Hispanics/Latinos and Cardiovascular Disease

Heart disease is the leading cause of death for all people in the US, and stroke is the third leading cause of death. Heart disease and stroke are also major causes of disability and significant contributors to increasing health care costs in the US. The mortality rate for cardiovascular disease (heart disease, stroke, and chronic obstructive pulmonary disease) is greater than the combined rate for all other leading causes of death (cancer, unintentional injuries, pneumonia/influenza, diabetes, suicide, kidney disease, chronic liver disease and cirrhosis). (US DHHS, 2000). The major risk factors for cardiovascular disease are hypertension, smoking, hypercholesterolemia, high alcohol consumption, and lack of physical activity. (Tamir and Cachola, 1994).

Cardiovascular disease (CVD) refers to a wide variety of heart and blood vessel diseases and conditions, including coronary heart disease (CHD), stroke, high blood pressure, and high blood cholesterol. CHD accounts for the largest proportion of heart disease. (US DHHS, 2000). Medical research continually contributes to a body of data that confirms that certain populations are disproportionately affected by diabetes and CVD. (US DHHS, 2003).

Condition: Hypercholesterolemia
For adults, a normal blood cholesterol level is less than 200 mg/dL; borderline is 200 to 239 mg/dL, and 240 mg/dL or above is considered high. Based on the 1998 Heart and Stroke Statistical Update, an estimated 96.8 million American adults (51%) have blood cholesterol levels of 200 mg/dL or higher. (Hong and Bayat, 1999).

Condition: Hypertension
Hypertension (high blood pressure) is a leading cause of stroke, renal disease, and cardiac disease for all populations in the US. (Tamir and Cachola, 1994). Hypertension is defined as elevated blood pressure, or systolic blood pressure of 140 mmHg or higher and diastolic blood pressure of 90 mmHg or higher. One in four American adults has high blood pressure. (Hong and Bayat, 1999). Contributors to hypertension include age, gender, relative body weight, alcohol consumption, ethnicity, place of birth, education level, psychological factors, and knowledge and awareness. (Tamir and Cachola, 1994).

This section of the Provider’s Guide provides information on the incidence, health practices and beliefs, health challenges, and adherence factors for Hispanics/Latinos related to cardiovascular disease and stroke.

- **Incidence and Conditions**
- **Traditional Health Beliefs and Practices**
- **Risk Factors and Challenges**
- **Strengths and Protective Factors**
- **Adherence Factors**
- **References and Resources**

Risk Factors and Challenges

Cholesterol Levels

- **Among Mexican Americans aged 20 to 74, 53% of men and 48% of women have total blood cholesterol levels of 200 mg/dL or higher.** Eighteen percent of men and 17% of women have levels of 240 mg/dL or higher. (American Heart Association, 2003).

- **More than 41% of Mexican-American women have low-density lipoprotein, or "bad" cholesterol, levels of 130 mg/dL** or higher, putting them at higher risk for CHD. (National Women's Health Information Center, 2003).

- Data from the National Health and Nutrition Examination Survey (NHANES III) show that **there are no significant differences in serum total cholesterol levels among Mexican Americans, African Americans, and non-Hispanic whites.** (CDC, 2003).

Obesity

- Data from the 1999–2000 National Health and Nutrition Examination Survey show that more adult women (33%) than men (28%) are obese. **Forty percent of Mexican-American women are obese,** compared with 30% of non-Hispanic white women. (CDC, 2002).

- **Mexican-American adolescents aged 12 to 19 were more likely to be overweight (24%)** than were non-Hispanic white adolescents (13%). In addition, **Mexican-American children aged 6 to 11 were more likely to be overweight (24%)** than were non-Hispanic black children (20%) and non-Hispanic white children (12%). (CDC, 2002).

- Mexican Americans of low socioeconomic status are often of Indian rather than European descent, in contrast to Mexican Americans of higher socioeconomic status. **Indian heritage is associated with a higher prevalence of obesity and therefore a greater risk for diabetes.** (National Women's Health Information Center, 2003).

- The **prevalence of obesity in the Hispanic/Latino population aged 18 and over increased from 11.6% in 1991 to 23.7% in 2001,** according to self-reported data from the Behavioral Risk Factor Surveillance System. (CDC, 2003).

Suggestion
Emphasize the strengths of the Hispanic/Latino diet and provide examples of low-fat alternatives by focusing on cultural values. For further information on healthy traditional foods and the patterns of a Latin American–style diet, see the Latin American diet pyramid at http://www.e-guana.net/organizations.php3?orgid=61&typeID=193&action=printContentItem&itemID=1535. (Oldways Preservation and Exchange Trust, 2003).

Physical Activity

- Hispanics in general are more obese, **less physically active,** and less likely to participate in lifestyles that promote cardiovascular health. As a consequence, they are more likely to have diabetes than the general US population. (National Women's Health Information Center, 2003).

