know that we have health insurance, but also understand and know cases of undocumented people that live here and I know that the cost of health care is super expensive for them, you have to think that most workers average wage is $700 dollars a week and when you go to the doctor, the minimum is $3,000 dollars, with this income is very difficult for families to go to the doctor

Language is the biggest barrier to obtaining health care in the Hispanic community. Everyone feels most comfortable communication in their native language. It is sometimes difficult to properly express your thoughts and ideas in another language. Even when you can speak a second language, it is challenging to express exactly what you are feeling and experiencing. This can make it more difficult for the provider to obtain a good history and physical from the patient.

The first is the language barrier. It's stressful when I don't speak the language of the provider. I get interpreter services on the iPad. Some of my appointments have been rescheduled because an interpreter is not available.

Communication barriers are hard. First is that I can't communicate. Second, I can't understand them, and they can't understand me. This is an issue because we're not on the same page.

When you go to a clinic or hospital and no one speaks Spanish, it's very difficult to go and make an appointment because we don't speak the language and the little we do, most of the time we feel like we're saying the words wrong or we don't know the medical word to explain what's happening to us. So we decide not to go.

There was a recent case where I finally got through to a Hmong staff, but they said they weren't the staff that provides the services. This is very discouraging to people like me. It makes me think how useless it is to have the Hmong staff as an option to speak to when they don't provide the services. It's disappointing and doesn't work for the elders like me.

It's not a major issue, but the clinic sends inaccurate translated notifications that are done with Google Translate instead of using a real person to translate it.

When it's an automated message, I can't get through. Sometimes when I do get through accidently and to a random voicemail, I do leave a message but no one returns my calls. I will only try to make calls two to three times only. After that I gave up. Then if I don't feel well, I don't have a choice but to go to the walk-in or emergency room. When I do get into an emergency I then could request for an interpreter and get the right help.

Language barriers, especially medical terms, are the most difficult. They're difficult to comprehend because there isn't always the equivalent Hmong word for it. If the interpreter isn't good and doesn't understand/use Hmong grammar at interpreting then it leads to confusion. Sometimes interpreters are too literal in their interpretation that the translations are inappropriate/vulgar.

Language barriers can lead to misunderstanding. A friend of mine whose grandpa doesn't know English was misinterpreted. Because he couldn't communicate that he wasn't comfortable with the things the care team is doing, he pushed them away and was labeled as an aggressive and abusive patient.

My husband always needs an interpreter. It's either myself or my children who are present at the appointment. His issue is that he can communicate with others, but if you're not familiar with his mannerism you would misinterpret him. He also is hard of hearing and will continue a conversation as if he understands it but he really doesn't. This is why even if there is an interpreter available, one of the family members has to be present to ensure accuracy.

*Interpreter at the appointment is not an issue. The issue is setting up an appointment. There was a situation where I couldn't answer the phone and a voicemail was left. However, when I returned the call, I can't understand the English message because it's instructed whether to press # * or three and I don't know which to press to make an appointment. I also have this issue communicating with my child's school too. I have missed important things because of this.*

I haven't encountered a situation where I didn't go see a doctor for an illness. However, two to three weeks ago I went to the emergency room for my ear pain. I waited from 9 am - 1 pm. I had already done the intake and interview. There was 1 more patient before me, but after I checked in, there were more patients. But the wait was so long that I finally gave up and left without receiving services. I left because it was close to the time my child was getting out of school, plus I had an appointment to evaluate the ear pain the next day so I just bore with the pain. When I informed them that I needed to leave, the receptionist said I had to sign a form which I did.

People are afraid to enroll in programs because they are afraid to been deported.

A lot of us are scared to go anywhere near a health system because we don't know if someone's going to ask for papers or report us.

All us people are the same, we should be treated equally to those who have papers.

I wish there was some method for transportation. I'm afraid of the police stopping me or my wife and being sent to jail and even deported.

You don't want to drive your car because you're afraid of the police and the ticket you get for driving without a license.

Not many Hmong elders can drive so their check-ups are limited to when family members are available. This impacts their quality of care and when they get a concern checked.

The elders in the family need interpreting that is reliable and accurate. This should also be available and communicated beforehand. As a young professional, it's hard for me to take time off to accompany a family member to their appointments.

If you work in a factory and you're undocumented, you're not going to go to the doctor, because if you ask for permission to leave, you're going to look bad, so people prefer not to go.

TOPIC 2 – COMMUNICATION AND LANGUAGE BARRIERS

As noted in the previous section, communication and language issued were noted as barriers to accessing medical care for Hispanic/Latino and Hmong community members. The interviews allowed participants to share more details and specifics about how communication and language barriers impact their ability to get the care that they or a family member need. We summarize key themes related to communication and language barriers below.

IMPACT OF COMMUNICATION AND LANGUAGE BARRIERS

Communication challenges and language barriers are significant issues for many Hispanic/Latino and Hmong community members. These challenges make it difficult to make appointments, to explain medical concerns to providers, and to understand medical conditions and treatment options. Participants noted that it is difficult to communicate with doctors, dentists, or others who work in the medical field, and it is also difficult to understand what providers are explaining if they do not speak the language. During communication, patients lose important messages about care due to a lack of understanding of options. One participated noted, "It is hard to make an appointment when you don't know the language and it's even harder to explain your symptoms because of a lack of familiarity with medical terminology and you get very nervous when they ask you questions." Another participant gave an example of where not knowing the language became a problem. When his son was born, they were in the hospital and needed to order food. The nurse only knew English and explained everything to him in English without asking for an interpreter or offering a different solution to their situation. He explained that they ended up not ordering anything to eat and that wait to be discharged to eat.

Language barriers can lead some to avoid seeking care. For some, language barriers prevent them from seeking care in the first place or from following recommended treatments, as they may be unable to ask clarifying questions. One participant's parents know that interpreters are available to assist them at medical appointments. However, they are reluctant to seek medical care because of the bureaucratic obstacles involved in arranging to have an interpreter, such as the numerous steps required, being placed on hold for long periods of time, etc. Another participant noted that elders are frustrated by difficulties in dealing with their primary care provider's office. If a medical issue arises, they prefer to wait until their next scheduled appointment, rather than try to communicate with the office staff regarding a new concern. Difficulties in dealing with the current interpreter system discourage older Hmong patients who are not fluent in English from seeking medical care.

Language barriers can impact the quality of health care that was received. Several participants described times where there were misunderstandings and in general, confusion between them and their doctors due to language barriers. This has caused one participant to avoid getting treatment because she is unsure about what she needed to do, what the problem is, how important or big the problem is, and more. Another participant described that he had a negative experience due to miscommunication when taking his daughter to the doctor, which nearly led to an adverse health outcome. He explained that due to incorrect interpreting they almost performed a surgery on her daughter that she did not need.

Having access to interpreters is important for patients who do not speak English. One participant grew up in a rural area with a small Hispanic population. Her mother and father did not speak fluent English. She remembers that her father was hesitant to seek medical care because communication difficulties when dealing with the medical system. When they did receive treatment, her parents would often complain about the medical care they received, saying that the doctor did not understand them or that he "didn't know what he's talking about." She believes that these negative attitudes regarding the provider were primarily due to problems involving the language barrier.

The quality and accessibility of interpretation services can be improved. Participants expressed concerns that sometimes interpreters are not available or the interpreters are not qualified. One participant has experienced interpreters that do not know the Hmong language as well or are not as fluent. They would sometimes use "Hmonglish" or speak a mixture of Hmong and English, and this can cause a lot of confusion. Communication is also sometimes difficult because of fundamental differences between English and Hmong. For example, there are no specific words in Hmong for "bacteria" and "virus." These concepts are grouped together and expressed with one word. This can make it difficult to explain medical diagnoses and treatments to non-English speaking Hmong patients. This primarily a problem for the older generation of Hmong, as the younger generation is generally fluent in English and is educated in basic biological concepts. Several Hispanic/Latino participants expressed similar concerns about challenges interpreting medical terminology between English and Spanish.

ILLUSTRATIVE COMMENTS

Not knowing the language has an impact on the health care received. It is stressful to not understand and to rely on an interpreter.

The language barrier can be an issue when filling out medical forms.

Communication is a struggle because if you can't explain things, it's hard to say where it's hurting and it's hard to explain things accurately.

