

Barriers To Healthcare Access In the Southeast Asian Community of Rhode Island

Margret Chang, Edward Feller MD, Jayashree Nimmagadda, MSW, PhD, LICSW

Most Southeast Asian (SEA) refugees came to Rhode Island in the 1980s. Although researchers studied their health care status, their access to care, and the clash between their traditional views and Western medical views at that time, few studies have looked at the status of Rhode Island's refugees today.

Nationally, the poverty rate is as much as double the general population, and an estimated 60% of Hmong, 56% of Cambodian, and 52% of Laotians are linguistically isolated (all adults in the household have difficulty communicating in English).¹ The US SEA population has the lowest breast and ovarian cancer screening rates of any US ethnic group, low levels of blood pressure and diabetes screening, and increased prevalence of complications from chronic diseases such as diabetes or stroke.²

We sought to assess physician and patient barriers to health access and quality of care in Rhode Island's SEA community, 20,000 people, through focus groups. We asked: 1) How do Southeast Asians access health care in RI? 2) If they do, what are their experiences in accessing these services? 3) If they do not, what are the barriers?

METHODOLOGY

Semi-structured focus groups were held with Rhode Island's Cambodian, Laotian, and Hmong communities at neighborhood centers. Men and women formed 3 separate groups. Respondents were ages 41 to 83; the mean age was 62. Two native speakers of each language facilitated and recorded data. Participants were offered light refreshments and given a \$25 gift card. At each session, only facilitators and participants were present.

A convenience sample of participants was recruited by the RI Southeast Asian Coalition—an organization of leaders from each major sub-group (Cambodian, Laotian, and Hmong). Potential participants were recruited from community events at ethnic grocery stores, cultural

festivals, and religious temples. Once participants agreed to participate, informed consent documents were mailed or handed to them, along with a letter describing the focus group.

Language and ethnic-specific focus group sessions were recorded, transcribed and translated. A member of the research team performed an initial review. No names or identifying information were included in the transcription.

Analysis of data was conducted independently by one researcher who derived thematic categories from the transcripts.

RESULTS

The 54 participants (28 men and 26 women) comprised Hmong (N= 17); Cambodian (N= 17) and Laotian (N= 20). They identified diverse barriers to healthcare. Most revolved around interpretation difficulties.

The content was divided into five general themes.

1) Health Systems Barriers

Participants needed caseworkers and advocacy organizations to help navigate the healthcare system. Although many had health insurance or Medicare/Medicaid, most did not understand how to use benefits. Members of the Laotian focus groups were particularly eager to relate their experiences. Several participants described being mysteriously "kicked off of Medicare" for no reason. Consequently, many felt "scared" to go to the doctor without insurance.

In addition, participants mentioned the frustrations of having only one SEA community organization in RI. Although the organization provides some services to SEAs living in Providence, many communities in other parts of the state felt isolated and believed that "they live too far to receive any help." Members felt that a central SEA agency would help address barriers to healthcare access, especially for the elderly.

"I would be happy to hear that the state could help older people and those who cannot work, drive, or go to the doctor along."

Transportation also impedes participants' access to healthcare. All groups voiced concern that the elderly rely so heavily on their children, who typically work during normal clinic hours. Although SEAs know that they can ride the bus, they do not: they fear getting lost because they cannot read signs in English.

"I used to live in Washington [state] and California. Things were much better there, because there was a nurse or someone else to help me with transportation. Here, we don't know where to go, so we stay at home sick."

2) Clinic/Office Interactions

Participants unanimously felt that interaction with office staff was as important as interaction with doctors. Yet few clinics have interpreters on site.

"We need Lao *people* in the clinic, not just doctors. [We] need staff that can help show us resources, explain what payment plans are to me, teach me how to take my medicines, whether it's 1 pill aspirin a day, 2 pills a day...etc."

"Not knowing how to speak English...when you're ill and meet the doctor, if there isn't a Hmong-speaking person to help, you might go early at 10 am and you go a half hour early and wait and they never call your name. This is a problem."

Table 1: Barriers To Care

System-based

- Underrepresentation as leaders, decision-makers
- Care received in safety net settings
- Limited clinic hours, follow-up, phone contact
- Inadequate interpreter services, linguistic competency
- Insurance issues
- Lack of case workers or advocacy
- Poor continuity of care
- Obsolete medical record systems

Physician-based barriers

- Linguistic discordance
- Availability and proximity of providers
- Limited time, expertise, experience with interpreters
- Referral gridlock for specialists, behavioral care
- Telephone access
- Intake logjam
- Poor cultural understanding

Patient-based barriers

- “Safety net” care; lack of medical home
- Health literacy, linguistic issues
- Mistrust, perceived provider bias
- Cross-cultural disconnect
- Transportation, insurance issues
- No media messages in native language
- Communication barrier with MD
- Use of unproven alternative remedies

Participants understood the difficulty of hiring and retaining SEAs in clinics. The majority of the RI SEA healthcare workforce have low-paying positions requiring little formal education. Although employed in clerical or custodial positions, many find themselves serving as *ad hoc* interpreters or social workers due to the high demand for language assistance. As a result, the burnout rate is high.

