NHMA Screening and Brief Intervention Toolkit For the Hispanic Patient

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National Hispanic Medical Association

SUMMARY REPORT

Alcohol Screening Instruments Used With Hispanic Populations
August 2006

INTRODUCTION

Alcohol consumption is the third leading cause of death in the Unites States and costs over $148 billion each year.[1] Studies have shown that rapid, accurate alcohol screening instruments can detect alcohol problems in primary care settings and can positively impact alcohol consumption, morbidity, and mortality.[2] Alcohol consumption plays a key role in a large percentage of trauma incidents, including motor vehicle crashes. It is important to find a screening tool that can be used specifically for Hispanics because although heavy drinking is as common in Hispanics as it is in African Americans and non-Hispanic Whites, serious consequences of heavy drinking are more common in Hispanics than in other ethnic groups.[3] Attempts have been made to evaluate screening tools among Hispanics, such CAGE (**C**ut down on drinking, **A**nnoyance with criticisms about drinking, **G**uilt about drinking, alcohol as an **E**ye-opener), which had been validated in Spain[4] and other, more lengthy instruments in Mexico; however, screening tests developed and tested outside the United States may not be valid for Hispanics living in the United States[5] because they rely largely on patients' perceptions of their drinking. These perceptions may differ for Hispanics living the United States based on their level of acculturation.[6]

Although all screening tools have their limitations and further research is needed to find the right tool for Hispanics; the National Hispanic Medical Association's Advisory Board for Alcohol Screening and Brief Intervention recommends that health practitioners consider the Rapid Alcohol Problem Screen-Quantity & Frequency (RAPS4-QF) for use in their setting.

Alcohol Consumption Among Hispanics

There are significant differences across the Hispanic groups in their drinking patterns and problems. Mexican Americans report the most frequent and heavy drinking, and the greatest prevalence of drunkenness and alcohol-related problems. Cubans report the lowest percentages, and Puerto Ricans and other Hispanics are in between the other groups.[7]

Screening for Alcohol Problems

Clinicians have the opportunity to play a key role in detecting alcohol problems and in initiating prevention or treatment efforts. A variety of relatively brief screen-

ing instruments are available for this purpose. These instruments do not provide a diagnosis, but help identify patients who might benefit from a more thorough assessment of their drinking behavior. Patients should be screened not only for alcohol use disorders, but also for drinking patterns or behaviors that may place them at increased risk for developing adverse health effects or alcoholism (i.e., risky drinking). Risky drinkers who have not yet become alcohol dependent often can be treated successfully within the primary care setting.

ADVISOR TIP

Javier Sanchez, M.D., has observed that many Latinos are like some college students in that they tend to binge drink. These individuals work Monday thru Friday and do not drink, but on the weekends they drink heavily. Dr. Sanchez used to ask how much his patients drank in a week and most would say not much. He then would ask specifically how many beers/drinks the patients had a day (Monday through Friday) and how many beers/drinks they drank on Saturday and Sunday. By asking about drinking behavior this way, Dr. Sanchez identified a greater number of patients who might have had a problem with alcohol.[17]

The **RAPS4** is a four-item questionnaire In both primary care and emergency room settings, RAPS4 showed consistently high sensitivity for detecting alcoholism across gender and ethnic subgroups, although its utility for screening for risky drinking or alcohol abuse has yet to be proven. RAPS4 outperformed other commonly used tools for alcohol dependence across all gender, ethnic, and service utilization groups, except among blacks and Hispanics. The available tools that were considered by the committee were: AUDIT, TWEAK, CAGE, and RAPS4. The AUDIT, although tested with many cultural groups (including Hispanics) is too long and complicated, which leaves us with the TWEAK, CAGE, and RAPS4. The TWEAK was dismissed because it didn't work well for those who use the emergency department (which is a key point of health access for Hispanic patients). In conclusion, we are left with the CAGE and RAPS4. While the RASPS4 did not perform well with Hispanic patients, if you add the QF questions it performs significantly better for alcohol abuse and outperformed the CAGE across all gender, ethnic, and service utilization groups, and so the committee recommends it.

Detailed comparisons of various screening toolkits and additional research and readings can be found on the National Hispanic Medical Association Web site at ***www.nhmamd.org***.