Due to language barriers, he (referring to her husband) does not like to go to the doctors. Sometimes, he can feel that doctors dismiss him, or they speak in a way that makes him feel dumb and he feels insulted.

During the early 1980s-1990s, interpreting was always in person and mainly family members were acting as interpreters. This continued until the 1990s. After the 1990s then the young Hmong professionals started to act as interpreters. Then once the elders population decreased reducing the demand for interpreting and fundings became less then the in-person interpreting declined. This gave rise to the iPad interpreting so there are less interpreters available.

Because I don't know English well and don't know the equivalent of medical conditions, I always need an interpreter. It's difficult to express myself without an interpreter.

I always need an interpreter because I know about 30% English, which is basic English, and I don't know over 60% English. The English I don't understand are medical/health care, legal and military terminologies. These are terminologies you need to study to know. It is essential to have an interpreter in these settings.

It's not only about how to translate words, but also about understanding our culture and being sensitive to our cultural background, so they can transmit that to the provider.

One of the barriers for my parents to seeing a doctor is the difficulty in getting a translation service to help them, since they do not speak English and it is difficult to make arrangements over the telephone.

Interpreters are the bridge between provider and patient.

Since I do not know all English and medical terms, there have been times where doctors have talked to me and I could not understand what the problem was exactly. Since I was confused and could not understand the problem

or diagnosis, I was not sure I wanted or needed to get the procedure or treatment done. Therefore, I just decided not to get it done because it was too confusing.

Communication and language barriers have played a role in the quality of health care that my family and I have received. When I was younger, I did not recognize that my dad's level of English was not as high as I had thought. My mom came to America at the age of 1, so she speaks English fine. However, my dad was in his teens when he arrived in America, so he did not have as much time to develop his English. As I got older, I started to notice that his English mainly was based on conversational English, and he still had an accent and had trouble understanding some things, especially medical or higher English vocabulary. I went with him to an appointment one time just to accompany him because I noticed that he had trouble telling me what the next steps were after his appointments or summarizing the appointments. When I went to that appointment, I realized he was having trouble telling the doctor what his symptoms were. He paused a lot, thought a lot, and he also would get frustrated. I realized that due to this, maybe he was not truly getting the best quality of care or the correct care. He could not translate exactly what he was going through. I helped him explain his symptoms and after, I talked with him about the appointment and what he understood. He was still confused on some things, which was fine, but I also think that's why it is important to have a sort of debriefing after appointments. He was confused about a lot of what the doctor was explaining and mostly just understood that he was getting medication for high blood pressure. However, he did not understand what high blood pressure meant, and what it can lead to.

FEEDBACK ON IN-PERSON INTERPRETATION

Participants consistently and strongly prefer in-person interpreters. Having an in-person interpreter can reduce the stress and nervousness associated with not speaking the language, can allow the patient to feel more relaxed, and allow patients to express themselves more freely when face-to-face. "When there is an interpreter in the room in person, everything works so much better, and you feel like you can trust the doctor." Another participant commented that, "I think in-person interpreting is the best as it has no barrier or delay in communication and brings more reassurance to the patients. The clinic that my parents-in-law go to has in-house interpreters. Not only did my father and mother-in-law feel heard because they could communicate their concerns to the doctor with the interpreter, but they built a trust/rapport with the interpreter.[15]

Accessing an interpreter in areas like the emergency room or clinic intake areas may be especially helpful. For example, "I think having an interpreter at high traffic clinics or the ER would be helpful. Again, patients don't always have access to an interpreter until they're in the exam room. This is a misconception that patients know their rights, can complete the in-take forms, have no questions at all except about their health…or how to navigate the intake process." Having access to interpreters across all touch-points within the health system would be helpful and improve patients' experiences and comfort with the process and care being provided.

Having an in-person interpreter allows patients to ask questions and communicate their needs. One participant appreciates the fact that he can ask questions if he does not understand something and feels that he can trust the interpreter more when he is there in the room with him. Another participant mentioned that, "Communication of the patient's needs is one of the most important things an interpreter can do to ensure the best outcome during the appointment, and if the message is lost during the initial appointment, things can go wrong very quickly."

[15] Let's Talk, Marathon County deliberative dialogue participants also strongly supported increasing access to multilingual translation and interpretation services in more health care settings, especially in-person interpretation services.

In-person interpreters can help patients feel more confident in their care. One participant noted that with an in-person interpreter, she is to communicate without being afraid of asking the wrong thing. She stated, "For example, now we take our son to pediatrics and the nurse only speaks English, but he tries to speak Spanish and if there is something we don't understand, it doesn't matter because the doctor speaks Spanish. We have the feeling that we can have confidence in what they are telling us because we understand everything they are saying." One participant mentioned having many good experiences with interpreters that led to positive health outcomes. Around eight years ago she was diagnosed with cancer in the ovaries. She had the same interpreter with her for every appointment. On the day of the surgery, she was going to have one ovary removed, but it was thanks to the interpreter that a big mistake was avoided. Since she was present in all the appointments, she explained that the patient needed both ovaries and cervix removed, which ultimately resulted in her being fully cancer free.

In-person interpreting permits more human interaction between the patient, the interpreter, and the provider. In-person interpretation enables the interpreter and the provider to see the facial cues and body language of the patient, which is an important part of the doctor/patient interaction. It also eliminates the delayed communication associated with the telephone and iPad methods. In-person interpreting occurs in real time and is more fluid than the electronic methods, which facilitates better communication.

Consistency in interpreters can be important to patients. One participant's family lived in St. Paul, Minnesota, which has a large Hmong population. Interpreters were widely available to her parents within the medical system. In fact, her parents were able to arrange to have the same interpreter present at most of their medical appointments. They developed a close personal relationship with that interpreter. Having this type of familiarity with the interpreter fostered an atmosphere of trust and greatly facilitated communication with the medical care provider. She stated that the Hmong culture is quite conservative, and Hmong patients are often reluctant to discuss personal medical issues in front of an interpreter who is a stranger, even if they are Hmong. She also acknowledged that while having the same interpreter to translate at each medical appointment is ideal, it might not be possible in an area where the Hmong population is smaller, and interpreters are not as plentiful.

Some expressed a concern that interpreters may not have adequate medical knowledge or familiarity with medical terminology. One participant noted that "many interpreters have no accreditation for translation in a medical setting. They are hired just because they have customer service experience and are unqualified to translate medical terms from English to Spanish." Another participant thinks that this is a significant problem in medical interpreting for Hispanic/Latino patients and needs to be addressed by implementing an accreditation program that ensures that interpreters are fluent in both Spanish and English and are thoroughly familiar with medical terminology and procedures. Another participant noted, "Recently, my grandma had an appointment where she had an interpreter. When I asked her how her appointment went, she mentioned that her interpreter seemed to be struggling to interpret and still used a lot of English words which confused her even more. She did not understand what condition she had or why she had been coughing for so long. She just followed the doctor's orders to take the medicine. This is why it is important for interpreters to check-in with patients and also to have qualified interpreters."

In-person interpreters should be fluent in both languages and have considerable experience with medical terminology. One participant noted that, "From my experience some of the interpreters don't have the best Hmong language skills. They may have nursing or medical education, but they don't know. They don't know the body parts such as confusing the "sab" (liver) with the "ntsws" (lungs); confusing the "ntsws" (lungs) with the "raum" (kidney) or "sab" (heart). These incidents make us distrust interpreters." Lack of fluency or familiarity with terminology lead some to be concerned about the accuracy of how their concerns were communicated.

One participant talked about a negative experience she had dealing with in-person interpreting services. She took her daughter to an area ER because she was only able to ingest liquid food. The interpreter did not translate correctly, and the daughter was sent for a procedure. When the surgeon came to talk to the mother while the interpreter was not present, they communicated the best they could with the little English she knew, and the surgeon decided to call the surgery off because it was not needed. She felt that the lack of medical knowledge/medical language, or ability to communicate from the interpreter created a misunderstanding that could have been dangerous and costly. Another participant had a situation where the interpreter was not able to translate correctly the reason for his medical visit, and the doctor kept asking the patient more questions, making him uncomfortable. He pointed out the importance of training interpreters in medical vocabulary and expressing ideas accurately.

