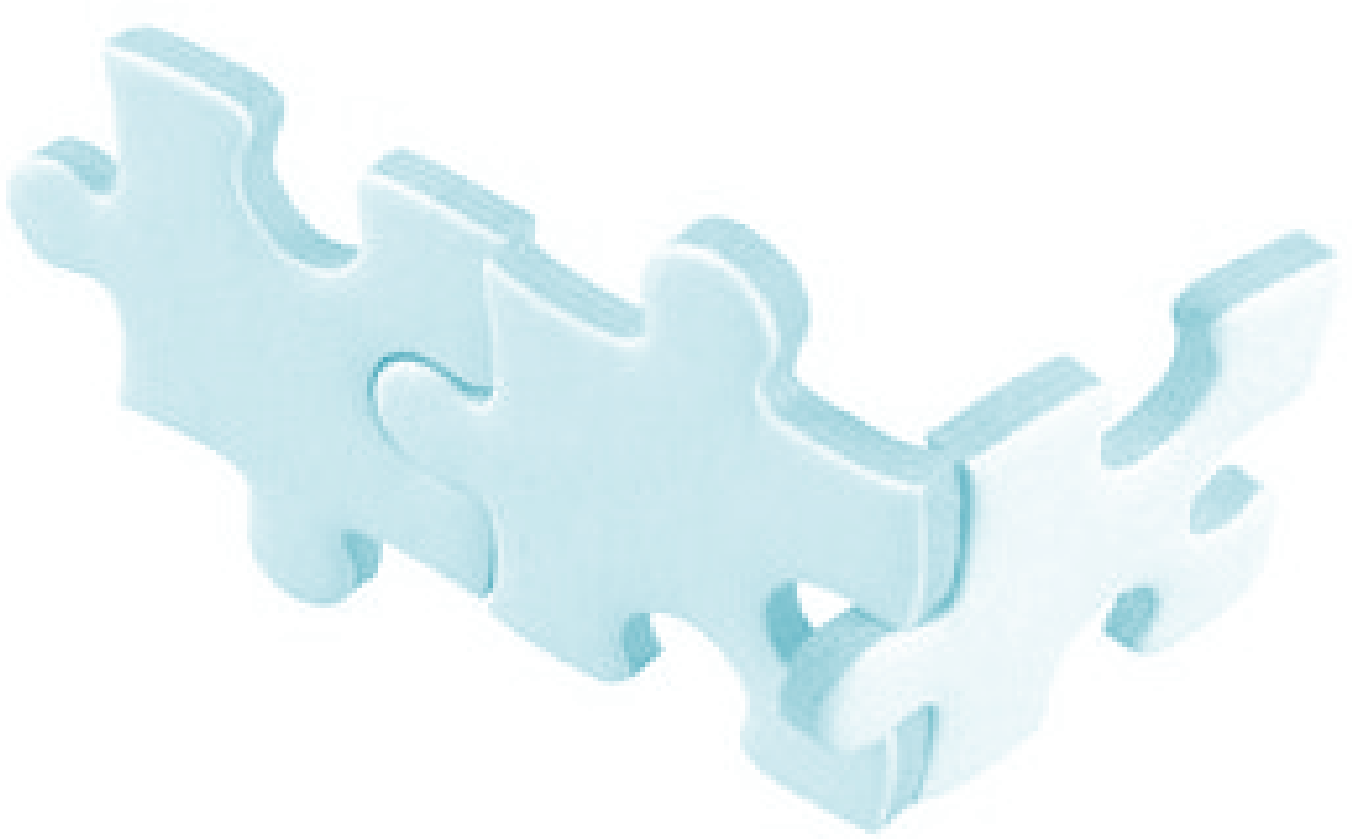
Primary Health Care for All: Overcoming the Linguistic Barrier



A synthesis of presentations and emerging themes from the Healthcare Interpreter Services: Strengthening Access to Primary Healthcare (SAPHC) project's national symposium

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Orangeville, Ontario

Health Canada Santé Canada

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Please note: This text represents the key themes from keynote speakers and panelist presenters at the SAPHC national symposium as noted and paraphrased by the organizing committee. The content does not necessarily reflect the views or opinions of individual conference attendees or sponsoring organizations, nor does it necessarily represent the views of Health Canada and the Primary Health Care Transition Fund.

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Purpose and Project Background

Purpose

For three days in early May 2005, in the Hockley Highlands outside of Toronto, individuals representing many of the sectors involved in primary health care and interpreter service delivery came together with a common interest in moving forward the agenda of improved access to primary health care for individuals who have limited proficiency in Canada's official languages, English or French.

The symposium was a significant step in the research and consultation process initiated through the Healthcare Interpreter Services: Strengthening Access to Primary Health Care (SAPHC) project. With the funding support of Health Canada's Primary Health Care Transition Fund, the SAPHC project's symposium provided the opportunity for stakeholders from coast, to coast to coast to come together and learn from each other's successes and challenges and provide direction and insight into the project's final phase.

Project Background

Initiated in the Fall of 2003, the overall objective of the SAPHC project is to initiate, implement and evaluate a series of activities that address the importance of trained spoken language interpreters in the delivery of primary health care services to patient populations who have limited proficiency in English and/or French.

The project began with an investigation and analysis of:

- The current approaches employed by providers of primary health care in delivering care to patients with whom the service provider does not share a common language;
- The identification and analysis of approaches and models utilized in the delivery of interpreter services in targeted areas of the primary health care sectors; and
- The provision of options to consider for potential interpreting service models, which might be most effective in meeting the identified needs of targeted primary health care sectors.

This research, which was undertaken in Montreal, Toronto and Vancouver, was followed with various community consultations and feedback sessions in the three sites, culminating in the national symposium.

Following the symposium, the emerging themes gathered from the research, consultations and symposium discussions will be analyzed for strategic pilot project ideas to be developed and implemented in the final phase of the project, ending in March 2006.

Introduction

Context

Symposium Context

While interpreter services range from non-existent to regional and provincial solutions, the intent of the symposium was to analyze the diversity of the Canadian perspective and to understand our common ground. The goal was to seek input on project-specific activities, but also to provide a forum for consensus building and collaboration between previously unmet counterparts. Given the vast distances and diversity that Canada embodies, the symposium represented a significant step in addressing the key issues facing health care providers, health care organizations and organizations that provide interpreter services as they try to facilitate clear and accurate communication between patients and providers in a multi-lingual, multi-cultural health care environment.

