"Bridging the Cultural Gap with Minnesota’s Immigrant Patients From East Africa – What Providers Should Know"

Mohamed Hassan  MD
Division of Gastroenterology
Department of Medicine
University of Minnesota
Immigrants in Minnesota

- Every week, at least 50 new immigrants arrive in MN
  - >68,000 in the 5 years, ending in 2006.

- Minnesota ranks second after California in the number of refugee arrivals/year
  - In 2005, >6,000 refugees arrived in Minnesota

- More than 60,000 Hmong individuals live in Minnesota
  - At least half live in St. Paul, making it home to the largest urban population of Hmong in the world

- 13% of Minnesota’s foreign-born residents are from Africa—a higher percentage than any other state in the country

- There over 50,000 Somalis in Minnesota.
What was in the news from East Africa within the last one Month concerning the whole of humanity?

a) An attack from Alshabab
b) The piracy in the Indian ocean.
c) Fossils.
-This fossil jaw bone with the teeth is the missing link between the Australopithecus genus that includes Lucy (Hominid) and Homo (H. Erectus) (200,000 years after Lucy)
- *Au. afarensis*: Hominid, which lived over 3.0 million years ago.

- All these fossils and much more were discovered in the Middle Awash area.
We are all from the Rift valley (E.A)
Primary* Refugee Arrivals to MN by Region 1979-2006

Refugee Health Program, Minnesota Department of Health

*First resettled in Minnesota
East African Refugees

YEAR

2007 2008 2009 2010 2011

ERITREAN  ETHIOPIAN  SOMALI  TOTAL
E.A. Immigrants in Minnesota

- Somalia
- Ethiopia:
  - Somalis
  - Amhara
  - Afar
  - Tigre
  - Oromo
  - Others
- Eritrea
- Djibouti
E. A. Immigrants in Minnesota

Somalis: Who is a Somali?
- Share a common ancestry
- Ethnicity
- Language
- Religion
- Are the dominant Ethnic group in Somalia proper.

- Minorities in Somalia proper are:
  1) Arabs
  2) South Asians
  3) Bantus.
Humphrey School Researchers Call for U.S. Government to Expand Role in Helping Rebuild Somalia

Interviews with Somali diaspora show need for infrastructure, health care, education

(Minneapolis, 2/26/2015) — As Somalia continues to rebuild after a prolonged civil war that began in the early 1990s, researchers at the University of Minnesota’s Humphrey School of Public Affairs recommend the U.S. government consider shifting its work from peacekeeping to rebuilding in ways that will help grow Somalia’s economy. In a unique collaboration with the Peace Research Institute Oslo in Norway and The Heritage Institute in Mogadishu, Humphrey School researchers interviewed members of the Somali diaspora who had returned to help their home country rebuild. Despite a deep desire to help, the Somali diaspora reported considerable barriers to their work, and researchers have identified several ways the U.S. government and nonprofit or nongovernmental organizations (NGOs) could help create better opportunities for growth and stability.

“Tremendous investments made by the U.S. and governments of other countries have helped create a more safe and stable environment in Somalia, and it’s time to take the next steps,” says Ryan Allen, Humphrey School of Public Affairs associate professor, who worked closely with Humphrey School associate professor, who worked closely with Humphrey School associate professor in the study. “But,” he adds, “maximize the effectiveness of development assistance in Somalia.”

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E. A. Immigrants in Minnesota

Religion

1. Islam
2. Christianity.
3. Other.

Urban Vs Rural.
Downtown Mogadishu
What are the Barriers to Care

- Barriers to healthcare can be grouped into three categories:
  - Financial and insurance issues
  - Cultural Factors:
    - Trust.
    - Compliance with visits and medications.
    - Gender
    - Religion
  - Language

Will use a case report to explore how these factors impact in individual patients.
Our case is

- A 32 year old Somali female presents to ED with abdominal pain
  - Started 2 weeks prior, worsening since
  - Most severe in RUQ
  - Worse after eating
  - Associated with nausea and anorexia but no emesis
  - She had insurance.
Barriers to Care

- Financial issues: can be a significant barrier to healthcare.

- The number of uninsured immigrants has increased significantly since passage of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996.

- Legal immigrants who entered the US after 8/06 were not eligible for Medicaid until they had been in the US > 5 years and refugee immigrants lost their coverage after 5 yrs in the US.
Barriers to Care

- Foreign-born adults are now nearly three times as likely as native-born adults to be uninsured

- This difference in coverage remains even after statistically controlling for income, education, employment, and health status
Case Report Continued (Exam)

- Vital signs were stable
- Appeared uncomfortable
- HEENT exam remarkable for scleral icterus
- Exam otherwise unremarkable.
Total bilirubin 11.4
Alk phos 210
ALT 1619
AST 3961
Albumin 3.2
Total protein 9.2

INR 1.51
PTT 35

Amylase/lipase normal

UA: + bilirubin, otherwise unremarkable
## Work up

The following labs return:

