

**HEALTH CARE EXPERIENCES AMONG  
LIMITED ENGLISH PROFICIENT INDIVIDUALS**

**SUBMITTED TO:**  
OFFICE OF MINORITY HEALTH  
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

DEVELOPMENT OF A DRAFT HEALTH CARE  
LANGUAGE SERVICES IMPLEMENTATION GUIDE  
*National Standards for Health Care Language Services Contract*

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**FINAL FOCUS GROUP REPORT  
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## TABLE OF CONTENTS

<b>1.0</b>	<b>INTRODUCTION .....</b>	<b>1</b>
1.1	RATIONALE FOR FOCUS GROUP COMPOSITION .....	1
1.2	LAYOUT OF REPORT .....	3
<b>2.0</b>	<b>METHODS .....</b>	<b>4</b>
2.1	RECRUITMENT .....	4
2.2	DATA COLLECTION.....	4
2.3	DATA ANALYSIS.....	5
2.4	LIMITATIONS .....	5
<b>3.0</b>	<b>PARTICIPANT CHARACTERISTICS .....</b>	<b>6</b>
3.1	HISPANIC SEGMENT .....	6
3.2	CHINESE SEGMENT .....	7
<b>4.0</b>	<b>ANALYSIS .....</b>	<b>9</b>
4.1	HISPANIC SEGMENT.....	9
	<i>Choosing a Health Care Provider.....</i>	9
	<i>Scheduling an Appointment.....</i>	9
	<i>Notification of LAS Services.....</i>	10
	<i>Language Assistance through an Informal Interpreter.....</i>	11
	<i>Language Assistance through a Formal Interpreter.....</i>	12
	<i>Language Assistance through Bilingual Staff and Providers.....</i>	14
	<i>Translated Signs and Materials.....</i>	15
	<i>Emotions.....</i>	16
	<i>Improving Communication.....</i>	16
4.2	MANDARIN SEGMENT.....	18
	<i>Choosing a Health Care Provider.....</i>	18
	<i>Scheduling an Appointment.....</i>	18
	<i>Notification of LAS Services.....</i>	19
	<i>Language Assistance through an Informal Interpreter.....</i>	19
	<i>Language Assistance through a Formal Interpreter.....</i>	19
	<i>Language Assistance through Bilingual Staff and Providers.....</i>	21
	<i>Translated Signs and Materials.....</i>	23
	<i>Emotions.....</i>	23
	<i>Improving Communication.....</i>	24
4.3	COMPARISONS BETWEEN HISPANIC AND MANDARIN GROUPS.....	25
<b>5.0</b>	<b>GUIDE RECOMMENDATIONS.....</b>	<b>27</b>
<b>6.0</b>	<b>CONCLUSION .....</b>	<b>29</b>
<b>APPENDIX A: RECRUITMENT SCREENERS .....</b>		<b>30</b>
	<i>SCREENER FOR FOCUS GROUPS WITH HISPANIC PARTICIPANTS (ENGLISH) .....</i>	30
	<i>SCREENER FOR FOCUS GROUPS WITH CHINESE PARTICIPANTS (ENGLISH).....</i>	35
<b>APPENDIX B: MODERATOR GUIDE (IN ENGLISH).....</b>		<b>39</b>

## FIGURES

<b>FIGURE 1: NUMBER OF PERSONS SPEAKING ENGLISH AT HOME (2000)</b> .....	<b>2</b>
<b>FIGURE 2: NUMBER OF PERSONS SPEAKING ENGLISH AT HOME (2002)</b> .....	<b>2</b>
<b>FIGURE 3: COUNTRY OF ORIGIN AMONG ASIAN IMMIGRANTS (2000)</b> .....	<b>3</b>
<b>FIGURE 4: COUNTRY OF ORIGIN AMONG HISPANIC PARTICIPANTS</b> .....	<b>6</b>
<b>FIGURE 5: AGE BRACKETS AMONG HISPANIC PARTICIPANTS</b> .....	<b>7</b>
<b>FIGURE 6: INCOME BRACKETS AMONG HISPANIC PARTICIPANTS</b> .....	<b>7</b>
<b>FIGURE 7: AGE BRACKETS AMONG CHINESE PARTICIPANTS</b> .....	<b>8</b>
<b>FIGURE 8: INCOME BRACKETS AMONG CHINESE PARTICIPANTS</b> .....	<b>8</b>

## 1.0 INTRODUCTION

As part of its mission, the Office of Minority Health (OMH), U.S. Department of Health and Human Services (HHS) seeks to “improve the health of racial and ethnic minority populations through the development of effective health policies and programs that help to eliminate disparities in health.” According to the US Census, the number of limited English proficient (LEP) individuals<sup>1</sup> increased from 5,764,638 in 1990 to 9,664,875 in 2000, reflecting a 68% rise in the number of LEP individuals in the US over the ten year period. The provision of language access services (LAS) in health care settings increases the likelihood that LEP individuals will receive appropriate care that will contribute to improving their health status.

Due to limited resources, small health care organizations are often constrained in their ability to provide effective LAS. In order to meet the needs of LEPs and small health care organizations, OMH is supporting the development of a guide that will help small health care organizations to implement LAS for LEPs. The American Institutes for Research (AIR) is providing assistance to OMH in the development of a draft Health Care Language Services Implementation Guide (HC-LSIG). The guide will provide practical, ground-level suggestions and detailed, action-oriented alternatives for how health care administrators and providers can implement LAS in their health care settings. The development of the guide will be based on the OMH Recommended National Standards for Culturally and Linguistically Appropriate Services (CLAS) in health care,<sup>2</sup> issued in 2000. The guide will also take into account other existing federal guidance such as the Revised HHS LEP Guidance (Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons),<sup>3</sup> last updated in 2003.

AIR will solicit expert guidance and use field research to develop the implementation guide. AIR established a panel of experts in the field of LAS to provide valuable input on the content and format of the implementation guide. The first expert panel meeting was convened in August 2004, during which preliminary input on the guide was solicited. Field research included site visits to small health care organizations with experience implementing LAS, telephone interviews with health care professionals, and focus groups with LEP individuals. This report focuses on the results of the focus group component of the project.

### 1.1 Rationale for Focus Group Composition

AIR conducted focus groups with LEP individuals in order to better understand their experiences when seeking health care. The information provided by participants during these discussion

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<sup>1</sup> LEP individuals are defined as those 18 years old and over that speak English “not well” or “not at all” (as opposed to “well” or “very well”).

<sup>2</sup> Office of Minority Health, Public Health Service, U.S. Department of Health and Human Services (2000). Recommended National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care. 65 Fed. Reg. 80,865 (Dec. 22, 2000). Available at: <http://www.omhrc.gov/clas>.

<sup>3</sup> Office for Civil Rights, U.S. Department of Health and Human Services (2003). Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons. 68 Fed. Reg. 47,311 (Aug. 8, 2003). Available at: <http://www.hhs.gov/ocr/lep/revisedlep.html>.

groups will be used to develop portions of the HC-LSIG that relate to such issues as interpreter training, requirements for interpretation, and management of LEP patient care.

Census data reveal a trend of changing demographics among LEP populations in the United States (US). The current research was designed to explore the language needs of the main LEP population groups in the US. Using qualitative methodology, focus groups were conducted with Hispanic and Chinese participants.

As discussed in a 2002 Report to Congress,<sup>4</sup> determining the size of LEP populations can be challenging. The report recommends determining LEP size by examining foreign languages spoken at home and immigration data. It is important to note that both methods have limitations. For example, examining languages spoken in the home does not accurately determine LEPs, because it does not account for those who speak English as well as another language at home. Even with these limitations in mind, analysis of languages spoken at home and immigration data is likely one of the best means available for deriving an approximation of LEPs in the US.

According to the US Census Bureau (see Figure 1), the majority of people in the United States in 2000 spoke English at home (82.12%). Of the 17.88% who speak other languages at home, 60% speak Spanish. The next most common language spoken in the home is Chinese. This reflects a change since 1990, when French was reported as the language most commonly spoken at home in the United States, after English and Spanish. The trends above are also verified by the 2002 American Community Survey (see Figure 2).

**Figure 1: Number of Persons Speaking English at Home (2000)**

Language	Total
English	215,423,557
Spanish or Spanish Creole	28,101,052
Chinese	2,022,143
French (incl. Patois, Cajun)	1,643,838

Source: US Census Bureau, 2000

**Figure 2: Number of Persons Speaking English at Home (2002)**

Language	Total
Speak only English	213,350,672
Spanish or Spanish Creole	28,985,921
Chinese	2,149,165
French (incl. Patois, Cajun)	1,389,987

Source: American Community Survey (2002)

<sup>4</sup> Report to Congress. Assessment of the Total Benefits and Costs of Implementing Executive Order No. 13166: Improving Access to Services for Persons with Limited English Proficiency (March 14, 2002). Available at: <http://www.whitehouse.gov/omb/inforeg/lepfinal3-14.pdf>

In terms of immigration, the US Census Bureau reported that in 2000, among the foreign-born population in the US (by country of origin), most were born in Latin America (51.7%), followed by Asia (26.4%), Europe (15.8%), Africa (2.8%), and others (3.2%).