CONCLUSION

The RAPS4-QF appears to be more sensitive than the other tools for identifying alcohol dependence and alcohol abuse, respectively, across gender, ethnic, and service utilization groups in a general population sample, suggesting that these may be the instruments of choice in brief screening for alcohol use disorders, both in clinical populations and in the general population among Hispanics. However, further research is needed to determine the usefulness of screening instruments for problem drinking within gender and ethnic subgroups in non-clinical populations.

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This toolkit should be used as a supplement to the existing screening toolkit developed by the American College of Emergency Physicians.

REFERENCES

1. Mokdad, A,H., Marks, J.S., Stroup, D.F., and Gerberding, J.L. (2000). Actual causes of death in the United States. *The Journal of the American Medical Association*, 291, 1238-1245.

2. Kahan, M., Wilson, L., and Becker, L. (1995). Effectiveness of physician-based interventions with problem drinkers: a review. *Canadian Medical Association Journal*, 152, 851-859. ABSTRACT

3. Sutocky, J.W., Shultz, J.M., and Kizer, K.W. (1993). Alcohol-related mortality in California, 1980 to 1989. *American Journal of Public Health*, 83, 817-823. ABSTRACT

4. Díez Martínez, S., Martín Moros, J.M., Altisent Trota, R., et al. (1991). Cuestionarios breves para la detección precoz de alcoholismo en atención primaria [Quick questionnaires for the early detection of alcoholism at primary care]. *Aten Primaria*, 8, 367-370. MEDLINE

5. Caballero Martínez, L., Caballero Martínez, F., and Santodomingo Carrasco, J. (1988). Instrumentos de detección de alcoholismo: precisiones sobre el cuestionario CAGE [Instruments for detecting alcoholism]. *Medicina Clinica* (Barc) 91, 515.

6. Aguirre-Molina, M., and Caetano, R. (1994). Alcohol use and alcohol-related issues. In Hispanic Health in the US: A Growing Challenge, 393-424. Washington, DC: American Public Health Association.

7. Cherpitel, C.J. (1998b). Performance of screening instruments for identifying alcohol dependence in the general population, compared to clinical populations. *Alcoholism: Clinical and Experimental Research*, 22, 1399–1404.

8. Cherpitel, C.J. (1995c). Screening for alcohol problems in the emergency room: a rapid alcohol problems screen. *Drug and Alcohol Dependence*, 40, 133–137.

9. Cherpitel, C.J. (2000). A brief screening instrument for problem drinking in the emergency room: the RAPS4. *Journal of Studies on Alcohol*, 61, 447–449

10. American Psychiatric Association. (2000). Diagnostic and Statistical Manual of Mental Disorders, Text Revision. 4th ed. American Psychiatric Association, Washington, DC.

11. Cherpitel, C.J. (2002). Screening for Alcohol Problems in the U.S. General Population: Comparison of the CAGE, RAPS4, and RAPS4-QF by Gender, Ethnicity, and Service Utilization. *Diagnosis and Treatment*, 26(11), 1686-1691.

12. Cherpitel, C.J. (1999). Screening for alcohol problems in the U.S. general population: a comparison of the CAGE and TWEAK by gender, ethnicity and service utilization. *Journal of Studies on Alcohol, 60,* 705–711.

13. Cherpitel, C.J. (1998a). Differences in performance of screening instruments for problem drinking among blacks, whites and Hispanics in an emergency room population. *Journal of Studies on Alcohol, 59*, 420–426.

14. Mayfield, D., McLeod, G., and Hall, P. (1974). The CAGE questionnaire: validation of a new alcoholism screening instrument. *The American Journal of Psychiatry*, 131, 1121-1123. ISI | MEDLINE

15. Wenrich, M.D., Paauw, D.S., Carline, J.D., Curtis, J.R., and Ramsey, P.G. (1995). Do primary care physicians screen patients about alcohol intake using the CAGE questions? *Journal of General Internal Medicine*, 10, 631-634. ISI | MEDLINE

16. National Institute on Alcohol Abuse and Alcoholism. (1995). *The Physicians' Guide to Helping Patients With Alcohol Problems* (NIH Publication 95-3769). Bethesda, MD: National Institute on Alcohol Abuse and Alcoholism.*

17. Sanchez, J. Physician-in-charge, Urgent Care Center, Kaiser Permanente Fontana Medical Center. E-mail sent on Thursday, 04 May, 2006 at 7:08pm ET.

