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Abstract:

This research study explores the circumstances and experiences of LatinX patients with limited English proficiency (LEP) when seeking treatment in the healthcare system of Southwest Michigan, in addition to proposing solutions to better facilitate this population’s access. The terminology used in this research, LatinX, is an American English neologism used as a gender-inclusive term used interchangeably with Latino/a and/or Hispanic. This research provides an overview of the current socio-political legislature and climate of the American healthcare system as it pertains to the LatinX population to spread awareness and identify the barriers existing in our current healthcare model. This study will also catalog existing resources for the LatinX community of Southwest Michigan to serve as a guide and point of comparison to identify what resources still need to be made available and what action still needs to be taken. In order to best serve LatinX patients in Southwest Michigan, it is imperative to spread awareness of existing resources that facilitate population’s access to healthcare, as well as propose additional resources that consider the unique challenges this population faces when accessing healthcare.
1. **Introduction:**

This research study provides details of the experiences and circumstances of LatinX patients with limited English proficiency (LEP) when seeking treatment in the United States Healthcare system to better understand what needs to be done to facilitate access. This has been a topic of research in dire need of attention for decades, and while numerous studies have been conducted on the barriers this population faces, this study will first create an overview of the challenges this population faces in accessing healthcare. Second, this study will present and analyze currently available resources to facilitate the LatinX population’s access to healthcare. Lastly, the study will propose solutions to facilitate healthcare access in Southwest Michigan. The terminology used in this research, LatinX, is an American English neologism used as a gender-inclusive term used interchangeably with Latino/a and/or Hispanic. The U.S. Census Bureau defines Hispanic or Latino as “a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture regardless of race” (United States Census Bureau, 2021). The term LatinX simultaneously recognizes the many ethnicities and cultures of Latin America as a point of cultural affirmation and pride while remaining gender neutral. The term Hispanic is most frequently used by mass media outlets and government administrations after its introduction in 1970 by President Richard Nixon. Some members of the LatinX population oppose this terminology because they associate the term Hispanic as only reflecting Iberian ancestry. The term LatinX will be used throughout this research to provide a gender-neutral and culturally responsive term for this community. It is important to note, however, that the term Hispanic as well as the terms Latino/a or LatinX are derived from Latin and are all of Roman or European origin (United States Census Bureau, 2021). Overall, this research provides an overview of the current socio-political legislature and climate of the American healthcare system as it pertains to
the LatinX population to spread awareness and identify the barriers existing in our current healthcare model. This research also catalogs existing resources for the LatinX community of Southwest Michigan to serve as a guide and point of comparison to identify what resources still need to be made available and what action still needs to be taken. In order to best serve LatinX patients in Southwest Michigan, it is imperative to spread awareness of existing resources that facilitate population’s access to healthcare, as well as propose additional resources that consider the unique challenges this population faces when accessing healthcare.

2. Current Policy

2.a Long-standing Issue:

To begin the analysis of the current policy related to marginalized patients’ access to healthcare, it is important to first note that this ubiquitous and pressing issue is not a modern phenomenon. Although research on the healthcare access barriers for the LatinX population has been published for decades, the systematic exclusion of this population remains as a pervasive concern today. Looking to the past, one 1993 study conducted by Dr. Burciaga Valdez et al. analyzed the current socio-economic factors, demographic trends, and experiences of LatinX patients. In 1993, the research team identified that more than 7 million Latino(a)/X patients did not have health insurance (Valdez et al., 1993, p.535). Additionally, the research team identified that only one-third of LatinX patients without health insurance rated their own health as excellent or very good, in comparison to the one-half of insured individuals who rated their health similarly. Two decades ago, it was also identified that uninsured Latino(a)/X individuals experienced alarmingly high rates of hospitalizations for conditions such as asthma and diabetes that “could have been prevented, treated, or controlled with inexpensive and timely primary care” (Valdez et al., 1993, p.534). Modern research continues to uphold this finding that the
existing barriers to this population’s access to primary care perpetuates the preventable
deterioration in their health due to systemic barriers to preventative care. To further that point, in
1993 the number of uninsured Latino(a)/X individuals increased by 151% alone, and when this
statistic is considered in combination with the simultaneous rise in out-of-pocket costs for
medical visits and stagnation or decline of wages in the Latino(a)/X community- it comes as no
surprise that this population has been experiencing a health care access crisis for decades (Valdez
et al., 1993, p.536). Before continuing with the modern presentation and analysis of the issues at
hand, it is important to note that this research has been conducted for decades now, even prior to
1993.

2.b: Title VI of the Civil Rights Act of 1964

This section pertains to existing legislature that has been passed to protect marginalized
populations in the US. Specifically, “based on Title VI of the Civil Rights Act, LEP patients and
families must have meaningful access to language services” (Steinberg et al., 2016, p.1318) and
“all entities receiving federal funding (including private entities accepting payment from
Medicare or Medicaid) [are required] to take reasonable steps to ensure meaningful access to
their programs and activities by LEP persons” (Nathenson et al., 2016, p.772). However, as the
health of the LatinX population continued to be marginalized, and their access to healthcare
continued to be systematically barricaded, the Office of Minority Health from the US
Department of Health and Human services in 2000 published the National Standards for
Culturally and Linguistically Appropriate Services in Health Care (CLAS standards) to specify
and provide guidance for Title VI compliance (Steinberg et al., 2016, p.1318). The CLAS
standards specified that the “appropriate accommodations for LEP patients include the right to
language-concordant providers with sufficient target language proficiency and/or certified,
professional interpreters” (Steinberg et al., 2016, p.1318). These standards have been implemented into the Joint Commission accreditation process for hospitals. Many hospitals across the nation, however, fail to meet these standards and risk their accreditation as an institution (Steinberg et al., 2016, p.1318). Hospitals face the responsibility of staffing bilingual providers and interpreters but considering the devastatingly low numbers of bilingual providers in proportion to the LEP patient population, and the financial implications of professional interpretation, this responsibility often presents financial and logistical challenges for health care systems. The next section will elaborate on the role medical interpreters play in LEP patient access to healthcare to analyze their impact in fulfilling the rights granted in Title VI of the Civil Rights Act, and subsequently the CLAS standards.

2.c: Medical Interpreter’s Role in Promoting Equitable Healthcare

Medical interpreters play a foundational role in bridging the linguistic and cultural gap between healthcare providers and the over 60 million people in the US that speak a language other than English at home, 30 million of which report that they speak English “less than very well” (Canenguez & Nunes, 2016, p.252). Specifically, these “patients who are limited English proficient (LEP) are twice as likely to suffer from adverse events in the hospitals, as compared to English-speaking patients” (Canenguez & Nunes, 2016, p.254). This alarming statistic highlights the need for certified, professional medical interpreters in the American healthcare system. A medical interpreter has numerous roles within the medical encounter; they act as a “conduit, clarifier, cultural broker, and advocate” (Canenguez & Nunes, 2016, p.251). These professionals are mediators between two distinct cultures and languages and have the crucial role of advocating for their clients. Interpreters, when not available in person, can be utilized over phone or video chat as well, making their necessary services more available.
When medical interpreters are not utilized, whether that be from a lack of proper staffing in the hospital or a failure to request on behalf of the providers, patients must rely on ad hoc interpreters. An ad hoc interpreter is anyone who is linguistically competent on some level but has no formal certification or training. These can be the patient’s bilingual friends or family members, or bilingual but uncertified staff. Studies show that “the frequency of errors and clinical significance of those errors were much greater when ad hoc interpreters were used” (Canenguez & Nunes, 2016, p.252). The frequent use of uncertified bilingual staff as interpreters poses the risk of sub-par communication, in addition to breaching patient-provider confidentiality and violating Title VI of the Civil Rights Act. Additionally, the uncertified bilingual staff are often taken away from their own patients and are expected to perform translations that fall outside of their certified scope of practice (Canenguez & Nunes, 2016, p.253). The use of family and/or friends as ad hoc interpreters is not only in violation of HIPPA and Title VI of the Civil Rights Act, but it has been found that patients feel disconnected from their provider and report feeling “unheard” (Canenguez & Nunes, 2016, p.253).