Within Asia, most were born in China, followed by the Philippines, India, Vietnam, and Korea in descending order (see Figure 3). The researchers chose to recruit Chinese participants that spoke standard Mandarin, as it is the language most commonly spoken in China, and it is the official language of the People’s Republic of China in mainland China, and the Republic of China in Taiwan.

**Figure 3: Country of Origin among Asian Immigrants (2000)**

<b>Asian Country</b>	<b>Total</b>
China	1,518,652
Philippines	1,369,070
India	1,022,552
Vietnam	988,174
Korea	864,125

Source: US Census Bureau (2000)

## **1.2 Layout of Report**

Chapter 2 details the methods used to recruit focus group participants and describes the procedures used to collect and analyze the focus group data. The chapter concludes with a discussion of study limitations. Chapter 3 presents a summary of respondent characteristics. Chapter 4 provides an analysis of the focus group data, with the findings from the focus groups with Hispanic patients presented first, followed by the findings from the focus groups with Chinese patients. Chapter 5 provides recommendations for improving the HC-LSIG. Chapter 6 provides a conclusion to the report.

## **2.0 METHODS**

This chapter presents the methodology used to recruit focus group participants (Section 2.1), followed by the methods used to collect (Section 2.2), and analyze (Section 2.3) the focus group data. The chapter concludes with a discussion of study limitations (Section 2.4).

### **2.1 Recruitment**

AIR coordinated with a professional recruiting firm to recruit participants through its database. The Hispanic participants were recruited directly from the database. Due to the limited number of LEP Chinese participants in the database, a mass e-mail identifying the project was sent to these participants offering them an incentive if they recommended anyone who met the screening criteria and participated in the group. All Chinese participants who responded spoke with a fluent Mandarin-speaker during the screening process.

The screening guides (Appendix A) used to recruit both the Hispanic and Chinese participants were developed by AIR in consultation with OMH. AIR monitored recruitment and provided approval for each screened participant. Participants received a reminder call the day before the scheduled group.

All participants were required to have seen a health care professional in the last year and to be comfortable participating in a group discussion conducted entirely in Spanish (for Hispanic participants) or Mandarin (for Chinese participants). For the purposes of the research, each participant must have been deemed to be LEP. For the participant to be designated as an LEP participant, he/she had to meet three conditions:

1. The participant was not comfortable speaking English in public.
2. The participant had difficulty understanding a health care professional because they spoke English only.
3. The participant preferred to read consumer information in Spanish (for the Hispanic participants) or Mandarin (for the Chinese participants).

### **2.2 Data Collection**

Four focus groups, lasting approximately 90 minutes, were held in the Washington, DC metropolitan area. Two of the focus groups consisted of Spanish-speaking LEP individuals, and two consisted of Mandarin-speaking LEP individuals. Both focus groups with Hispanic participants had 9 participants each. The focus groups with Chinese participants had 9 participants in the first group and 7 participants in the second group.

The focus groups were semi-structured in nature and questions were open-ended to elicit in-depth responses from participants. The discussions focused on four key areas:

1. General communication with health care providers
2. Personal experiences using interpreters
3. Need for translated material and signage
4. Language needs at all points-of-contact during the visit

Two professionally trained moderators, one fluent in Spanish and one fluent in Mandarin, conducted the focus groups. The moderator guide (Appendix C) for the focus groups was developed by AIR in cooperation with OMH and translated into Spanish and Mandarin. The guide was also approved by AIR's Institutional Review Board (IRB).

Upon arrival to participate in the focus group, participants were greeted by a language-appropriate native speaker and provided with a consent form in their primary language. The consent form outlined the purpose and procedures involved in the research, the duration of the subject's participation, risks and benefits, issues of confidentiality, the primary point of contact for questions, and a statement that interviewee participation is voluntary. The consent form also requested permission to audio-record the interview. Participants received a monetary incentive for their participation.

The focus groups were audio-recorded and then transcribed and translated into English. AIR researchers observed the focus groups and noted their observations and impressions to later inform the analysis.

### **2.3 Data Analysis**

AIR researchers followed a systematic methodology to analyze the focus group data. First, researchers read the transcripts (translated into English) from each focus group and coded the transcripts based on recurring themes. Preliminary findings were shared with and reviewed by other project staff, most notably other researchers present during the focus groups.

For each of the language segments, the findings are presented according to language group with the Hispanic group analysis preceding the Chinese group analysis. For each of the Hispanic and Chinese segments, the analysis is presented according to the underlying themes identified in the interview guide. Comparisons between language segments are included in the final analysis section.

### **2.4 Limitations**

Qualitative methods were appropriate for this study because they allowed the researchers to obtain highly detailed responses in the words of the respondents rather than limiting their responses to categories that are difficult to predefine given the issues discussed. In addition, while the sample size is small, the respondents in the sample offer unique ground level perspectives that are too pertinent to exclude.

The findings presented in this report are based on the opinions expressed during the focus groups. Care was taken in presenting the results to give an accurate depiction of the degree to which opinions were shared. However, in using qualitative methods, statistical significance or generalizability of the results is not feasible, nor was it the intent of the study. The findings are based on input from a relatively small sample of participants and thus do not provide generalizable views about the audiences examined. Therefore, although the findings presented in this report accurately reflect the opinions expressed during the focus groups, they should be interpreted as suggestive and directional rather than definitive.

The goal of the study was to uncover general patterns in the data, explore interesting or unexpected ideas or perspectives raised by participants, and to establish a firm basis for future decision making. In this case, the data provide a means for making decisions about what issues are important to LEPs when seeking health care and further, what issues are relevant for inclusion in a health care language services implementation guide.

### 3.0 PARTICIPANT CHARACTERISTICS

The impact of demographic trends within language groups should be considered in the assessment of differences between the two groups. However, demographics between the two language groups cannot be directly compared due to cultural differences not assessed by this research.

#### 3.1 Hispanic Segment

The screening guides did not set recruitment quotas for participants’ countries of origin. Figure 4 indicates that the 18 recruited participants came from a variety of countries. The Hispanic groups had relatively the same number of men and women participating (10 and 8 participants respectively). In terms of age, the Hispanic groups had a larger representation of participants in the 35–49 age bracket, as compared to other age brackets (see Figure 5).

The educational background of participants varied widely. While roughly half of the Hispanic participants were non-high school graduates (8 participants), 5 had high school/high school equivalent degrees and 5 had college or more advanced degrees. The majority of Hispanic participants reported earning \$20,000–\$39,000 annually (see Figure 6). In addition, the majority of Hispanic participants (15 of the 18 participants) reported that they did not have health insurance at the time of the focus groups.

**Figure 4: Country of Origin among Hispanic Participants**

Country of Origin	Number
El Salvador	6
Honduras	3
Bolivia	3
Peru	1
Guatemala	1
Venezuela	1
Colombia	1
Argentina	1
Uruguay	1
<b>Total</b>	<b>18</b>

**Figure 5: Age Brackets among Hispanic Participants**

<b>Age</b>	<b>Number</b>
18–34	4
35–49	10
50–64	4
65>	0
<b>Total</b>	<b>18</b>

**Figure 6: Income Brackets among Hispanic Participants**

<b>Income Bracket</b>	<b>Number</b>
Less than \$20,000	5
\$20,000–\$39,999	12
\$40,000–\$49,999	0
\$50,000–\$75,000	1
More than \$75,000	0
Currently not employed	0
<b>Total</b>	<b>18</b>

### **3.2 Chinese Segment**

In terms of country of origin, 9 of the 16 recruited participants were from Taiwan and 7 of the participants were from mainland China. The female participants in the Chinese groups outnumbered male participants by slightly more than 2 to 1 (11 and 5 participants respectively). The participants in the Chinese focus groups present a continuum of ages decreasing in representation from youngest to oldest (see Figure 7).

The majority of the Chinese participants (13 participants) stated that they had college or more advanced degrees, while 2 participants had high school/high school equivalent degrees, and 1 was a non-high school graduate. The Chinese participants were distributed evenly throughout the income brackets (see Figure 8). However, the largest portion of participants reported that they were unemployed. In addition, the majority of Chinese participants (14 of the 16 participants) reported that they had health insurance at the time of the focus groups.

