

D.C. Language Access Coalition

Primary Health Care and Language Access in the District of Columbia

September 30, 2009

Introduction

The D.C. Language Access Coalition received \$30,000 from the Consumer Health Foundation in FY2008–2009 to help lay the foundations of a health care campaign that exposes and confronts language access barriers in the District of Columbia’s hospitals and health clinics. The Coalition utilized its funding to hire a health organizer and develop mechanisms for assessing and monitoring the linguistic accessibility of services at District health centers to individuals that are limited and non-English proficient (LEP/NEP). The Health Care Research Project has two components. The first consists of a survey of pharmacies and hospitals carried out through provider interviews, direct observation, and over-the-phone testing. The goal of the survey is to identify the major practices and potential gaps to health care access for the District’s LEP/NEP population. The second component of the research project is the collection of stories from LEP/NEP patients about their experiences attempting to access health care services in the District. This component focuses on the barriers and gaps that affect LEP/NEP individuals’ access to primary health care. A preliminary overview of data collected so far paints an emerging picture of a health care system in the District that takes inadequate steps to provide language access to its LEP/NEP patrons and falls far short of providing equal access to English language learners – especially among non-Spanish speaking immigrants.

Hospital and Pharmacy Surveys: Preliminary Findings

The Coalition has used surveys of the District’s hospitals and clinics to yield baseline data on the types of language resources that frontline staff members utilize to serve limited or non-English proficient individuals. This survey focuses on the points of entry of hospitals or health clinics, especially the main lobby and the emergency room. The survey has three components: (a) observation of the types of multilingual signage posted on walls, (b) interviews with frontline employees about the types of oral language services and translated documents that they offer to patrons, and (c) testing the availability of oral languages over the phone through phone inquiries in foreign languages. The data yielded from these methods provide an indication of whether or not these spaces might be perceived as LEP/NEP friendly environments and illustrate staff members’ preparedness to address the needs of the LEP/NEP population. Here are some cogent points yielded from the survey data.

1. Hospitals often use interpreters and bilingual staff as a first option, but rely heavily on telephonic interpretation to fulfill their communication needs. Staff members at all the hospitals surveyed (7/7) contract with telephonic interpretation companies. These staff members claimed that they or their colleagues use the service to communicate with individuals of a variety of language backgrounds. At least two hospitals had blue CyraCom phones with two headsets distributed throughout the facility for use in communication with patrons. Other

hospitals were able to use telephonic interpretation with standard desk phones through other providers. Most of the hospitals (4/6) used interpreters or bilingual staff (4/6) as the first option to assist Spanish-speaking LEP/NEP patients at points of entry with telephonic interpretation as a last-resort, but on-site interpretation was scarce for other languages widely spoken in the District. In contrast, less than half of the clinics (7/15) surveyed reported having access to telephonic interpretation and most of them (12/15) use bilingual staff as the primary mode of communication with Spanish-speaking LEP/NEP patrons. Very few clinics were equipped with bilingual staff to serve individuals that spoke other languages widely spoken in the District such as Amharic (5/15), French (3/15), Mandarin/Cantonese (1/5), Vietnamese (2/15), or Korean (0/15).