“There was [a Laotian worker] at the [clinic],” explained a Laotian participant, “but she moved up...interpreters get tired of it...or worn out...so they move on to a higher position if they get a chance.”

Also, answering machine services and appointment reminders are usually given in English, which makes it difficult

to make appointments, remember them or get test results.

“...if you can't speak English, you can't even tell them you need a translator... when they call your house to inform you of an appointment, you can't understand what they are saying.”

3) Poor Doctor-Patient Communication

All respondents were troubled at the possible medical consequences of poor communication. Many feared that US medications or vaccines wouldn't work because doctors didn't understand their diseases.

“Maybe, the vaccines, because we are from a different country, when we fall ill, they might not be the right vaccines to treat our illnesses...or if they do understand our illnesses, they might not have the right medicines [available].”

The clinical impact of inadequate interpreter services extends directly to the doctor-patient relationship. With very few certified interpreters, many patients rely on friends and family members to interpret. Due to the lack of specific vocabulary words in SEA languages to describe symptoms and signs, many important clinical details frequently get lost in translation.

“For example, there is generally one word that means ill, injured, hurt, sick, or pain. It is generally used to describe any kind of illness from something minute to something serious, so translation requires in-depth explanations of symptoms and scenarios for others to comprehend meaning.”

Because of this inherent complexity, an untrained friend or family member serving as an *ad hoc* interpreter may make crucial mistakes.

Physicians often give incomplete or inadequate explanations of how to use medications. This led many to be-

lieve that US medications are ineffective, even harmful. In all groups, participants turned to traditional healing methods.

“Tnam borun (herbs and vodka) is important if you do it right and use it right, and don't drink a lot of cold water; better than doc medicine. If you use both, you get better faster.”

Communication difficulties also affected the physical examinations and procedures, particularly during gynecological exams. Participants in the Hmong women's group discussed a particular male interpreter whom they were not comfortable with, but who was the only person available.

“When it comes to the woman's part [of the physical exam], then they don't want him to know anything about it. So they say very little to the doctor because they are not comfortable with his presence.”

4) Lack of Education On Chronic Disease and Nutrition

Participants reported diabetes, hypertension, high cholesterol, cancer, and liver disease. Although they were aware that screening and regular doctor visits are important for prevention, most found it difficult to keep appointments for every checkup.

Participants were interested in learning about diet and nutrition. They understood the relationship between diet and good health. However, when asked about receiving dietary advice, many felt that their healthcare providers did not understand their culture.

“Sticky rice...the doctor told [my dad] he can't eat sticky rice, and my dad says 'that is like telling a fish not to swim! I am a Laotian man; I have to eat sticky rice...’”

Asked what nutrition advice they needed, participants were forthright:

Table 2: Recommendations for Addressing Barriers

Barrier	Interventions / solutions
Health services / Systems	<ul style="list-style-type: none"> • Increased access to care • National focus on recruiting and maintaining minority groups in health leadership positions • Home health agencies for SEAs
Clinic / Office Issues	<ul style="list-style-type: none"> • Native clinic workers • Telephone messages in native language • Technology promotion (electronic records, telemedicine, telephone interpreter services)
Doctor-Patient Miscommunication	<ul style="list-style-type: none"> • Adequate interpreter services • Telephone interpreters • Information in native language • Improving access to interpreter certification
Cultural / perceptual Barriers	<ul style="list-style-type: none"> • Cross-cultural education for health workers • Recruit SEA health professionals • Community outreach programs
Educational Barriers	<ul style="list-style-type: none"> • Dissemination of health education materials (e.g., community workshops, radio / TV public service announcements) • Collection of race and ethnicity data to monitor outreach efforts

“We keep hearing that our nutrition and diet isn’t correct...But things like how much fats, protein, sugar to eat—we don’t understand those things. Someone needs to tell us what to do”

In addition, these limited-English patients do not get important health messages that appear in print, Internet, and television. Some have limited or inaccurate family health history from their parents or grandparents.

5) Cultural Barriers To Care

Participants identified diverse socio-cultural barriers, including lack of culturally appropriate care, perceived unfair treatment, provider bias on racial or ethnic grounds, and unawareness of the heterogeneity of SEA cultures.

Groups valued interpersonal relationships and interactions with their doctor. A persistent theme was the importance of family as the primary social unit and source of support and advice. Rather than consult the health care system, par-

ticipants often initially sought help from family, churches, or traditional healers. Because modesty and privacy are important, participants did not readily discuss some concerns with family members, especially of the opposite gender.