Medical interpreter availability varies widely between institutions as not all facilities rely solely on medical interpreters. In some facilities, bilingual employees who have been subsequently trained as medical interpreters are hired as dual employees and medical interpretation is thus within their scope of practice. In other cases, medical interpreters may only be available remotely through phone and/or video calls (Canenguez & Nunes, 2016, p.254). While many hospitals argue that the costs of medical interpreters cannot be justified within their budget, failure to provide competent interpreter services is a violation of Title VI of the Civil Rights Act and is considered discrimination based on national origin, in addition to being ethically debased (Canenguez & Nunes, 2016, p.256). The need for unhindered communication
between patient and provider can be demonstrated with the case of Willie Ramirez. An unconscious 18-year-old Ramirez was brought to an emergency room in South Florida by his Spanish-speaking family. At no point in the visit was a Spanish-speaking medical interpreter requested, and the English-speaking healthcare provider could only grasp the word “intoxicado”. While this word sounds very similar to the English word *intoxicated* the translation means poisoned, as with food or medicinal poisoning. However, the medical team proceeded to incorrectly treat Ramirez for a drug overdose, and after two days spent in the hospital, Ramirez died from an untreated intracerebellar hemorrhage related to the poisoning (Canenguez & Nunes, 2016, p.262). This example is unfortunately one of many where the negligence to provide medical interpretation and discrimination by healthcare providers had fatal repercussions. In summary, studies have shown that medical care is undoubtedly improved when patients have access to qualified medical interpreters, as is their right by law. Categorically, interpretation errors are less likely to occur, greater patient comprehension is achieved and thus better adherence to medical recommendation is observed with the use of medical interpreters. Increased patient satisfaction has also been reported when medical interpreters have aided physicians and patients (Canenguez & Nunes, 2016, p.265).

2.c: Patient Protection and Affordable Care Act of 2010

In 2010 President Barack Obama signed into legislature the Patient Protection and Affordable Care Act, commonly known as “Obamacare”. The ACA allowed previously excluded populations to enter the healthcare system by reducing insurance costs and expanding Medicaid for low-income Americans. With what had been projected to be 24 million new enrollees, approximately 23% would speak a language other than English at home (Canenguez & Nunes, 2016, p.252). This highlights the changing demographic that the American healthcare sector
needs to accommodate for and to provide culturally aware care by ensuring that patient-provider interactions are professionally interpreted and safe. Importantly, the passing of the ACA was by no means a solution to the problem. In fact, 3 years after the implementation of the ACA, one in three Latinos in the U.S. were still reported to be uninsured (Mazzula & Torrez, 2016, p.77). Additionally, it is important to note that sub-ethnic groups of the Latino population have unique challenges. For instance, the percentage of uninsured Mexican-Americans is higher than Puerto Rican-Americans. Another aspect to consider is the difference in barriers to obtaining insurance within the sub-ethnic groups of the LatinX population. Mexican immigrants report “early residency in the United States [as] a documented barrier”; however, among the Puerto Rican migrant population language difficulties are cited as a primary barrier to obtaining insurance (Mazzula & Torres, 2016, p.77). While the LatinX population in the USA experiences similar injustices, there are nuances unique to each subgroup’s experience. The cross-section of the LatinX population that is undocumented experiences heightened difficulty in accessing and affording health care due to their ineligibility for federally funded public health insurance programs such as ACA, Medicare, and Medicaid (Doshi et al., 2020, p.3). This presents a massive barrier to accessing regular care except in emergencies and is a subset of the population that experiences extreme difficulty in routinely accessing our health care system.

2.e: Effects of Changes in Government

The inauguration of Donald Trump in January of 2017 and the subsequent change in the American socio-political climate sent a ripple effect throughout the Healthcare system. Research done by Doshi et. al on “social and economic policies [that function] as forms of structural racism” found “differential treatment of Latina patients by healthcare providers following implementation of immigration laws and/or enforcement” (Doshi et al., 2020, p.2). Looking at a
specific case study conducted in Washtenaw County, MI, “participants reported higher rates of immigration enforcement stress and lower self-rated health following an immigration raid” (Doshi et al., 2020, p.2). Specifically, this study analyzed the effects of increased immigration enforcement in the post-2016 election climate on the LatinX population’s access to healthcare. The research team achieved this analysis by identifying influential social, political, and economic factors. First, the legislation that restricts undocumented immigrants’ access to education has been shown to hinder social and economic mobility, which was also found to have serious, negative impacts on health outcomes as a result (Doshi et al., 2020, p.2). Second, regulatory policy for obtaining a driver’s licenses often prevents undocumented immigrants from legally driving, and adds another, often over-looked, barrier to accessing healthcare services (Doshi et al., 2020, p.10). It has also been found in past empirical studies that “fear of deportation is a significant factor in influencing access to and utilization of healthcare services among undocumented immigrants” (Doshi et al., 2020, p.2). The overall result from these systematic barriers is a “mistrust from overt and/or perceived experiences with discrimination” that further excludes this population from the American healthcare system (Doshi et al., 2020, p.2). In Doshi et al.’s research they interviewed frontline health care providers from federally funded medical institutions that serve undocumented LatinX immigrants to understand their perspective on the challenges faced by their clients when accessing care in Michigan. Amid the post-2016 election socio-political climate the providers noted an “intensification of rhetoric, policies and laws against immigrants generally and undocumented immigrants more specifically” (Doshi et al., 2020, p.3). Providers also expressed that following the 2016 presidential election they have observed “an increase in stress, anxiety, depression, and trauma among their undocumented clients -an outcome of increased fear and immigration-related [traumatic] events” (Mesa et al.,
2020, p.2006). In summary, the socio-political climate over the past five years has detrimentally impacted both the documented and undocumented LatinX population in the US by intensifying the “routine searches without a warrant” performed by ICE and other hostile behavior towards the LatinX community that instill a distrust and fear of the American institutions that further exacerbate the existing barriers to healthcare access in this population (Doshi et al., 2020, p.3).