Some patients may have strong preferences for a male or female interpreter, especially when discussing sensitive topics. In some cases, Hispanic/Latino and Hmong patients can be uncomfortable with having the interpreter present during some conversations. One participant noted a drawback of in-person medical interpretation "is the awkwardness when you need to go to OB/GYN appointments and the interpreter is a man. However, most of them are very respectful and will use a curtain to interpret or be facing to the other side to interpret." Another participant mentioned that she does not like that she cannot choose if the interpreter is going to be a man or woman. She gave the example of going for an appointment with "women's health problems" and feeling uncomfortable with the interpreter being male. Likewise, a male interview participant described the awkwardness of needing to go urologist appointments and the interpreter is a woman.

MIXED VIEWS ON THE ROLE OF FAMILY MEMBERS IN INTERPRETATION

Participants expressed mixed views about the role of family members in assisting patients at medical appointments and with serving as informal interpreters in medical systems. One participant noted that a benefit of having a family member interpreting is that "they already know you, so they can help explain what you cannot. They already know your medical history and things like that as well, so they can fully communicate with the doctor about your needs. The only con is that sometimes family members may not be as fluent or knowledgeable about medical terminology or the Hmong language. This can sometimes cause confusion between the doctor and the patient, or in more severe cases, a misdiagnosis." One participant takes his parents to their medical appointments whenever possible to serve as a back-up interpreter in case an interpreter is not available for the appointment. He can effectively explain to his parents the details about their medical conditions and the provider's treatment recommendations. He is also able to advocate on behalf of his parents to ensure that their concerns are communicated to the provider. Several participants expressed concerns about having a minor child interpreting during medical appointments, especially during an OB visit or in a difficult conversation involving a terminal illness.

Having a family member present can help with understanding behavioral or non-verbal cues. For example, one participant noted that "there hasn't been a communication problem because one of the family members is always with him. We are there to prevent miscommunication. When we spot that he shakes his head or looks down or mouth is open before the doctor's finishes talking then we know we need to step in and respond. Because shaking one's head and nodding have two different meanings. There have been times when he's appreciative of the care and nods his head down but it gets mistaken for 'yes.' These types of body language and miscommunication is what we've seen so we always make sure one of us is with him."

Some participants have concerns about family members serving as interpreters due to a lack of fluency and lack of familiarity with medical terminology. One participant used to attend her mother-in-law's appointments in the past and be an interpreter for her. However, she could not find the right way to interpret or describe what her mother-in-law's symptoms were sometimes. She also said that the doctors would prescribe temporary medication to help with the pain, but it seemed that the doctors were not finding the root causes. The medication often did not work and it caused them both to feel frustrated that it kept on happening. She was frustrated that maybe she was not explaining things correctly the way her mother-in-law described. It got to a point where her mother-in-law stopped wanting to go to the doctor. Instead, she said she would rather rely on herbal remedies. Another participant mentioned that there may not be literal translations. "Growing up bilingual, it was hard sometimes to find the right words and there are some unknown words in both languages." He mentioned that it was a struggle sometimes to try and explain what his mom meant to the doctors and vice versa. For example, he was unsure of the name of some organs and diseases, but he just did his best and tried to explain it in so both sides could understand. Some prefer a family member over an in-person interpreter that they do not know, even recognizing that a family member may not adequately understand medical terminology.

GENERALLY NEGATIVE EXPERIENCES WITH ALTERNATIVE INTERPRETATION TOOLS

Participants had generally negative experiences with alternative interpretation tools such as telephone interpretation or iPad devices. Participants cited concerns including technology glitches; a lack of reliability or interruptions in service due to poor Internet connections; a perception that these methods are not personal or empathetic; a perception that those on the other end of the line are not paying attention; and challenges for those with hearing impairment. For example**,** regarding the use of an iPad for interpretation, one participant mentioned that "it only works half of the time and sometimes they get stuck." When they do they get disconnected and a new interpreter is put on the line, it makes things difficult because "you feel like you have to explain everything again." He also mentioned that when you go to the doctor, "nurses and staff do not like to use iPads and sometimes we use our phones to do the interpretation."

Several participants suggested that health care providers should be more cognizant that certain kinds of appointments may necessitate in-person interpreters instead of an iPad. One participant states, "I think (health systems need) to be aware of what kind of appointment requires a phone interpreter and what kind of appointment clearly requires a face-to-face meeting to be able to explain how you feel."

A lack of understanding due to technology glitches can contribute to patient worry. Not fully understanding the language has hindered one participant's ability to get adequate health care. He shared an experience of getting an exam to rule out cancer in his stomach. On this occasion, he was getting interpretation through an iPad. He was not able to understand the results that the doctor was explaining because the audio was cutting out. When he went back to get the results explained again, the interpreting service was down and there was no in-person interpreter available. He had to go back a third time to get his results explained. This situation that took weeks to resolve created a great deal of anxiety for him.

Technology can be a barrier to the patient feeling assured that their concerns have been communicated. One participant admits that "language is a major barrier to getting appropriate health care for Hispanics." She mentioned she did not like the iPad interpreting services offered at a local health system in comparison to the in-person interpreter she had at the Bridge Clinic. She had a situation last December in which she had to bring her child to the emergency room and she felt she had a hard time explaining the child's symptoms to the providers. They used the iPad translation services. She felt that an in-person interpreter would have made her feel more reassured about the accuracy of what was being communicated and more efficient overall.

Telephone interpretation has limitations. Over the phone interpreting may also be confusing. For example, one participant recounted that Medicare calls him for his annual review and even though the interpreter is Hmong, he doesn't comprehend the questions. The questions of "when were you born?" (koj yug thaum twg?) or "how old are you" (koj muaj pes tsawg xyoo lawm) can be problematic/ineffective. Parents during the elders' time did not keep records of their children's birth dates so time is associated with events like the harvest season or the collapse of the Secret War. It would be more effective if the question was phrased as "what is the date of your birth, the month of your birth and the year of your birth?" and then the interpreter or rep on the other line can figure out the age of the person. Another participant mentioned, "We speak Portuguese from Brazil, not from Portugal. There was an occasion when we went to (the clinic), and they did put an interpreter on the line that was not speaking Brazilian Portuguese and it was hard to understand him, because in Portugal they use some words that we don't use in Brazil. It was an awkward experience because when I asked questions to the interpreter from Portugal, she could not understand my Brazilian Portuguese."

Translation should be done with an actual person, not a computer (or Google Translate). One participant noted that the structures of Hmong grammar and English grammar are different. For example, the structure of the Hmong language is "pen red" and the English language is "red pen." When a computer translates English to Hmong, the grammar can be "off." Another participant noted that in his country, instead of saying, "I have a fever" (Tengo fiebre), they use the term "Tengo calenture," that can be misunderstood or not translated accurately by a translating app. That is why he thinks an in-person interpreter is preferable because the person has a better chance of knowing other cultures terms and can ask and make sure he understands.

Some participants did value alternative communication and interpretation methods. One participant has observed many different language/interpreting services and thinks that it is great that there are so many different options now. She noticed that now, many interpreters are resorting to iPad or telephone lines to interpret. One participant prefers communicating through email or text messages to set up appointments because he has no cellphone service where he works. He understands that this might not be the preferred method of communication for everyone, but he thinks that it is good to provide multiple options or communication channels. He communicates with the Wausau Free Clinic in Spanish because they have interpreters to call or send text messages and emails in Spanish. One participant noted, "an iPad interpreter is good because it doesn't require the interpreter to travel. It's convenient."

ILLUSTRATIVE COMMENTS

I believe that in-person interpreting is the most accurate and effective way to interpret. As an in-person interpreter, you can fully see what is going on in the room, you can converse with medical providers, and it provides you time to ask contextual questions. However, I do think that language lines and telephone interpreters are still needed for accessibility reasons and ensuring that there are multiple options for patients. Family interpreters are great because they already have a built-in relationship with the patient, but sometimes they may not be as fluent or knowledgeable about medical terminology as a trained or professional interpreter. I also have had times where because I am their family, they do not want to show any weakness around me. They do not want to admit in front of me that they are in pain, or that they need my help. This can cause them to have delayed treatment until they are ready to share that they are going through this pain.

In-person is a lot better. There is more empathy on the room because the interpreter is seeing your face expressions, and you are able to see the interpreter.

In-person interpreting is better versus a language help line or via telephone. This can help build a connection between the interpreter and the family.