Fundamental to the project is the tenet that the inability of a health care provider to communicate adequately with patients can have a significant negative impact on their health status. Improving access to health care and improving the quality of service received by patients who have limited proficiency in English or French (LEP/LFP) can limit delays in diagnosis, mis-diagnosis, inappropriate referral, failures to explain a patient's condition or recommend care, failures to ensure confidentiality or obtain informed consent [1]. Addressing language barriers not only improves quality of care, but can also have a positive effect on operational efficiencies and utilization.

Canadian language access programs have evolved in an organic manner, often adapting to the predominant issues of specific locales and stakeholder populations and have largely grown out of a rights-based argument that focuses on access and equity in health care services. While this community-based momentum has resulted in many positive initiatives, it has simultaneously created an ad-hoc patchwork of programs across the country. Symposium invitees thus represented this diversity and range of perspectives. In an effort to streamline the provision of interpreter services and create a sense of commonality among participants, the symposium's agenda took aim at investigating various streams of the health care agenda to decipher the most advantageous location for the advancement of language access.

With many programs based on a foundation of advocating for rights and equity, the symposium began with a presentation by Raj Anand, a partner with WeirFoulds LLP and former Chief Commissioner of the Ontario Human Rights Commission, who provided a legal perspective on language rights.

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Lifeline: Language Access as a Human Rights Issue

Raj Anand

Arguably, language rights are protected under the Canada Health Act, various language statutes, human rights codes and the Charter of Rights and Freedoms, however there is no explicit inclusion of 'language' and little legal precedence related to language access in the health care sector.

Beginning with possibly the most applicable legal framework, the objective of the Canada Health Act is "to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers" [2]. Although the Act has five key principles, the principles of *accessibility*, *universality* and *comprehensiveness* are the ones most applicable to language access. *Accessibility* involves a commitment that all insured persons across Canada have reasonable access to hospital and medical treatment in an unimpeded way and that individuals receive equal care with respect to services offered by a particular health care provider. *Universality* implies that all insured residents of a province are entitled to receive health care of an equal standard. And finally, *comprehensiveness* refers to the idea that the health care insurance plan of a province must insure all health services provided by hospitals, medical practitioners and, where the law of the province so permits, similar or additional services rendered by other health care practitioners. Under this section, all services that are medically necessary for the purpose of maintaining health, preventing disease, or treating illness, injury or disability are supposedly included. However, health care interpreter services are not considered to be medically necessary, but rather ancillary [3].

> *Language is so intimately related to the form and content of expression that there cannot be true freedom of expression by means of language if one is prohibited from using the language of one's choice…language is not merely a means and medium of expression, it colours the content and meaning of expression (from Ford v. Quebec in the context of Canada's official languages)* [4].

Similar to the Canada Health Act, language is not given direct legal recognition under various human rights codes, but all thirteen jurisdictions across the country represent comparable laws that could indirectly include language. Human rights codes are considered to be quasi-constitutional, meaning they are statutes passed by parliament and legislators with a higher priority and importance than ordinary statutes, but of less significance than the founding documents of the Charter of Rights and Freedoms and the Constitution. The various codes include approximately fifteen grounds and five distinct areas of social activity, with services, employment and professional self-governing organizations representing the three areas of activity applicable to language.

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Although one cannot apply to a Human Rights Commission directly on the basis of discrimination due to linguistic barriers, one could present a complaint on the grounds of race, national or ethnic origin, or place of origin. Language itself is not a protected ground, but it can be considered one of the many identifying features of ethnicity [5].

Two examples of case law under the Human Rights Code where individuals have successfully brought complaints essentially based on language, but argued on the grounds of national or ethnic origin or place of origin, include Espinoza v. Coldmatic Refrigeration of Canada Ltd. [6] and Segula v. Ferrante and Ball Packaging Products, Inc. [7]. These cases inform us that language, although not a protected or enumerated ground, can and has been used in order to make claims under Human Rights laws. Although these two cases do not pertain to the health care sector per se, from a patient's perspective, they could serve as a precedent for a claim of discrimination against health care providers for failure to provide interpreter services. However, the courts would have to ask themselves whether the provision of interpreter services for a health care provider would amount to undue hardship on the health care provider.

One of the most commonly cited legal cases related to language access is the case of Eldridge v. British Columbia (Attorney General) [8]. The appellants contended that the absence of sign-language interpreters impaired their ability to communicate with their doctors and other health care providers and thus increased the risk of mis-diagnosis and ineffective treatment. In addressing the issue of health care delivery, the Supreme Court said that "effective communication is quite obviously an integral part of the provision of medical services. At trial the appellants presented evidence that mis-communication can lead to mis-diagnosis or a failure to follow a recommended treatment. This risk is particularly acute in emergency situations...That adequate communication is essential to proper medical care is surely so incontrovertible that the court could, if necessary, take judicial notice of it"[9].

Fundamentally, the Eldridge decision granted deaf patients the right to sign language interpreter services, but the decision did not set a direct precedence for other populations facing language barriers. The court expressly said that "from the perspective of a patient there is no real difference between sign language and oral language if there is no ability to communicate with a physician" [10], but it went on to state that "without wishing to minimize the difficulties faced by hearing persons whose native tongues are neither English nor French, it is by no means clear that the communications barriers they face are analogous to those encountered by deaf persons" [11]. Thus, while the Eldridge decision recognizes that effective communication is essential to the provision of medical services, it cannot be directly applied to the broader context of immigrants, minority Francophone or First Nations communities. From a legal perspective there is no direct or satisfactory position on language access to health care services, but the possibility of future precedent-setting cases to challenge the disparities that undoubtedly exist, is open.

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Without an overriding legal framework to guide programs, responses to language barriers have continued to grow in organic rather than strategic directions. As presented by Sarah Bowen, an experienced researcher in the field of language access and the Director of Research and Evaluation with the Winnipeg Regional Health Authority, and Elizabeth Stanger, the Regional Coordinator of Language Services, Cross-cultural Health and Diversity with Vancouver Coastal Health, it is essential to re-examine approaches to, and perspectives on, language access services in order to maintain positive momentum and ensure relevance to the ever-changing state of health care in Canada.

Paradigm Shift: Making the Case for Language Services in Primary Health Care

Sarah Bowen and Elizabeth Stanger

Over the past decade there have been a number of positive and innovative language initiatives and there are some signs that the health care system is taking greater responsibility for providing interpreter services, rather than relying on settlement services. In many parts of the country, there is evidence of greater funding stability, more centralization and coordination of services, and continued innovation in programming. However, from a national perspective, development is inconsistent and often limited to acute care settings. There is still relatively poor integration into the overall health system, inadequate policy development and uneven utilization among providers. In some centres, use of ad hoc, untrained interpreters is still the norm.