- According to the 1997 Behavioral Risk Factor Surveillance System Report, **65% of Hispanic adults in Texas do not participate in regular physical activity.** (Talamantes et al., 2003).

Recommendation
Encourage your Latino patients and their families to take up a physical activity that the whole family can enjoy: dancing. Suggest that they move to the beat of salsa, meringue, tejano, cumbia, and other Latin music, and that they dance to three of their favorite songs every day. Other suggestions could include going for a walk with a friend or family member, walking around while talking on the phone, or taking the stairs instead of the elevator. (American Diabetes Association, 2003).

Smoking

- Data from the 1997 National Health Interview Survey show that **overall, smoking prevalence among Hispanic adults was 20.4%,** compared with 25.3% for whites. Among Hispanic men, 26.2% smoked, compared with 27.4% of white men. For Hispanic women, the smoking rate was 14.3%, compared with 23.3% for white women. (CDC, 1998).

- The Centers for Disease Control and Prevention's Youth Risk Behavior Surveillance System found that about **one-third of Hispanic students in grades 9 through 12 were current cigarette smokers.** (CDC, 1998).

- Among Hispanic adults, **19% were current smokers, 16% were former smokers, and 65% had never smoked.** (Pleis and Coles, 2002).

Racism

- **Vulnerable and marginalized groups in society experience an undue proportion of health problems.** Many health disparities are rooted in fundamental inequalities in the social structure, which are inextricably related to racism and other forms of discrimination in society. Research has shown that inequalities in the health and health care of ethnic and racial groups are evident, and racism is the most disturbing explanation for these inequalities. (World Health Organization, 2001).

- **Studies in the US report an association between perceived racial discrimination and high blood pressure, birth weight, and sick days.** In a recent study from the United Kingdom, victims of discrimination were more likely to have respiratory illness, high blood pressure, anxiety, depression, and psychosis. Stress responses have been considered possible mechanisms for the effects of racism on health. (McKenzie, 2003).

Health Insurance Coverage and Access to Quality Care

- **Of all major racial or ethnic groups, Latinos have the lowest rate of health insurance coverage.** (Pew Hispanic Center, 2002).

- In 1999–2000, **32.9% of Hispanics were without health insurance coverage.** (US Census Bureau, 2002).

- **The probability of Hispanics/Latinos under age 65 being uninsured is 35%,** compared with 17.5% of the general population under age 65. This disparity results largely from the lack of job-based insurance provided to Hispanics/Latinos, who work disproportionately in blue-collar and service-oriented jobs. (Smedley et al., 2003).

- **The vast majority of Hispanics are in working families, yet only 43% receive health insurance through work.** Cuban Americans have the highest rate of job-based or private health insurance coverage (65%) and are less likely to be uninsured (21%). **Less than half of people of Puerto Rican (45%), Central and South American (46%), and Mexican (44%) origin have job-based or other private insurance.** Over one-third of Puerto Rican Americans (34%) are insured by Medicaid or other publicly funded programs. More than 40% of Americans of Central and South American heritage are uninsured, including 38% of Mexican Americans. (Smedley et al., 2003).

- Quality care comes from a doctor who knows you, but not everyone has a regular doctor. According to the Commonwealth 2001 Health Quality Survey, **43% of all Hispanics in this country do not have a regular doctor.** By contrast, only 20% of white Americans do not have a regular doctor. (National Cancer Institute, 2003).

Language and Communication

- **More than 25% of Hispanic/Latino individuals in the US live in linguistically isolated households.** In addition, nearly 8 million Hispanic/Latino Americans do not speak English "very well." Given recent population shifts, it is likely that these figures grossly underestimate the number of Hispanic/Latino Americans with limited English proficiency. (Smedley et al., 2003).

- According to the Commonwealth 2001 Health Quality Survey, **33% of all Hispanics in the US report having difficulty communicating with their doctors.** By contrast, only 16% of white Americans report the same difficulty. (National Cancer Institute, 2003).

- Among Hispanic/Latino elders, **Cuban elders are the least likely to be proficient in English (54% are not proficient), making them the most isolated linguistically.** Thirty-six percent of Puerto Rican elders are not proficient in English, as are 28% of Mexican-American elders. (Talamantes et al., 2003).

Recommendations
To improve communication with your Hispanic/Latino patients:

- Utilize trained medical interpreters when communicating with Hispanic/Latino patients who are not proficient in English.
- Avoid using friends, family, or children for medical interpretation.
- When using a medical interpreter, arrange the seating so that you are facing the patient, and have the interpreter sit alongside or slightly behind the patient.
- Use appropriate titles, such as *Señor* for Mr., *Señora* for Mrs., and *Señorita* for Miss, even if you don't speak Spanish. Using these titles shows respect for your patients. If you speak Spanish, show respect by using the more formal *usted* rather than *tu*.

(Kaiser Permanente, 2001).

