

## Research Article

# English Classes for Foreign-born Uninsured Free Clinic Patients in the United States: A Qualitative Study

Ha N. Trinh<sup>1</sup>, Sullivan Howard<sup>2</sup>, Sayro Paw<sup>2</sup>, Samin Panahi<sup>2</sup>, Edward Lee<sup>2</sup>, Jeanie Ashby<sup>3</sup> and Akiko Kamimura<sup>2\*</sup>

<sup>1</sup>University of Kansas Medical Center, Kansas City, Kansas, U.S.A

<sup>2</sup>University of Utah, Salt Lake City, Utah, U.S.A

<sup>3</sup>Maliheh Free Clinic, Salt Lake City, Utah, U.S.A

## ABSTRACT

In an effort to reform patient-provider communication, most notably in underrepresented populations, a series of English classes were offered to patients of a metropolitan free clinic in the intermountain region of the United States (U.S.). A cohort of sociological studies undergraduates, graduate students and professors from a local university assembled to conduct research in the summer of 2018. Fifty-two participants enrolled in 39 classes, with 35 participants completing a comprehensive survey. In addition, pre-class surveys, field notes and class satisfaction surveys were collected to accurately capture participant characteristics, evaluate class quality and identify participants' motivation, needs/challenges, or barriers to

learning English in their U.S. community. The classes elicited mostly positive feedback with the majority of participants showing excitement, motivation to continue, and inquiry as to future classes at the clinic. Field note findings indicated that language proficiency is essential to communication in clinical and communal settings. Due to the qualitative nature of this study, participants were able to express personal recounts of barriers and challenges to learning English. The study also resulted in several implications for holistic improvements in future classes offered to the free clinic patients.

**Keywords:** Limited English proficiency; English class; Immigrant health; Uninsured free clinic patients

## Introduction

The United States (U.S.) receives approximately two million immigrants annually [1]. Many reported limited English proficiency, along with existing trauma while facing discrimination in their receiving communities [1]. Limited English proficiency was identified as the most challenging barrier for immigrants, adversely impacting their overall well-being in a foreign community [2]. English proficiency is regarded as having direct casual effects on educational opportunities, higher income, improved occupational prestige and greater success in the labor force [2,3]. In addition, English proficiency is associated with higher levels of self-esteem, increased social capital and social participation at a younger age, resulting in long-term effects on one's success later in life [4].

Language barriers also displace immigrants of limited English proficiency in the U.S. healthcare system [5]. Patients with a restricted English vocabulary often report less access to care and poorer self-rated health status, compared to patients who are fluent in English [6]. Patients with limited English proficiency also present more often with psychological distress, poorer emotional and mental health, lower vaccination rates, higher fall risks, adverse maternal and child health outcomes, increased length of hospital stay and inadequate healthcare utilization [5-9]. Children born to parents with Limited English proficiency are also at higher risk of low birth weight and/or are increasingly lacking physical activity at a young age, compared to children born to parents with higher levels of English proficiency [9].

Previous studies regarding individuals of minimal English proficiency receiving healthcare services recommend the

following to significantly improve access to care and health status among susceptible populations: Provision of language assistance services to patients, and cultural competence training for providers [6,10]. A proposed overhaul to alleviate this issue centered around three core factors deemed "the triple threat" to effectively communicate with patients of limited English proficiency [11]. Unfortunately, these recommendations faced several hurdles in a variety of healthcare settings [12]. The first obstacle for communication between patients and providers reported was language barriers. Second, cultural differences in health and the U.S. healthcare system were identified as the determinant of their perceived safety and quality of care. Health literacy was reported to be the third factor, highly correlated with the previous two.

These factors varied vastly among different ethnic groups, making it more difficult to follow the appropriate language and cultural competency approaches. Programs training healthcare provider's provision of qualified interpretation services had been offered among a variety of healthcare settings [13]. However, only a small number of providers received these trainings, yet those who had been aptly trained reportedly provided superior patient care [14]. One concern voiced by patients included the decision to utilize qualified interpretation services which evokes disdain and fear related to trust, personal control and power among all parties [13]. In aforementioned cases, patient factors such as language skills should also be taken into consideration and tailored in intervention strategies to improve their health status and quality of care.