*Update published September 2005 – Helping Patients Who Drink Too Much: A Clinician's Guide. **http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/guide.pdf**

INTRODUCTION TO ALCOHOL SCREENING TOOLKIT FOR HISPANIC PATIENTS

Alcohol Screening & Brief Intervention for Hispanic Patients

Alcohol use and abuse is a major preventable public health problem, especially among the increasing Hispanic population. It contributes to over 100,000 deaths each year[1] and costs society over 185 billion dollars annually.[18] Patients represent the entire spectrum of alcohol-related problems. This includes drinkers at-risk for injury and illness, those presenting with "harmful/problem drinking" such as impaired drivers, and at the far end of the spectrum, those with signs and symptoms of alcohol dependence.

Fortunately, there is something we can do.

Screening and Brief Intervention (SBI) does work.

There is compelling evidence in the literature that screening and brief intervention (SBI) for alcohol problems addresses those problems effectively and minimizes subsequent harm from drinking.[2] A recent evidence-based review of SBI examined 39 published studies including 30 randomized controlled and 9 cohort studies. A positive effect was demonstrated in 32 of these studies.[3] Multiple studies have demonstrated the efficacy of brief intervention in a variety of settings including general populations, primary care,[4] emergency departments, [5 6 7 8] and inpatient trauma centers.[9] Screening and brief interventions have been successful in communities that have taken steps to ensure cultural sensitivity in minority populations, especially among Hispanics.

The emergency room or trauma center visit is an opportunity for intervention.[10]

Patients presented to the emergency department (ED) are more likely to have alcohol-related problems than those presented to primary care. Cherpitel[11] recently compared patients presented to an ED with those presented to a primary care setting in the same metropolitan area. She found that ED patients were one and a half to three times more likely to report heavy drinking, consequences of drinking, alcohol dependence, or ever having treatment for an alcohol problem, than patients presented to a primary care clinic. In addition, the ED visit offers a potential "teachable moment" due to the possible negative consequences associated with the event bringing them into care in the first place.[12 13] Many Hispanic patients, especially those without insurance, may use emergency medical services in lieu of traditional primary care.

The primary care setting is an effective opportunity for intervention as well.

As stated earlier, primary care facilities don't report as high of levels of Hispanic patients with serious alcohol issues as do EDs. As Hispanic patients become more aware of their communities and of "Hispanic friendly" clinics in their area, primary care facilities will see an increase in Hispanic patients with alcohol issues and thus, should be prepared with the proper resources such as this toolkit. In addition, EDs are more accessible to Hispanic patients because they are easier to find and aren't as stringent with insurance policies and scheduling appointments.

ADVISOR TIP

> **Luis Aguilar, M.D.** suggest that *"The best results we have had in the primary care setting have been when intervention was initiated in the emergency room and the provider M.D., P.A., or social worker had the foresight to involve family, recognizing the power that the head of the household wields be it wife, mother, or grandmother. In that setting, referral follow-through is extremely high."*

Practical Screening Tools Are Available for Hispanic Patients.

This resource kit was developed to make the process as easy as possible. The kit provides three main components:

- A summary of existing screening tools with a recommendation by Hispanic Physicians
- A quick reference card (English and Spanish) that can be used for brief interactions with patients
- A guide to communicating effectively with Hispanic patients developed with input from members of the National Hispanic Medical Association

Screening

After careful review, RAPS4-QF seems to be the instrument of choice for Hispanic patients. A variety of screening tools are available. Their utility varies according to their availability, ease of administration, adverse consequences, and test characteristics. The utility of screening instruments is reduced with Hispanic patients since most tools are not translated or culturally relevant. The National Institute of Alcohol Abuse and Alcoholism (NIAAA) recommends the use of quantity and frequency (Q&F) questions as well as the Alcohol

Use Disorders Identification Test (AUDIT) developed by the World Health Organizations. The Q&F questions can elicit whether the patient is over the recommended levels for moderate drinking and therefore "at risk" for illness and injury. Although AUDIT is very effective among the general population, RAPS4-QF appears to be more sensitive than some other common screening tools for identifying alcohol dependence and alcohol abuse in Hispanic populations. This suggests that RAPS4-QF may be the instrument of choice in screening for alcohol use disorders, both in clinical populations and in the general population among Hispanics.