The interpreter has been beneficial in my clinic visits especially when I don't understand something new. For example, if the diagnosis is new. For the most part, I haven't encountered any complicated health situation so I haven't encountered any bad interpreting experience. Overall, having interpreters allow me to understand and make more informed decisions.

I think it's important to have an in-person interpreter. As I've said previously, it brings reassurance to the client and family members. Oftentimes the client can't access an interpreter unless they're in the exam room and/or when there's an issue. It would be helpful to have an interpreter available so they could help with simple things such as checking in or educating the client about their patient rights.

My wife was diagnosed with leukemia last year and had to get a tube in/near her neck. There was also the interpreting of what a "fungus" and "bone marrow" are. Because of the interpreter we understood that fungus caused the rash. The interpreter helped us understand the bone marrow process. We were very scared because we thought it would be dangerous. Through back and forth talking and interpreting, we became at ease. We learned that it's part of the process of leukemia testing so we agreed to it. After the testing, we learned and received confirmation that she has leukemia and moved forward with treatment. Without the interpreter, we wouldn't know these things and wouldn't have move forward with the treatments. Our decision was based on the interpretation.

Communicating your feelings is hard and when you have to go with an interpreter everything is more complicated, you also have to think that when explain things is not only a verbal communication but also your body is saying things and an in-person interpreter can read that language versus a phone interpreter, the hospital and clinics need to take that in consideration when seen a patient that is not able to communicate.

The positive thing about interpreting is that in-person interpreting is live and consistent. It's easier to communicate and be expressive with a live person too. Interpreting on the iPad can lag because the interpreter has missed some of the words said and there's also a technology lag. Speaking to an interpreter over the iPad can make a person nervous and shy so they don't share all of their symptoms. This is not very impactful.

The interpreter should have more Hmong fluency and use commonly used word. For example, Americans refer to computer interaction as virtual, but for the Hmong community we refer to it as computer. Instead of using the word computer grammatically correct such as "peb yuav xam phaj koj hu computer" (we will interview you on the computer), the word virtual is used grammatically incorrectly such as "peb mam ua virtual nrug koj" (we will do virtual with you). The word virtual is unknown to the Hmong community. They're only familiar with the term computer and know what interacting on the computer is like. They are left wondering about the location of virtual. Interpreters need to know and use everyday terminologies that Hmong use. Don't use new words that aren't commonly used because it can lead to confusion.

Most of the interpreters I've worked with are fluent in English and Hmong, but a few aren't. The few that aren't fluent struggle to interpret English to Hmong and Hmong to English and cause confusion. If the interpreting mishap is minor then I brush it off, but if the interpreting is major then I tell the doctor directly. I tell them to find a better interpreter. I have also directly complained straight to the interpreter to go and obtain more education.

Although family members as interpreters are more trustworthy because you know them, they may not have the medical vocabulary that professional interpreters have.

If there's a family member that does the translation, it's better because they know the patient well and can be more thorough about the patient's health. An interpreter will only translate what the patient tells them.

I think family members interpreting for me is fine too. My children aren't fluent in English so they could only do simple translations and leave some things out. I also trust my family members' interpreting in that they have my best interest more than others too.

We went to the appointment and I tried to explain things to the doctor because my brother did not speak the language. During the whole appointment I felt that the doctor ignored me, it was almost like I was not there. I don't know why, maybe because I was a minor or Latino or they didn't understand me. I felt bad for my brother because I was not able to help him.

We don't rely on our children to interpret because they don't have the Hmong language skills.

Family members can speak English well, but they do not know how to communicate in Hmong. They are not suited for translating or interpreting.

In the case of an emergency or last minute then I'm open to using my sons and daughters in law as interpreters too. However, if I know that my children aren't fluent then I will request for an interpreter over iPad. This is my preference because what if I said I don't agree to a surgery but my child said I agree to a surgery. I have heard cases of elders dying because of similar miscommunication.

Even with Google translator you find Portuguese from Brazil or Portuguese from Portugal.

I would like to suggest to clinics that a good sound system connected to the I-pad and/or phone makes a world of differences in the quality of virtual interpretation.

Telephonic is the worst form of interpreting because there is no visual feedback for the interpreter, and it is very challenging to establish an effective line of communication between the doctor and the patient.

Interpretation over the phone is not ideal, because most of the time I need to ask about phrases that I don't understand from the interpreter.

A long time ago there were in-person interpreting, but now there's just iPad interpreting. I am more open and share more to an in-person interpreter than an iPad interpreter. I feel more shy with the iPad interpreter.

*I like the language line/phone, but I wish to have a Hmong line directly to a person instead of getting a voicemail to leave a message. It should be a special number to the person so I could connect with a person and be connected with a provider or get the services I need. Now a days, I have to follow instructions such as press # or * or an extension to get to a person, but I don't know what I should do to get to a person. And even when I press 3 to leave a message, I don't get a call back after leaving a message. It's just the end of it after I leave a message.*

I-pad interpretation or phone will give you more privacy. The cons with iPad are that some of them are busy typing on their computers while interpreting, and that gives us the impression that they are social chatting.

TOPIC 3 – CULTURAL BELIEFS AND PRACTICES

Interview participants were asked to share their perspectives on whether health care providers in Central Wisconsin consider the unique cultural needs of Hispanic/Latino and Hmong residents. In addition, they were asked to identify some key cultural beliefs about health and illness that impact health care decisions within the Hispanic/Latino and Hmong communities. Some participants shared examples of situations where a cultural barrier lead to an issue with a quality or safety concern in a health care setting and it contributed to a negative health outcome. They also shared examples of situations where having culturally appropriate care helped mitigate a quality or safety concern and contributed to a positive health outcome.

EXAMPLES OF CULTURAL BELIEFS AND FACTORS THAT IMPACT HEALTH CARE

Hispanic/Latino and Hmong community members can experience difficulties navigating health care systems as a result of cultural backgrounds and language differences. The extent to which patients feel accepted is provider- specific. Educating health care providers would help them be more culturally sensitive. "Health care providers should make an effort to educate themselves on culture and beliefs so that they can understand how their patients view things." Some of the cultural health care practices and beliefs discussed by participants include:

- **Different perceptions of the importance and role of preventive care.** For example, there may be a lack of understanding about the need for preventive care and the value of establishing a relationship with a primary care provider, especially within Hmong communities.
- **Avoiding medical treatment until serious symptoms arise.** Some Hispanic/Latino patients and Hmong elders will not seek treatment until the problem is serious, such as a broken bone or active bleeding. One participant told a story about her grandmother, who was experiencing shortness of breath and chest pain but refused to seek medical care. She eventually was unable to walk and was taken to the hospital, where it was determined that she had a myocardial infarction. By that time, her condition was so severe that little could be done, and she was placed in hospice care. Fortunately, the younger generations of Hmong are educated about the importance of preventive care and are more likely to seek treatment when symptoms are emerging.
- **Lack of understanding of the structure and process of U.S. health care systems**. One participant mentioned that when Hispanic/Latino people go to a medical provider in the U.S., they need to quickly learn how everything is very structured, that there is a protocol, and that doctors are not going to prescribe what the patient thinks they need, but what the doctor thinks is best. Patients need to understand that providers in the U.S. are also going to run certain tests before prescribing medicine. Medical providers need to have the patience to explain why they are prescribing a certain medication and may not necessarily be doing what the patient asked for.
- **Self-prescribing medication or medical non-compliance.** A very common cultural practice among Hispanic/Latino communities is to self-prescribe medicine or to give advice to other community members. It is a very informal way of dealing with health issues. Many Hmong patients do not understand the importance of taking prescribed medications on a long-term, daily basis for chronic medical conditions. They feel fine, so they stop taking their medications. This can result in poor treatment outcomes for diseases that can be effectively managed in the early stages with appropriate drugs.
- **Herbal medicines play a key role in Hispanic/Latino and Hmong patients' health care.** One noted that, "Some believe herbal medicines could cure all of their illnesses." One participant thinks it is important to allow patients to be in charge of their health and making their own decisions. "As long as the herbal

medicine is not hurting them, they should be able to do what they want so that they feel in control of their health."