DISCUSSION

Focus groups identified the lack of interpreters and poor transportation as major barriers. A challenge specific to RI appears to be mobilizing the SEA community. Unlike states with multiple SEA advocacy organizations devoted to health and social service outreach, RI has none. Only the **Socio-Economic Development Center (SEDC)** has some of the cultural and linguistic resources needed to engage SEAs. Due to insufficient funding, SEDC cannot serve as a comprehensive vehicle for community outreach.

Challenges faced by SEAs in RI are amplified by the absence of a single SEA community geographic center. Instead, there are pockets of SEAs living in South Providence, Warwick, Smithfield, and Woonsocket. Because many SEAs do not have ready access to transportation, many

go to the nearest emergency department, “safety net” clinic or traditional healers for non-urgent treatment rather than to a fixed medical home. Indeed, informal meetings of the primary author with executives from local community hospitals revealed that their emergency departments have felt overwhelmed by the medical needs of SEA patients.

The lack of interpreter services contributes to adverse outcomes, including less screening and immunizations; more treatment errors; non-compliance with medication or treatment plans; missed appointments, and patient dissatisfaction.³ Ideally medical interpreters should be professionally trained. Family, friends, office employees or strangers recruited from waiting rooms misinterpret or omit up to half of all physicians’ questions, and are more likely to commit errors with clinical consequences. When children are present, ad hoc interpreters are likely to ignore embarrassing issues.⁴

Others suggest that incorporating cultural values into health education and outreach programs would make SEAs more accepting of services.⁵ One strength of the SEA community is its strong cultural identity and connection to local temples. This linkage has been helpful for health outreach, particularly health screenings held at local Buddhist temples. Such partnerships between cultural and medical resources are crucial for providing the information and the trust needed for the SEA community to participate more fully in health education and prevention efforts.

Among the recommendations for improving access to healthcare are: 1) Incentives for interpreter certification in SEA languages, 2) Initiation of home health agencies and outreach to care for SEA elders, 3) Educate providers on linguistic and culturally-specific issues, 4) Broad initiatives to increase SEA representation in the medical fields, with internship opportunities for SEA youth.

REFERENCES

1. California Endowment. Bridging Language Barriers in Health Care: Public Opinion Survey of California Immigrants from Latin America, Asia, and the Middle East, 2003. <http://www.ncmoline.com/mecia/pdf>
2. National Diabetes Education Program. *Silent Trauma: Diabetes, Health Status, and the Refugee—Southeast Asians in the United States*. Washington

DC, US Department of Health and Human Services, 2006.

3. Jacobs, et al. Legal and regulatory obligations to provide culturally and linguistically appropriate emergency department services. *Clin Ped Emerg Med* 2004;5: 85-92.
4. Brach, et al. Crossing the language chasm. *Health Affairs* 2005;24: 424-34.
5. Yee BW. Health and Healthcare of Southeast Asian American Elders: Vietnamese, Cambodian, Laotian, and Hmong Elders. 2001. <http://www.stanford.edu/group/ethnoger/southeastasian.html>.

Margret Chang is a 4th year medical student at the Warren Alpert Medical School of Brown University.

Edward Feller, MD, is a Clinical Professor of Medicine, Adjunct Professor of Community Health and Co-director of the Community Health clerkship at Brown.

Jayashree Nimmagadda, MSW, PhD, LICSW, is Interim Chair, MSW Program, Rhode Island College.

Margret Chang completed this project as part of required work in the Community Health clerkship at Brown. This is an edited version of her report.

Disclosure of Financial Interests

The authors have no financial interests to disclose.

CORRESPONDENCE

Edward Feller, MD
Box G- S121-2
Brown University
Providence, RI 02912
Phone: (401) 863-6149
e-mail: Edward_Feller@brown.edu

Lead Psychiatrist/Medical Director Adult Services



The Kent Center a nationally recognized progressive CMHC is seeking a team oriented Board Certified/Board Eligible Adult Psychiatrist whose professional goal aspires to provide medical leadership and direction to a team of colleagues and associate staff while continuing to provide direct client care.

Our Psychiatric Consultation Service Team provides direct psychiatric services to a diverse population focusing on recovery of adult clients with mental health disorders, trauma, and substance abuse.

Team responsibilities include comprehensive evaluations, treatment planning, medication prescribing and monitoring of clients, and consultation services to members of clinical treatment teams.

Competitive salary, comprehensive benefit package including 4 weeks vacation, Blue Cross/Blue Shield medical, dental, life and long term disability insurance and 401K retirement plan. Send resume to Director of Human Resources, The Kent Center, 2756 Post Road, Suite 104, Warwick, RI 02886. Fax 401-691-3398.or e-mail hr@thekentcenter.org EOE.