Brief Intervention

Brief interventions are short counseling sessions that can be as short as five minutes.[16] They often incorporate the six elements proposed by Miller and Sanchez summarized by the acronym FRAMES: feedback, responsibility, advice, menu of strategies, empathy, and self-efficacy. This model of communication avoids blaming or directing the patient to change his or her behavior. Instead, it works with the patient to develop a plan to reduce the negative consequences of their drinking. For "at-risk" or "harmful" drinkers who are not dependent, goal setting within safe limits, discharge instructions and a referral to primary care is all that may be needed. Since many Hispanic patients are reluctant to visit primary care, an ED could refer the patients to community clinics that offer complimentary services or reduced fees for minority or low-income patients. For those patients who are dependent or whose position along the spectrum of alcohol problems is unknown, the brief intervention is a negotiation process to seek further assessment and referral to a specialized treatment program.

Referral/Available Resources

Each facility must develop a culturally relevant resource list for their community. Communities should ensure that they are offering resources and referrals that have similar standards of cultural sensitivity toward Hispanic patients as their own community. Since most Hispanics require higher levels of trust when looking for assistance or establishing new relationships, more effort should be placed on providing services and resources that purposefully connect and make Hispanic patients feel comfortable.

By taking extra steps to ensure sensitive and trustworthy resources, the percentages of Hispanic patients who follow up on referrals and resources provided to them will increase.

REFERENCES

1. Harwood, H.J. (2000). Updating Estimates of the Economic Costs of Alcohol Abuse in the United States: Estimates, Update Methods and Data. Report prepared by the Lewin Group for the National Institute on Alcohol Abuse and Alcoholism.

2. Wilk, A.I., Jensen, N.M., and Havighurst, T.C. (1997). Meta-anaylsis of randomized control trials addressing brief interventions in heavy alcohol drinkers. J*ournal of General Internal Medicine*,12(5), 274-83.

3. D'Onofrio, G., and Degutis, L.C. (1997). A review of screening and brief intervention for alcohol problems: Implications for Emergency Medicine Practice. *Academic Emergency Medicine* (in press).

4. Fleming, M.F., Barry, K.L., Manwell, L.B., Johnson, K., and London, R. (1997). Brief physician advice for problem alcohol drinkers. A randomized controlled trial in community-based primary care practices. *The Journal of the American Medical Association, 277,* 1039-45.

5. Chafetz, M.E., Blane, H.T., Abram, H.S., Golner, J., Lacy, E., McCourt, W.F., Clark, E., and Meyers, W. (1962). Establishing treatment relations with alcoholics. *The Journal of Nervous and Mental Disease, 134,* 395-409.

6. Wright, S., Moran, L., et al. (1998). Intervention by an alcohol health worker in an accident and emergency department. *Alcohol & Alcoholism, 33,* 651-656.

7. Monti, P., Spirit, A., et al. (1999). Brief intervention for harm reduction with alcohol-positive older adolescents in a hospital emergency department. *Journal of Consulting and Clinical Psychology, 67,* 989-994.

8. Bernstein, E., Bernstein, J., and Levenson, S. (1997). Project ASSERT-An ED based intervention to increase access to primary care, preventive services, and the substance abuse treatment system. *Annals of Emergency Medicine, 30,* 181-189.

9. Gentillelo, L., Donovan, D.M., Duna, C.W., and Rivara, F.P. (1995). Alcohol interventions in trauma centers: current practice and future directions. *The Journal of the American Medical Association, 274,* 1043-1048.

10. D'Onofrio, G., Bernstein, E., Bernstein, J., Woolard, R.H., Brewer, P.A., Craig, S.A., and Zink, B.J. (1998). Patients with alcohol problems in the emergency department Part1: Improving detection. *Academic Emergency Medicine, 5,* 1200-1209.

11. Cherpitel, C.J. (1999). Drinking patterns and problems: a comparison of primary care with the emergency room. *Substance Abuse, 20,* 85-95.