3. Demographic Information

The demographics of the United States as well as the state of Michigan are important in researching the experience of the LatinX population. Concretely, Latinos are the largest ethnic minority population in the United States (Steinberg et al., 2016, p.1318). Of the 25 million people in the U.S. with LEP, over 60% are Spanish speaking (Morales et al., 2015, p.1434). In 2020 the total population of Americans of Hispanic origin is 62.3 million people (Instituto Cervantes, 2020, p.4). The LatinX population is expected to grow from 14.8% to 24% of the entire US population by the year 2050 (Morales et al., 2015, p.1434). Specifically, the countries with the largest representation of the total LatinX immigrants are Mexico with 61.9%, Puerto Rico with 9.7%, Cuba with 4%, El Salvador with 3.9%, and the Dominican Republic at 3.5% of the total LatinX immigrants coming from these respective countries (Instituto Cervantes, 2020, p.4). In Michigan, the overall population is 9.9 million, of which the LatinX population is 507,353 (World Population Review, 2021). In Michigan, the estimated population of undocumented immigrants is 130,000 (Doshi et al., 2020, p.3). In Southwest Michigan specifically, the LatinX population accounts for 5.9% of the total population (Southwest Michigan First, 2021).

Another important consideration of demographics is emerging population migration trends. Specifically, Nathenson et al. conducted research on the “emerging destinations” for
LatinX immigrants in comparison to “traditional destinations” (Nathenson et al., 2016, p.768). Their research found that “recent population flows have shifted toward “emerging destination” areas […] often located in the Southeast and Midwest” (Nathenson et al., 2016, p.770), and that in these emerging destinations 50% of the immigration population is LEP (Lanesskog, 2018, p.382). This means, however, that in these emerging destinations there is a severe lack of accessible infrastructure to facilitate this population’s access to healthcare. Nathenson et al. found in their research that LEP Spanish-speaking patients in emerging destinations, such as Michigan, are 40% less likely to receive an appointment with a safety net provider than at traditional established destinations (Nathenson et al., 2016, p.769). This is in part due to the startling finding that only 54% of federally qualified health centers in emerging destinations offered services with Spanish-speaking providers or bilingual staff in comparison to 92% of federally qualified health centers in traditional destinations offer these services (Nathenson et al., 2016, p.769). This research effectively quantified the lack of infrastructure for LatinX healthcare access in emerging destinations, such as Michigan.

4. Experiences of LEP patients in US healthcare system

4.a: Insurance and Citizen Status

One of the most prolific barriers to healthcare for the US LatinX population is access to health insurance. A study published by Mazzula and Torres found that approximately one in three LatinX patients is uninsured in the United States (Mazzula & Torres, 2016, p.77). While the Affordable Care Act (ACA) provides health insurance to any adult citizen or lawfully present non-citizen, so long as they have lived in the United States for a minimum of five years, research shows that this alone is not meeting needs of this population. Due to the mixed residency status of some LatinX families, family members in need of medical attention often refrain from seeking
treatment out of fear of the consequences it could have on non-citizen family members (Mazzula & Torres, 2016, p.78). Additionally, current health law requires that all individuals have some form of health insurance, and those without are subject to heavy tax penalties. This tax penalization adds undue financial stress to patients who have sought care without insurance and are often already paying a premium for their services (Mazzula & Torres, 2016, p.78). In addition, undocumented immigrants, including undocumented minors, are not eligible to apply for Medicaid (Mazzula & Torres, 2016, p.78).

4.b Language and Culture

It is undisputed that language barriers in health care precipitate negative outcomes in health for patients. Specifically, patients confronted by the language barriers of American health care report lower overall satisfaction rates with care and receive poor-quality patient education which can lead to serious, if not life-threatening misunderstanding of their diagnosis and/or treatment plan (Mazzula & Torres, 2016, p.80). Additionally, researchers have found “non-English speaking patients tend to be misdiagnosed and [are] also perceived to lack awareness of their medical conditions” and this implicit bias can be dangerous in medical settings (Mazzula & Torres, 2016, p.80). These negative outcomes are correlated to recent findings that a majority of providers who are considered linguistically competent to treat LEP Spanish-speaking patients only have a high-school level of Spanish language competence (Mazzula & Torres, 2016, p.81). This extreme barrier is often exacerbated by the over-reliance on family members or ad hoc interpreters that not only violates patient-doctor HIPPA regulations but adds undue strain to family dynamics (Mazzula & Torres, 2016, p.81). In addition to linguistic barriers, the cultural awareness of healthcare providers needs to be addressed at a national level, and not only for LatinX patients. The current medical model of U.S. health care is firmly rooted in Western
medicine, and blatantly overlooks client’s global perspectives on health, medicine, and healing. When overlooking these cultural nuances of a patient, the provider fails to treat the individual and has been proven to cause worse medical care outcomes (Mazzula & Torres, 2016, p.88). The dangers of simultaneous cultural and linguistic barriers between provider and client further highlight the need for internal processes that standardize protocols to give providers the best practices to improve integrated health at a national level (Mazzula & Torres, 2016, p.88).

Participants in the 2016 study conducted by Dr. Emma Steinberg et al. reported an even heightened frequency of negative experiences in health care settings other than primary care, specifically in emergency care, child health services, and other specialty care (Steinberg et al., 2016, p.1320). This study also found that to confront the language barrier, participants stated a “strong preference for bilingual providers compared with interpreted encounters” and reasoned that the bilingual providers facilitated improved understanding, strengthened rapport, and relieved overall anxiety (Steinberg et al., 2016, p.1321). One testimony from a participant in this study states: *translated from Spanish to English* “And so… when they were going to operate him, on the day of the operation, a Spanish speaking person, asked if we knew, you know that you have to sign before the procedure, and she said that they were done with the anesthesia and now they are going to insert the tubes inside his ears, and I said, no one said anything about tubes, and she just stood there, how could she not know, right? Everything was ready for the operation, but I really never knew the reasons why they had to put them, and… in, in other words, they never explained it” (Steinberg et al., 2016, p.1323). Another participant states: *translated from Spanish to English* “you can’t understand…at best what he’s recommending… or even the medication, how to administer it” (Steinberg et al., 2016, 1323). Another participant states: “Honestly, I sort of have seen that there is a lot of racism at the hospitals. Sometimes they
don’t want to understand you because you are Hispanic”; another participant states “They humiliate you…I feel they discriminate because they speak English” (Steinberg et al., 2016, p.1324). These quotes are only a few accounts that exemplify the severity of language barriers in healthcare and the extent of the linguistic service inadequacy and prejudice in the U.S. healthcare system. A study by William A. Calo et al. conducted interviews with LatinX patients and identified three common themes of concern: The first is the inconsistent registration of multiple surnames that contributes to patient misidentification and further delays in receiving care. Secondly, a lack of Spanish language services in front desk medical settings proves to be a substantial barrier in care coordination and patient satisfaction. Lastly, the group of LatinX patients identified a perceived discrimination from staff that created a discomfort with services (Calo et al., 2015, p.4). When these experiences and data are considered together, the severity of the language and cultural barrier in American Healthcare is unmistakable.

4.c: Overview of the study “Barriers & facilitators to healthcare and social services among undocumented Latino(a)/LatinX immigrant clients: Perspectives from frontline service providers in Southeast Michigan by Doshi et al, 2020.

Monika Doshi et al. from the Department of Health Behavior and Health Education at the University of Michigan examined barriers and facilitators to health services access in the undocumented LatinX community in the post 2016 presidential election socio-political climate to better understand the experience of this population in Michigan. The research team concluded that the experience of these undocumented clients can be explained using a “three phases delay” model. The first delay being “a delay in the decision to seek care”, the second being “a delay in
identifying and traveling to healthcare facilities” and the third being “delay in receiving adequate and appropriate care at healthcare facilities” (Doshi et al., 2020, p.3).