**Figure 7: Age Brackets among Chinese Participants**

<b>Age</b>	<b>Number</b>
18–34	7
35–49	5
50–64	3
65>	1
<b>Total</b>	<b>16</b>

**Figure 8: Income Brackets among Chinese Participants**

<b>Income Bracket</b>	<b>Number</b>
Less than–\$20,000	0
\$20,000–\$39,999	3
\$40,000–\$49,999	3
\$50,000–\$75,000	4
More than \$75,000	0
Currently not employed	6
<b>Total</b>	<b>16</b>

## 4.0 ANALYSIS

This chapter presents the findings from the focus groups. The findings from the focus groups with Hispanic patients are presented in Section 4.1, followed by the findings from the focus groups with Chinese patients in Section 4.2. The chapter concludes with a comparison of findings between the two segments (Section 4.3).

### 4.1 Hispanic Segment

#### *Choosing a Health Care Provider*

The majority of participants follow friend and family recommendations when selecting a health care provider. Participants also emphasized that the cost of services and the capabilities of personnel to communicate in Spanish served as determining factors when choosing a provider. Participants said they rely on recommendations from friends and family because friends and family often recommend providers who offer language assistance through Spanish-speaking personnel and affordable medical services. Participants also mentioned obtaining recommendations from Medicaid personnel at social services, a listing of providers in a directory or a health insurance manual, and a Spanish newspaper.

*“In my case, the times I have needed medical service, the first thing I do is ask a family member or my friends if they know of an [affordable] place because I do not have insurance. The first thing I look at is how much are they going to charge me. I have to have someone who is affordable.”*

*“Well in my case, I went to a doctor who spoke my language and who was accessible to a person without insurance...The first doctor I found was like that [from a directory]. The second came from a referral from a friend. I connected with him.”*

One participant used a provider at the participant’s place of employment and another two participants said that they used the emergency room as their primary provider. In addition, a couple of participants mentioned that they have chosen a provider off the black market (i.e., a legal U.S. resident who is a trained professional from another country who has not yet been licensed in the United States). Participants said that the fees for black market services are half the normal office charges from a licensed health care provider.

*“...because the black market is half price. He did a good job. I don't see illegals. They are people who are legal. Who come and are professionals in their own countries, but they come here and they do not have a license, but they have the knowledge.”*

#### *Scheduling an Appointment*

General medicine visits constitute most of the provider visits, although participants also reported seeing specialists, pediatrics, obstetricians, and emergency room physicians. Although a few

participants chose to get assistance from other people when scheduling appointments, the majority had scheduled their own appointments with health care providers (15 participants total). Nearly all of the participants reported using the telephone to schedule appointments, but a few chose to do so in person when possible.

*“I called and made the appointment. At the hospital, there is always a number you can call in Spanish. You can ask for someone in Spanish.”*

Of the participants who scheduled their own appointments, all reported that at least one staff person in their provider’s office spoke Spanish, so it was relatively easy to schedule appointments, provided that staff person was available. All of these participants preferred setting appointments with Spanish-speaking personnel for the ease of communicating the details of the visit. One respondent stated that the lack of Spanish-speaking personnel to assist in scheduling appointments has been the reason for switching to another provider.

*“For me, the appointment was easy because I found someone who could speak Spanish. To make the appointment, I always need to find someone who speaks Spanish.”*

### ***Notification of LAS Services***

Nearly all participants stated that they were asked about their LAS needs at the beginning of their appointment, including assistance filling out the required paperwork. These participants said that the office provided personnel who were able to communicate with them in Spanish or inform them that someone from staff would be joining them to assist with any language needs. One participant also described an office visit where the organization collected data on the participant’s family background, race, and ethnicity through requested intake forms.

*“I went with my little girl...I had an appointment for her. I had to fill out a mountain of papers so they would know what country I am from and where my little girl was born, all of that.”*

However, one participant reported that language assistance services were offered only at the point of scheduling the appointments and not during the actual appointments.

*“Only for the [making of the] appointment when I contacted them. I needed somebody who spoke Spanish. After the [making of the] appointment, they didn't ask where I was from. They didn't ask me if I needed [an interpreter].”*

Participants recommended notifying the community of LAS services through radio, local community groups, and health fairs. They felt it is helpful for organizations to provide informational pamphlets on their available services, as well as available programs that could assist patients in paying for medical services.

*“We have a very big need for information for all services offered by each hospital and each health care center...things that we can access. These are our rights. I tell people, ‘This is your right. You have to reach out [to] them.”*

### ***Language Assistance through an Informal Interpreter***

The majority of participants had used an informal interpreter (i.e., a friend or family member) to help them communicate during a health care visit. Many of the participants named immediate family members including spouses, sons, and daughters, although a few had chosen a friend to accompany them. A few participants had gone alone to office visits, but nearly all participants said that they preferred to have someone accompany them to interpret. The presence of an informal interpreter during the appointment was preferred over going alone, mainly due to the participant’s confidence and trust in the person acting as an informal interpreter. Being unable to fully express one’s own thoughts and concerns in a foreign language, the participants felt added comfort in depending on someone who speaks English and knows them personally to speak on their behalf. Therefore, bringing an informal interpreter provided them with an assurance that their needs would be fully communicated to the provider.

*“What happens is that sometimes someone speaks and you need the person who is doing the translating that knows you well. Not just like someone who is only translating the word. No, this person needs to know what you feel. That’s why you take someone you’re confident in.”*

Most participants indicated that communication with staff was much easier when they were accompanied by an informal interpreter. When an informal interpreter was present, the participants felt that they had a greater understanding of what staff members said during the visit and staff also had a greater understanding for the concerns of the participants.

When using an informal interpreter, participants said that the friend or family member talks with the provider before the exam. Participants stated that taking informal interpreters into the exam room depended on the comfort level of the participants and the reason for the exam.

*“I asked them to stay because I wanted to know everything and at that time the two doctors who were with me didn’t speak Spanish.”*

*“I have my opinion and if the case is [serious] and you have to consult a specialist, then the person can go in. That is going to help you with translations.”*

Although participants said that they feel comfortable in depending on close friends or family members to serve as informal interpreters, they also noted that using the assistance of children is not the best option. Several participants expressed that it should not be the responsibility of the child to communicate vital medical information back and forth between the provider and participant.

*“It’s hard for a child to act as an adult.”*

Participants also expressed that they did not think it was appropriate to involve their child in situations dealing with serious medical conditions they would rather keep private.

*“I didn’t want my son to accompany my husband because I didn’t want my son to have to find out about the problem my husband had. He was the only one that could translate. They gave us someone else to translate. It was a case of cancer and it was private.”*

Participants stated that another difficulty in using informal interpreters is that they sometimes do not possess the proper language skills. A few participants explained that they have used family members as informal interpreters because they trusted them, but the family members were not the best choices because they were raised in America and did not speak Spanish fluently. Therefore, these informal interpreters were able to communicate well with the providers in English but sometimes could not interpret correctly into Spanish for the participant.

*“I have a nephew and sometimes he gets the words incorrect. He doesn’t understand Spanish very well. He has to learn a little bit more.”*

A few participants reported that difficulties can occur in medical cases where the informal interpreter may not be familiar with the medical terminology and is unable to explain what the provider is saying. Communicating with a provider through an informal interpreter can also be challenging because some words have no direct translation. In those cases, some participants stated that it would be better to request a professional interpreter.

### ***Language Assistance through a Formal Interpreter***

The majority of the participants had used a formal interpreter in the past. Formal interpreters utilized by participants included staff members who have been hired as interpreters, telephonic interpretation services, and interpreters from community agencies that accompany patients during appointments upon request. The participants agreed that the gender of the interpreter is not relevant to them, except in the case of OB/GYN exams.

Similar to the use of an informal interpreter, participants stated that the ease of communication between themselves and the provider depends on the skills of the formal interpreter. It is important for interpreters to possess the knowledge of medical terminology to ensure accurate communication from patient to provider and vice versa. Participants expressed that the vocabulary used in daily Spanish conversation is very different from the medical terminology used by health care professionals. Therefore, the participants felt it is necessary for formal interpreters to be qualified at a level where they are able to simplify medical terms and to communicate the provider’s thoughts in a clear and comprehensive fashion to the participants.

*“The language of doctors is distinct. That's why away from the house, you can communicate. Like if you are going to supermarket or other activity. Basically, the language of doctors is difficult to understand. It's difficult Spanish.”*

Participants agreed that it is also crucial for formal interpreters to be familiar with the differences among cultures since those differences can affect how the participant will respond in certain situations.

*“I think it's important for the person who is going to translate and the doctors that they should know the culture. They should respect our values and they should also respect our customs, Or at least try to understand what is happening to our body, our emotions, Because many times we have many habits and it benefits you when you go somewhere and they tell you...you are thinking that they don't care. But for us, men and women, we have customs. It is important that they understand.”*

*“Basically, the person who is going to help me, we don't need that they interpret our words, but that they also interpret our emotions”*

Due to the differences among cultures, one participant expressed a preference to use a Hispanic formal interpreter over a non-Hispanic formal interpreter. The participant felt that the Hispanic interpreter would be more familiar with the participant's culture.