12. Longabaugh, R, Minugh, P.A., Nirenberg, T.D., Clifford, P.R., Becker, B., and Woolard, R. (1995). Injury as a motivator to reduce drinking. *Academic Emergency Medicine, 2,* 817-825.

13. Cherpitel, C.J. (1996). Drinking patterns and problems and drinking in the event: an analysis of injury by cause among casualty patients. *Alcoholism: Clinical and Experimental Research, 20,* 1130-1137.

14. D'Onofrio, G., Mascia, R., Razzak, J., and Degutis, L.C. (2001). Utilizing health promotion advocates for selected health risk screening and intervention in the ED. *Academic Emergency Medicine, 8,* 543 (abstract).

15. Cherpitel, C.J. (1995). Screening for alcohol problems in the emergency department. *Annals of Emergency Medicine, 26,* 158-66.

16. D'Onofrio, G., Bernstein, E., Bernstein, J., Woolard, R.H., Brewer, P.A., Craig, S.A., and Zink, B.J. (1998). Patients with alcohol problems in the emergency department Part2: Intervention and referral. *Academic Emergency Medicine, 5,* 1210-7.

17. NIAAA's 10th Special Report to the U.S. Congress on Alcohol and Health, 2000. NIH publication No.00-158318. Aguilar, L. Vice President, El Dorado Internal Medicine PC. E-mail sent on Wednesday, 10 May, 2006 at 2:14 p.m. ET.

18. Sanchez, S. Director of Language Interpretive Services, Department of Multicultural Affairs, Grady Memorial Hospital, Atlanta, Georgia. E-mail sent on Tuesday, 18 April, 2006 at 11:17 a.m. ET.

19. Sanchez, J. Physician-in-charge, Urgent Care Center, Kaiser Permanente Fontana Medical Center. E-mail sent on Thursday, 04 May, 2006 at 7:08 p.m. ET.

20. Nieto, J. Assistant Clinical Professor of Surgery Division of Emergency Medicine University of Texas Health Science Center, San Antonio. E-mail sent on Wednesday, 03 May, 2006 at 3:21 a.m. ET

21. Mancini, P. Executive Director of CETPA, Atlanta, Georgia. E-mail sent on Monday, 17 April, 2006 at 5:03 p.m. ET

22. Aguilar, L. Vice President, El Dorado Internal Medicine PC. E-mail sent on Wednesday, 10 May, 2006 at 2:14 p.m. ET.

COMMUNICATING WITH HISPANIC PATIENTS

How to maximize your alcohol screening and brief intervention opportunity with Hispanic patients

In providing medical care to Hispanic patients, communication always takes place within a cultural, social context. Effective bicultural communication builds on cultural awareness and cultural sensitivity. This awareness is essential to successfully implementing alcohol screening and brief intervention with Hispanic patients.

Traditionally, and until recently, when targeting consumers across cultures, cultural awareness has been lacking. Good information regarding increasing cultural awareness can be found in "Marketing to American Latinos - A Guide to the In-Culture Approach" by Isabel Valdez. (Paramount Market Publishing, New York, 2000). Although Ms. Valdez addresses the Hispanic consumer, much of the information pertains to increasing the cultural relevance and it can be applied to alcohol screening and brief intervention with the Hispanic patient. Ideally, when working with consumers of different cultures, it is important to think and feel from the perspective of that culture. Messages should let patients know that the provider knows them and understands them.

ADVISOR TIP

Sandra Sanchez, Director of Language Interpretive Services at Grady Health System in Atlanta, Georgia, emphasizes the importance of cultural and lingual sensitivity in healthcare settings:

"Ideally the provider is both bilingual and bicultural. However, in many situations, that is not the case. Materials should be translated by certified translators and tested by several individuals who speak the target language and know the culture, to determine the appropriateness and intelligibility of the translated text."

Speaking the language is not enough. Cultural sensitivity is the key to ensuring that messages do not backfire or distract the patient from effectively hearing or understanding what is being communicated. Any alcohol information presented to patients as part of the alcohol screening and brief intervention should be reviewed in this way.

The National Hispanic Medical Association offers the follow key points for adapting your alcohol screening and brief intervention materials to effectively address Hispanic patients in your practice.