<table>
<thead>
<tr>
<th>Test</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hep B surface Ag</td>
<td>negative</td>
</tr>
<tr>
<td>Hep B surface Ab</td>
<td>positive</td>
</tr>
<tr>
<td>Hep Bc antibody</td>
<td>positive</td>
</tr>
<tr>
<td>Hep Be antigen</td>
<td>negative</td>
</tr>
<tr>
<td>Hep C Ab</td>
<td>negative</td>
</tr>
<tr>
<td>Hep A IgM</td>
<td>negative</td>
</tr>
<tr>
<td>Hep A IgG</td>
<td>positive</td>
</tr>
<tr>
<td>HSV IgM</td>
<td>negative</td>
</tr>
<tr>
<td>HSV IgG</td>
<td>positive</td>
</tr>
<tr>
<td>ANA</td>
<td>1.4 (weakly positive)</td>
</tr>
<tr>
<td>Anti smooth muscle Ab</td>
<td>High degree of non specific fluorescence</td>
</tr>
<tr>
<td>Anti-LK microsomal-1 Ab</td>
<td>&lt;1:20</td>
</tr>
<tr>
<td>AFP</td>
<td>7.3 (nl 0-8)</td>
</tr>
<tr>
<td>Ferritin</td>
<td>54</td>
</tr>
</tbody>
</table>
Over the following week

- She was started on prednisone
- She also developed significant encephalopathy requiring lactulose
- Given progression of liver disease, GI service made decision to pursue transplant evaluation
Transplant Evaluation

- She underwent psychosocial assessment during which she clearly stated that she understood the process of transplantation and would want a deceased donor transplant if her liver completely failed.

- No family members were with her during this assessment, but an interpreter was used.
In the Somali culture:

- Healthcare decision making is done in concert with family members; specially elder members of the family.
- Male members have a greater say in the decision process than their female counterparts.
- Decisions made by the patient can be overturned if they are not in conformity with the family wishes.
Clinic Follow Up

- Fortunately the clinical condition of the patient improved.
- She was discharged to home on prednisone taper (starting at 40mg) and azathioprine with close follow up in the transplant clinic.
- Patient was seen 2 weeks after discharge.
- She reported that she was feeling better, although she still had RUQ pain and diffuse weakness.
- **When questioned about medications, she replied that she was not sure what she was taking.**
Clinic Follow Up

- Exam remarkable for scleral icterus, tender RUQ; she had multiple scabbed marks over skin from cauterization (lesions c/w traditional healing techniques)

- Labs:
  - INR 1.47 $\rightarrow$ 1.73
  - AST 165 $\rightarrow$ 297
  - ALT 144 $\rightarrow$ 388
  - Tbilirubin 9.7 $\rightarrow$ 10.8

5.8 10.4 162,000
Harmful Traditional practices

There are many traditional practices in Africa which are termed as HTP.

- Group male circumcision
- Uvulectomy
- Female circumcision
- Premolar teeth extraction
- Tattooing
- Cauterization
- Cupping
HTP

- Scarifications and/or incisions.
- Rectal salting.
- Infibulation or female genital mutilation
- Blood letting.
Clinic Follow Up

- She appears to be headed towards remission
- Will continue prednisone taper and current dose of azathioprine
- Reinforced the importance of compliance with medications

- She will follow up in 2 weeks with repeat labs
Clinic Follow Up

- 2 weeks later, the patient failed to show up for her appointment
- Multiple attempts were made to contact her using an interpreter
- They were unable to get through as the patient did not have a working phone at home
- The clinic contacted the patient’s pharmacy and found that she was not filling her prescriptions, apparently due to financial issues
Barriers to Care

- How can you explain this behavior?
- Cultural factors
  - Differences in healthcare systems
    - Somalia vs. the US
- In much of rural Somalia, the only accessible health care providers are traditional healers and midwives
- “Western” medicine is primarily practiced in urban clinics and hospitals
Barriers to Care

- Cultural factors
  - Differences in healthcare systems
  - **Somalia vs. the US**

- An individual typically would not seek this type of care until significantly ill despite traditional remedies
- Care is focused on treating symptoms rather than prevention of disease
- Medications are nearly uniformly given at all visits, but are taken only to treat symptoms
- Healthcare decisions often made based on the input of multiple people e.g. Husband, wife.
Barriers to Care

Gender

- The healthcare worker gender working with the patient is important for compliance with:
  1. Visits
  2. Procedures

  e.g. You can increase compliance with colonoscopy if you offer doctor of the same gender to do the procedure.
Barriers to Care

- When interviewed about US healthcare, multiple MN Somalis commented that the medications given to them in Somalia always made them feel better, but those in the US often did nothing for their symptoms
  - “I have yet to take a medication that made me feel better.”
  - “They actually make you sicker.”
Barriers to Care

- Many also reported that if their medications worked and they felt well, that they would stop the medication and would not go back to their doctor for follow up
Barriers to Care

• Cultural Factors
  • Lack of trust in the Western Medical System
    • “They experiment on us”
    • “Doctors make money from all of the pills they prescribe”
    • Medications may contain ingredients made of pork products.
    • “Doctors may take your organs”