2. Hospitals and clinics are rarely equipped to answer oral language inquiries over the phone. Health researchers used over-the-phone oral language inquiries in Spanish, Amharic, and French to test providers' ability to successfully respond to LEP/NEP patrons' needs by telephone. Of the nineteen over-the-phone inquiries made by directly to a staff member of eight District hospitals, hospital staff members only successfully connected the caller with a bilingual staff member or interpreter that could answer the inquiry ten percent of the time. Most phone calls made to community clinics were directed to an automated system or answering machine that was often available in Spanish (12/16) or Amharic (1/16), but clinic staff rarely answered inquiries in Spanish (1/8), Amharic (2/16), or French (0/13) with success at the times they were reached.
3. Signage is seldom available in Spanish and considerably less in other languages. Many hospitals post patient rights signs (4/6) and notices of interpretation services in Spanish (4/5) and other languages (2/5). Directional hallway signs (2/6) and patients rights information (5/6) is also posted in Spanish, but no other translated signs in any other languages were found in hospitals. The few community clinics that served a large contingent of immigrant patients offered a variety of signage in Spanish, but rarely in other languages.
4. Hospitals and clinics seldom offer vital documents in languages other than Spanish. Instead, they rely heavily on sight translation to help LEP/NEP patrons understand vital documents. Vital documents include consent forms, policy forms, and patient rights information. Sight translation here is defined as an instance where a bilingual staff member or a monolingual staff member with the help of an interpreter either explains the content of a document and/or assists a person in filling out a document in their own language. Most of the hospitals (4/6) and clinics (12/14) surveyed reported that they offer some vital documents in Spanish, but hospitals (1/5) and clinics (4/13) rarely distribute documents in other languages. Few hospitals (1/5) or clinics (4/13) offered vital documents in other languages. Instead, providers greatly rely on sight translation to assist LEP/NEP patrons in completing documents using telephonic interpretation (8/15) or a bilingual staff member or interpreter (8/13).
5. Clinics and hospitals rarely use resources like "I Speak" cards to identify the language spoken. Only half of all hospitals (3/6) and one clinic (1/10) surveyed reported that they used an "I

Speak” card or poster to identify the language that an LEP/NEP individual speaks. Most providers reported that they have staff members that identify the language spoken by LEP/NEP patrons and never use an “I Speak” card or other resource.

The points above do not yield conclusive data. However, they do begin to paint a picture of the resources that resource-rich hospitals and under-resourced community clinics are taking to address the needs of the LEP/NEP communities. The data shows that some hospitals have developed systematic procedures for addressing the needs of the immigrant communities while others respond to these needs in a relatively haphazard manner. It also demonstrates gaps – most prominent is the fact that, while the Spanish speaking community in the District has a plethora of linguistically accessible health care resources available to it, speakers and readers of Chinese languages, French, Amharic, and other language communities widely represented in the District do not.

Story Collection: Preliminary Findings

Trained volunteers gathered stories from 12 Limited English proficient (LEP) community members, using a standard survey form. In addition, two focus groups were held with community groups of LEP members, which engaged 24 participants in story gathering. 42 short stories were gathered through a survey of students at a local ESL school. Lastly, 6 community advocates that work directly with LEP community members were interviewed. In sum, 72 community members have contributed their voice to this project. In each of the interviews and surveys, participants were asked to identify times in the recent past when they have been able to access interpreters or translated documented in medical setting or have had trouble accessing medical care due to a lack of these language services.

Of the stories considered for this analysis, those that were explicitly stated to have taken place in the past 2 years were given the most weight. However, it should be noted that many of the responses from the survey of ESL students did not indicate a date of occurrence. These stories were still taken into account for the purposes of this analysis, but were used only to substantiate themes that arose in other, more recent, events.

All of the respondents were LEP and attested that they speak English less than very well. The majority of the respondents were Spanish speaking (only two spoke a foreign language other than Spanish), however advocates from the African communities were consulted in order to bring in the perspectives of those LEP communities. Of the respondents who received in-depth interviews, about half utilized the D.C. Alliance as their main form of health insurance. All others were uninsured.

Twelve different medical facilities were discussed in the interviews and surveys, including five community health centers, a specialty clinic, and six hospitals. In addition, three pharmacies were discussed. The majority of the complaints focused on five of the hospitals, the specialty clinic, and one of the health centers. One of the hospitals received equal amounts of praise and complaints, and the remaining four community health centers were identified as places where patients can always interact with bilingual staff and/or receive an interpreter.

The stories indicated the great value and importance of receiving an interpreter. One of the interviewees whose husband received interpretation through a bilingual staff member at a hospital emphasized that, if she hadn't been able to communicate through an interpreter and understand everything the doctor said, she and her husband wouldn't have been able to prepare for her husband's surgery in the correct way, which may have been dangerous to her husband's life.