This study delivered an intervention and prevention program focused on the improvement of English language skills among

foreign-born patients at a free clinic. The research cohort developed educational materials to use as visual aids during the delivery of free English classes for patients during their wait time in the clinic's waiting room. The objectives of this study included to evaluate English classes for foreign-born free clinic patients, describe the characteristics of the limited English proficiency patient population at a free clinic, identify their needs and barriers for enrolling in a language class, and propose suggestions for future interventions.

## Methods and Materials

### Settings

This study was conducted at a free clinic in a metropolitan area of the intermountain of the U.S. in summer 2018. Funded by donations and private grants, the clinic has been in operation since 2005 and has provided free primary care services, including adult family medicine, pediatric care, (limited) dental services, diabetes management, and healthy living classes. Patients who qualify for services at the free clinic are uninsured and have an annual house hold income below 150% of the federal poverty level. The clinic has 12 full-time, paid employees and over 400 volunteers. The total number of visits in 2016 was 15,344, with more than 80% of the patients aged between 21 and 64. The clinic serves a diverse population, with patients originally from more than 50 countries. More than half of the patients speak Spanish and many of them have limited English proficiency [15]. The clinic relies on volunteer interpreters or patients' families and friends who are bilingual to help with patient care.

### Study procedure

The research cohort was assembled from a pool of scholars who routinely participate in various research projects encompassing free clinic patients. The study was approved by the university's Institutional Review Board (IRB). Data collection included a pre-class survey, field notes taken during each class, and a post-class satisfaction survey. Patients who were younger than 18 years old could participate in the class as learners or interpreters, but were ineligible to complete surveys. A small incentive such as a first aid kit, notebook, or exercise resistance band was provided to each participant at the end of the class.

Three researchers actively recruited study participants, provided English classes and collected data in the waiting room of the clinic. The researcher instructing the course had relevant certification to teach English as a second language. The pre-class survey asked about socio-demographic characteristics, difficulties with communication in English with the clinic staff, usage of the clinic's interpretation service versus having family/friends acting as an interpreter at each visit, and whether the patient had previously taken an English class.

Each English class covered essential words to effectively aid the patient in conveying health-related concerns to a medical provider. Study materials included a handout with a list of medical terms and their corresponding images such as "knee," "sore throat," "temperature," "fever," "rash," "swollen ankle," and "headache." Short sentences for communication within the clinic were also included in the handout. Upon the request of

the patient, the instructor also helped write down any specific words to describe their symptoms. The class was informal by nature, as the instructor first would read and describe a term and the participants would repeat and enunciate until they felt confident in their ability to recall the new terms. The instructor also verified comprehension and engaged participants by asking short, yet simple questions to which participants would recall one of several new phrases. During the course of instruction, a separate researcher conducted field notes.

At the end of each class, all researchers cross-checked field notes to ensure accuracy of the findings and validity of the study. The field note template followed the Theory of Planned Behavior (TPB). The TPB is aimed at understanding individuals' motivation to change a specific behavior [16]. According to the theory, the most important predictor of behavioral change is the individual's intention, which is determined by their attitude, perceived norms, and personal agency. The theory has been proven to be applicable in a wide range of behaviors, including English learning and retention. At the end of the class, each participant filled out a class evaluation survey which indicated their satisfaction (excellent, good, average, poor, very poor, or "don't know") regarding the overall structure and content of the class. A total of 39 English classes were offered during the summer of 2018, consisting of 52 participants. Among these participants, 35 filled out and returned the pre-class surveys and satisfaction surveys to the researchers.

### Data Analysis

Data from the pre-class and evaluation surveys were entered and analyzed in SAS 9.4 (SAS Institute Inc. 2013. SAS® 9.4). The researcher who documented detailed field notes organized the qualitative data into themes. Any participants comments in Spanish were translated into English. The first author and the principal investigator examined themes for correction, analyzed initial consistencies and then validated the preliminary results with the research cohort. Feedback provided warranted further revisions, until a consensus was reached on data analyses. This team approach warranted study reliability.