- Out of a sense of *respeto,* **many Hispanic patients tend to avoid disagreeing with or expressing doubts to their health care providers** about the treatment they are receiving. They may even be reluctant to ask questions or to admit that they are confused about their medical instructions or treatment. Associated with this is a cultural taboo against expressing negative feelings directly. This taboo may manifest itself in a patient's withholding information, not following treatment orders, or terminating medical care. (Management Sciences for Health, 2003).

References and Resources

American Diabetes Association. (2003). The diabetes assistance & resources (DAR) program. http://www.diabetes.org/main/community/outreach/latinos/dar.jsp. Cited September 23, 2003.

American Heart Association. (2002). Heart disease and stroke statistics—2003 update. http://www.americanheart.org/downloadable/heart/10590179711482003HDSStatsBookREV7-03.pdf. Cited August 6, 2003.

American Heart Association. (2003). Hispanics and cardiovascular disease. http://www.americanheart.org/downloadable/heart/1059108199897FS05HIS3REV7-03.pdf. Cited August 6, 2003.

Centers for Disease Control and Prevention (CDC). (1998, last reviewed April 2003). *Hispanics and tobacco.* Atlanta, GA: CDC. http://www.cdc.gov/tobacco/sgr/sgr_1998/sgr-min-fs-hsp.htm. Cited August 5, 2003.

Centers for Disease Control and Prevention (CDC). (2002). Obesity still on the rise, new data show. http://www.cdc.gov/nchs/releases/02news/obesityonrise.htm. Cited September 15, 2003.

Centers for Disease Control and Prevention (CDC). (2003). National health and nutrition examination survey: Cholesterol status among adults in the United States. http://www.cdc.gov/nchs/data/nhanes/databriefs/adultcholesterol.pdf. Cited September 26, 2003.

Centers for Disease Control and Prevention (CDC). (2003). Obesity trends: 1991–2001 prevalence of obesity among US adults, by characteristics. http://cdc.gov/nccdphp/dnpa/obesity/trend/prev_char.htm. Cited September 15, 2003.

Hoffman, C., and Pohl, M. (2000). *Health insurance coverage in America: 1999 data update.* Washington, DC: Kaiser Commission on Medicaid and the Uninsured.

Hong, B., and Bayat, N. (1999). National Asian American and Pacific Islander cardiovascular health action plan: Eliminating racial and ethnic disparities in cardiovascular health: Improving the cardiovascular health of Asian American and Pacific Islander populations in the United States. http://www.apiahf.org/publications/cvd1.html. Cited July 31, 2003.

Kaiser Permanente. (2001). *A provider's handbook on culturally competent care: Latino population.* Oakland, CA: Kaiser Permanente National Diversity Council.

National Diabetes Information Clearinghouse. (2002). *Diabetes in Hispanic Americans.* NIH Publication No. 02-3265. Bethesda, MD: National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), National Institutes of Health. http://www.niddk.nih.gov/health/diabetes/pubs/hispan/hispan.htm. Cited August 5, 2003.

National Women's Health Information Center. (2003). *Frequently asked questions about health problems in Hispanic American/Latino women.* Washington, DC: US DHHS, Office on Women's Health. http://www.4woman.gov/faq/latina.htm. Cited July 30, 2003.

Oldways Preservation and Exchange Trust. (2003). The Latin American diet pyramid. http://www.e-guana.net/organizations.php3?orgid=61&typeID=193&action=printContentItem&itemID=1535. Cited September 23, 2003.

Pleis, F.R., and Coles, R. (2002). Summary health statistics for US adults: National health interview survey, 1998. *Vital Health Statistics* 10(209). Atlanta, GA: National Center for Health Statistics.

Smedley, B.D., Stith, A.Y., and Nelson, A.R. (eds.). (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care.* Washington, DC: National Academies Press, Institute of Medicine of the National Academies.

Talamantes, M., Lindeman, R., and Mouton, C. (2003). Ethnogeriatric curriculum module: Health and health care of Hispanic/Latino American elders. Stanford University. http://www.stanford.edu/group/ethnoger/hispaniclatino.html. Cited September 23, 2003.

Tamir, A., and Cachola, S. (1994). Hypertension and other cardiovascular risk factors. In Zane, N.W.S., Takeuchi, D.T., and Young, K.N.J. (eds.). *Confronting critical health issues of Asian and Pacific Islander Americans*. Thousand Oaks, CA: Sage, pp. 209–246.

US Department of Health and Human Services (US DHHS). (2000). *Healthy people 2010: Understanding and improving health,* 2nd ed. Washington, DC: US Government Printing Office. http://www.bphc.hrsa.gov/quality/HealthyPeople2010.htm. Cited August 26, 2003.

US Department of Health and Human Services (US DHHS). (2003). *Demographics and health disparities.* Draft curriculum module 2 for Cultural Competence in the Clinical Care Model Project. Health Resources and Services Administration, Bureau of Primary Health Care.