*“If I see an interpreter who is American and one who is Latino, I will go with the Latino one. I know that he feels what I feel. He knows my culture and he knows my dialect.”*

As this participant mentioned, dialect also plays a large role in cultural differences. Participants explained that being able to speak Spanish is sometimes not enough because patients come from a variety of countries that have different regional dialects. This can be an issue in working not only with non-Hispanics who have learned a certain dialect of Spanish, but also with Hispanics who have grown up learning a certain dialect. Therefore, one participant said that since patients often do not know who their assigned formal interpreter will be, some prefer to rely on informal interpreters because they know that the informal interpreter shares the same dialect.

*“Because we are very distinctive in our expressions and the person that they put to translate, doesn't understand what we are asking of the doctor. Sometimes that's why we take people that we have confidence [trust] in.”*

Several of the participants had previously used telephonic interpretation during appointments. One participant said that the patient is given one phone and the provider is given another, and they are communicating to each other through the interpreter who is at the other end of the phone line. Although a couple of respondents seemed pleased with telephonic interpretation services, several had complaints about the quality of equipment used and trying to communicate with

someone who is not present in the room. Nearly all participants preferred to have an interpreter physically present during the appointment.

*“...sometimes you don’t understand what they are saying to you because they are talking so fast.”*

*“In my case, it is better to have direct communication. If it’s over the phone, sometimes you miss it or if you’re on the speaker it sounds far away. You don’t feel the same confidence with a telephone apparatus as you do with a person you trust.”*

One participant also said that trusting an interpreter that you cannot see can be difficult and the participant often wonders if the interpreter is really providing an accurate interpretation of what the provider is trying to communicate.

A couple of participants also noted that they sometimes felt the formal interpreters were adding their own opinions to the interpretations. The participants were frustrated with this because they were not seeking the input of the interpreters. They just wanted to be able to understand what the providers were saying.

### ***Language Assistance through Bilingual Staff and Providers***

Several participants mentioned that language assistance through bilingual providers is the optimal choice because it allows the participants and providers to communicate directly with each other. However, participants did express a few points of concern. Similar to the use of formal interpreters, participants felt that one point of concern with using bilingual staff and providers was the importance of cultural understanding. One participant explained a preference to use a Latino provider who can speak English over a non-Hispanic provider who can speak Spanish because the participant felt the Latino provider would be more familiar with the participants’ culture and upbringing.

*“If I have a treatment, and if the doctor is an American who has learned to speak Spanish and if I have a Latino that speaks English, I will feel a thousand times better with the Latino that speaks English”*

Participants also stressed that a provider or staff member should not claim to be bilingual unless they are positive that they can fluently speak Spanish. Although participants stated that the ability to speak some Spanish does improve the level of understanding, they also mentioned that a staff member or provider who speaks broken Spanish does not instill the same trust and confidence in the respondent.

*“The doctor called the assistant who was a person who spoke Spanish. But her translation, I didn’t understand what it was. It wasn’t very efficient for me and I had problems understanding what they needed to do.”*

Participants also discussed that they have trouble placing trust in providers who do not understand Spanish at all. They feel that the providers do not explain what they are doing during procedures. The participants also feel that it is not possible for providers to properly serve the participants if they cannot understand the symptoms the participants are trying to describe. One participant described an instance where there was no interpreter and the provider was not bilingual. The participant felt that the appointment could have been more efficient and productive if an interpreter had been present.

*“I feel uncomfortable and dissatisfied because I thought he did not have sufficient information in my case. Having a person that could translate would make it much better.”*

One participant described an experience where the provider depended on the internet to translate the thoughts he entered into the computer. The participant said that the translations were confusing and inaccurate, so the provider and the participant were unable to communicate well. Participants said that providers who do not speak or understand Spanish do not take the time to understand the participants’ concerns and discharge them early without providing complete treatment.

*“Because of the language, he wasn't interested in searching into what was wrong with me and finding a person who could explain. I don't think it's discrimination, but they just don't want to take the time. They just want to keep moving from one patient to the next.”*

### ***Translated Signs and Materials***

Most of the participants had seen translated materials in some format. Pamphlets that describe the topic in both Spanish and English were preferred by participants. Participants also stated that they preferred materials that they can take home with them and that written materials are faster to review than video-based media. One participant seemed to be pleased with the availability of translated materials.

*“Well in my case, I feel I have found good information in Spanish in most hospitals and clinics. I think they have concentrated their efforts into trying to give us good translated information. I don't have any complaints.”*

Other participants were not as satisfied and felt that the quality of available materials could be improved if they were written by individuals who have a greater understanding of the language.

*“It's poorly translated. I forget where I went the other day that the information was poorly translated. They are translated poorly because the people...the ones who translate...that's why I say that the person who speaks must know how we speak Spanish so it can be translated well in English and that the person knows both Spanish and English. At times they put things that we have a hard time learning in Spanish. Very poorly written.”*

Participants stated that they had received translated materials including prevention materials, materials that explained diseases, and a video about vaccinations from their health care provider. One participant said that they retrieved patient education materials via the internet.

The majority of participants said they would like to see more translated materials on available services, medication instructions, details about their health conditions, and materials on preventive health to avoid unnecessary visits to the emergency room. Participants noted that they would like more translated information on navigating through the health system and finding doctors who work well for them. In addition, several participants described a lack of available information regarding the billing system and understanding why certain charges were incurred.

### ***Emotions***

Most participants reported positive experiences when visiting a health care provider where a native Spanish-speaking interpreter was available. A Hispanic (formal or informal) interpreter was preferred over a primarily English-speaking provider with Spanish-training. When a primarily English-speaker interprets, the participants reported that they were dissatisfied with the explanation, and were left doubting the treatment plan.

*“I believe that discrimination is a lack of patience. They see that you cannot speak much English and then they don't want to waste their time. So that causes them to dispatch you quickly.”*

Although none of the participants reported a sense of embarrassment or relief when the appointment was over, many participants indicated that a sense of trust was absent in their visits. Some participants stated that this was due to the frustration they felt with being unable to get the care they needed due to language barriers.

*“The problem is communication. Because I could see in the hospitals where I was at [receiving] care, that there were problems because of communication. The [patient] couldn't express themselves. Sometimes they would speak a little English and get frustrated. I think that's the problem, not discrimination. That [patient] gets frustrated because they can't express themselves well; what hurts; what they feel.”*

Overall, participants stated that they had confidence in their doctors, as long as there was a formal or informal interpreter present to understand. They did not feel confident with a provider who spoke broken Spanish. Some participants said that they thought language difficulties contributed to providers not fully explaining what will happen during the exam. A couple of participants attributed this to a feeling of being cheated through huge provider bills and an incomplete understanding of potential charges ahead of time.

### ***Improving Communication***

Many participants stated that often they will arrive at an appointment and learn that no interpreter is available at that time.

*“But how can a doctor cure you if he doesn't know what you have.”*

Most participants suggested improving communication by increasing the availability of professional interpretation services.

*“It could be a medical student, a member of the medical profession who knows about illnesses. So they will also take some interest in what they are doing. So they can also help the community.”*

One suggestion from a respondent was that during the initial call, when a respondent must select ‘1 for English’ or ‘2 for Spanish’ on the telephone keypad, the next question should include an option to request an interpreter during the appointment. When an interpreter has not been scheduled, participants stated that 24-hour access to interpreters should be made available for them through a 1-800 number that they can bring with them.

Participants also stated that when an understanding of culture is missing, it can lead to frustration. Health care providers and interpreters have missed out on a deeper level of communication according to participants.

*“Basically, the person who is going to help me, we don't only need that they interpret our words, but that they also interpret our emotions.”*

Participants also requested that translated materials and a formal or informal interpreter be available for insurance and billing concerns before and after the visit. Without an understanding of the nature of the charges, participants stated that they do not feel trust or confidence in the providers.

*“Because of the economic factor. Maybe not so much information, but also the many services that we can use, we don't know about because of lack of information.”*

*“Yes and when you don't have insurance, there should be an easy way to pay, payments or something. A representative that could help with insurance. In my case, I don't have insurance.”*

Participants also stated that basic communication during the exam should not be discontinued in the face of language difficulties. Patients have a right to be informed of the procedures that will be conducted during the exam.