> *We need to outline the pathways that lead to poor health outcomes and increased costs associated with inefficient use of the health care system. We have to make the connection between waiting lists and sending people for unnecessary tests due to a lack of communication. Language barriers impact on many of the other challenges currently facing the health care sector.*

While evidence on language barriers from the international research is strong and consistent (and there is increasing use of quantitative methods and attempts to undertake economic evaluation of language access programs), little of this evidence has been incorporated into planning, policy and decision-making within the health care system. Dr. Bowen presented a summary (based on the available research) of the pathways through which language barriers affected access, quality of care, service utilization and health outcomes. However, she noted that the challenge before us today is not absence of evidence; rather it is finding effective strategies for ensuring that the available evidence is integrated into organizational planning and program development.

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A number of barriers to action to address language barriers within the health system were identified and discussed – these include cultural/historical factors, addressing the needs of various language constituencies in isolation, inadequate pre-service preparation for health professionals, and marginalization of language minorities from the decision-making process.

In order to move language access into the mainstream of health care reform, it was argued that a paradigm shift is required. This can be defined as a major change in certain thought patterns, personal beliefs, systems or organizations, replacing a former way of thinking or organizing in a radically different way. This will involve a shift from thinking about language barriers in terms of 'multi-cultural health' to that of 'addressing health disparities'; and from the language of 'cultural sensitivity' to that of 'risk management'. Rather than viewing interpreter services as a new, add-on program for patients, addressing language barriers must be understood as part of an integrated strategy for achieving organizational objectives. This shift focuses not on individual and community deficits (lack of fluency in an official language), but on organizational deficits (failure of health care organizations to ensure effective and equitable service provision in a culturally diverse society).

Integrating this shift involves changing the language we use and 'interpreting' evidence between decision-makers and the community. Credible evidence needs to be included in decision-making and knowledge brokering roles may help foster effective communication of the evidence to decision-makers and clinicians.

In order to remain viable and relevant, language services need to be aligned with current health care agendas, including those of quality, patient safety and risk management. Inclusion in these agendas will ensure that language programs are not viewed as an expensive add-on service, but rather an integral part of the overall framework aimed at meeting organizational goals. The move away from 'cultural sensitivity' towards service delivery and service outcomes will frame language access as a clinical issue, with clear effects on both patients/clients and an organization's bottom line.

From a logistical standpoint, Elizabeth Stanger discussed how policy must be the vehicle to mandate language access services. Four stages of policy and planning need to be considered:

(1) Agenda Setting – Attain recognition among decision-makers that the issue requires public or organizational resources and effort

(2) Formulation – Generating a solution to the issue and a strategy to address it

(3) Implementation – Putting the strategy into practice

(4) Evaluation – A strategic means to incrementally integrate interpreter services into the organization's operations

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While stages two, three and four are significant, agenda setting remains one of the most difficult obstacles to overcome. However, there are several approaches to use in order to present linguistic barriers as a priority issue:

(1) Linguistic barriers are normative. They are no longer a private trouble, but a public problem;
(2) Linguistic barriers have significant, quantifiable impacts (interpreter services ensure adequate patient/provider communication, reduce diagnostic errors, improve patient flow and reduce over-utilization of acute and emergency services); and
(3) Linguistic barriers are related to quality and risk management, which have already been framed as compelling normative issues on the health care agenda.

Ultimately, language barriers need to be presented normatively, but with a practical solution. Whether an organization represents a local community, a region or an entire province, it is imperative that language access programs be portrayed as an essential, integrated solution to organizational deficiencies, rather than a peripheral, add-on service.

To further develop the effectiveness of using an integrative approach, Sarah Bowen and her colleague Dave Rubel, Director of Risk Internal Audit for the Winnipeg Regional Health Authority, outlined the potential of integrating communication about the importance of language barriers into organizational risk management activities.

A Risk Management Approach to Addressing Linguistic Barriers

Sarah Bowen and Dave Rubel

Because health care is a high risk area, there is a need to manage risk on a regular basis in order to be able to deliver quality care and improve patient safety. In response to this risk environment, the Winnipeg Regional Health Authority (WRHA) developed an Integrated Risk Management Framework based on the Canadian Council of Health Services Accreditation (CCHSA) standards. It identifies 154 high level risks, including risks to quality care and patient safety and broader organizational issues. Of the 154 risks, there is good evidence that thirty-five of those high-level risks are affected by language barriers. Of the thirty-five, twenty-two are in the area of quality and patient safety, with the remaining thirteen in areas of corporate government, operations and business support, policy, environment, health and safety, human resources and staff relations.

> *One of the key benefits of creating a pro-active risk management framework is that it promotes a healthy risk culture by increasing awareness and understanding. By developing a common language and a consistent approach to dealing with risk, existing processes can be formalized to mitigate risk to an acceptable level.*

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Risk management should lead to improved outcomes by the achievement of objectives. The most simple and effective definition of risk is 'anything that may compromise the achievement of the organization's objectives'. As goals become more strategic, managing risk ensures that strategies are fully implemented and that the impact of a risk in one area is understood with respect to its impact on another area.

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Overcoming the Linguistic Barrier

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The risk management process includes:

(1) Identifying your objectives
(2) Identifying the risks
(3) Analysing the risk for likelihood and impact
(4) Evaluating the risks to establish priorities
(5) Performing a gap analysis to see what remains to be done
(6) Accepting the risks ***OR***
(7) Treating the risks

In order to gain support and foster buy-in for the WRHA risk management strategy, risk management was combined with the other critical process of quality improvement. The strategy had teams self-assess to determine how well they were meeting the CCHSA standards (expected controls). Subsequently, by identifying the likelihood and impact of a potential risk a risk heat map was produced that delineated risks as critical, high, moderate or low. This risk assessment was used to produce a final risk report card, giving each program, team or site a clear indication of where to focus their quality improvement plans. Such an analysis can provide a better understanding of risks, highlight priorities, identify necessary actions and help focus the use of scarce resources.

To demonstrate the potential of using a risk management framework to communicate the impacts of language barriers and the importance of health care organizations ensuring language access, Mr. Rubel and Dr. Bowen led the plenary, using interactive voting technology, through an assessment of a number of risks affected by language barriers. This activity demonstrated several of the principles for effectively communicating evidence on topics on which decision makers often have low awareness – integrating the need to address language barriers with organizational priorities (e.g. patient safety); aligning with existing processes and activities (e.g. risk management); and using the language of decision makers. Incorporating evidence of the risks of language barriers into risk management activities can demonstrate the necessity of eliminating linguistic barriers in the health care sector.

