May 30, 2014

To: Michigan College of Optometry
Sabbatical Committee

Re: Sabbatical Final Report for Fall 2013 Sabbatical Leave

Often when one searches for an answer to a problem they end up finding more questions than answers. This proved true for me as I strove to understand, at a greater level, the barriers to eye care for Hispanic patients in West Michigan. My ambition to provide specific solutions to eye care practitioners to improve their care for this population turned out to be beyond my abilities given the time and resources I had during my time away from my teaching responsibilities.

When I developed my sabbatical proposal I thought I had a good general understanding of the issues and adequate resources to investigate this problem. As it turns out I greatly underestimated the size and complexity of the problem. As I sought to take courses to enhance my Spanish language capabilities I found that none of the local courses I planned to take were either appropriate or offered during my sabbatical period. Additionally, the self-paced / on-line courses were expensive and usually directed towards basic conversational or tourist type language development. I was able to investigate some of the new technological solutions being developed to aid communication across language barriers, but in the end most of these fall short of their promise.

As a result of my literature review I found that the barriers to health care for Hispanic patients revolve around and overlapped between four major areas: 1 – language, 2 – Financial, 3 – Access, 4 – Social-Cultural. For any particular patient any one, or all, of these may be factors in their obtaining high quality eye care. As a result, the general problem of understanding and accommodating all of the potential barriers to eye care for Hispanic patients is overwhelming for individual practitioners. I found that many practitioners handle barriers on a case-by-case basis and generally do a good job of helping patients who have a specific need and whom also contribute some of their own accommodations. However, it appears that only large institutions are capable of providing healthcare that has comprehensively addressed the majority of these barriers. Hospital systems, community health clinics, and some large multi-doctor practices usually have dedicated staff and services to support the health care provider and patients.

Even though I was not successful in determining the specific problems and solutions that can be addressed to make the greatest impact on the disparity in quality of eye care provided to Hispanic patients, I do feel that my activities during my sabbatical leave have given me a better understanding of the problem here in West Michigan. I have established good relationships with others who work with or are part of the Hispanic community so that MCO and other health care programs at FSU will have the potential to make some practical changes to address some of the barriers to health care within their current delivery systems. Additionally, if we decide to move forward with developing a specific program for the Hispanic community, we will be more prepared to address their priorities, coordinate with other local services, and understand the costs of operating such a program.

Since I have been back in my normal teaching role, I have been able to share some of my experiences with the few students who rotate through the Mercy Health Eye Clinic. I have also started working with a task force with Optometry, Pharmacy, and Health Professions colleges to investigate the feasibility of establishing an FSU Healthcare Hub in the Grandville Avenue area of Grand Rapids. I will also return to my lecture course this fall and plan to incorporate new information about the impact of Low English Proficiency and English as a Second Language from a clinical care perspective, as well as an academic development perspective. I also feel that I will be able to more effectively lobby for developing specific curricular goals for teaching cultural sensitivity (diversity) and working with certified medical interpreters (public health and inter-professional education) as we develop our new curriculum.

This sabbatical leave experience has been mostly very rewarding for me and I am grateful to the committee and the Administration for providing me this opportunity. I plan to promote participation in the sabbatical leave program to my colleagues, with the caveat to make a distinct separation from College activities. I allowed and voluntarily participated in College activities including some committee meetings, covering a few clinics, etc. which took a little extra time but was more disruptive than I realized to my productivity. I am frustrated to have been impeded at so many of my planned activities and specific objectives. I still plan to pursue additional language training on my own time. I have also been successful in having vision care questions added to the Kent County Health Department Community Health Needs Assessment for 2014 which should provide additional statistical information about the vision care needs of the Hispanic community, along with other populations, which will provide more data to be studied.

Sincerely,

Mark Swan, OD, MEd

Sabbatical Leave Activities and Outcomes

My initial activities were to collect further information about the scope of the problem. There are several articles that cover the disparity in access to care, decreased quality of care due to language barriers, and epidemiology of the Hispanic population in terms of incidence/prevalence of disease for several different populations. General epidemiological information of the Hispanic population was collected from the US Census, CDC reports, etc. I found that specific information for West Michigan Hispanics was unavailable. I found information from Kent County Health Department, Michigan Department of Community Health, and other agencies was not very specific for health issues of different demographic populations and was non-existent for vision and eye care.

The Behavioral Risk Factor Surveillance System (BRFSS) conducted by the Centers for Disease Control has a specific vision module but this optional module is not conducted for Michigan. Additionally, the initial Kent County Health Department Community Health Needs Assessment contained no specific vision or eye care information. This was surprising to me since Michigan is generally recognized as a progressive state in terms of having a vision screening program and the fact that the population studies of the different agencies address most of the other U.S. Department of Health and Human Services' Healthy People 2020 objectives.