Many interviewees told stories about trouble accessing medical services because of their limited English capability. Twenty of the stories collected discussed medical encounters that took place without an interpreter. During these encounters, the patients had trouble communicating their concerns and understanding the instructions of the provider. In many cases, the patients resorted to using hand signals to try to get their points across. In other cases, the patients felt discriminated against. As one man put it, "My wife doesn't speak any English and when they went to get a prescription exam, they just made fun of her." Many of the interviewees did know that they could request an interpreter for their appointments; in fact, two of them talked about times when they requested an interpreter at the medical facility and weren't provided with one. In five of the stories, the interviewee suffered negative health outcomes as a result of not being able to get quality medical attention through an interpreter. One woman had blood tests done on her because they confused her with someone else with the same last name, and she was unable to ask why they were doing it to her. Another man was unable to explain his diabetes concerns and receive proper treatment. One young woman, Daniela, had a particularly troubling experience:

I was 8 weeks pregnant and began to bleed. I went to the ER because I was afraid I was miscarrying. None of the staff there spoke Spanish and I was not checked. They just prescribed me medicine for Chlamydia and sent me away. I didn't know what to do. Everything moved so fast.

In some of these cases, patients avoid problems of not being able to access an interpreter by bringing a family member or a friend along to interpret. Advocates in the African community indicate that this is the main way LEP African immigrants receive health services in D.C. Nevertheless, there are many problems that arise from using informal interpreters in this way. One of the community advocates interviewed, for example, told the story of what happened when a 9-year old girl was interpreting for her grandmother:

The grandmother was receiving electric shock treatment as part of the therapy and the girl was scared because she knew her grandmother was in pain. She decided on her own to tell the therapist that the voltage was too high.

Two other major issues identified in the stories are the long wait times and canceled appointments that LEP patients often experience. Interviewees mentioned wait times between two and five hours in emergency rooms and outpatient clinics of four of the hospitals. One woman said that, even after waiting for five hours, they canceled her appointment and asked her to come back the following day. These interviewees were all certain that their limited English capabilities were the main reason there were "left for last," as they could see other people who arrived after them being called in as they

waited. Other interviewees mentioned having their appointments canceled because no interpreter was available.

Of all the respondents inquired about translated documents, all but one said that they did not receive documents in their language in the hospitals and pharmacies. Others expressed their frustration in trying to navigate the medical system as an LEP individual, because most of the necessary forms are in English and many of the calls they are told to make are to staff members that only speak English.

In addition to trouble accessing care, a number of the stories also pointed to cases when language access was successfully achieved. The interviewees mentioned that interpreters are available at two of the hospitals and that there is bilingual staff available to interpret at two others. In addition, a number of interviewees (7) mentioned times when interpreters from two of the health centers accompanied them on their hospital visits and specialty appointments. This service helps fill the gaps in lack of interpreter services at the hospitals. Nevertheless, when one considers the stories that this project has documented, it is clear that many people are still falling through the cracks.

Next Steps

The last several months have been spent developing and refining mechanisms for collecting baseline and ongoing data on the best practices and barriers that help and hinder the LEP/NEP community's access to health care in the District. Clearly, gaps to access exist that disproportionately impact the limited and non-English proficient community's access to basic health care. Many providers have begun to take steps to close this gap, but their efforts have not gone far enough. The D.C. Language Access Coalition is committed to refining these mechanisms and tools for exposing these gaps, but the most important part of the work is ahead of us. Our Coalition strives for a health program that is by the community and for the community. We plan to morph the health research project into a participatory research project – one that integrates current and former limited-English proficient community members and makes them the lead in data collection, data analysis, advocacy, and organizing. We hope to hire on a part-time health organizer to advance community integration and gather community members together incrementally to identify and prioritize the issues that their own communities face and take the necessary steps to resolve these issues. The story collecting process, in particular, will be a technique that plays a key part in the organizing. Whatever method the organizer uses, community members must be brought in to take the lead on addressing health care issues and tell the providers directly about the linguistic barriers that they face in accessing quality care.