Beginning with the first phase of delay, the research team identified four socio-political, economic, and cultural factors that impact the delayed decision to seek care. The first of these factors is summarized as generalized fear resulting from anti-immigrant rhetoric. This study found that the dehumanizing portrayal of the LatinX population, and specifically those in this group that are undocumented, in addition to the surge in detainments and deportations characterized the current socio-political context of the United States (Doshi et al., 2020, p.7). The second factor that Doshi et al. identified is “behavior change due to threat of immigration enforcement” (Doshi et al., 2020, p.7). This testimonial from a Michigan primary care provider provides insight into this factor: “people are fearful to come out because they’re being stopped… [and] because some of them don’t have driver’s licenses, they’re risking [detainment/deportation] if they get caught. Some of our patients that are in our project have been deported. Some of our patients’ loved ones have been deported. Not being able to participate in activities that they normally would have done, and certainly coming for healthcare is one of them” (Doshi et al., 2020, p.8). The third factor identified for this phase is “financial and opportunity costs” and is characterized by the prohibitive out-of-pocket costs and overall lack of options for health insurance for undocumented immigrants in conjunction with the associated opportunity costs. Opportunity costs can be characterized as time away from work, and/or the decision (and cost) to leave children in the care of other while seeking personal healthcare. The third identified factor is “home country health practices” and can be described as personal health-related behaviors and practices originating from their native country’s culture (Doshi et al., 2020, p.8).
The Phase II delay is the postponement in “identifying and traveling to healthcare facilities” (Doshi et al., 2020, p.9). The first identified factor in this delay is the presence of police, Customs and Border Protection (CBP) and U.S. Immigration and Customs Enforcement (ICE). Participants in this study cited a direct link between the presence of law enforcement agents and heightened reluctance for LatinX patients to drive to their appointments in fear of local and federal police forces (Doshi et al., 2020, p.9). Additionally, the researchers identified the factor of transportation generally as a cause in delay as the regulations and requirements to obtain a driver’s licenses are significant barriers to this form of transportation. The final factor that the research team identified is the “navigation and coordination of care” (Doshi et al., 2020, p.11). In addition to the previously mentioned factors, LatinX patients are often unfamiliar with the U.S. healthcare system and how to access the available resources. The architecture of the healthcare system is often a considerable barrier in identifying how and where to access care as it is often vastly different than previous healthcare systems with which the patients have had prior experience (Doshi et al., 2020, p.11).

The Phase III delay is described as the delay in “receiving adequate and appropriate care at healthcare facilities and has two identified factors as the causative agents in this delay” (Doshi et al., 2020, p.11). The first of these factors is “language and/or culture congruence” (Doshi et al., 2020, p.11). This factor encompasses the root of the US healthcare system’s inadequacy for treating patients with LEP as the simple fact that the lack of communication is a barrier to receiving quality care. In addition, the need for cultural awareness and training for providers is paramount for the successful and ethical treatment of culturally diverse patients. The second factor the research team identified is “facility culture/environment” and can be described as “discriminatory and racist practices” in the healthcare facilities (Doshi et al., 2020, p.11). One
participant shared the following: “I overheard the receptionist saying, yelling to a patient that they needed to bring someone in English. That she wasn’t going to help them. They [patient] spoke Spanish. They [receptionist] refused to help” (Doshi et al., 2020, p.12). This first-hand account embodies the racism, ignorance, and discrimination that LatinX and other marginalized communities often must face when accessing healthcare. To further this point, researchers documented differential treatment of LatinX patients by healthcare providers following implementation or enforcement of immigration laws (Doshi et al., 2020, p.12).

5. Experiences of Health Care Providers

In a study conducted by Lanesskog in 2018, researchers interviewed bilingual providers to understand their perspective. Bilingual providers found that treating LEP patients is often associated with “difficulty and frustration” and they reported feeling “overwhelmed and isolated by the complexity of their cases”, in addition to feeling “unsupported and undervalued by colleagues” (Lanesskog, 2018 p. 384). Importantly, in this same study, bilingual providers expressed feelings of being “unprepared professionally to navigate the challenges of working across languages and cultures” (Lanesskog, 2018, p.384). These quotations highlight the importance of understanding the root of the language barrier that stems from a systemic failure to provide highly qualified and trained bilingual healthcare workers.

The same study also found that the providers for LEP LatinX immigrant families felt especially motivated to provide heightened levels of care in response to and in compensation for the mistreatment these clients receive in the broader community and in prior healthcare experiences (Lanesskog, 2018, p.386). This study ultimately proposed a team approach to treating LEP patients so that the patients received the best care while simultaneously supporting the bilingual staff who were often shouldering a heavier workload. It is also imperative to
consider the necessary training prior to working as a medical interpreter or bilingual provider, as
one study found that only one in five (20%) of all staff working as medical interpreters indeed
had sufficient skills to serve as the sole interpreter in each medical encounter (Piedra et al., 2011, p.64).

However, the feeling of moral obligation and duty to provide excellent care as observed
by Lanesskog is unfortunately not universally accepted by healthcare providers in the United
States. A tragic example of this is the case of 13-year-old Gricelda Zamora. Gricelda was
brought to the Emergency Department by her parents who only spoke Spanish. Gricelda, who
was bilingual, often interpreted for her parents, but when she was brought into the Emergency
Room with extreme abdominal pain, she was unable to communicate. The hospital offered no
translation services, and the physician assigned to her case performed a pregnancy exam on the
13-year-old and instructed the family to make an appointment within three days. The blatant
racism in assuming a 13-year-old Latina patient to be pregnant proved to be a fatal prejudice.
After leaving the hospital, Gricelda passed away two days later from a ruptured appendix. After
the Zamora tragedy, one emergency-department physician wrote a letter to the editor of a
publication on the story asking “is it really the responsibility of the medical community to take it
upon ourselves to be yet more ‘consumer-friendly?’” and continued on to advise, “if you have
trouble in the ER (Emergency Room) or any situation because you don’t speak English, learn
English, and do it soon. Until then, at least try to bring along a bilingual friend of family
member” (Piedra et al., 2011, p.57). This statement goes against every protection guaranteed to
patients under the Title VI of the Civil Rights Act that guarantees “patients and families have
meaningful access to language services” (Steinberg et al., 2016, p.1318), in addition to being an
affront to the desire to improve the health of all patients and the Hippocratic Oath sworn by all physicians.