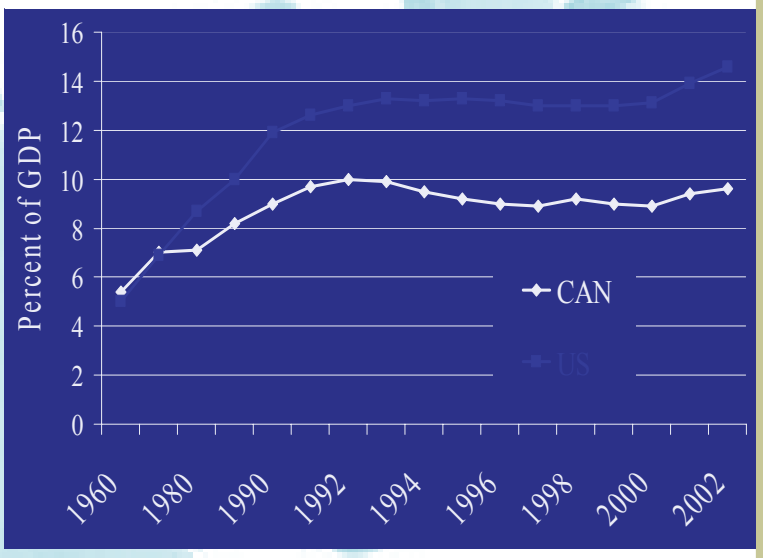
In contemplating a proposed paradigm shift for the micro-practice of interpreter services and the possibility of incorporating language access into a risk management framework, delegates were also provided a glimpse into the broader, macro processes of health care reform. Dr. Michael Rachlis, a health policy analyst and consultant, provided participants with an overview of the health care system, past, present and proposed future, with an optimistic eye on reform and integration.

A Failure to Communicate: Improving Interpreter Services in Primary Health Care

Dr. Michael Rachlis

To analyse the Canadian health care system, it is important to realize its origins to understand the current context of reform. Approximately fifty years ago the majority of Canadians received their health insurance through their employers – a system very similar to the current American system. The Canadian government increasingly provided coverage for high-risk individuals – people with cancer, sexually transmitted diseases, tuberculosis, etc. – and in 1946 Tommy Douglas's government in Saskatchewan implemented a public hospital insurance program. This program set in motion a series of events that resulted in a federal hospital care program ten years later and eventually the enrolment of all Canadian provinces in a publicly funded health insurance program by 1971[12].

Health care spending in Canada and the United States as a Percentage of Gross Domestic Product



The effectiveness of the Canadian shift to a public Medicare system can be evaluated by comparing the Canadian and American systems pre and post reform. Prior to Canada's medical insurance program, Canadians and Americans had a very similar health status, with comparable life expectancy and infant mortality rates. However, a current comparison reveals that Canadians have a higher life expectancy and an infant mortality rate that is 30% lower than the Americans. Similarly, both countries spent roughly the same share of their GDP on health care until 1970, but when Canada implemented Medicare, the proportions divided, with Canada now spending roughly 10% and the Americans approximately 14.5% of their GDP. In Canada, that difference of 4.5% is worth roughly $50 billion[13].

As Canada has become more politically and economically integrated with the United States, Canadians should be proud that we have created a very different health system, built on uniquely Canadian values.

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As the Canadian system comes under increased scrutiny, three perspectives seem to be emerging:

(1) Health care costs are escalating and given the inefficiencies of the public sector, some privatization of finance and delivery should be implemented to save Medicare;
(2) Medicare requires a major re-investment from the federal government and the provinces and greater enforcement of the Canada Health Act;
(3) Government-run health systems are plagued with inefficiencies, difficult to finance and therefore privatization of the system is required.

Although these perspectives seem to represent the majority of popular responses to the challenges facing the Canadian health care system, the problems facing Medicare are based on its design. Between the first proposition of Medicare over 100 years ago and the present day, Canada has gone through an epidemiological transition. A century ago, Canadians were young and the majority of health care concerns were acute – related to infectious diseases, accidents and injuries. However, Canadians of today are largely dealing with chronic conditions in a system designed to deal with acute cases.

Many attribute the quality problem to a lack of money. Evidence and analysis have convincingly refuted this claim. In health care, good quality often costs considerably less than poor quality (Saskatchewan Fyke Report)[14].

Furthermore, the critiques of health care being under-funded or a sector where spending is wildly out of control are unfounded. Spending has been stable over the past 15 years and represents about a 2.5% increase per year, per person, controlled for inflation. The increase has been roughly equivalent to the same share of the economy for the last fifteen to twenty years[15].

The bottom line is that funding is not the limiting factor when analyzing the Canadian health care system, quality is. Mis-use, over-use and under-use seem to plague the system to a point that quality is compromised. According to the Canadian Adverse Effects study somewhere between 9,000 and 24,000 Canadians die in hospital every year because of preventable adverse events associated with their care[16]. Data also shows that over 25% of all women over the age of 65 are taking long-term benzodiazepine drugs[17]. This mis-use and over-use have an obvious and measurable impact on the quality of service patients receive.

Removing the financial barriers between the provider of health care and the recipient is a minor matter, a matter of law, a matter of taxation. The real problem is how we reorganize the health delivery system. We have a health delivery system that is lamentably out of date (Tommy Douglas)[18].

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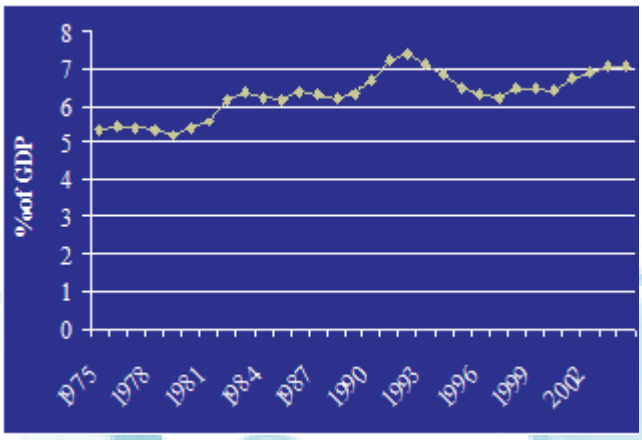
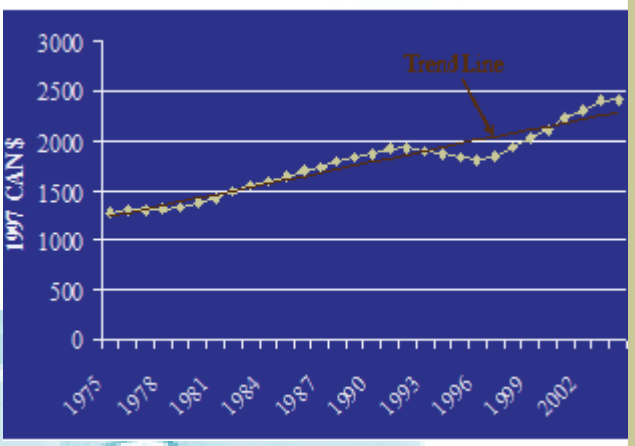
Canadian public health care spending as a percentage of Gross Domestic Product