*“You have to take someone with you who can explain things well because like when I went to that little Chinese doctor, he put his hand here and he scared me. He didn't explain that he was going to check me there. He didn't ask for permission to check me. I asked him, ‘What is happening.’ ‘No’ he said, ‘I'm just checking you.’ He checks and checks the heart and all.”*

## 4.2 Mandarin Segment

### *Choosing a Health Care Provider*

Many of the participants used their insurance company's information to identify a provider. Most of the participants said that information from their insurance companies is in English; however, a few stated that when they call the company to select a provider (in English) they are told which doctors speak Chinese. Several others reported that they use the Internet to find a provider. A few of the participants relied on referrals from friends or family to find a provider, and one participant used advertisements, such as those in newspapers. Overall, access to a Chinese-speaking provider was the main consideration for most of the participants.

*“I look it up on the internet. Checking to see what my insurance company offers. After we find one, then we go. They have a list of health care providers. Then we enter a code to find one. This is all in English.”*

### *Scheduling an Appointment*

The Mandarin-speaking participants said that they had visited primary care providers, dentists, and specialists in the last year. The majority of participants in the Chinese groups said they made their own appointments. Some depended on spouses or relatives to schedule appointments because they are not confident about their own English skills. A few participants, who now schedule their own appointments, added that when they first arrived in this country, a family member needed to schedule the appointments for them.

*“... because my English is not good. I tried before to make an appointment, my accent is too heavy so they don't understand too well or can't clearly hear what I am trying to say.”*

Making an appointment was considered somewhat difficult by some of the participants. The majority of participants scheduled their appointments in English. Some participants explained that locating a Chinese health care professional can be difficult. Those participants explained that the number of Chinese health care professionals is limited, and not often available within their particular health plan. A number of participants stated that, as a result, they are limited to English-speaking providers.

While scheduling an appointment is relatively easy for most participants, they stated that communication difficulties occur when they are asked to describe their symptoms over the phone. One respondent stated that his/her hospital provides immediate interpretation services through a three-way calling system, but none of the other participants were familiar with this type of service.

*“When we first started, 10 years ago, when you made an appointment, it didn't go very well. Or like when the doctor's report came back and would like to discuss it with you and you are scared you won't be able to understand, the nurse would call and say 'the doctor wants to discuss your*

*report with you.’ And if you are scared you won’t understand, the nurse would ask if you needed an interpreter and I would say ‘yes.’ Then they would immediately on the same phone line have an interpreter come in as well, so like a three way phone call.”*

### ***Notification of LAS Services***

Some of the participants reported that staff inquired about a need for LAS services during their visits. However, participants stated that they find it difficult to have a Chinese-speaking interpreter available at the right time. None of the participants reported being asked about their race, although one participant was asked about ethnicity.

### ***Language Assistance through an Informal Interpreter***

The majority of participants said they had taken a friend or relative with them to interpret during a health care visit. Most of participants stated that they choose someone whose English skills are better than their own. However, a couple of the participants mentioned that while their husbands do not speak Chinese, they interpret in English by choosing simpler words that are more familiar to the participants.

*“...when it comes to describing my health/body I have difficulty. When he speaks, I would try to figure it out with a dictionary but if I still can’t then I ask him to expand on it.”*

All the participants stated that communicating with the provider was easier when an informal interpreter accompanied them. One participant described feeling capable of handling the appointment alone but felt extra assurance in taking a family member.

*“For the instances where I can’t speak clearly, he can help chime in...I mean right now I myself can do it but I feel that two heads are better than one.”*

The majority of participants chose to have an informal interpreter accompany them throughout the appointment, including during interactions in the exam room. Participants felt that interpretation was needed throughout the office visit, such as during registration, nurse and provider exams, and billing and insurance procedures.

### ***Language Assistance through a Formal Interpreter***

Nearly all participants stated that formal interpretation services would improve communication with non-Chinese speaking providers. A few participants had used formal interpretation services, including a couple of participants who had used telephonic interpretation services.

One participant described a preference to use a formal interpreter over an informal interpreter due to knowledge of medical terminology.

*“I mean, having a relative like my husband, his English is better than mine, but there are some medical terms that he doesn’t know.”*

Another participant felt that if the informal interpreter has the same language skills as the formal interpreter, the participant would prefer the informal interpreter because the participant would feel more comfortable around a friend or family member. In addition, participants preferred to have a formal interpreter physically present during the appointment over a formal interpreter speaking through a phone because the interpreter is better able to recognize when the participant or provider is having trouble understanding.

*“Because after the examination, the time after is really short...So during the discussion, I will have some questions I need answered and I want to ask the doctor but right when you want to ask the question, they will stop the telephone line. They can stop the service at any time. I don’t think it’s good.”*

One participant described three-way telephonic interpretation where the participant is on one phone line at home, the provider is on another at the office, and they are both communicating with each other through a formal interpreter who is on the third phone line. The participant was pleased with the service and was informed that it was a free service.

*“So once you start talking and you seem to have difficulty understanding, you can tell them that I don’t understand. Then they will ask you what language you belong to and I reply with ‘Chinese’ and then they will ask you if you need an interpreter and I will say, ‘yes that would be best,’ and then they will tell me to wait and they immediately go and try to find an interpreter. Immediately another person comes on the line and says, ‘I am your interpreter for today, we can start now.’ Then the interpreter starts off talking to the doctor and then interprets for you. All you have to say is one word and they will immediately translate it to the doctor.”*

However, a few participants did express concern about telephonic interpretation. They have more confidence in a formal interpreter when they can see each other.

*“It’s a matter of trust, I guess. If you can see their face, it gives you a more relaxing feeling. It’s a more comfortable feeling. If you listen over a phone, you don’t get the same feeling. You wouldn’t be as trusting.”*

Although some participants preferred to use interpreters of their own gender, many said that it was not much of a concern as long as the formal interpreter was qualified.

*”No, I never thought about it. Because as long as they can correctly translate the information, I myself would like to know what is going on with my health. So as long as I can understand the information, it doesn’t matter what gender they are.”*

Those who felt that gender was important stated that they felt more comfortable speaking freely about their health around a formal interpreter who was of the same gender.

*“I would prefer male because I myself am a male. I feel that communicating male to male is better because I can open up easier and talk a lot more. To me, gender is an issue.”*

*“...I just recently went to go see my OB/GYN. It’s better to have a female because it would make it a lot easier to open up and speak and makes it more convenient.”*

Participants said they feel that formal interpreters make communication easier during the exam and noted that interpretation services need to be available throughout the health care experience.

*“Sometimes the interpreter doesn’t explain it that well, but you can ask them questions, such as, ‘In this instance, there are some things that I still don’t understand or can’t hear well.’ They can then discuss with the other person in English.”*

### ***Language Assistance through Bilingual Staff and Providers***

When asked for their preferred method of interpretation, nearly all of the participants said they would choose a bilingual provider who spoke their language. Participants stated that a provider who speaks Chinese would be able to better understand and explain their illness. Participants also reported that this relieves them of their concern about receiving an incorrect interpretation.

*“I feel that it’s the most efficient way of interaction. Because you yourself want to understand your illness and you want your doctor to be able to understand, if the doctor can understand your language, he can quickly deliver the news. He can quickly explain to you the situation of your illness much clearer. It is also easier for him to tell where and who you need to go see.”*

*“You are more relaxed. You can say that it makes it much easier to communicate and if the communication is better, you can talk a lot more. So you are more at ease to tell him more.”*

One participant said that some providers or staff members who are Chinese but were raised in America are able to communicate in Mandarin but are unable to speak the language fluently. Therefore, the participant thinks it is easier to communicate with these individuals in English rather than Mandarin. Similarly, a few other participants stated that they can speak some English and do not have great difficulties in communicating with providers or staff members in English when necessary. However, many participants felt that the most difficult part of communicating with an English-speaking provider or staff person is finding the English words to explain their health conditions. Many participants stated that if the provider spoke their language, the provider would provide more details regarding their illness. If the provider only spoke English

though, participants say the provider would be more likely to reveal only what they believe to be the source of their illness.

*“I still feel that when the doctor discovers that you are having a difficult time understanding the language, then he’ll feel that there is no need to explain it any further to you because you don’t understand.”*

Participants said they feel that the level of discussion, as well as the number of questions asked by providers and staff, depends on language comprehension. According to participants, Chinese-speaking providers will ask them for a full patient history.

*“He will ask what your parent’s health history is like, your family’s health history. This will give you a better understanding of your body. [Moderator: The American doctors, they don’t ask these questions?] No. I don’t think so.”*

However, they state that when there is a language difference, non-Chinese speaking providers do not spend the time asking questions, explaining their diagnosis, or exchanging pleasantries such as asking about their children and family, their work or their interests.

*“I feel that they talk more with American people but with me they don’t make conversation. They probably feel a lot of times that if communication isn’t as well, then they feel they don’t need to do more, but with the doctor it is their responsibility to see you for your illness, they have to discuss it with you.”*

One participant described visiting a provider more than once but never understanding the health issue because of the language barrier between the participant and the provider. The participant stated that as long as the provider made it clear that the health condition would not worsen, the participant was okay with not understanding the details around the health issue. Other participants said that when providers use terms that they do not understand, they sometimes look up the words in a dictionary or search for explanations via the Internet after returning home from the appointment.