6. Overview of Spanish in Medical School Curriculum

In 2015, Dr. Raymond Morales et al. conducted a national survey of Medical Spanish curriculum in U.S. Medical Schools to better understand how these institutions are adapting to the patient demographic of the United States. To begin, the research team met with the Latino Medical Student Association (LMSA) of over 4,000 medical students to identify major areas of concern and focus moving forward with their research. From these focus groups, they identified three main issues as provided by current medical students in the LMSA: 1) the lack of consistency of Spanish curriculum at each US Medical School 2) minimal course assessment 3) the course delivery is student initiated and driven (Morales et al., 2015, p.1435). After identifying the areas of concern for their study, Morales et al surveyed 132 medical schools in the U.S. to quantify and qualify their medical Spanish curriculum. Morales et al. found that 66% of schools reported that a medical Spanish curriculum was currently offered in their program, with 62% being in existence for more than 5 years (Morales et al., 2015, p.1436). Additionally, 32% of schools with no current medical Spanish curriculum planned to incorporate one in the next two years (Morales et al., 2015, p.1436). The research team also found that of the schools that did not currently offer a medical Spanish curriculum, 27% had offered a program in the past that had since been discontinued (Morales et al., 2015, p.1437). As for the course instruction, of the 62 schools that reported a medical Spanish program, 37 are primarily instructed by a faculty member, 6 are taught solely by students, 6 are taught by a trained medical interpreter, 5 are taught by language instructors without medical training, and 2 are taught using a non-medical commercial language program (Morales et al., 2015, p.1437). This collection of data highlights
the lack of standardization and the wide range in quality of instruction in established curriculums. Additionally, of the schools with medical Spanish programs, 75% of their medical students conducted patient interviews in Spanish or worked as interpreters in hospitals and local clinics, and of these students, 57% were not required to show any proof of language competency prior to language application in the clinical setting (Morales et al., 2015, p.1437). This fact demonstrates how unregulated and unstandardized these programs are, as only 14 of the 62 schools with medical Spanish curriculum required any type of proficiency or interpreter certification test at any point in their programs (Morales et al., 2015, p.1437).

Morales et al. also surveyed the schools without medical Spanish programs to better understand what barriers exist to implementing these programs. They found that among the 10 schools that had reported discontinuing their existing medical Spanish programs, the most common reason for discontinuation of the programs was “too many students had signed up for the course, making it too expensive to support” (Morales et al., 2015, p.1437). This embodies the larger issue at hand of unethical allocation of funds that facilitate LEP LatinX patients access to healthcare. This statistic demonstrates that while medical students are showing interest and a desire to help, their programs are citing lack of funds as justification for further reinforcing existing barriers to healthcare. It is also important to note the demographic of American Medical Schools. Concretely, in the past 30 years there has been a decline in the number of LatinX physicians, while the number of LatinX patients continues to rise (Steinberg et al., 2016, p.1324). While training in medical Spanish will not resolve the complex issue of healthcare access, it is nonetheless a crucial factor that has the potential for great change and improvement.

Western Michigan University’s Homer Stryker M.D. School of Medicine offers multiple Spanish medical courses. These courses are provided for levels I, II and III and range from 0.5-1
credit. These courses are described to teach “English-speaking providers the skills needed to communicate effectively with Spanish-speaking patients” (WMed Catalog, 2021). While these courses are not required, the availability of these courses is indicative of student interest and faculty responsiveness. These medical Spanish courses are created by Canopy Learn and are delivered entirely through a modular online lesson design (WMed Catalog, 2021). While this online delivery method poses some challenges, the presence of these courses is characteristic of a medical school with the intention of serving the community of LatinX LEP patients.

7: Resources in Southwest Michigan

The state of Michigan defines the following counties as Southwest Michigan: Allegan, Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, and Van Buren counties (Michigan Department of Transportation, 2021). The following sections will provide an overview of the resources available to facilitate LatinX LEP patient’s access to healthcare for each of these counties. The first source that the clinics and hospitals gathered information or assistance from is 211. 211 is a phone number much like 911, but that can be called to provide referrals and information regarding health, human, and social services organization and is regarded as a lifeline in times of crisis. 211 is also an extremely useful website that can be accessed to find the same information. Specifically in Southwest Michigan, the Gryphon Place works in collaboration with 211 as a community resource to help direct patients seeking care to accessible medical facilities. From this resource, each county in Southwest Michigan was searched for all available clinics or hospitals that listed Spanish in the language information category, and thus indicated Spanish-speaking resources are available at that location (Gryphon Place 211, 2021).
The Federally Qualified Health Centers (FQHC) are listed for each county in Southwest Michigan as well. According to Health Resources and Services Administration (HRSA), FQHC’s are health centers that receive funding from the U.S. National Government under Section 330 of the Public Health Service Act (PHS), as well as additional reimbursement from Medicare and Medicaid. This allows FQHC’s to serve underserved populations by offering sliding fee scales and providing transportation services, in addition to providing hospital and specialty care. As all FQHC’s receive federal funding, they are required to provide interpretation services and have been listed as well for each county. In each of these counties there are hospitals that under Title VI of the Civil Rights Act must provide interpretation services and are also listed as a resource (FQHC Associates, 2021).

7.a: Hospitals and Clinics in Southwest Michigan

Resource(s) in Allegan County:

- Resource(s) found from 211 website:
  - Intercare Community Health Network: 5498 109th Avenue, Pullman, MI 49450

- Federally Qualified Health Center(s):
  - Community Health Center: 601 Michigan Ave, Suite 201 Holland MI 49423

- Hospitals and Emergency Rooms:
  - Ascension Borgess Allegan General Hospital: 555 Lin Street Allegan, MI 49010
  - Ascension Borgess Pipp Hospital: 411 Naomi Street Plainwell, MI 49080

Resource(s) from 211 in Barry County:

- Resource(s) found from 211 website:

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1 Federally Qualified Health Centers were found using the Federally Qualified Health Centers Provider Directory (2019). The Hospitals and Emergency Rooms were found using the U.S. Hospital Finder (n.d.), and County Office (n.d) as online resources.
Federally Qualified Health Center(s):
  - N/A

Hospitals and Emergency Rooms:
  - Spectrum Health Pennock Hospital: 1009 West Green Street Hastings, MI 49058

Resource(s) from 211 in Berrien County:
  - Resource(s) found from 211 website:
    - N/A
  - Federally Qualified Health Center(s):
    - Cassopolis Family Clinic: 60 N St Joseph Avenue Niles, MI 49120
    - Intercare Child And Adolescent Health Center: 870 Colfax Avenue Benton Harbor, MI 49022
    - Intercare Riverwood Center: 1485 M-139 Benton Harbor, MI 49022
    - Intercare Women's Health Center: 796 Highway M-139 Benton Harbor, MI 49022
    - Mercy Family Medical Center: 800 M-139 Benton Harbor, MI 49022
    - Niles Community Health Center: 24 N Joseph Ave, Suite G Niles, MI 49120
    - Solis Memorial Health Center: 6270 W Main St. Eau Claire, MI 49111

Hospitals and Emergency Rooms:
  - Community Hospital: 400 Medical Park Drive Watervliet, MI 49098-92256
  - Lakeland Community Hospital, Watervliet: 400 Medical Park Drive Watervliet, MI, 49098
  - Lakeland Continuing Care Center: 6418 Deans Hill Road Berrien Center, MI, 49102
Resource(s) in Branch County:

- Resource(s) found from 211 website:
  
  o N/A

- Federally Qualified Health Center(s):
  
  o N/A

- Hospitals and Emergency Rooms:
  
  o ProMedica Coldwater Regional Medical Center: 274 East Chicago Street
    Coldwater, MI, 49036

  o Ascension Borgess Medical Center: 375 N Willowbrook Rd, Coldwater, MI
    49036

  o Community Health Center of Branch County: Emergency Room 274 E Chicago
    St. Coldwater, MI, 49036

Resource(s) from 211 in Calhoun County:

- Resource(s) found from 211 website:
  
  o Grace Health: 181 West Emmett Street, Battle Creek, MI 49037 ** is a FQHC

- Federally Qualified Health Center(s):
  
  o Family Health Center of Albion: 115 Market Place Albion, MI 49224

  o Family Health Center of Battle Creek: 632 North Ave Battle Creek, MI 49017
• Hospitals and Emergency Rooms:
  • Battle Creek VA Medical Center: 5500 Armstrong Road, Battle Creek, MI 49037
  • Bronson Battle Creek Hospital: 300 North Avenue, Battle Creek, MI, 49017
  • Bronson ProHealth- Battle Creek: 265 Fremont Street, Battle Creek, MI 49017
  • Oaklawn Hospital: 200 North Madison Street, Marshall, MI, 49068
  • Southwest Regional Rehabilitation Hospital: 393 East Roosevelt Avenue, Battle Creek, MI 49017

Resource(s) in Cass County:
• Resource(s) found from 211 website:
  • N/A
• Federally Qualified Health Center(s):
  • Lakeland Immediate Care Center: 109 School Street Cassopolis MI 49031

Resource(s) in Kalamazoo County:
• Resource(s) found from 211 website:
  • Ascension Borgess Medical Center: 1521 Gull Road Kalamazoo, MI 49048
• Federally Qualified Health Center(s):
  • Family Health Center: 117 W Paterson St Kalamazoo MI 49007
  • Family Health Center: 505 Alcott St Kalamazoo MI 49001
  • Family Health Center Crosstown Parkway: 615 E Crosstown Pkwy Kalamazoo MI 49001
- Family Health Center Inc City of Portage: 325 East Centre Street Portage MI 49002
- Family Health Center-Sheridan: 2918 Portage Street Kalamazoo MI 49001

**Hospitals and Emergency Rooms:**
- Bronson Methodist Hospital: 601 John Street Kalamazoo, MI 49007
- Bronson Healthcare Group: 1 Healthcare Plaza Kalamazoo, MI 49007
- Kalamazoo Psychiatric Hospital: 1312 Oakland Drive, Kalamazoo, MI 49008
- Bronson Vicksburg Family Medicine Hospital: 13320 N Boulevard St. Vicksburg, MI 49097

**Resource(s) in St. Joseph County:**
- Resource(s) found from 211 website:
  - Covered Bridge Healthcare of Saint Joseph County: 658 East Main Street, Centreville, MI 49032 *also a FQHC*
- Federally Qualified Health Center(s):
  - Covered Bridge Healthcare of Saint Joseph County: 658 East main Street, Centreville, MI 49032
- Hospitals and Emergency Rooms:
  - Sturgis Hospital: 916 Myrtle Sturgis, MI 49091
  - Three Rivers Health Hospital: 701 S Health Pkwy, Three Rivers, MI 49093
  - Bronson Primary Care Partners- Three Rivers: 601 S. US Hwy 131, Three Rivers, MI 49093

**Resource(s) in Van Buren County:**
- Resource(s) found from 211 website:
- Holy Family Healthcare: 301 North Center Street, Hartford, MI 49057
- Intercare Bangor Office: 308 Charles Street, Bangor, MI 49013

  - Federally Qualified Health Center(s):
    - Bangor Community Health Center: 308 Charles St Bangor MI 49013
    - Pullman Health Center: 50 Industrial Park Drive Bangor MI 49013
    - Southside Family Health Center: 11637 M-140 Highway South Haven MI 49090

  - Hospitals and Emergency Rooms:
    - South Haven Community Hospital: 955 South Bailey Avenue South Haven, MI 49090-9797
    - Bronson Lakeview Community Hospital: 408 Hazen Street Paw Paw, MI 49079-0209

7.b: Websites and Online Resources:

In this era, it is crucial to examine the role the internet plays as a tool to identify resources that facilitate healthcare access for the LatinX community. Specifically, the online resources Healthline, Zocdoc, Alianza Nacional para la salud de los hispanos, Hispanic Access Foundation, and UnidosUS are sources that facilitate the LatinX population’s access to healthcare.

Beginning with Healthline, this website published the article “Cómo encontrar profesionales de la salud bilingues en Estados Unidos” (*How to find bilingual health professionals in the United States*) in 2021 that highlights search engines and interpreter services, in addition to the program “Su familia” (*Your Family*). Healthline provides general information on the tools available to facilitate the LatinX population’s access to healthcare. To begin, the article summarizes and explains their legal rights according to the Affordable Care Act.
Act, in addition to Medicare and Medicaid. The article also identifies numerous search engines such as Zocdoc that can search your zip code for bilingual providers, as well as information on the Alianza Nacional para la Salud de los Hispanos (*National Alliance for the Health of Hispanics*) (Healthline, 2021). The Alianza Nacional para la Salud de los Hispanos is an organization that was started in 1973 with the goal of optimal health for the LatinX community. This organization publishes health announcements, starts public health initiatives, and disease-specific informative pamphlets all in Spanish. In addition to these resources, the Alianza Nacional para la Salud de los Hispanos has a confidential helpline 1-866-Su Familia (866-783-2645) designed specifically to help callers navigate the U.S. healthcare system. The call line is staffed with bilingual health promotion advisors that have access to the national database of over 13,000 providers so that the advisors can refer caller to health care services in their local communities (National Alliance for Hispanic Health, 2021).

Search engines such as Zocdoc allow users to search by medical specialty, location, and insurance coverage. Other similar search engines include vitals.com and Opencare.com, however; these search engines lack the crucial language preference filter that makes Zocdoc stand out. Using Zocdoc you can filter through providers in your area based on your language preference. While the software and fundamental idea behind this search engine has the potential to facilitate countless patients finding their desired provider, the number of providers currently in the system is a serious limitation and further speaks to the barriers in accessing care. Specifically, when searching the entire state of Michigan for a primary care physician there is only one doctor available that is bilingual, in comparison to the 50+ providers that populate without the language preference filter (Zocdoc, 2021).
The Hispanic Access Foundation works to create equity for the LatinX population by promoting civic engagement, physical health, environmental health, education, and economic success through meaningful partnerships and connections to and from the LatinX community on a national scale. Specifically, the Hispanic Access Foundation’s MANO project (My Access to Network Opportunities) works to support and develop LatinX leaders to strengthen and serve their communities through outreach programs. Additionally, the Hispanic Access Foundations Conservation program is dedicated to supporting LatinX leaders in combatting global environmental issues (Hispanic Access Foundation, 2021).

UnidosUS is a national organization, previously known as NCLR (National Council of La Raza) that was founded by Ernesto Galarza, Herman Gallegos, and Julian Samora to “empower Latinos to define and achieve their own American Dream” in 1968 (UnidosUS, 2021). UnidosUS is the largest Hispanic civil rights and advocacy organization in the nation, and tackles issues on education, health, housing and finances, immigration, racial equity, workforce development, and voting and political empowerment. Focusing on UnidosUS contribution to health, the organization started the movement Esperanza to disseminate accurate and quality information to help build trust in the safety and efficacy of the COVID-19 vaccines. Additionally, UnidosUS offers information on health coverage options, specific articles on children’s health, and their program Comprando Rico y Sano (Buying Healthy and Delicious). Comprando Rico y Sano is a program led by community health workers and is designed to promote healthy shopping habits and facilitates enrollment in the Supplemental Nutrition assistance Program (SNAP) (UnidosUS, 2021). UnidosUS is also a partner of the American Hospital Association (AHA). This partnership focuses on connecting UnidosUS leaders with executive opportunities to increase
diversity among health care executives, as well as address social determinants of health and foster programs to improve opportunities for the LatinX population (UnidosUS, 2021).