Government health care spending, per capita, controlled for inflation (1997 constant)



According to the report entitled 'Crossing the Quality Chasm' from the US Institute of Medicine, there are six values used to guide quality improvement practices[19]:

(1) Safety
(2) Effectiveness
(3) Patient-Centredness
(4) Timeliness
(5) Efficiency
(6) Equity

> *Patient centred care involves health care that establishes a partnership among practitioners, patients and their families (when appropriate) to ensure that decisions respect patients wants, needs and preferences and solicit patients' input on the education and support they need to make decisions and participate in their own care (Crossing the Quality Chasm)[19].*

However, arching over all of the values and recommendations is the tenet that quality improvement is not possible without effective communication. Whether Canadian health care reform is focusing on improving primary, secondary or tertiary prevention, reorienting models of care to deal with the increase in chronic conditions, redesigning systems to enhance flow or addressing delays for service, better communication is the foundation that will improve patient outcomes and result in more efficient use of resources. Discussing language access programs requires one eye to the current context of the Canadian health care system and another eye to improving quality. Effective communication is the key determinant of quality care.

The Symposium

Learning from our peers: the primary effectiveness of community-based models, Migrant-Friendly hospitals in Europe and "Bridging" barriers in Vancouver

With a thorough foundation in the broader strategies of reforming language access programs to align with the current health care agendas of quality improvement and risk management, delegates were presented with a selection of particular models, services and initiatives to spotlight successes, challenges and strategies to overcome linguistic barriers.

To further develop the reform perspective and the position that primary care is the sectoral leader in creating a more sustainable and effective system, Jack McCarthy, the Chairperson of the Canadian Alliance of Community Health Centre Associations and Executive Director of Somerset West Community Health Centre in Ottawa, brought delegates back down to the local level to promote the efficacy of community-based primary care.

Canadian Perspectives on Language Access and Primary Health Care Reform

Jack McCarthy

The Somerset West Community Health Centre is one of 55 CHCs in the province of Ontario and one of 300 in Canada. The centre has about 80 staff, 12,000 clients and a budget of $5.3 million. 35% of clients declare their mother tongue as something other than French or English, yet only $20,000 is provided annually by the Ontario Ministry of Health for interpreter services. It is through this lens of a multicultural neighborhood in the city of Ottawa, in which the presentation is based.

Fundamentally, primary health care reform needs to be just as much about building healthy and caring communities as helping individuals access faster medical care. Community Health Centres (CHCs) represent one model that could lead the way in primary health care reform, if adequate resources were provided.

Beyond the clinical encounter, primary health care reform also requires community capacity building in order to be effective. The success or failure of reforms is directly related to how community-driven an initiative is.

To illustrate the comprehensive and efficacy of the CHC model, an example of an effective, interdisciplinary, community-based response to a local tragedy was presented:

In the early morning of April 5th fire swept through the Mekong Grocery Store on Somerset Street in Ottawa, about two minutes from our community health centre. Five members of a Cambodian family died of smoke inhalation – a mom, her 23 year old daughter, and her three sons, Gary, Danny, and Sonny ages 13, 12 and 11. Surviving the blaze was the father, his son-in-law and a toddler.

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A wave of shock, disbelief and profound sadness swept through the community. The Cambodian community came to us, the primary health care centre, and the community health centre, to ask for help. In the hours and days after this terrible tragedy the staff at our community health centre responded.

Our Cambodian social worker met with the remaining family members and immediate leaders of the Cambodian community to offer support and to make funeral arrangements. She played a pivotal role in coordinating things.

Our youth workers got on the street within hours and reached out to area youth to help them deal with the deaths of their chums, school buddies and fellow members of the volley ball team. These youth were Vietnamese, Cambodian, Chinese, East Asian and others.

Our staff worked with area schools, the police, and local recreation centre staff and asked for youth workers from other community health centres to be deployed to our neighbourhood to get on the street and to talk to youth. Four days after the fire, over 250 youth came together. They talked, they cried, they read poems and they marched with police escort in candlelight procession to a makeshift memorial across from the burned out grocery store. They did what they had to do to grieve the loss of their friends.

We also set up a fund at the centre. To date over $47,000 has been raised. Our administrative staff were very gracious in doing all the coordination, issuing tax receipts, etc. I met with leaders of the Cambodian community to help them plan a memorial service and for three days there was a memorial service in our community health centre where three Buddhist monks came together, prayed and chanted with family members, and the Cambodian community mourning within their cultural and religious traditions. Hundreds came to these memorial services, again at the community health centre.

We did what needed to be done to help a grief-stricken family and traumatized Cambodian community come together to mourn and to heal. We orchestrated, I believe, a community process that broke down the barriers of access, particularly around language and culture, but I say with unabashed pride I felt the staff at the centre were absolutely wonderful in doing what needed to get done. Our response was immediate and it was coordinated well with other agencies. It was culturally very sensitive. We worked as an integrated team of community-focused professionals from all health disciplines.

Whether primary care involves individuals with spinal cord injuries, isolated and remote northern and First Nations communities, exploding multicultural populations in a large urban environment or a grieving Cambodian community in downtown Ottawa, the affected community must be consulted and included in activities in order to have a meaningful impact. The key is to break down the existing silos to increase access to medical care in an efficient and effective way, but not at the expense of communities being unable to influence and shape the kind of primary health care for their respective communities.

Learning from our peers: the primary effectiveness of community-based models, Migrant-Friendly hospitals in Europe and "Bridging" barriers in Vancouver

It is at the community level that change should begin. Involving the community ensures effectiveness, but by highlighting the local initiatives occurring across the country, creative local solutions can escalate to regional and provincial solutions. Effective evaluation, dissemination and communication will allow the small spark to engage the broader population, with measurable, positive impact occurring. The purpose of primary health care in Canada must have building healthy communities as its foundation.