## Results

### Survey results

Table 1 presents the characteristics of study participants. Two-thirds of the English class participants were female. The average age was 51 (SD 13.43), ranging from 21 to 85, yet over 80% of study participants were older than 40. Only one participant was born in the U.S. and more than half were originally from Mexico. Other participants were from Peru (n=4), Venezuela (n=3), Argentina (n=1), Brazil (n=1), China (n=1), El Salvador (n=1), Honduras (n=1), Samoa (n=1), Tonga (n=1), and Ukraine (n=1). More than 80% of the participants identify Spanish as their preferred language. The average time of having lived in the U.S. was 13 years (SD 9.61), ranging from 3 months to more than 25 years. Less than one third of the participants did not complete high school, 34% had a high school degree, and 37% had some college or higher level of education. Half of the participants stated they held current employment of a part-time job, while 42% had a full-time job at the time of the class (Table 1).

**Table 1:** Characteristics of survey participants.

Variables	n	% or Mean (SD)
<b>Gender</b>		
Male	12	34.29
Female	23	65.71
<b>Age</b>		
		51.08 (13.43)
Less than 40	5	14.29
40-49	12	34.29
50 or older	18	51.43
<b>Country of Origin</b>		
Mexico	18	51.43
Peru	4	11.43
Venezuela	3	8.54
Others	10	28.6
<b>Survey Language</b>		
English	6	17.14
Spanish	29	82.86
<b>Years Living in U.S.</b>		
		13.63 (9.61)
10 Years or Longer	23	65.71
Less than 10 Years	12	34.29
<b>Highest Level of Education</b>		
Less than High School	10	28.57
High School	12	34.29
Some College or Higher	13	37.14
<b>Employment</b>		
Full-time	15	42.86
Part-time	17	48.57
Others	3	8.57
<b>Interpreter service at the free clinic</b>		
Yes	29	82.86
No	5	14.29
Missing Information	1	2.86
<b>Family/Friend as interpreter at the free clinic</b>		
Yes	15	42.86
No	18	51.43
Missing Information	2	5.71
<b>Difficulties communicating with the free clinic staff</b>		
Yes	14	40
No	19	54.29
Missing Information	2	5.71
<b>Previous enrollment in any English class</b>		
Yes	17	48.57
No	16	45.71
Missing Information	2	5.71
<b>English class rating</b>		
Excellent	14	40
Good	12	34.29
Average	1	2.86
Don't Know/Missing Information	8	22.85
Total (N)		35

More than 82% utilized interpreter services at the free clinic, and 43% relied on their family/friends as interpreter during their clinic visit. When asked, 40% of participants identified some difficulties communicating in English with the clinic staff. Interestingly, 49% of the participants had previously enrolled in an English class. Table 1 displays results for the class evaluation surveys. Around 75% of participants rated the class as “excellent” or “good”. One participant rated the English class as “average”, and the rest responded with “don’t know” (n=4) or had missing information (n=4).

## Results

Table 2 demonstrates the English class summary. Each class had one to three participants and was approximately 9 minutes in length. Some classes were shorter as the participants were called back for their appointments immediately after they had class started. Due to the class being held in the free clinic’s waiting room, many class sessions were distracted with background noise, or participants attending to their children. With these circumstances, instructors had a difficult time keeping the participants engaged in the class. Many participants had never participated in any English course (formal or informal), or perhaps spoke English at a basic level, the U.S., had a difficult time understanding the instructor. In several cases, participants were able to read English and repeat phrases after the instructor, yet were not able to comprehend the meanings of the medical terms. In such cases, the instructor showed them the picture associated with the symptom or physiological process to encourage participants understanding. In group settings, participant’s at a beginner level were very timid and did not engage in the class, while participants who were more fluent in English were more likely to engage in the class. Many classes were a group session of participants who all spoke Spanish (Table 2).

Participants who were able to stay engaged with the class agreed that learning English was essential to communication with their healthcare providers. One participant expressed that he “wanted to feel more confident by doing the job myself rather than using translation apps from a phone.” Many participants used the opportunity to ask the instructor to teach them how to make an appointment, describe the reasons of the visit, or learn vital vocabulary to communicate with their healthcare providers in English. Due to language-related miscommunication, one participant presented to the clinic with a headache and eye pain, though the reason for this visit was stomach pain. The educator went over his health problems in English. The participant wrote down the new vocabulary akin to his symptoms so that the participant could effectively communicate with his doctor. Most of the medical vocabulary presented in the class was new to many participants. They expressed their enthusiasm and excitement to learn these words, which could help them better communicate with providers and other staff of the clinic. One participant stated that “This class is good. Sometimes when I go to the clerk, I don’t know what to say to them. This handout will help me.” At the end of the class, some participants were able to pronounce the medical terms perfectly, and others were confident that they could now make future appointments by themselves.