7.c: El Concilio:

*El Concilio* is a non-profit organization that was started in 1981 with the goal of serving the LatinX community in the greater Kalamazoo area. *El Concilio* has achieved this goal for the past 40 years by providing programs and services dedicated to helping the LatinX population attain "self-sufficiency and a higher level of social and economic well-being" (*El Concilio*, 2021). This non-profit strives to help the LatinX community preserve their distinct cultural identities and to prosper in the broader Kalamazoo community. *El Concilio* achieves this through intentional programming in their broader Academia Azteca program such as Niñas del Corazón that helps girls ages 8-15 heal from “acculturation, language barriers, environmental high-risk factors, and disparities”, the Aztec FC soccer team, the Danza Folklórica dance group, tutoring programs, the Spanish as a Second Language for Professionals program, as well as an English as a Second Language for adults’ class (*El Concilio*, 2021). Additionally, *El Concilio* created a bilingual Pre-School, Escuelita Nuevo Horizonte. El Concilio also promotes local LatinX- owned businesses and has their own radio station, M.I. Gente radio. In terms of resources to facilitate healthcare access, the Resource Center at *El Concilio* offers interpretation services, translation services, as well as financial aid for medical bills. *El Concilio* also assists with immigration services such as naturalization and Permanent Resident Card renewal, legal action in cases of workplace discrimination, food security through their partnership with Kalamazoo Loaves and Fishes, as well as cases of sexual abuse and domestic violence. In terms of breadth and depth of services, *El Concilio* has a diverse and inclusive range of services offered to support the LatinX community of Kalamazoo. In addition to providing their own resources, *El Concilio* partners
with and promotes local organizations events. Since the COVID-19 pandemic, *El Concilio* has promoted local vaccine events in the LatinX community and held a series of virtual seminars on racial and ethnic disparities in medical attention, one of which was titled “*Explorando el Escepticismo de las Vacunas en la Comunidad Hispana/LatinX*” / “Exploring vaccine skepticism in the Hispanic/LatinX community”. This series was hosted by the organization ACEH (*La Alianza por la Armonía Cultural y Étnica / The Alliance for Cultural and Ethnic Harmony*) (*El Concilio*, 2021). *El Concilio* is a multifaceted organization dedicated to the LatinX community that serves by providing resources, preserving culture, and promoting prosperity through education and outreach.

**7.d: Farmworker Legal Services**

Farmworker Legal Services (FLS) serves as an active advocate for all immigrant, seasonal, and migrant farmworkers by providing legal services and additional resources in the state of Michigan. These additional resources include other legal organizations, migrant education programs, farm labor advocacy sites, immigration sites, and other nationwide resources. Many of the LEP and LatinX farmworkers who are so important to our state’s economy face additional challenges in accessing healthcare as many are seasonal workers. FLS provides numerous resources on their website to facilitate farmworker healthcare access (Farmworkers Legal Services of Michigan, 2021). The first healthcare related source is a direct link to the Environmental Protection Agency Occupation Pesticide Safety and Health government website that provides in depth information on laws and health protection existing for farmworkers (Environmental Protection Agency, 2021). One such law is the EPA’s Worker Protection Standard (WPS) that was put into effect to prevent pesticide poisoning and injury among the agricultural labor force (Environmental Protection Agency, 2021). Additionally, FLS
provides direct access to the Migrant Health website, that provides a blog-style and interactive approach to disseminating health information written by doctors. However, this resource does not offer any other resources in addition to these health blogs (Migrant Health, n.d.).

FLS also provides a direct link to the Migrant Clinicians Network, an organization dedicated to creating “practical solutions at the intersection of vulnerability, migration, and health” and ensuring “health justice and equity, where migration is never an impediment to well-being” (Migrant Clinicians Network, 2017). The Migrant Clinicians Network provides a vast array of publications and information on medical issues pertinent to migrant health. Some of these issues include women’s health, hypertension, cancer, diabetes, immunizations, COVID-19, behavioral health, climate change and migration, and children’s health. In addition, the Migrant Clinicians Network (MCN) provides information on health care centers and created a search engine tool that allows users to locate one of these migrant health care clinics near them. MCN provides a host of information on migration health overall, health systems, health justice, and environmental and occupational health. This resource is invaluable to the farmworker community and specifically LatinX individuals with LEP as these resources are all made accessible in Spanish (Migrant Clinicians Network, 2017).

The final health related source referenced by FLS, is the National Center for Farmworker Health, Inc. (NCFH). The National Center for Farmworker Health is a non-profit corporation located in Buda, Texas that is dedicated to improving health of farmworker families. NCFH provides a broad array of information services and trainings to community and migrant health centers across the U.S., in addition to universities, researchers, and organizations involved with farmworker health. One program from NCFH that facilitates the LEP LatinX farmworker population’s healthcare access is “Una Voz Para La Salud (Call for Health)” (National Center
for Farmworker Health, n.d.). This a nation-wide, bilingual, health information program specifically designed for farmworkers and their families. This resource assists with limitations to healthcare due to financial burdens, as well as providing education about the U.S. healthcare system overall. This crucial support service facilitates the LEP LatinX community’s access to healthcare by providing free, accessible, helpful, and thorough information on the American healthcare system. In addition, NCFH has programs on diabetes education, social determinants of health, mental health, and infectious diseases, as well as training programs for professionals working with the LatinX farmworker population. All the resources from NCFH are available and accessible in Spanish to ensure accessibility for their numerous programs and resources (National Center for Farmworker Health, n.d.).

7.e: MyChart in Spanish: WMed Health

On September 1\textsuperscript{st}, 2021, WMed Health made a monumental step with their launch of Epic System Corp MyChart in Spanish. MyChart is a widely used electronic medical records program that allows patients to access their records from their personal accounts. The student-led initiative for MyChart in Spanish was developed by two Western Michigan Medical Students, Andrew Lynch and Sorabh Singhal. Lynch and Singhal lead the project with the help of WMed’s chapter of the Latino Medical Student Association and especially fellow medical student Daniela Pinto Payares to ensure accurate translations. This incredible development of MyChart in Spanish will enhance accessibility for the more than 300 current patients who now have access to their medical documentation in their primary language (WMed, 2021). These patients “seek primary and specialty care, tallying 600 to 1,000 patient visits a year” and the positive consequences of this development will be felt throughout the community as they join the Family Health Center in Kalamazoo in utilizing MyChart in Spanish (WMed, 2021). In 2019, Lynch and
Singhal provided MyChart in Spanish for the Family Health Center in Kalamazoo before beginning their project with WMed. Both Singhal and Lynch had prior experience working for Epic’s technical teams and software implementation that allowed to launch this program in the interest of increasing healthcare access (WMed, 2021). Their faculty advisor, Dr. Cheryl Dickson, MD, MPH stated that only 17 percent of the Spanish-speaking patients at WMed were enrolled in MyChart prior to the launch of MyChart in Spanish (WMed, 2021). This statistic clearly outlines the drastic need for accessibility for Spanish-speaking patients to their medical records, further highlights the importance of the work done by these Western Michigan University medical students. With the success of MyChart in Spanish, now launched for the second time by these WMed students in Southwest Michigan, the potential for national application of this same technology is evident. The ability for LEP LatinX patients to access their medical records in their native language is monumental, and the potential for increased accessibility on a national scale should patient’s medical records be available to them in their native language is galvanizing.