According to participants, Chinese-speaking providers and staff tend to be native speakers. As a result, participants compared non-Chinese speaking and Chinese speaking providers when discussing bilingual staff and providers. Participants indicated that they provided bilingual providers full medical information. They also stated that they felt a greater degree of satisfaction with bilingual providers due to the increased level of detail discussed, facilitated by ease of communication.

*“So when the doctor begins to read my report and discuss with me, he’s afraid I won’t understand so he asks me if I need an interpreter. So I think to myself that since it’s a report, I really need to understand what my current health situation is, so I said yes. Then they just so happen to have a nurse that came from Taiwan. So the nurse came into the room and stood*

*next to him, when he spoke one sentence, she would translate it, sentence after sentence. Because it is his nurse, she is in the specialist area, I can understand better. So it is very convenient.”*

### ***Translated Signs and Materials***

The majority of the participants had not seen or received health care materials in Chinese. Some of the participants are able to read the English-language pamphlets, although they report that they need to use the dictionary to translate the medical terminology, which can make translation and full understanding of the materials difficult.

*“Because there was a time where I had a cold, my body and age were getting older; I went to an American help desk. I trusted him and know that the medication he showed me was right, but I myself couldn’t understand what I was reading and what the side effects were and the length of time in between to take it. Now if there were Chinese documents, then I would be able to know what the effects of the medication are, what medications I shouldn’t take together with it, but with English it is a bit more difficult.”*

Participants stated that they would like to see Chinese translations of preventative materials to improve health on topics such as nutrition and exercise. Additional translated materials that participants requested included explanations about diagnoses that require a lifestyle change (such as diabetes, or high blood pressure), materials regarding follow-up care for medical procedures and surgeries, as well as full instructions on medicine bottles.

*“Also, the reactions, in the reactions there are a lot of things to be explained, he will tell you the reasons why it’s high, normal, or low. Also he will tell you what you should keep an eye on such as types of food and drinks you have to do what or other areas.”*

### ***Emotions***

Most participants stated that they experience nervousness or anxiety regarding their health care visits. Some described it more fully as frustration with not being able to describe the way they are feeling. Some participants reported feeling unsatisfied after their visit because they were unable to communicate completely with the provider regarding their illness, or that they were not able to understand everything that the provider said to them.

*“It’s a matter of trust, I guess. If you can see their face, it gives you a more relaxing feeling. It’s a more comfortable feeling. If you listen over the phone, you don’t get the same feeling, you wouldn’t be as trusting.”*

A few participants mentioned a lack of patience among health care staff and providers when communication becomes difficult.

*“You will feel anxious and then add on the possibility that you might not communicate well. Because if I become anxious starting from home then I won’t be able to communicate well once I get there. And then once I get there, if the problem isn’t solved then I’d have to go back and follow up. It doubles the interaction.”*

Participants experienced a lack of social graces specifically in cases where they do not understand what the provider says. Participants felt that non-Chinese speaking staff and providers would give up trying to communicate with participants when the staff and providers were unable to find alternative methods of understanding each other.

*“When you go visit the doctor, they should give service with a smile. Be more hospitable. Talk to you more....or if you have an illness and your child has a fever and the specialist is busy, they come and comfort you, giving you feeling of warmth and security.”*

### ***Improving Communication***

Spoken interpretation is preferred over translated materials according to most participants, because the information is received instantly. However, participants thought that interpreters need to be more readily available. Participants also reported that they were not aware of any community volunteer language services that could provide interpretation in Chinese.

Participants would like to receive and take home more translated information relating to diagnoses and aftercare procedures so they can review the material and clarify any comprehension difficulties at a later time. In addition, participants prefer that all lab reports and physician instructions be in Chinese.

*“Information from your insurance company. What you need to do each year or what you should do each year. That is really important because a lot of it I don’t really know.”*

They also stated that home health materials in Chinese should be available in the waiting room so that they can read while they wait for their appointment.

*“Such as if you come across what illness/sickness, what medicine to have at home for preparation. In America, I really don’t know which one to take, even when I go to buy it, I don’t even know which one to buy. But I know that these are the things I need at home so it can be readily accessible. Such as if your child is sick or you have a cold, you can immediately take the medication and you might get well the next day...I guess household prevention items.”*

### 4.3 Comparisons between Hispanic and Mandarin Groups

The Hispanic and Chinese groups present a difficult challenge in terms of providing a fair comparison across groups. The two language groups consist of very different demographic profiles. Therefore, any comparisons made below cannot be adequately compared for differences across ethnic groups. Instead comparisons between the groups should be viewed as a range of attitudes and beliefs among LEP persons and should not be interpreted as differences between the ethnic groups.

The Hispanic and Chinese groups have different methods for overcoming the language barriers. Participants in the Hispanic groups said they relied on Spanish-speaking staff persons to schedule appointments, going so far as switching providers if only English-speaking staff members are available. Chinese participants, in contrast, tended to schedule their appointments in English.

Both tended to use insurance company provider lists and referrals to choose providers, and preferred a provider or staff who spoke their language. However, provider cost as a deterrent was only mentioned in the Hispanic groups. This difference could potentially be explained by the low rate of health insurance among the participants in the Hispanic groups, and the larger proportion of participants who fell in the lower income and education brackets.

Accuracy of the interpretation was a key concern for both groups. Chinese and Hispanic participants preferred to use a bilingual provider for this assurance. While both groups have used informal interpreters, the Hispanic group had more exposure to formal methods of interpretation. This could be due, in part, to the lack of availability of Chinese interpreters as reported by some participants. Although in-person interpretation was preferred by both groups, the use of telephone interpretation was approved by both groups as long as quality equipment is utilized.

The prevalence of Spanish-speakers among non-Hispanics creates a unique situation not mentioned among the Chinese participants. Hispanic participants report concerns resulting from cultural differences with providers. Participants of the Chinese groups stated that their providers were Chinese or from a similar culture. While Chinese participants did not mention lack of cultural awareness among providers as a barrier, they did explain that, as patients, they provide more complete information and are asked more detailed questions when working with a Chinese-speaking provider.

Another difference existed in the role of interpreters during exams. Members of the Hispanic groups stated that interpreters would only enter the exam room if it was necessary, whereas the Chinese participants preferred that interpreters stay in the exam room for full interpretation during the exam. However, participants from both groups stated that female interpreters would be preferred during obstetric or gynecological visits.

Translated materials were prevalent in Spanish, but not in Chinese. As a result, materials in Spanish on prevention and health care issues were readily available. The Chinese participants reported that materials in Chinese are not available, so they take the materials in English home to translate. Materials on prevention and health care, such as those seen by the Spanish-speaking

participants, were specifically requested by the Chinese participants. Participants in both groups stated that there was a need for instructions on medications and explanations about diagnoses to be translated into their own language.

Overall, participants in both groups said they felt frustration with not being able to communicate efficiently with their providers. Hispanic participants mentioned a lack of trust, and Chinese participants mentioned a lack of satisfaction. This lack of satisfaction results from an absence of the pleasantries of communication, “bedside manner,” and basic instructions during the exam.

Improvements suggested by participants of both groups included increased interpreter availability when needed, and at all points of the health care visit. The provision of translated materials to aid patient compliance was also suggested by participants of both groups as a quality of care improvement.

## 5.0 GUIDE RECOMMENDATIONS

Practical ideas for administrators and providers to improve the care for LEP persons were suggested throughout the focus groups. For the purpose of the Health Care Language Services Implementation Guide, key suggestions that have been presented by participants in both groups are discussed below. Excerpts of these conclusions may have the potential for expansion within the guide.

- A common complaint during the focus groups is the lack of availability of trained interpreters during the health care visit. One source of value for the guide could result from the provision of resource listings for each of the methods of interpretation. First, provider awareness of the available methods during emergency visits and administrator awareness of services available for scheduled visits would improve. Then, procedures would be instituted to ensure scheduling of LAS services when the appointment is made for the LEP person. A special provision should be made at health clinics for females to ensure the availability of female interpreters.
- Participants in both groups expressed concern regarding the accuracy of the interpretation provided by formal and informal interpreters. At the provider and administrator level, the opportunity exists to improve the availability of quality interpreters for current LEP patients. Formal interpretation training guidelines could serve as a baseline for organizations to measure their instructional and testing programs. The guide would benefit from a specific training protocol that could be used to develop interpreter training programs, as well as evaluate and revise existing trainings.
- Telephone interpretation was criticized by participants in terms of the quality of the sound during the interpretation. In addition, participants expressed a lack of trust in depending on individuals they cannot see to interpret personal and vital medical information. As a method for interpretation, some participants from both groups regarded it as an effective method. Therefore, recommendations could be included in the guide for a minimum quality requirement to ensure effective interpretation and for telephonic interpreters to allow enough time for participants to have all questions and concerns thoroughly addressed. This would serve to encourage that quality equipment is purchased by facilities and recommended by telephone interpretation services, as well as ensure that participants are well-informed and secure with all medical decisions.
- According to the focus group discussion, providers are not able to offer patients the same level of care when there is a language barrier. The guide could use this opportunity to highlight some of the concerns of patients regarding communication etiquette with LEP persons in spite of language difficulties. This may also provide additional motivation to providers to ensure that the LEP systems are in place for their patients.
- Participants also stated that beyond interpretation competency, an understanding of culture is key. The guide could highlight ways to promote cultural awareness and the utilization of resources such as cultural mediators.