- **Expectations surrounding wait times for appointment.** One participant mentioned that it is important to understand that if a patient goes to a Free Clinic where he is not paying for services, they are not going to have the capacity to assist him like in other clinics. They might not be able to do some studies or give them the medicine that they need right then and there. They need to understand that everything has its due process and is not immediate like Hispanic/Latino people may be used to.
- **Personal preferences and trust in the medical care system.** One participant's uncle passed away from a brain aneurysm. He had the option to have surgery, but he refused and wanted to go home and pass away in the home peacefully. The doctor seemed frustrated as to why he refused to get this procedure done. However, the participant's uncle was very traditional and did not seem to have a sense of trust in the medical care system.

Interview participants also shared comments and experiences that highlighted other cultural beliefs and practices that are often overlooked, from their perspective, in U.S health care systems. These include family structures; dietary considerations; alternative medicine practices; and religious and spiritual beliefs. Participants also highlighted the need for culturally sensitive interpreters and training and education for medical staff and provider. More insights on these topics are discussed below.

GENDER ROLES AND FAMILY STRUCTURES

Providers need to be aware of beliefs about gender roles and family structures within Hispanic/Latino and Hmong cultures and how these beliefs may influence medical treatment. One example is the concept of "machismo" in Hispanic/Latino culture. Hispanic/Latino cultures value the idea of manliness and male leadership. The father is the patriarch of the family and has the ultimate authority to make decisions regarding the family and all its members. For example, a husband may object to his wife having a gynecological examination because he does not want another man examining his wife's private areas. Machismo can also have a negative effect on the treatment of mental health problems, especially for men. Males are supposed to be strong and not show weakness. If a man states that he is feeling depressed, family members and friends are likely to tell him, "What are you worried about? You have no reason to be sad. God will take care of you."

Hmong culture is patriarchal and patrilineal and stresses the leadership role of male family members. This is an important cultural characteristic that influences medical decisions for all members of the family, such as whether to comply with treatment recommendations. Another consideration is that health care systems need to be more understanding and respectful of the Hmong elders. One participant noted, "The young Hmong patients don't need an interpreter, but we do. When they see us elders with an interpreter, they're put off by it and see it as an inconvenience. Health providers need to see us as equal."

Families are expected to show support. One participant noted that, from their perspective, the majority of health systems do not consider Hmong cultural beliefs and practices. "The health system is still very much a business, so they don't consider the Hmong cultural needs of the patient to support them. Americans follow the church/Christianity religion and pray in the clinic to cope with mental challenges. The Hmong community doesn't pray to cope. Their family members show up in big numbers to show care and support their loved ones so the patient doesn't feel alone." Hispanic/Latino patients also may express a desire for the support of many family members. When a Hispanic/Latino patient is hospitalized, the entire family and extended family will visit the patient. Rules limiting visitors may cause relatives to feel excluded. A lack of understanding of HIPPA regulations can cause distrust when family members cannot communicate with their loved-one's provider.

Some patients strongly prefer care provided by a provider of the same gender. For example, Hispanic/Latino men and women are very private about discussing personal matters, so if the clinic is scheduling an appointment for a man to discuss his genitalia, the appointment should be with a male nurse/physician and the same goes if the patient is a female. This sentiment was expressed by several Hispanic/Latino participants, as well as Hmong interview participants. This concern also extended to the ability to request interpreters of a specific gender.

DIETARY CONSIDERATIONS

Diet and food play an important cultural role. Several participants remarked that health care systems are getting to a place of better understanding cultural beliefs surrounding food. In Hispanic culture, for example, they give food as an expression of gratitude. "It would be nice if doctors understood this." One participant mentioned that when she gave birth, she had the option of foods that supported the Hmong chicken diet. After birth, mothers will follow a diet for the whole month of only eating chicken and rice. The hospital had these foods available for her, which was nice. Another participant shared this sentiment, noting, "I think the health system needs to consider the Hmong diet, especially the women that deliver a baby. Hmong women in postpartum don't consume foods such as cereal, Jello, or veggies. We consume rice, boiled chicken broth (chicken bouillon broth), and boiled chicken. It would be great if boiled chicken was incorporated in the menu so after delivery the women can have access to this food option in the case that their family members can't deliver home cooked chicken and rice to them."

CULTRUAL PREFERENCES FOR ALTERNATIVE AND HERBAL MEDICINES

Alternative medicine plays an important role in Hispanic/Latino and Hmong cultures. For many members of the Hispanic/Latino and Hmong populations in Central Wisconsin, natural medicine is the preferred, first option for addressing health issues. Several participants noted that doctors are not necessarily trained in alternative medicine, and it would be useful for them to learn some of the medicinal cultural practices when interacting with patient populations. Others expressed that their medical providers dismissed or discouraged their use of herbal medicines. One participant talked about a negative experience that a cousin had with a doctor that disapproved of her cousin giving her son shark oil (a popular home remedy on the coast of Mexico to treat cough symptoms). The doctor told her that it was negligent to give him shark oil and threatened to call social services if it happened again. Some Hispanic/Latino and Hmong community members will not take medications prescribed by their doctors because of a preference for culturally-specific remedies. Or they may try natural approaches because of the costs of going to a clinic. Another participant mentioned, "We have come a long way…Although we have evolved, there are ways to improve." She thinks that health care providers should study and understand cultural beliefs and backgrounds. "Learning what kinds of medicine and herbal remedies Hmong people like. This will help health care providers help their Hmong patients in the best way that they can so they can meet their needs."

Cultural beliefs suggest trying a natural or herbal remedy before going to the doctor, especially within Hispanic/Latino families. For example, many Hispanic/Latino patients believe in the practice of "curanderismo," which is an alternative form of medicine that utilizes natural herbal remedies. A popular herbal treatment in Mexico is chamomile tea, which is used for a wide variety of ailments. Another "curanderismo" remedy is honey and lemon in hot water. Many Hispanics will try these traditional herbal remedies before seeking treatment from a convention medical facility. One participant said that her family members preferred herbal remedies and tried to avoid taking conventional western medications as much as possible. In her experience, some patients will be abruptly dismissed by the physician when they try to discuss herbal treatment. This lack of respect for the patient's culture can foster an attitude of distrust in the patient and can inhibit open communication.

Health care providers need to be aware of this cultural tradition in the Hispanic/Latino community and should avoid disparaging herbal medicine because it is still an important part of Hispanic/Latino culture.

Beliefs in alternative or herbal medicines can sometimes result in conflicts with providers and some cultural practices may not be aligned with traditional expectations of medical care in the United States. For example, one participant thinks that providers need to learn more about unique cultural beliefs of each community. She gave the example that in Mexico it is very common to start giving vitamins to kids after the age of two, and that most people take vitamins. In her country not many foods are enriched with vitamins and minerals and diet is not very varied. She shared that when she took her kid to the pediatrician, she asked the doctor about giving the kid vitamins and they said there was no reason to do so. She was confused because that is a common practice in Mexico even when a child is healthy. She felt that the doctor shut her down and that he could have made a bigger effort to understand where she was coming from. Another participant gave the example of a common practice people do every six months that is called "desparasitarse" (deworm), which refers to the use of over-the-counter medication to help eliminate potential intestinal parasites. He recalls mentioning this to a doctor and being told it was not needed, and that he should not do it. He also mentioned some providers do not understand the use of herbal teas as medicinal to cure some afflictions.

Respecting cultural beliefs can improve the patient's experience. One participant had a positive experience at the Wausau Free Clinic. She feels the providers there take into consideration her medical beliefs. She recounted that she recently went to a follow-up appointment. She had lost eight pounds in that month and mentioned that she was drinking some herbal teas to help her with her weight loss. The doctor was very respectful and looked into all the herbs to make sure it was safe to continue using them and ordered some bloodwork. He concluded that she could still use herbal teas and that he would follow up in a couple months. She felt that the doctor respected her cultural beliefs and practices.

RELIGIOUS OR SPIRITUAL BELIEFS AND RITUALS

Participants would like more respect for religious beliefs within health care systems. Some hospital policies are viewed as "really strict" and prohibitive. Examples of policies cited by participants include limits on the number of people that can visit the patient, the number of people that can be in the room, as well as the ability to practice religious and spiritual beliefs. For example, Hispanic/Latino patients frequently depend upon religious faith to deal with feelings of anxiety and depression and are often hesitant to seek psychiatric care. One Hispanic participant mentioned that he feels free to mention God in his medical consultations without any kind of criticism and this increases his comfort level during his medical appointments. It is important to him "when they realize the most of Latino population are Christians, and they allow us to mention God or pray before of a surgery or major procedure." Another participant shared an experience working with Hispanic/Latino individuals where the patient's religion did not allow him to take pain medication, so he would not accept the medication the provider prescribed.