Moving from the Canadian perspective to European initiatives, Antonio Chiarenza, of the Azienda Sanitaria Locale di Reggio Emilia and Coordinator of the Health Promoting Hospitals Task Force on Migrant-Friendly Hospitals with the World Health Organization, presented on a successful European project aimed at making hospitals migrant-friendly environments.

Towards Migrant-Friendly and Culturally Competent Health Care: Improving Interpreting in Clinical Communication

Antonio Chiarenza

The Migrant Friendly Hospital (MFH) project, completed in March 2004, was a two and a half year initiative of the European Commission that worked with 12 diverse European hospitals to address inequalities in health status for migrants and ethnic minority groups. Arising from the increasing diversity and mobility of migrants in Europe, the project offers Canadians a glimpse into possible pathways, models and solutions in dealing with linguistic barriers in the primary health care sector.

The health status of migrants principally depends on their ability to access health services, which is attributed to three major causes:

(1) Linguistic and cultural barriers
(2) A low level of health literacy (lack of information and education on how to use and access the health system)
(3) A low level of cultural competence among health care staff

The aim of the project was to address these three realities by identifying, developing and evaluating models of good practice to promote the health and health-related knowledge and competence of migrants and ethnic minorities as well as to improve hospital services for these patient groups.

The strategy involved establishing a network of European pilot hospitals to implement and evaluate effective models to address specific aspects of migrants' health care needs. Evidence-based models of good practice were researched in the literature and combined with local needs assessments and cross-analyses to identify solutions to run in parallel between the 12 countries over a six month period. Various monitoring and evaluation tools were created to measure the effectiveness of the

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interventions. Despite the diverse local realities in the 12 countries, it was important to create a common framework. The common framework provided an opportunity to increase cooperation, collaboration and the exchange of ideas, practices and policies. The aim was to change the culture and organization of the hospitals to create culturally competent and migrant-friendly organizations.

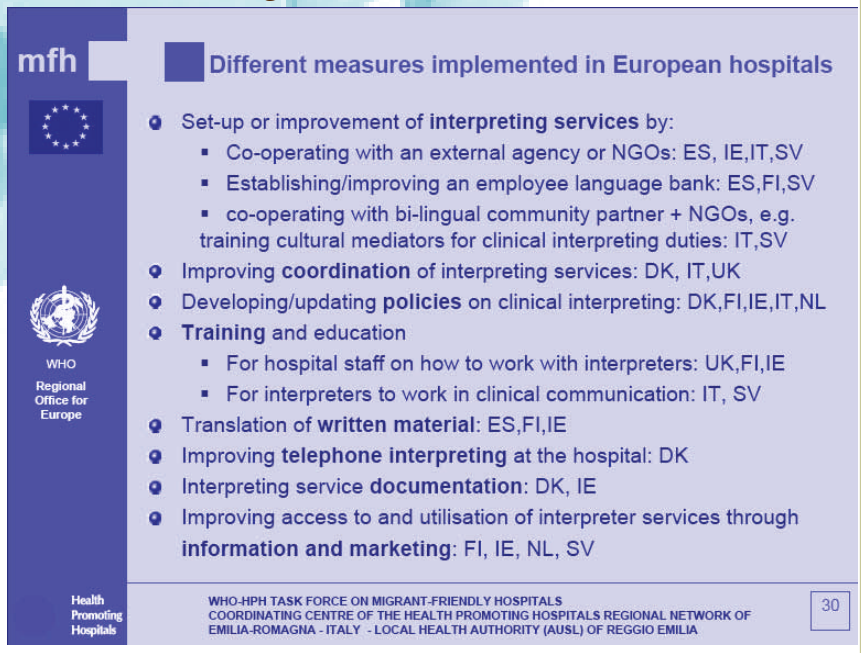
Based on the literature reviews and needs-analyses, three sub-projects were developed. The first was aimed at improving clinical communication – stressed as the highest priority among all 12 countries. The second was to improve migrant-friendly information and training for mother and child care and the third project focused on enabling hospital staff to better handle cross-cultural encounters.

Focusing on the first project, the literature clearly showed that:
(1) migrant patients do not receive complete information about their care;
(2) clinical staff are not able to understand migrant patients' needs;
(3) frequent communication problems and misunderstandings occur; and
(4) language barriers have adverse effects on the accessibility of care, the quality of care received, patient satisfaction and patient outcomes.

In response, the subproject focused on developing interpreting and language services among the hospitals and/or to optimize existing services. Pilot hospitals identified a model department, assessed the language needs and either looked at optimizing processes for existing services or setting up new interpreting services. By using a model department approach, it was ensured that the department with the greatest need for language services would be targeted and could also stand as a model for other departments.

The measures suggested for optimizing existing services were of two kinds: measures to improve timely access and measures to facilitate better service utilization. The measures implemented in each region are outlined to the right.

The specific objectives of the sub-project were that professional interpreter services should be made available whenever necessary; patients should be fully informed of language services; clinical staff need to be able to work competently with interpreters; and patient education



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material should be made available in non-local language. The indicators to evaluate the effectiveness of the measures were the increase in the number of interpreter supported clinical encounters; the decrease in the use of adopting interpreters; and improvement in more widespread use of interpreting services. Perceived quality improvement in communication was considered another important indicator as well as an increase in the health literacy of foreign language patients and the improvement in patients' compliance with follow-up treatment.

At the end of the project, changes were evident, but not as evident as had been expected. The limitation of the six month trial period meant that measures were not necessarily adequately adopted to show progress. However, the process, measures and tools served a useful purpose for further implementation and evaluation. Ultimately, the project provided the impetus for the further evolution of improving linguistic access for migrant populations.

The final result of the MFH project was the creation of the Amsterdam Declaration – a political document that summarized the recommendations of the project for policy makers, hospital owners, managers, professionals and patients' associations.

Following the completion of the project, an international task force within the World Health Organization's Health Promoting Hospitals project was created to further disseminate the outputs of the MFH project and further develop the work on these issues.