1. Cultural Competence

For a provider, it is important to understand that the Hispanic market is segmented. It is important to identify Hispanics of different regions, acculturation levels, countries of origin, and legal and socioeconomic status. Know the segmentation of the Hispanic community in which you work (are they predominantly Mexican, Puerto Rican, Cuban, Salvadorian?).

Impact Hispanics feel a strong sense of pride in their specific country of origin and a person will lose credibility if they feel that person is generalizing.

Suggestion Learning about specific services and supports available for alcohol use problems within each community is an important first step a provider can take in increasing the potential effectiveness of screening for this population.[2 3 4]

2. Mistrust

Hispanics tend to rely less on institutions than do middle-class Anglo Americans. Lack of trust in institutions (government, businesses, banks, health institutions) is a common trait among many Latinos. On many occasions Latinos/Hispanics view non-Latino/Hispanic doctors as too impersonal and distant. Latinos/Hispanics, the concept of "personalismo" (personal touch) in the doctor-patient relationship is crucial. When compared to non-Latino/Hispanic individuals, Latinos/Hispanics usually express more caution about the degree to which they should trust others and about how helpful people are. It is important to note that trust can be developed even without contact with the doctor or employees by creating an atmosphere that is "user friendly" to Hispanics (e.g., translated medical and insurance forms).

Impact When Latinos/Hispanics distrust a doctor they are less likely to comply with the recommended treatments or medications.

Suggestion Make patient/families feel comfortable by using better body language. Don't seem to be in a rush, sit down at eye level, give a pat on the shoulder and use some basic Spanish words. Acknowledge the family and make a connection. [2 3 4]

ADVISOR TIP

Dr. Sandra Sanchez feels that developing a professional relationship between interpreters and health care providers and establishing clear roles and expectations for both parties will support the establishment of a trusting patient-provider relationship.

3. Family Interdependence

For Anglos, individual achievement rules, but for Latinos family interdependence takes precedence, especially in the healthcare setting. The individual in the Anglo model tends to make decisions unilaterally, while the Latino will try to make his or her decisions to complement the needs of the family group. Whereas Anglos tend to be task oriented, Latinos focus on relationships.

Impact If the head of the households (usually women) are not part of the "prescription" as well as other important family members, their will most likely not follow through on the "prescribed" intervention.

Suggestion Acknowledge family members and try to creatively invite them into the decision-making process and intervention for the patient. Try to pay special attention to the individual who seems to be the "head" of the household because that person can be the point of influence.[2 3 4]

ADVISOR TIP

Javier Sanchez, M.D., has noticed that since Latinos usually arrive at his facility with other family members, he finds that most leave the facility and walk directly into the treatment facility, which is across the street, to begin treatment.

4. Lifestyles

Latino/Hispanic perception of drinking is different from the perception of Americans. Food and drink is the main focus of almost all Latino/Hispanic social activities and refusing to eat, even when it is in excess, is considered somewhat disrespectful for some Latino/Hispanic subgroups.

Impact A Hispanic patient will not go to "intervention" if it is for something that has been defined in their culture as normal. They won't understand!

Suggestion Take extra time with Hispanic patients to define the "Anglo" definition of alcohol misuse or have a chart in Spanish with examples of quantity and frequency consequences of alcohol misuse.[2 3 4]

5. Cultural/Religious Beliefs

Some Latinos/Hispanics define their illnesses according to folk practices and are referred to as folk-defined illnesses or culture-bound syndromes. Many prefer to rely on folk or home remedies instead of seeking professional health care. Folk healers such as "curanderos," "yerberos," or "santeros" and/or folk and home remedies are often used to treat these illnesses. Some Latinos/Hispanics think that illnesses (such as diabetes) are hereditary and determined by God, therefore, they believe that the disease must be accepted and endured as a possible "castigo divino" (punishment) for personal sin or sins of family members. Latino/Hispanic elderly may refuse to accept government help for health care because they perceive a welfare stigma attached to it.