Being able to follow religious and faith-based rituals was especially important to Hmong participants. One participant stated, "If they want to build trust, they need to allow things such as simple shaman rituals or big families to be at the hospital because Hmong families tend to be bigger." Those that follow traditional faith may tie a string to a hospitalized family member's wrists, with one noting, "The strings that are tied to our ankles, necks, and wrists shouldn't be cut off too." There is also the practice of "khawv koob" (spiritual healing practice) that is "tshuab" (literal translation is "blow") to help the patient and participants feel these practices should be allowed. Several participants mentioned the importance of spiritual rituals such as "ua neeb" healing ceremonies.

Traditional shamanism within Hmong culture can have a significant impact on elders' willingness to seek health care. The older members of the Hmong community have experience with traditional shamanism, which includes healing practices that uses communication with spirits to diagnose and treat illnesses. Many of the older Hmong will first seek medical treatment from a shaman rather than utilize the conventional American medical system. They would pursue standard medical treatment only if they did not get relief from shamanistic rituals or their symptoms worsened. Younger generations of Hmong have less connection to traditional shamanism and are more likely to obtain conventional medical care throughout their lifetime. Hmong culture is such that community members tend to avoid medical treatment until absolutely necessary. This is especially true for the older Hmong generation, many of whom believe in traditional shamanism for treatment of medical disorders. The shaman creates various medicinal concoctions and instructs the patient how to use them. The reluctance to seek preventive medical care can have significant harmful effects, especially the individual is suffering from one of the "silent diseases," such as diabetes or hypertension.

CULTURALLY-SENSITIVE AND FLUENT INTERPRETERS

Participants expressed a need for culturally-sensitive and fluent interpreters in all areas of the health care system, including the emergency department, walk-in clinics, and hospitals. "These locations should have interpreters, because they have more traffic. The Hmong staff can help us with paperwork and interpret." One participant thinks that having an in-person interpreter that is culturally sensitive can be a great asset. She feels that it would make people more comfortable and feel understood. She said that she worries about going to the doctor and not being able to express her symptoms correctly, and that an in-person, culturally sensitive interpreter can make her feel more confident about it. Another individually noted that in his country instead of saying, "I have a fever" (Tengo fiebre), they use the term "Tengo calenture," and that can be misunderstood or not translated accurately by a translating app. That is why he thinks an in-person interpreter is preferred, because the interpreter has a better chance of knowing cultural terms and can make concerns are communicated. One participant noted, "I think the health care system should hire Hmong interpreters to assist Hmong elders because we need it. The hired Hmong staff should be fluent too. It shouldn't just be any young adult Hmong that should be hired, because sometimes they're just Hmong but they're not fluent in Hmong. The Hmong population that doesn't have health literacy (medical terminology) is more and the population that knows is less."

TRAINING AND EDUCATION FOR MEDICAL STAFF

Many participants expressed that they wished health care providers would receive more education and training about cultural beliefs; others recommended increasing the diversity of medical staff to include more Hispanic/Latino and Hmong providers. One participant recommended "having the nurses and doctors go through cultural trainings. It would be beneficial to have them learn about our traditions and our ways of life, as well as diversifying food choices for patients." Another participant's found a Hmong physician to serve as their primary doctor. Her mother told her that she would often ramble on about all her various medical issues because she was able to converse with this doctor in her native language. Her interactions with previous doctors were often truncated because of the language barrier and a perceived lack of cultural awareness. Having access to a provider with a deep understanding of Hmong language and culture facilitated an open and honest doctor-patient relationship that her parents valued greatly. Even small efforts, such as greeting a patient in Spanish or Hmong, can have a positive impact on the patient, especially older Hmong patients.

Hispanic/Latino patients have a reverence and respect for physicians that is part of their culture. This can sometimes prevent them from asking relevant questions regarding their medical condition or questioning treatment recommendations. They may be hesitant to advocate for themselves or for family members because of this cultural practice. Hispanics/Latinos are taught to have respect for authority and to "do as you are told." They have a difficult time pushing back against health care providers even when they believe that they are not being heard. This may compromise a patient's ability to be an active and informed participant in their own health care.

ILLUSTRATIVE COMMENTS

Treat undocumented immigrants the same us everyone else. Everyone in a hospital should be welcoming, patient, and listen to us. (She would also like providers to try to understand cultural practices and not minimize or ignore them.)

Before we go to the doctor, we try all the remedies we know from our country because we fear the financial cost involved in going to the doctor.

I'm not sure about the health system's consideration of our culture. I have heard of cases where Hmong community members take medication or pills that cause health complications for them.

I did have a situation with a urologist that was a woman. I did feel embarrassed because she needed to touch my private parts.

I would suggest that at the time the appointment is scheduled, they ask if the doctor who will touch them for examination purposes will be a male or female doctor.

For Hmong people, the chicken diet helps heal a woman's body after giving birth.

When my wife was hospitalized for leukemia, for the most part everything was positive. However, it was challenging for her to follow the low-fat American diet. For example, Hmong eat traditional boiled pork or chicken but they still have fat in these dishes which increases high blood pressure. So overall, the low-fat diet is good for health such as 1 slice of bread or ½ a banana, but it's hard to adapt to this diet. This is not the Hmong palette we're used to. The dishes I brought her were not fried food or anything oily. They were more boiled foods. The health care team hasn't opposed to any of the food I brought to my wife to eat during her recovery time.

A lot of Hmong people do not like to have organs or body parts removed. For example, diabetes is pretty prevalent in the Hmong community. When you have diabetes, there is a chance of needing an amputation in the future. There was a patient that needed to get an amputation, but he was against it. The doctor was upset and frustrated because without this, the patient would die. In the end, the patient did not get the procedure done and he passed away. A big reason as to why this person did not want to get anything amputated is because in our culture, we believe in reincarnation. If you notice, many Hmong people are also not organ donors for this reason. We believe that if we lose a certain body part or organ, we will not have it with us in the next life. This organ or body part is also considered a soul to us, and we do not want to lose that soul. Although that amputation could have saved his life, spiritually and culturally, it made sense not to go into your next life like that. To explain this to a doctor is not an easy thing and for a doctor to understand it is not easy as well. It can be frustrating, but it is an example of how cultural beliefs play a role in health care decisions.

Other cultural beliefs include religious rituals such as "ua neeb" or "hu plig" (soul calling). These can be kind of loud, but I have heard that some hospitals do permit them to happen. This can make Hmong people feel more at ease, and more involved in the treatment process. Even if you do not believe it as a medical provider, you can at least understand that it will calm some of their worries and anxieties.

I still practice the traditional Hmong religion. From what I've encountered, between 1-10, I think about only one out of the 10 times that the Hmong culture would be considered. Such as the "khawv koob" (spiritual healing practice and chant) is considered a good healing practice. The 9/10 times providers would not consider the Hmong culture. Especially if it's the belief that the illness is caused by ancestors and spirituals, then it's the 1 chance that the Hmong traditional practices are believed and considered by western medicine.

If they (Christian followers) could practice their faith (in the hospital) why can't we (Hmong faith followers) practice ours? For example, if the physical health is being cared for and the patient's health still doesn't improve then Hmong spiritual care practices (ua neeb ua yaig) should be considered. Same with the American patients' health: if their health doesn't improve and praying suddenly helps resolve their illness, then it's something they will believe greatly in. We are all human and we want to support our person's mental health so they will be healthy.

Younger generations can Google symptoms and research ways to describe our symptoms such as a dry cough versus a regular cough. However, with the older generation, they describe symptoms differently and it is hard to directly translate them.

The doctors should be accepting of the Hmong beliefs. The "khawv koob" is done responsibly in that the incense stick or candle is blown out after the ceremony.

I think the most important thing is to allow the Hmong to practice our simple culture. Five-to-10-minute rituals such as "khawv koob." Even if lighting anything is not allowed, we don't want it to be put down if we are seen doing it. What we are doing is positive and to encourage the health of the patient. We appreciate the health care services for helping (rescuing) the patient, but because we believe in this faith, we want to practice it to contribute to the health of the patient. We don't want it to be a "ib tug ua ib tug rhuav" (one person does one thing and another destroys it).