• US providers often do not understand traditional healing
  • Hmong experience
Clinic Follow Up

- The patient again missed her follow up appointment and was not filling prescriptions at her pharmacy.
OSH Admission

- 6 weeks after her previous clinic, she was brought to an OSH emergency department by family for evaluation of abdominal pain, jaundice and confusion

- They reported that she had not been taking her medications because she had been feeling well

- Somnolent
- icteric
- Has RUQ abdominal tenderness
- Skin with jaundice and multiple circular burns
- Asterixis
Total bilirubin 17.6
Alk phos 111
ALT 339
AST 890
Albumin 1.7
Total protein 7.8

INR 4.3
PTT 40
Ammonia 54
OSH Course

- While awaiting transfer to UMMC, the patient developed respiratory distress requiring intubation
  - Thought due to volume overload related to multiple units of FFP

- While in the ICU, she had multiple complications including
  - E. coli sepsis requiring pressors
  - Renal failure requiring dialysis (? hepatorenal syndrome)
  - Persistent coagulopathy

- She was eventually stabilized and was transferred to UMMC 21 days after her initial presentation
At time of admission, patient was **intubated** and minimally responsive.

The following labs were obtained:

- Total bilirubin: 33.1
- Alk phos: 129
- ALT: 245
- AST: 476
- INR: 3.74
- PTT: 38
- Ammonia: 43
- MELD: 40
Early morning, on the day after being listed, a liver became available:

- The patient was intubated at the time.
- An in-house interpreter was unavailable, so a phone interpreter was used to contact the patient’s mother.
- She arrived with multiple family members at 6am.
- The phone interpreter was used (via speaker) to facilitate discussion between the transplant team and family members.
Per nursing notes, the family had multiple questions about the procedure.

The nurse commented that there was extensive discussion between the family and the interpreter with little being passed on to the MDs. "I felt that things were not being conveyed correctly."

Eventually, the family turned down the liver.

There was no documentation in the chart from the transplant team about this meeting.
Barriers to Care

- **Language**
  - Immigrants with limited English proficiency are less likely to seek care
  - They also report lower satisfaction with care and less understanding of their medical conditions
Barriers to Care

- **Language**
  - When interpreters are used, perceived quality of care is directly linked to quality of interpreter, not the healthcare provider.
  - Doctor/patient language concordance might help that.
  - Children as interpreters.
  - Interpreters proficiency in the ethnic language.
Barriers to Care

- Useful tips for evaluating the interpreter:

1. Age of the interpreter at the time of immigration to the US.
2. Level of education.
3. Interpreter/patient gender concordance.
4. Does the patient trust the interpreter.
Barriers to Care

- Access to appropriately trained interpreters inadequate
- Although federally funded health facilities must provide interpretation for all patients who request it (Title VI of the Civil Rights Act of 1964), this is not universally being implemented
- Few financing mechanisms to support it (for example, only ten states require Medicaid to cover access to an interpreter)

www.sph.umn.edu/img/assets/9103/SPHbrief8-04.pdf
Barriers to Care

- In a statewide survey conducted by the U of M School of Public Health
- Nearly 75% of Hmong patients and 50% of Somalis reported that they did not get the right interpreter when needed in the healthcare setting
MICU

- Shortly after this meeting, the primary team arrived and arranged a care conference
  - A professional in-house interpreter was used

- The patient’s family was updated on her current situation

- They were able to ask questions about aspects of transplant that they still did not understand:
  - Will a student be doing the surgery alone?
  - How is the quality of the donor organ determined?
  - What if the donor is old?
  - What will happen to her if she doesn’t get a liver?
Once the family understood the process and consequences of not having surgery, they decided that they wanted to go ahead with the transplant.

Unfortunately, by this time, the available liver had gone to another candidate.

The family was very confused about this.
- The patient’s brother asked “but where is the supply kept?”

The team explained the protocol for transplant allocation.

The patient was again placed on the list.
Over the following 3 weeks the patient developed:
- Worsening renal failure requiring dialysis
- Coagulase negative staph bacteremia
- Enterococcal lung infection
- Pulmonary hemorrhage
- DIC
- Multisystem organ failure

She remained ineligible for a transplant during this period given clinical instability.

She was eventually made DNR and died 20 days after admission.
SUMMARY

- To have a good outcome, the healthcare professional should address many of the issues raised by this case in the first few visits.
  - Involve the social worker early, if you identify financial or insurance issues.
  - Study more diligently the interfamily dynamics and identify who are the decision makers.
  - If patient is uncomfortable with the gender of the healthcare professional, try your best to accommodate.
SUMMARY

- If you plan to give medications for a prolonged period of time or even lifelong, explain to the patient the rationale for taking it and the consequences for non-compliance.
- If you are using an interpreter, make sure he or she is proficient in the native language and ask the patient if they are comfortable in their presence.
- Your conversation with the patient might be more fruitful if the interpreter is of the same gender as the patient.