- Participants stated that it is difficult to be compliant with their doctor's prescriptions when they cannot read the instructions on their medication bottle or read the explanations about a diagnosis. Online resources such as databases on organizational intranets could be promoted in the guide to improve providers' awareness of the existence of already developed materials for use with their patients.

## **6.0 CONCLUSION**

The development of the draft HC-LSIG is one of many ways OMH seeks to improve the health of minority populations and to eliminate health disparities. The development of the guide involves a number of research components, including the focus groups with LEP individuals described in this report. The focus groups allowed the project team to gain insight into LEP individuals' experiences when seeking health care, with particular regard to communication and language access services. The focus group data were collected through the implementation of sound methodological procedures. In using qualitative methods, statistical significance or generalizability of the results is not feasible, nor was it the intent of the study. Rather, the goal of the study was to explore interesting or unexpected ideas raised by participants and to establish a firm basis for future decision making. The content analysis by main topic provided a means for organizing the data in a way that is relevant to the development of the guide. The synthesis of recommended changes to the guide contributes directly to the improvement of the guide. The use of these focus group data helps ensure that the guide is rooted in and responsive to real-world experiences among LEP individuals.

## APPENDIX A: RECRUITMENT SCREENERS

### *Screeners for Focus Groups with Hispanic Participants (English)*

#### **Inclusion Criteria**

- Hispanic/Latino/Latina women and men
- Limited English proficiency (i.e., Spanish-speaking participants)
- Not comfortable speaking English in public
- Has difficulty understanding English
- Prefers reading information in Spanish
- Age 18 or older
- Has sought health care services in the last 12 months

#### Additional information

Recruit 12 participants to seat 6–8 participants for each group

Group 1 - Recruit (7) Women and (5) Men

Group 2 – Recruit (7) Men and (5) Women

Hello, my name is \_\_\_\_\_, from \_\_\_\_\_, a consumer research firm. We are conducting a focus group on health issues on behalf of the Office of Minority Health. The focus groups will be conducted in Spanish. We would like to ask you several questions to see if you meet the specific criteria for participation. Do you have a few minutes?

#### **A. Confirm Gender.**

Male..... 1 [CONTINUE]

Female..... 2 [CONTINUE]

#### **B. Would you describe yourself as Hispanic, Latino, or Latina**

Yes ..... 1

No ..... 2 [THANK & END]

**C. How would you identify your ethnicity? (check as many as apply)**

- Cuban..... 1
- Dominican ..... 2
- Mexican, Mexican American, Chicano..... 3
- Puerto Rican ..... 4
- Other (Please Specify) ..... 6

**D. Are you comfortable participating in a group discussion conducted entirely in Spanish?**

- Yes..... 1
- No..... 2 [THANK & END]

**E. When was the last time you had the opportunity to participate in an interview or group discussion for the purpose of marketing research? (READ AND RECORD)**

- Never ..... 1
- More than 4 months ago..... 2
- Less than 4 months ago .... 3 [THANK & END]

**E1. What was/were the topics(s) of these discussions? \_\_\_\_\_  
(If health care was the topic, thank and end. If questionable, place on hold and consult with AIR)**

**F. Please tell me if you or anyone living in your household currently works or has ever worked in any of the following professions:**

- Marketing research or advertising ..... 1 [THANK & END]
- Doctor, nurse, or other health professional ..... 2 [THANK & END]

**G. Which of the following categories includes your age? [NOTE: RECRUIT A MIX.]**

- Younger than 18 .. ..... 1 [THANK & END]
- 18 through 34 ..... 2
- 35 through 49 ..... 3
- 50 through 64 ..... 4
- 65 or older ..... 5

**H. In the past 12 months, have you seen any doctor, dentist, nurse, or other health professional to get any kind of care for yourself?**

Yes..... 1  
No..... 2 [THANK & END]

**I. In the past 12 months, have you ever had difficulty understanding a doctor, dentist, nurse, or other health professional because they did not speak Spanish?**

Yes..... 1  
No..... 2 [THANK & END]

**J. How often do you feel comfortable speaking English in public?**

All of the time .....1 [THANK & END]  
More than half the time..... 2 [THANK & END]  
Less than half the time ..... 3  
Never .....4

**K. Thinking about the information you receive from a variety of companies, do you prefer to receive information in Spanish or English?**

Spanish ... ..... 1  
English ... ..... 2 [THANK & END]

**L. What was the last grade you completed in school? [READ AND RECORD]**

Less than high school..... 1  
High school diploma, GED, or technical school .. ..... 2  
Any college or beyond ..... 3

**M. Which of the following categories contains your household's annual income? [READ AND RECORD]**

Less than \$20,000 ..... 1  
\$20,000 to \$39,999 ..... 2  
\$40,000 to \$49,999..... 3  
\$50,000 to \$75,000..... 4  
Over \$75,000..... 5  
Currently not employed ..... 6



If you have any questions or find that you can't attend, please call us right away at \_\_\_\_\_ so that we can find a replacement. Thank you for your time and for agreeing to participate in this study.

**Again, the group will be held on (DATE) at (TIME). Please remember to bring eyeglasses if you need them to help you see and try to arrive a few minutes early so the group can start on time. If you are unable to attend for any reason, please notify us in advance at (PHONE) so we can replace you in the group.**

**Thank you for agreeing to participate. We'll see you on (DATE).**

*Screener for Focus Groups with Chinese Participants (English)*

**Inclusion Criteria**

- Chinese women and men
- Limited English proficiency (i.e., Chinese-speaking participants)
- Not comfortable speaking English in public
- Has difficulty understanding English
- Prefers reading information in Mandarin
- Age 18 or older
- Has sought health care services in the last 12 months

Additional information  
Recruit 12 participants to seat 6–8 participants for each group  
Group 1 - Recruit (7) Women and (5) Men  
Group 2 – Recruit (7) Men and (5) Women

Hello, my name is \_\_\_\_\_, from \_\_\_\_\_, a consumer research firm. We are conducting a focus group on health issues on behalf of the Office of Minority Health. We would like to ask you several questions to see if you meet the specific criteria for participation. Do you have a few minutes?

**A. Confirm Gender.**

Male..... 1 [CONTINUE]

Female ..... 2 [CONTINUE]

**B. Would you describe yourself as Chinese?**

Yes..... 1

No ..... 2 [THANK & END]

**C. Which of the following languages do you speak?**

- Mandarin .....1
- Cantonese.....2 [THANK & END]
- Other.....3 [THANK & END]

**D. Are you comfortable participating in a group discussion conducted entirely in Mandarin?**

- Yes.....1
- No.....2 [THANK & END]

**E. Please tell me if you or anyone living in your household currently works or has ever worked in any of the following professions:**

- Marketing research or advertising ..... 1 [THANK & END]
- Doctor, nurse, or other health professional..... 2 [THANK & END]

**F. Which of the following categories includes your age? [NOTE: RECRUIT A MIX.]**

- Younger than 18 ..... 1 [THANK & END]
- 18 through 34 ..... 2
- 35 through 49 ..... 3
- 50 through 64 ..... 4
- 65 or older ..... 5

**G. In the past 12 months, have you seen any doctor, dentist, nurse, or other health care professional to get any kind of care for yourself?**

- Yes ..... 1
- No .....2 [THANK & END]

**H. In the past 12 months, have you ever had difficulty understanding a doctor, dentist, nurse, or other health professional because they did not speak Mandarin?**

- Yes .....1
- No .....2 [THANK & END]

**I. How often do you feel comfortable speaking English in public?**

- All of the time .....1 [THANK & END]
- More than half the time .....2 [THANK & END]
- Less than half the time .....3
- Never .....4

**J. Thinking about the information you receive from a variety of companies, do you prefer to receive information in Mandarin or English?**

- Mandarin .....1
- English .....2 [THANK & END]

**K. What was the last grade you completed in school? [READ AND RECORD]**

- Less than high school . ..... 1
- High school diploma, GED,  
or technical school ..... 2
- Any college or beyond ..... 3

**L. Which of the following categories contains your household's annual income? [READ AND RECORD]**

- Less than \$20,000 .... 1
- \$20,000 to \$39,999 .. 2
- \$40,000 to \$49,999.....3
- \$50,000 to \$75,000.....4
- Over \$75,000.....5
- Currently not employed .....6

**M. Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare? [READ AND RECORD]**

- Yes .. 1
- No..... 2
- Don't Know/Not sure ..... 3
- Refused..... 4



## APPENDIX B: MODERATOR GUIDE (IN ENGLISH)

### Moderator's Guide (Final)

#### I. EXPLANATION (The following points will be covered) (10 minutes)

##### A. Introduction

- My name is \_\_\_\_\_. I'm an independent research consultant and I have been asked to serve as the moderator for tonight's discussion.
- Thank you for joining us tonight.
- Your presence and participation are important.