I haven't encountered a situation where my faith or practice was discriminated against but I have seen cases where patients' strings are taken off. The Hmong that practice the faith closely will often tie a string to their loved ones to bring them good spirit and confidence as they go into the clinic or hospital. Sometimes after a person undergoes a major surgery, a shaman will "ua khawv koob tshuab" the person with the use of a lit incense stick or candle. In our area I haven't seen these practices allowed, but I know they're allowed in Minnesota and densely Hmong population areas.

I think it's important for health providers to respect and understand seizure patients and the people who are shamans. These individuals have spiritual guides not physical illness.

I don't have experience with the blessing strings. If it's necessary when they're going to do something then they'll request the strings to be cut off. However, health care providers have never restricted me from having them if they're not doing anything.

Interpreters should be trained in culturally appropriate medical terminology; in different countries we use different terms.

The fact that we all speak Spanish doesn't mean that we all understand each other. (on cultural differences between Hispanics)

One solution to this problem is to get more Hmong physicians into the health care system. Hmong patients are more likely to follow medical recommendations from a provider who looks like them and shares their language and culture. A Hmong primary care provider would be familiar with the dietary habits of Hmong patients and the traditional medical practices that are likely to be employed by the older members of the community.

I want to change the patient wait time to see a provider. The wait time can be so long. There have been instances where the people that come after me get called before me. If they don't change this then they don't respect us.

TOPIC 4 – BUILDING TRUST IN COMMUNITIES

Interview participants were asked if they or a family member experienced racial discrimination when getting health care in the Central Wisconsin area. Twenty-four (24) of the 29 interview participants provided feedback on this topic. Of those commented on this during their interview, about 30% (n=7) reported that they or a family member had experienced racial discrimination in health care settings in Central Wisconsin; a majority (70% or n=17) reported that they had not experienced racial discrimination. Of those who reported that they had experienced racial discrimination, there was a fairly even split between the Hispanic/Latino and Hmong interview participants. Below we summarize key aspects of their experiences that were shared during the interviews, organized by topic area.

EXPERIENCES WITH RACIAL DISCRIMIATION OR BIAS

Insurance and billing issues. Hispanic/Latino and Hmong interview participants reported that difficulties with insurance, billing, and the financial aspects of health care can result in feelings of distrust about health care systems and their providers. For example, one participant expressed that "(health care organizations) should be more inclusive with undocumented immigrants." She commented that in order to have financial assistance with an area health care organization, she was told that she "needed to have children." She said, "That is a discriminatory practice." Another patient lost her medical financial assistance when her income exceeded the limit by $100. This caused her to "lose trust in big clinics" so she started going to the Wausau Free Clinic.

Long wait times to schedule appointments. Some interview participants expressed that they had experienced long wait times when scheduling appointments. This caused some to question if they were singled out by the scheduler due to their racial/ethnic background. For example, one participant mentioned that sometimes when she is sick, she tries scheduling an appointment and one is offered in several months. She wonders if not being able to schedule an appointment sooner might be due to discrimination.

Long wait times in the emergency room or in a waiting room. Some interview participants described that they have experienced long wait times in area emergency rooms or walk-ins. Similar to the prior comment, some wondered if the long wait times were the result of discrimination. For example, one participant stated, "We went to the emergency room. I think they gave us less attention because we were standing there. It was an emergency and we were there for about two hours without getting the attention we needed in the hospital. I went to talk to the doctor a couple of times to tell her how long we were waiting and she just said, 'we can't let you in just like that, you have to wait.' In my opinion there is a bit of discrimination because I might be from a different country." Other participants shared similar feedback about not understanding why some patients who arrived after them might have be seen before them, resulting in them wondering if the delays were due to discrimination. A cultural broker could potentially help Hispanic/Latino and Hmong community members better understand the dynamics of how health care services are triaged and with education, their perceptions of the reasons for delays may be understood differently.

Lack of interpretation services or frustration expressed by medical staff when patients request or need an interpreter. Some participants expressed situations where they were not offered an interpreter or they perceived frustration on the part of the medical staff if they did request an interpreter. In other words, they felt they were treated differently as a result of needing an interpreter, with some feeling like they were a burden for the staff. For example, one participant shared that her elder Hmong parents have expressed that they do not like going to the hospital because they feel like a burden to the workers who have trouble understanding them or when they must find interpreters for them. Another noted, "I have not dealt with racial discrimination, but when I have gone to interpret for patients and for my family, I have sensed the impatience that people have

for patients who need interpreting. A lot of Hmong elderly people never learned how to read or write. Usually, patients need to sign forms and it takes them a while to write their names. I have seen multiple times, staff rolling their eyes and sighing heavily waiting for the patient to write their signatures. This is unacceptable in my opinion. Other times, providers have totally ignored questions and concerns that patients might have. They just shrug it off and say it's not a big deal."

Being ignored, spoken to in a disrespectful way, or a lack of eye contact by health care staff. Dynamics of interpersonal relations between the patient and the health care staff can contribute to distrust of the health care system and can cause some patients to experience this as a form of discrimination. One participant mentioned that during an appointment, he wanted to interact with the provider, but he was ignored. "He didn't talk to me, he didn't say anything to me. I felt like I was asking the right questions, but he preferred to ignore me because, I think, because... because I'm Latino." Another participant noted that language was a significant barrier to receiving optimal health care for her parents, especially when they first arrived in the U.S. They had difficulty communicating with providers because of a lack of English fluency. She said that her mother still has a slight accent and she has noticed that people sometimes speak down to her in a condescending manner because of it. She often accompanies her parents to their medical appointments if there is an important decision to be made so that she can advocate on their behalf.

Unprofessional conduct and negative interactions with staff. One participant experienced what she described as "unprofessional conduct" by a health care staff member when she was being treated by a "female doctor of color." After the doctor left the room, the nurse made a comment to the participant about the doctor's accent, saying that "the doctor's accent is too strong" and that "she (the nurse) stated that she could not even understand what she was saying." This comment by the nurse caused the participant to think "if this is happening within the staff, could they also be saying things about me?" She thought that this was unprofessional, and it caused her to distrust the nurse. Another participant noted that his wife was treated rudely by janitorial staff who were fixing an item in her room and this resulted in a negative experience that he perceived to be due to his wife's race.

INTERVIEW PARTICIPANTS' FEEDBACK FOR INCREASING TRUST

Interview participants were asked to share feedback on specific ways that health care providers can build trust within the Hispanic/Latino and Hmong communities, as well feedback on information resources that can help Hispanic/Latino and Hmong patients better understand health care systems. Themes for participant responses are summarized below.

Have more racially diverse staff and/or provide cultural training to staff on the history of the populations they are treating. Having a deeper understanding of Hispanic/Latino and Hmong culture can help providers better connect with their patients. For example, one participant suggested that doctors should "learn more about Hmong people, their history, and cultural beliefs." Another participant noted that, "a way to build trust in the Hmong community is to understand and know their cultural practices." This participant cited an example that a traditional practice in Hmong culture is to spit small amounts of water on an ill person to rinse the soul and to ward off evil spirits. A shaman performed this ritual for a Hmong family member who was an inpatient at an area hospital facility. Some staff members witnessed this and believed that the shaman had assaulted the patient, which lead to some turmoil. The relatives of the patient were eventually able to explain to the staff that this was part of a traditional Hmong healing ritual, and the situation ended without involving the police. Many of the Hispanic/Latino interview participants echoed the sentiment that providers should have awareness of cultural traditions across Mexico, for example, and they cautioned against "lumping" all Spanish-speaking

patients together.[16] One participant noted that their first language is Mixteco and Spanish is a second language. "Culturally, … the clinic has to understand the regions of Mexico in order to understand the culture."

Encourage staff and providers to attend cultural and social events and festivals in local communities in order to gain a deeper understanding of those unique cultures. One suggested that, "Medical providers should go out of their comfort zones and immerse themselves in the community by attending their cultural holidays, festivals, and events." Another reinforced this point, adding, "Have health care providers immerse themselves in the cultures that are around them. Hmong people are pretty tight knit, and word travels fast. If you have a good experience with one patient, word will spread and that doctor will get more patients. If you are out in the community such as at the Hmong Wausau Festival, word will travel that we can trust this doctor because they care and they are trying."