8: Proposed Solutions:

Now that the reality faced by LEP LatinX patients in the U.S. has been established, it is crucial to propose new ideas to help resolve these identified problems. I would like to present my proposal for solutions to these identified barriers. Specifically, I will propose resources that should be made available as well as systematic changes that can be made to facilitate the LatinX community’s access to healthcare in Southwest Michigan.

8.a: Improving Healthcare Provider Curriculum & Education

To improve the LatinX population’s access to healthcare, it is paramount to consider the education of the providers that is truly the foundation of any patient’s experience. Specifically, I
would like to propose a mandatory language minor to all degree-holding healthcare providers. This progressive new requirement is a necessary response to the heightened globalization of the modern health system. Increasing globalization should be reflected not only in the health care model, but also in the healthcare professional education model. In addition to the medical skills and training received by students in higher education for healthcare, I believe that the ability to speak more than one language is crucial. As our nation becomes increasingly more diverse and the number of LatinX patients continues to grow, the proportion of bilingual providers in American healthcare should also reflect the growing diversity of patients requiring care. The minor could be in any language, as the access of all LEP patients should be considered in this discussion; however, the LatinX population is the largest ethnic minority in the United States and proportionately then would also represent the largest proportion of minority patients seeking care. The requirement of a language minor for all college degree holding health care professionals would be an attainable requirement. This would not pose an extra financial burden as all students in higher education must already choose a minor to complete their degree, and language is paramount in health care services. Not only would a language minor drastically increase the linguistic capability of the next generation of health care providers, but it would also facilitate a globalization of the providers’ mindset and further their cultural understanding. Minoring in a language not only grants linguistic dexterity and proficiency, but also teaches the culture of those who speak the language. Requiring a language minor has the potential to increase empathy and understanding between provider and patient that is often lacking in the American healthcare system currently. The future of health equity would be positively impacted by a generation of healthcare providers who are linguistically capable of treating their patients in the increasingly globalized modern era.
8.b: Improved Training & Protocol

Another element that is crucial to consider when improving health care access is the utilization of existing protections. Specifically, Title VI of the Civil Rights Act of 1964 grants all patients the right to an interpreter or a competent and certified bilingual provider. However, the existing infrastructure does not guarantee that this right is granted to all patients. Many providers do not understand how to access interpreters or are negligent to seek help from interpreters when they are truly needed. I would like to propose a mandatory reeducation of all current health care providers on how to access these existing resources, so that they may be better utilized. This also takes into consideration the need for a more robust interpretation service within the hospitals so that providers can have easy access to interpretation services for their patients. I would also like to propose that all current bilingual providers that are not using interpretation services should be required to become certified medical interpreters, so that their level of expertise and linguistic competence is measured for quality assurance. In addition to retraining all health care providers, it is imperative to also re-train front desk staff and receptionists so that they feel supported by the availability of interpretation services as they too have direct patient contact. If from the moment that an LEP LatinX patient enters a facility they are given the proper interpretation services, as is their right, the potential to significantly decrease the linguistic barrier in healthcare would positively impact their experience and care. I would also propose that with this interpretation service reeducation, there is a prolific need of cultural competence training that could allow providers to empathize with and better understand their patients. While this training will not be without cost to the hospital, I would argue that it is of ethical and moral obligation. It is mandatory to provide the highest possible quality care to every patient, and the current health care system model is neglecting to do so for the LatinX population, and other minority groups. A
large scale, re-education would increase efficiency for use of existing services that are
guaranteed under current law and has the potential to increase positive health outcomes for
patients.

8.c: Virtual APP

It is also important to propose a solution for hospitals and clinics that are not currently
staffed with sufficient interpreters or bilingual providers, as is frequently seen in new
destinations such as Michigan. I would like to propose the implementation of virtual Advanced
Practice Providers (APPs) in these destinations instead of solely relying on phone interpretations
in the instance of in-person interpreter shortages. Advanced Practice Providers, such as a
Physician Assistant or Nurse Practitioner, have a master’s level education and a wide base of
knowledge that can be used as a virtual resource. I would like to propose a Virtual APP resource
as an alternative to traditional phone interpretation services. A network of Virtual APP’s that can
be shared between hospitals and clinics would provide patients with language consultations by
professionals who not only have the medical knowledge of a health professional, but also the
linguistic capability to treat the patient. Essentially, this fully staffed ‘bank’ of Advanced
Practice Providers available between clinics and hospitals would facilitate a sharing of resources
to fill in the gap in linguistically capable care. By sharing resources between clinics and
hospitals, these virtual APPs could simultaneously be interpreting for patient interactions while
the in-person provider is performing tests and hands on care. The use of a Virtual APP
additionally has the benefit of potentially increasing patient flow, especially in Emergency
Rooms as virtual APPs could be treating a patient in tandem with an in-person nurse. This would
allow for that unit’s other staff to be treating other patients. Having web visits would allow for
the qualified bilingual APP to be assisting in various specialties, and even different locations
during their same shift. This proposal also has the potential to illuminate or greatly reduce the reliance on an ad hoc interpreter that is often the fallback option when no interpreters are available.

Another way to facilitate this population’s access to health care would be an increase in home visits. As seen earlier in the research presented in this paper, there is a host of barriers that prevent patients from physically coming into clinics or hospitals for their care. Implementing a more robust system of at home care would have the potential of facilitating more regular patient visits and accommodating the needs of this population.

8.d: Community Outreach

I would also like to propose a reprioritization of community outreach. The trust between the LatinX population and the American health care system needs to be fixed, and I would like to propose that individuals from the community be the main source of feedback and input on what changes need to be made. Instead of expecting large hospital corporations to anticipate and respond to the needs of the LatinX population, I would like to propose an inclusive and community-based option. The implementation of discussions within the community that could be facilitated by El Concilio would give the community a voice to express what they need from health care, and what could be changed to reestablish the trust between provider and patient. Overall, these discussions between the LatinX community and hospital policy makers need to be a space for the community to share where their needs are not being met. All the research that has gone into this field has clearly shown the numerous existing barriers but reaching out to this community and asking for their input directly is paramount in the success of increasing accessibility to the health care system. We as a community need to begin prioritizing the needs of this population by understanding from firsthand discussions what would be truly beneficial.
The health of America rests on the health of individuals, and we cannot hope to improve our nations when we have barriers in place that systematically exclude the LatinX community from our healthcare system. It is our responsibility to act on this injustice and inequity. We have the capacity to prioritize equity and accessibility in healthcare through community outreach.

9. Conclusion

To facilitate the LEP LatinX communities’ access to healthcare in Southwest Michigan, education on the existing resources is vital, as is proposing solutions to improve the accessibility of the American healthcare system. The research conducted in this study detailed the experiences, circumstances, and barriers faced by the LatinX population when seeking healthcare. While these issues are historically evident in public health, the modern resources available in Southwest Michigan were cataloged and detailed to present a clear representation of how these barriers are currently approached. The subsequent solutions proposed in response to this fact aim to alleviate the burden that our healthcare system’s pervasive barriers pose for LEP LatinX patients. Research remains to be done to determine the efficacy of the prospective solutions in practice. Future research has the potential to expand on these proposals to acutely focus on community outreach, improve hospital protocols and trainings, enhance healthcare provider education, and better utilize modern technology by implementing virtual APPs in our current healthcare model.
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