The key learnings and processes to take-away to the Canadian context include:

(1) Obtaining Management Support (both symbolic and practical) by presenting:

- *needs assessments;*
- *the disadvantages of not having language services;*
- *the advantages for the health care service in having language services available;*
- *the advantage for the patient in having language services available.*

(2) Establish Central Interpreting Coordination

- *Centralise services*
- *Justify centralisation of services*
- *Write guidelines*
- *Set up a system to identify language needs*
- *Create a scheduling system*
- *Create a documentation method*

(3) Choose Interpreting Resources

- *Pick one or multiple resources*
- *Evaluate advantages and disadvantages*
- *Write job descriptions for the interpreters*
- *Develop working standards, guidelines and policies*
- *Liaise with your human resources department*
- *Develop a guide of health care service expectations*

(4) Skills Assessment and Training

- *Create a preliminary evaluation tool*
- *Create more comprehensive evaluation*
- *Develop a training course for interpreters*
- *Develop a training course for clinical staff*

(5) Market and Evaluate the Service

- *Inform areas about how to access the service*
- *Create guidelines to request the service*
- *Conduct a survey of health care staff and patients facing language barriers*

The final learning was to ensure that planning is based on an integrated approach that acknowledges existing structures and local challenges and needs. For more information or to access any further documents and resources, visit www.mfh-eu.net .

To further develop the concept of appropriate services for immigrant and refugee populations, Chris Friesen, Director of Settlement Services for the Immigrant Services Society of British Columbia, and Dr. Rolando Barrios, Physician Leader at the Bridge Community Health Clinic in Vancouver, co-presented on a collaborative model of providing immediate access to primary and preventative health services for refugees and new immigrants.

Adapting to Cultural Diversity: A Practical Look at Funding, Policy and Service Delivery

Chris Friesen and Dr. Rolando Barrios

In order to best understand how to serve immigrants and refugees, some background is required on the new realities that are happening in Canada and the impact of federal policy, in this case the Immigration and the Refugee Protection Act, on local communities. Some stories will help contextualize these realities.

- *In September 2004 an Iranian political refugee arrived in Canada as part of the Government of Canada's Resettlement Program. He was considered under the urgent protection program. Because of the urgency of his situation, he arrived in Vancouver without his wife and child. He only spoke Turkish and Farsi. He arrived at the refugee reception center shortly before midnight where he was welcomed. It was noticed that he was walking with a limp in his leg. This limp evolved. Given the local context of Vancouver, he was able to be transferred to the Bridge Clinic where he underwent a primary health care screening. After undergoing the primary health care screening he was referred to a spine specialist at Vancouver General Hospital and also to the cancer agency. Although an interpreter was available at the Bridge Clinic, it was not possible to have an interpreter for appointments at either the Vancouver General Hospital or the cancer agency. As a last result, volunteer interpreters were called upon and were used for up to four hours per day, off and on, for several weeks as this individual underwent various tests to complete his diagnosis. Two and a half months after arriving in Vancouver he underwent surgery to have a non-cancerous cyst removed from his lower spine. Today he is doing fine. His family has since rejoined him.*
- *There was a family from Guyana who arrived, again, just after midnight with an eight month old child who was admitted to hospital within the first 24 hours in Canada with pneumonia and later diagnosed with sickle cell anemia.*
- *A large group of refugees arrived from an Asian country and within 48 hours one was diagnosed with tuberculosis and spent the next six weeks in quarantine. This initiated contact testing within the immigrant serving agency and 20 of the staff were asked to receive contact testing. Over 35% of this refugee group continues to receive ongoing medical attention.*

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Focusing more specifically, the following details represent further developments in this new and evolving reality:

- Currently, there are approximately 7,300 to 7,500 government assisted refugees that are coming to Canada annually. They are settled in a variety of communities across the country, with 75% of resettled refugees considered to be special needs cases, meaning they are medically compromised, lone parent families, have endured extensive stays in refugee camps, etc. Just a few years ago, it was approximately 25% that were deemed special needs.
- Individuals have often had longer stays in refugee camps, finding themselves in Charlottetown, Regina, Vancouver or Calgary after six, seven or even eight years.
- Children are arriving with little or no formal education.
- There is an increase in the diagnosis of clinical depression and chronic conditions, such as diabetes, heart disease, kidney problems and tuberculosis.
- There are higher rates of illiteracy among families, compounding the issue of interpretation because family members cannot interpret for one another.
- With the introduction of refugee group processing, there has been an increase in large groups of refugees arriving all at once in Canada, sometimes representing the first of a particular ethnic group, especially with the onset of a dramatic shift in source countries.
- 50% of resettled refugees tend to arrive in Canada between September and December, resulting in a huge influx of refugees during a tight time period, stressing existing services.
- Medical screening of refugees can take place up to 12 months prior to coming to Canada, leaving the possibility that an individual's health status may have changed dramatically.

These stories and figures provide a glimpse into the new reality since the Immigration and Refugee Protection Act came into effect in June 2002, which has left many programs struggling to deal with these profound changes. As a response to such emerging needs, the Bridge Community Health Clinic represents a promising primary health care practice that is uniquely targeting refugees who are newly arrived in Canada. With issues compounding themselves as the numbers increase, there is a strong need to develop collective models and approaches such as this.

The Bridge Community Health Clinic was established in September 1994 after the amalgamation of three small part time clinics that were targeting Latin Americans, South East Asians and Kurdish refugees at that time. It was developed after a series of discussions and community consultations and involved a formal partnership agreement with the then Vancouver Health Board, Immigrant Services Society of British Columbia, British Columbia Multicultural Health Services Society and Providence Health Care - one of the largest groups of hospitals in Vancouver. In addition there was strong newcomer community involvement through the British Columbia Multicultural Health Services

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Society and Providence Health Care - one of the largest groups of hospitals in Vancouver. In addition there was strong newcomer community involvement through the British Columbia Multicultural Health Services Society that hosted about 12 different ethno-specific groups at the time undertaking various health promotion activities.

The purpose of the clinic is two-fold: to improve access to primary and preventive health services and to address immediate health needs that groups of refugees might need. The goal is to provide a 'bridge' for refugees. The clinic was never envisioned to be a huge institution taking over the primary care of all the refugees coming to Vancouver, but rather it is seen as providing facilitated integration into the system, particularly the health care system.

The clinic goals are to provide services in an integrated, comprehensive and culturally sensitive manner and to liaise with and develop partnerships. One of the keys to the relative success of the clinic is in the partnerships, such as one with the B.C. Center for Disease Control that provides support for screening tests and expertise on tuberculosis, hepatitis and some other parasitic infections. Clinically, one of the main diagnoses is depression, followed by anxiety disorder. Thus, another key partnership is with the Vancouver Association for Survivors of Torture.