Learn basic words, phrases, and greetings in order to "break the ice" with patients and ask simple questions that may reveal some of the patient's culture. One participant had a non-Hmong Asian doctor who would greet them "hello" and "good-bye" in Hmong. This simple courtesy was greatly appreciated by the participant's parents and facilitated their treatment because it indicated the doctor's interest in their language and culture. Similarly, having staff learn even basic Spanish phrases would be appreciated and would convey a sense of caring. Several participants mentioned that small gestures like taking an interest in patients' lives and their families can make the patient feel more comfortable. "I think some ways health care providers can build more trust is showing their interest in the patient. For example, a simple hello or learning how to say a simple greeting in that language shows a lot of character."

Address language barriers and offer quality, in-person interpretation services. Helping overcome language barriers is important to Hispanic/Latino and Hmong patients so that they can effectively communicate concerns; many are afraid to communicate because they do not know the language. One participant noted that, "If the interpreter is not quality and isn't able to communicate in Hmong in a way that makes sense, then it's pointless. It doesn't contribute to my health care decision making." The need for standard terminology was also noted, as there can be difficulties interpreting certain medical terms. "There isn't an official standard on how to properly do Hmong interpreting. Everyone just does what they know. In addition, if there is a medical terminology school then it might encourage the Hmong nurses to take the Hmong courses so they could better assist Hmong patients." Hispanic/Latino participants shared similar concerns about regional differences in terminology.

Provide information, flyers, and other materials in multiple languages. When clinics do outreach events, include the Hispanic/Latino and Hmong communities. Have individuals staffing events who speak the language and translate materials.[17]

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[16] All of the Let's Talk, Marathon County deliberative dialogue participants agreed with the need to improve cultural awareness of staff and for initiatives to help patients navigate health care systems from a cultural perspective. One participant commented that it would be nice if health care staff were more aware of cultural and religious differences. They said that sometimes not feeling understood makes people retract and stop sharing, noting that is especially harmful when dealing with health issues. Another participant agreed and expressed that cultural awareness is very important as some topics in cultures could be considered taboo or difficult to talk about and awareness of this could improve care. For instance, with contraception and fertility- in some cultures, contraception is prohibited.

[17] Let's Talk, Marathon County dialogue participants strongly supported the idea of promoting accurate information on healthy behaviors and community resources in multiple languages. By providing information in multiple languages, community members can better understand and act on the information. Participants want precise health information in their own language so they can understand best what to do to be healthy. This information should be shared in schools and churches, as this is the way most people will be informed. One participant said that if they can access information through work, that will help them. They did acknowledge that a challenge to implementing this is the cost of printing materials in different languages.

Improve communication, answer questions, and ensure patients understand their situations. Checking-in with patients to see if they truly understood their appointments or what the treatment plans are would help improve trust, with one participant noting, "It would be good to reassure them that any questions that they have can be answered. The types of language of choices should be basic terms that are easy for the patient to understand. If health education is done in a way that the patient understands, then they will understand the importance of the information discussed." For example, one participant referred to the word "psychologist," noting that "if the word 'psychologist' was used instead of the definition that 'a psychologist is a doctor that helps patients with mental needs', then I wouldn't know what the discussion is about."

Treat patients with kindness and respect, even if there are cultural or language differences. Many interview participants noted that they wished to be treated with kindness and respect. Some expressed that "they're put off by us when they provide services to us elders." Simple gestures of "be nice, kind, smile, and ask questions" can help build trust. One participant noted, "Patients always smile and feel more welcomed when they see that their doctor is smiling and welcoming them into their space. A lot of times, as patients, we are really nervous about our health, but also what kind of doctor we are going to get. Getting a doctor that is welcoming and willing to listen to our concerns is the foundation of trust."

Spend adequate time with patients. Feeling like the appointment was rushed or that the provider did not have time for them or their questions can contribute to feelings of distrust. One noted, "Having longer medical appointments will allow the doctor to know us better and that also will generate more confidence and trust." Another noted, "The doctors should give patients more time to discuss things with us. They shouldn't come in and talk quickly and leave. For we are ill patients, we desire for their care and help. For they are educated and skilled, they do want the patients' quota and the money that comes with this employment. It's not appropriate for them to leave quickly without asking if patients have questions and if there's anything else that is needed. They shouldn't wait for the patient to be dying to give families time to talk then return and provide answers. This is too late. We need their help when our illness is minor. The majority of the time, doctors I've encountered are always in a rush."

Retain providers in order to help Hispanic/Latino and Hmong patients have established relationships with a provider. One participant noted that, "If the doctors remain at the clinic for years, that will build more confidence in the patients who receive care. Also, if the appointment is longer, we can talk more about us and that also will generate more confidence and trust." Another noted, "If the doctors remain at the clinic for years, that will build more confidence in the patients who receive care."

Help patients navigate insurance, financial, and billing concerns, as well as help them understand the health care system more generally. Some people are afraid to apply for financial assistance or seek care because there is the belief that if they do, it will affect their immigration status or that "immigration can find you." One participant mentioned that he would like to have access to health insurance and in general access to the opportunities that others that are not undocumented have. He said that "makes Hispanics feel excluded, discriminated against, that they are not part of the community."

Address quality of care issues when they arise. One participant noted that, "Hospitals should also try to find the root causes and investigate to find the problem versus misdiagnosing and causing patients to continuously come back to the hospital. This causes mistrust and the patient may not believe that hospital or health care provider anymore."

ILLUSTRATIVE COMMENTS

Sometimes I feel discrimination because I don't speak the language.

You feel like they don't treat you the same way just because you are Latino.

Sometimes you feel the doctors ignored you. (due to race/ethnicity)

So far, my experience with the doctors here has been really good, but we know people who are discriminated against. I know people who go to their medical appointments and an interpreter is not always scheduled and the feedback or the feeling they get is not good. It's like a feeling that, "Oh right they need an interpreter," almost like an inconvenience due to the fact that they need interpretation services.

They assume that a patient is not smart and will not be able to understand sophisticated words because they have an accent. The provider tends to just tell the patient what they need to do rather than understanding and listening to their concerns.

There have been times when I go to the hospital and I sense some discrimination or racism. Sometimes the staff are disrespectful in their tone of voice, and sometimes when they talk, they don't even look at me.

Some ways to build trust in the Hmong community are possibly to learn more about Hmong people such as the Vietnam war, diet, lifestyle, etc.

My parents do not speak English, so they tried to find a Hmong provider this year with a cultural background and language. This helped in establishing care and providing trust needed in the doctor/patient relationship.

It would be nice if American doctors could learn a couple Spanish words, that could be useful. Just speak to me two or three words in Spanish, that breaks the ice. (on how providers can build trust)

When you come for a follow up appointment and the doctor asks you about your daughter, or they remember her name, things like that create trust with us.

The patient is trying to express whatever they are there for and the doctor is not able to understand, so it's easy for the doctor to brush it off and say "Okay, that's fine, let's move on."

My husband has that language barrier, so he does not like to go to the hospital. Some doctors talk to him like he is stupid, so he does not like to listen to their instructions.

The hospitals and clinics should have someone who speaks Spanish so you can effectively communicate your concerns and not be afraid to communicate because you don't know the language.

I only seek medical care until I don't feel well as the health-related things discussed during examination can be scary. It's especially anxiety-ful because I don't know the language.

It's not difficult to build trust with us: don't be cold, be nice and welcoming, and smile.

The way the doctor communicates needs to improve especially when giving a diagnosis. For example, their tone and demeanor. It's important that they speak to us kindly to show that they care about our help. If they look mean and share the diagnosis then it may scare us for a few days.

I think it would be good to be treated kindly and to reduce the wait time. The wait time should be communicated if there is conflict. If the wait time is more than 3 hours, then it's too long.

I can tell the difference between providers. I had ear pain and went to the walk-in. I was prescribed medications and took it for a few days, but the pain was still present. Then I went to see my doctor's colleagues because she was out of the office. This doctor prescribed different medication. I took all five and the pain went away. I don't know if the walk-in doctor doesn't know or doesn't want to treat my illness, but I know that my doctor's colleague treated my illness effectively.

There is no other additional literature or resources that would build more trust. Hmong have been in the United States for 40+ years and know what to expect from the health care system. If anything, I encourage patients to seek medical care if they don't feel well. The doctors need to be more patient and accurate in medical documentation. If this is accurate then people would trust medical providers more.