In conclusion, West Michigan has a large Hispanic community comprised of a full spectrum of socio-economic classes; including patients with full third party benefits provided by their employer, the working poor with no insurance, those with citizenship and eligible for government services, those without legal documentation, and seasonal residents (migrant farmworkers). They generally have a higher representation in the lower socio-economic classes and thereby have more health problems. The prevalence of specific eye and vision problems must be extrapolated by applying the frequencies reported by other studies, until a more extensive study of West Michigan can be completed. Because of my work with the Kent County Community Health Department we have added a few vision and eye care questions to the 2014 Community Health Needs Assessment.

My attempts to take specific language courses to enhance my own Spanish skills were unsuccessful. Voices for Health, a Grand Rapids based language offers specific courses for Healthcare providers, however, they have not offered an open course since 2011. Private courses proved too costly. If a small group of providers could be compiled and schedules coordinated, this will probably be a viable option. Other courses provided at the community level local Universities and Community Colleges only offered general Spanish language for conversation. This was also the case for most on-line or computer-based Spanish courses. Interestingly, I spoke with the Hispanic Center of Western Michigan about taking a Spanish language course and the person I spoke with told me this was the first time anyone asked for a Spanish lesson. All of their language classes involve teaching English. Rosetta Stone does not have a specific product for medical Spanish, however, they did develop a specific program for a medical school in New Jersey which was highly rated. Other web-based programs such as MedicalSpanish.com, BilinguaSpanish.com, do have several products available, most were an on-line classroom format and I was not able to coordinate this. There are many "Apps" for phones and tablets that have been created for teaching different languages but these are generally basic vocabulary translators. These amount to a digitized version of the English-Spanish dictionaries that most of us are already familiar with. They are easy to use and have some other nice features but don't amount to a true language course and have a very limited medical lexicon.

My assessment of mobile translation applications for use in clinic failed to find a practical and dependable product. There are many available and they are making great headway in their development. Few scientific articles are available. Those that I found came to similar conclusions, that they are useful, but not very efficient and prone to errors and misinterpretation. There are,

as you might expect, many testimonials and reviews of programs which I found to be not always reliable. One program, Canopy, shows very good promise and has received an award from the National institutes of Health and has been adopted by several medical programs. This service has a suite of tools including a digital translator with built in medical exam phrases, an incorporated telephone link to a certified medical interpreter, and online medical Spanish courses.

The gold standard for providing healthcare to non-English speaking patients is to have a completely bilingual staff and physicians. While there are many locations where this is possible, it certainly is not largely available. The next best thing is having a certified medical interpreter available in the health care facility. For large facilities like hospitals and even large physician practices, this is common. Another option that has benefitted from modern telephony technology is having phone access to a medical interpreter. There are many services available, just a phone call away. Dual handset phones are available and inexpensive, but conference call features of cell phones allows hands-free access. Some services are offering video-conferencing with the medical interpreter. Cost is approximately $1 to $2 per minute with many plan options available for systems that have high usage. The cost for live medical interpreters ranges between $20 and $30 per hour, however, having fast, unplanned access to this person can be difficult for certain locations and health care facilities often have to pay for transportation costs and the hourly rate may include the time it takes to commute to the location.

I have not prepared any publications or made any presentations at this time. I have an article in process to be submitted to the Michigan Optometrist that will complement the article authored by Soshie Levine and give the individual practitioner resources for meeting their obligations for serving patients with communication barriers. I am also preparing a white-paper of sorts to be used by the Grandville Avenue Hispanic Initiative (College of Optometry, College of Pharmacy, and College of Health Professions). I am also preparing to present a summary of my findings to an MCO Faculty Development Seminar.

I did not take any specific courses or seminars during my sabbatical leave. I did attend the American Academy of Optometry and attended a public health course on “At Risk” populations which described the South Jersey Eye Center model of care. This course proved to be an accurate summary of the social-cultural barriers to eye care that I discovered in my experience, readings, and discussions with other healthcare providers. In addition to the language barrier, access to care (including geographic location and time of service), affordability, and awareness of the need for comprehensive eye health care (beyond refraction and eyewear) are consistent barriers that need to be addressed.

My future plans include continuing to work on developing my own Spanish language skills, as time and budget allows. I will be participating in the evaluation of the vision and eye care data that will be available from the Kent County community survey. If this data shows a significant need for this population, I plan to prepare a proposal to expand the survey or possibly add the BRFSS Vision Module into the standard survey. I believe it would be feasible to develop a coalition of partners to apply sufficient influence and possible financial backing to achieve this goal. I am actively participating in the Grandville Avenue Hispanic Initiative and hope to develop a specific eye care program for the Hispanic populations in conjunction with the Mercy Health – Clinica Santa Maria Community Health Center. I also have a few ideas for surveys that I may conduct on my own or as part of a senior research project.

Overall, this sabbatical leave has not made any specific impact on my professional responsibilities, although I believe it has better prepared me to contribute to the current clinical services and possibly to developing an expanded clinical presence for FSU in the Hispanic community of Grand Rapids.