##### B. Purpose

- You're here today to take part in a focus group. It's a discussion to find out your opinions—like a survey, but with broad, general questions.
- I am interested in all of your ideas, comments, and suggestions.
- This discussion is being sponsored by the Office of Minority Health, U.S. Department of Health and Human Services. The Office of Minority Health is interested in improving access to health care for minorities. This includes improving language services.
- Please be assured that I am not here tonight to teach, or persuade, or sell anything. I am simply here to listen and to share. Also, I want to acknowledge that this is certainly a very personal topic of discussion. I applaud all of you for being here; I thank you in advance for sharing your experience with the group; and I promise that we're not going to put anyone on the spot. If a question makes you uncomfortable, feel free not to answer it or to let me know.

##### C. Procedural Details

- We are audio-taping this discussion. Everything you say is important to us and we want to make sure we don't miss any comments. Later we'll go through all of your comments and use them to prepare a written report of the discussion. However, all of your comments are confidential and will be used only for research purposes. Nothing you say will be connected with your name.
- I want this to be a group discussion, so you needn't wait for me to call on you. Please speak one at a time so the tape recorder can pick up everything that is said.

- Behind me is a one-way mirror. I have some colleagues back there, following the discussion and taking notes. They're making sure that I cover everything we need to know. They're not in the same room with us because that can be distracting.
- Please feel free to help yourself to refreshments. If you need to step out to use the bathroom, that's fine, but please try to step out one at a time.

## II. INTRODUCTIONS (5 minutes)

1. We're going to go around the room briefly to allow everyone to introduce himself or herself. When it's your turn, please tell us:
  - Your first name or whatever you'd like to be called during the group
  - Where you're from
  - One thing you like to do in your spare time

Thank you for those introductions.

## III. INITIAL EXPERIENCE PRIOR TO CARE (15 minutes)

I know that each of you have seen a doctor, dentist, nurse, or some other type of health care professional to get care. Throughout the discussion, I will refer to this person as your "health care provider." I would like to talk about your experience.

- a) First, how do you choose a health care provider?

Probes:

- a. Recommendation from a friend/relative/neighbor, etc.
- b. A list of doctors from your insurance company

2. How many of you have had to schedule an appointment to see your health care provider?
3. Thinking about a time when you scheduled your appointment, what type of health care provider(s) were you setting the appointment to see?
4. For those of you who have scheduled an appointment, did you schedule the appointment yourself?
5. Did some of you have someone else call and schedule your appointment?

Probes:

- a. Who scheduled the appointment for you?
- b. Why did you select this person?

6. How easy was it for you to set up the appointment?

Probes:

- a. What made it difficult?

**Choosing a  
health care  
provider**

**Scheduling an  
appointment**

#### IV. MAJOR CHALLENGES

(40 minutes)

##### Notification of LEP services

We talked a little about scheduling an appointment over the phone; now let's talk about your visit to your health care provider.

7. During your visit to the health care provider, did anyone ask if you had any language needs? Did anyone ask you what your race, ethnicity, and/or primary language were?

##### Taking someone with you

8. Do you prefer to take someone with you, to work with an interpreter, or to work with bilingual staff and providers?

9. Have you ever taken someone with you to help you communicate?

Probes:

- a. Who did you take with you?
- b. What is the relationship of this person to you?
- c. What was your reason for choosing this person?

##### Communication with staff

10. *If yes*, although you have someone with you, do you find it difficult or easy to communicate with the staff?

Probes:

- a. Did you understand what the staff said?
- b. What did you have difficulty with?
- c. Did the staff understand what you asked for?
- d. What parts did they have difficulty with?
- e. What made it difficult to communicate with the staff?
- f. What made it easy to communicate with the staff?

##### Communication with provider

11. *If yes*, does the person that came along with you, go with you when the health care provider is ready to see you/examine you?

Probe:

- a. *If no*, does the health care provider talk to the person that came along with you, after he/she has seen you/examined you?

12. *If yes*, Do you find it difficult or easy to communicate with the health care provider? *Explain if necessary*: Not the staff, but the person who is going to provide the care?

Probes:

- a. Did you understand what the provider said?
- b. What did you have difficulty with?
- c. Did the provider understand what you asked for?
- d. What parts did he or she have difficulty with?
- e. What made it difficult to communicate with the health care provider?
- f. What made it easy to communicate with the health care provider?

##### Use of an interpreter

13. Have you ever used an interpreter during any of your visits?

14. *If yes*, how comfortable do you feel when an interpreter is used?

**Communication  
with staff**

Probes:

- a. How comfortable do you feel using a male interpreter versus a female interpreter?
- b. How comfortable would you feel using a remote or telephonic interpreter?
- c. How comfortable would you feel using a video interpreter? (*Explain if necessary: interpretation conducted by someone at another location via video or computer screen*)

15. *If yes*, do you find it difficult or easy to communicate with staff?

**Communication  
with provider**

Probes:

- a. Did you understand what the staff said?
- b. What did you have difficulty with?
- c. Did the staff understand what you asked for?
- d. What parts did they have difficulty with?
- e. What made it difficult to communicate with the staff?
- f. What made it easy to communicate with the staff?

16. *If yes*, since you are not directly speaking to the health care professional, do you find it difficult or easy to communicate with the health care provider?

**Interaction with  
bilingual staff  
and providers**

Probes:

- a. Did you understand what the provider said?
- b. What did you have difficulty with?
- c. Did the provider understand what you asked for? Were you able to get your questions answered?
- d. What parts did s/he have difficulty with?
- e. What made it difficult to communicate with the health care provider?
- f. What made it easy to communicate with the health care provider?

**Communication  
with staff**

17. Have you ever interacted with bilingual staff and health care providers?

18. *If yes*, do you find it difficult or easy to communicate with staff?

**Communication  
with provider**

Probes:

- a. Did you understand what the staff said?
- b. What did you have difficulty with?
- c. Did the staff understand what you asked for?
- d. What parts did they have difficulty with?
- e. What made it difficult to communicate with the staff?
- f. What made it easy to communicate with the staff?

19. *If yes*, do you find it difficult or easy to communicate with the health care provider?

Probes:

- a. Did you understand what the provider said?
- b. What did you have difficulty with?
- c. Did the provider understand what you asked for? Are you able to get your questions answered?
- d. What parts did s/he have difficulty with?
- e. What made it difficult to communicate with the health care provider?
- f. What made it easy to communicate with the health care provider?

**Translated signs  
or materials**

20. Did you see or receive any translated materials during your visit from the health care provider or staff? If yes, how useful were they?

Probes:

- a. Would you like to receive translated materials?
- b. What materials would be particularly useful to have translated?

**Feelings /  
Emotions**

21. How do you feel emotionally when you get health care?

Probes:

- a. Do you feel embarrassment?
- b. Do you feel a sense of relief when the visit is over?
- c. Are you sometimes reluctant to get health care because of the language differences?
- d. How does the issue of trust factor into how you feel when you get health care?
- e. How does the issue of bias factor into how you feel when you get health care?
- f. Other emotions?

## **V. IMPROVING COMMUNICATION**

**(15 minutes)**

22. You have mentioned some of the challenges of getting health care. Can you think of anything your health care providers could do to make your visit better? Probe according to mode (i.e., taking someone with them, working with an interpreter, working with bilingual staff)

23. What are some of the language services that the organizations provide that you find useful?

24. What type of language services do you need most? Probes: Written? Spoken?

25. Have you utilized the services of any community organizations that provide language access services? If so, which ones have been helpful?

26. What advice would you give others who need to get health care but do not speak English or have difficulty speaking English?

## **VI. WRAP-UP**

**(5 minutes)**

- Before we wrap up, do you have any further thoughts to contribute on any of the topics we've been discussing? (Take this opportunity to step into the back room to address any issues.)
- Thank you very much for your participation. I've enjoyed talking with you. Your comments have been most helpful.
- Be sure to stop by the front desk on your way out to pick up your incentive for participating in today's session.