The inter-disciplinary staff includes:

- Physicians
- Nurses
- Multicultural health settlement workers
- On site interpreters for the main language groups
- A shuttle bus driver
- A mental health counsellor and off-site psychiatrists
- Medical office assistants
- Health promotion staff
- HIV/AIDS counsellors
- Many other service providers at Raven Song Community Health Center, such as a physiotherapist, a pharmacist and a dietician

In terms of funding, sources include:

- Vancouver Coastal Health (overall operating budget, administration, nursing, and support staff and services)
- Physician sessions from the Alternative Payment Program.
- Limited funding from Interim Federal Health Program (IFH) billings
- Free services/support from the other partner agencies, such as free deliveries with Women's Hospital for patients with no health insurance, free lab services, etc.

Clinical services include an initial health screening for refugees, health screening for communicable diseases, HIV, Hepatitis B, Tuberculosis, etc., the provision of vaccines, mental health services, chronic disease management programs, newcomers pediatric clinic, etc. - in general, the diagnosis and treatment of any acute or chronic conditions. The importance of having a site that is responsive to such needs is paramount.

The Symposium

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The Bridge Clinic has an average of 5,000 client visits per year and about 1,700 patients per year, 1,200 of which are new patients. In the last ten years the clinic has seen over 25,000 patients with the idea that they are not permanent, but in transition to the community.

The strengths of our program include:

- *Strong leadership from the Vancouver Coastal Health*
- *Highly committed and experienced interdisciplinary team*
- *Responsive to the needs*
- *Bilingual/Bicultural Staff*
- *Strong community partnership*
- *Shared vision to integrate newcomers into the community as soon as possible*

The challenges we still face include:

- *Limited interpretation services in other parts of the system (e.g. specialists)*
- *Shortage of family physicians or other health services*
- *Ever-changing demographics of ~ 1200 new patients each year*
- *Smaller language groups*
- *Cumbersome IFH billing system*
- *Responding to changing immigration regulations*

The Bridge Clinic is a model of service and collaboration that clearly meets the primary and preventative care needs of refugees and new immigrants to Canada, offering an example of how strategic partnerships and planning can result in an effective and sustainable response to community needs.

Further examples of promising practices and key learnings for language access in the primary health care sector were discussed in smaller working groups, including the following presenters and topics:

- **Triple 'A' Health Care: Accessible, Available and Appropriate – A Province-Wide Model for Language Services**
  Suzanne Barclay, Director, and Angela Sasso, Special Projects Coordinator, Provincial Language Service, Provincial Health Services Authority of British Columbia
- **La communication au cœur des soins : une approche intégrée**
  Isabelle Hemlin, Agence de développement de réseaux locaux de services de santé et de services sociaux de Montréal
- **Challenges and Advancements in Toronto's Language Services**
  Axelle Janczur, Executive Director, Access Alliance Multicultural Community Health Centre
- **Clinical Practice Issues & Cross-cultural Communication Skills**
  Ann Alsaffar, President, Ontario Family Practice Nurses Association
  Dr. Ralph Masi, Family Physician and Assistant Professor, University of Toronto
- **Major Challenges for Interpreter Training: Languages of Lesser Diffusion, Remote Areas and Community-Based Training**
  Silvana Carr, Coordinator, Interpreting Programs, Vancouver Community College
  Susan Sammons, Director, Translation and Interpretation Programs, and Maaki Kakkik, Instructor, Language and Culture Programs, Nunavut Arctic College
  Kiran Malli, Quality Assurance Coordinator, Provincial Language Service, Provincial Health Services Authority of British Columbia

Implementing Service Delivery Models
Integrating Risk Management and Assessment Tools

Given the breadth of the presentations and working groups during the symposium, delegates concluded the two days with a hands-on regional-based session on next steps and collaborations. The resulting dialogue was then combined with the preliminary research findings from the first phase of the project and compared with the topics highlighted in various community consultations from the second phase of the project. The various pieces were then integrated and reviewed to generate a list of possible pilot projects for the final phase of the project. Prevailing ideas were further developed into project proposals that the National Management Committee evaluated against a list of key criteria, including: portability or ability to replicate, linkages with existing work or services, and sufficient resources and capacity in place. Given the broad support, feasibility and expected impact on language barriers, the SAPHC project will be working on three key areas for the final stage of the project: interpreter service delivery, risk management and provider/interpreter training.

Implementing Service Delivery Models

For a specified period of time, this Toronto-based pilot project will provide interpreters who have been tested and trained according to the standards of service developed by the Healthcare Interpretation Network and Critical Link Canada, to work directly with primary healthcare providers and patients, transmitting messages between patient and provider, as faithfully as possible. The project will take place in various primary health care environments, such as private family practices, community health centres, etc. between October and December of 2005.

The purpose of the service delivery pilot is to implement and evaluate a proposed model for providing healthcare interpreters into a primary healthcare encounter and further develop and improve the model for subsequent use in other environments and locations.

Integrating Risk Management and Assessment Tools

Between September 2005 and March 2006, this Vancouver based project will pilot a tool based on a Winnipeg Regional Health Authority initiative that applied the region's Integrated Risk Management Framework to the issues of access, safety and health outcomes for non- and limited-English speakers[20]. The Assessment for Risk Management (ARM) tool will provide health managers with a concrete application to determine areas in need of attention and action and will be implemented at various pilot sites.

Next Steps

Learning to Work Effectively with Interpreters and as Interpreters

Working Beyond the SAPHC Project

Learning to work effectively with interpreters and as interpreters

Based on themes emerging from the research and various community consultations, this pilot involves several different training components for both service providers and health care interpreters.

In Montreal, the SAPHC project is involved in the production of a video resource to be used for training purposes among health care providers on how to work effectively with an interpreter. The video has been developed through several focus group sessions and will be a French-language resource, completed by January 2006.

In Toronto, two consecutive projects will be implemented:

- The Healthcare Interpretation Network will be developing a one-day training module for interpreters working in primary health care, to be integrated into the existing Core Training Program for Spoken Language Interpreting in the Healthcare Sector. The full training program will run from September to December 2005 and it is expected that the primary health care training curriculum will be a useful specialized tool that could be easily integrated into other core training programs.
- The Toronto Management Committee will be developing adaptable workshops on working with interpreters and language access strategies to be presented to health care clinicians in various health care organizations throughout Southern Ontario. The workshops will be developed and delivered between October 2005 and March 2006.

Working beyond the SAPHC project

Although the national symposium represented a key milestone for the SAPHC project, there are many opportunities to become involved in this initiative. Partner organizations are committed to the ongoing advocacy and development of effective, sustainable and progressive language access strategies and look forward to developing innovative partnerships and collaborations to eliminate linguistic barriers in the health care sector.

To learn more about SAPHC activities, contact:

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