Impact These informal health care systems could be counterproductive in delivering appropriate health care when the health care professionals are not aware of such activities

Suggestion A healthcare professional could ask the patient if folk medicine is common practice in their family. If so, taking time to explain that the alcohol problem has complications that "technically" cannot be fixed through faith or a folk healer. [2 3 4]

6. Not "User Friendly" or Accessible

Hospitals, primary care facilities, clinics, and most health systems in the United States can be difficult and stressful for English speaking citizens who have lived here all of their lives. The process of making an appointment, listening to automated answering services, finding the right room and department, finding a doctor within your "network," then having to fill out five pages of "pre-registration" is not very user friendly for those whose native language is English; imagine the increased difficulty faced by a non/limited English person dealing with all of these complexities.

Impact In order to avoid the stress and complexity of our health system, many Latinos will put off intervention or a medical visit, try to find a "folk remedy," or continue to ignore the medical issue.

Suggestion Have a Hispanic and/or bi-lingual receptionist to greet potential Latino patients. Have visible instructions in Spanish at your building's entrance with instructions on how to navigate through the building, where to sign in, how to fill out any paperwork and the options regarding insurance. Then, promote your institution among Hispanic community outreach/advocacy groups as a place that is "Latino Friendly."

ADVISOR TIP

Pierluigi Mancini, Ph.D., Executive Director for the Clinic for Education Treatment and Prevention of Addiction, Inc. in Atlanta, Georgia, believes that the process of interacting with United States institutions is overwhelming for many Hispanics. Most Hispanics with low acculturation levels and limited English proficiency assume that clinics, private practices, community health centers, and hospitals will not be "user friendly," and often they don't clearly understand insurance policies or how to access health programs that may be available to them. In turn, they revert to other types of providers to meet their health care needs or they give up. This is especially relevant when making a referral for further alcohol or drug treatment. Additional supports may be needed in order for this population to successfully access additional treatment providers after the initial brief intervention.

Suggestions provided are endorsed by the following Hispanic physicians who are project advisors for this toolkit from the National Hispanic Medical Association.

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Pocket Guide

RAPS4-QF (in the last 12 months)[1]

- (Remorse) During the last year have you had a feeling of guilt or remorse after drinking?
- (Amnesia) During the last year has a friend or family member ever told you about things you said or did while you were drinking that you could not remember?
- (Perform) During the last year have you failed to do what was normally expected from you because of drinking?
- (Starter) Do you sometimes take a drink when you first get up in the morning?
- (Quantity) During the last year have you had 5 or more drinks on at least one occasion?
- (Frequency) During the last year did you drink as often as once a month?

RAPS - QF en Español (RARC4-CF)

- (Remordimiento) ¿Durante el último año, se sintió culpable o tuvo remordimientos por haber bebido?
- (Amnesia) ¿Durante el último año, le ha hablado un amigo o familiar de cosas que usted haya hecho o dicho cuando estaba bebiendo, las cuales no recuerda?
- (Realizar) ¿Durante el último año, dejó de hacer algo que debería haber hecho por beber?
- (Comenzar) ¿Tomó usted en ocasiones una copa por la mañana inmediatamente después de levantarse?
- (Cuantidad) ¿Durante el último año, se tomo cinco o más bebidas en más de un ocasión?
- (Frecuencia) ¿Durante el último año, has bebido al menos una vez al mes?

POSITIVE SCREEN:[1]

- A positive response on any item qualifies as being positive on the RAPS:
- The first question of the RAPS, having to do with feeling guilt or remorse after drinking, identifies over 80% of those meeting criteria for alcohol dependence.
- A positive response on both of the Quantity and Frequency items increases sensitivity of the RAPS4 for identifying those currently meeting diagnostic criteria for alcohol abuse and harmful drinking.

THEN ASSESS FOR:[2]

- Medical problems: blackouts, depression, hypertension, injury, etc.
- Laboratory: Liver function tests, macrocytic anemia
- Behavioral problems
- Alcohol dependence

INTERVENE:[2]

If at-risk/harmful drinker:

- Advise patient of risk.
- Set drinking goals.
- Provide referral to primary care.

If alcohol dependent drinker:

- Assess acute risk of intoxication/withdrawal.
- Negotiate referral (i.e., detoxification, AA and primary care).

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Toolkit downloadable at **www.nhmamd.org/nhtsa.htm**

Toolkit references also available at **www.nhmamd.org**

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