**Table 2:** Summary of English class.

Class Numbers	Length (Minutes)	Number of Participants	Gender Distribution	Language
1	7	1	1 Male	Spanish
2	2	1	1 Male	Spanish
3	11	1	1 Male	Spanish
4	3	1	1 Female	Spanish
5	8	1	1 Male	Spanish
6	16	1	1 Female	Spanish
7	6	1	1 Female	Spanish
8	3	1	1 Male	Spanish
9	6	1	1 Female	Spanish
10	5	1	1 Female	Spanish
11	7	1	1 Female	Spanish
12	2	1	1 Female	Spanish
13	?	2	1 Male, 1 Female	Spanish
14	22	2	2 Females	Spanish, Russian
15	8	2	2 Females	Spanish
16	8	2	1 Male 1 Female	Spanish, Tongan
17	8	1	1 Male	Spanish
18	10	2	1 Male 1 Female	Spanish
19	2	1	1 Male	Spanish
20	10	1	1 Female	Spanish
21	9	2	1 Male 1 Female	Spanish
22	4	1	1 Female	Spanish
23	?	2	2 Females	Spanish
24	24	3	2 Females 1 Male	Spanish
25	20	1	1 Female	Spanish
26	6	1	1 Female	Spanish
27	6	1	1 Female	Spanish
28	17	1	1 Female	Spanish
29	11	2	2 Females	Spanish
30	17	2	1 Male 1 Female	Spanish
31	6	1	1 Female	Spanish
32	5	1	1 Male	Spanish
33	7	1	1 Female	Spanish
34	13	1	1 Female	Spanish
35	6	1	1 Female	Spanish
36	6	1	1 Female	Spanish
37	17	1	1 Female	Spanish
38	11	2	2 Females	Spanish
39	17	2	1 Male 1 Female	Spanish

In addition to communication at the clinic, participants expressed that having a small class and similar conversations would be immensely beneficial. Most participants acknowledged the importance of learning English: “English is [an] important language to learn. I took English classes in my home country when I was young.” All participants wanted to learn English in order to “read, write, and talk in English.” A participant mentioned that she wanted to learn English because “I want to communicate in English at my job with my co-workers.” Another motivation to learn English was “being independent in this country.” Most participants were very satisfied with the class, because they felt like they had “learned something new.” Participants also showed more confidence in communicating in English, with reports such as “I learn better now. I pronounce better than my brother.”

Some participants showed mixed attitudes toward learning English. Participants who were engaged in learning expressed more excitement and motivation to learn the medical vocabulary. They patiently repeated after the instructor and asked the instructor to correct their pronunciation. Some participants also came up with their own methods of learning new vocabulary by creating a sentence using these medical terms or asking for synonyms. Some participants were excited to learn more and asked if there were any other English classes being offered at the clinic or elsewhere, or if they could continue having such conversations with the instructor. A participant said that “I wish the English class was [offered] here every day. I have to go to my children’s school [to learn English]. I need English.” Another participant was excited by the class being offered at the clinic, because “I used to go to an English class in a high school and it was very helpful. I cannot go anymore because we have moved our house and now I live very far away.” A participant stated that he went to several English classes at church with his friends and wished to have more opportunities to enroll in other classes. Several patients at the clinic expressed interest in the class but their English was more advanced than the class materials. Some participants inquired if the research cohort would offer a higher level class, or a “conversation class” at the clinic in the near future.

In contrast, some participants did not express any excitement or motivation in learning English, mostly because of their language barriers. Language barriers often presented for participants who had lived in the U.S. less than one year. A participant who had immigrated to the U.S. just 5 months prior to the study asked her family members to make appointments and consistently had difficulties communicating in English with her healthcare provider and assistive staff at the clinic. Other participants who had lived in the U.S. for longer periods also reported having language barriers. Notably one participant had lived in the U.S. for 22 years and yet spoke English at a beginner’s level. She revealed that she had always wanted to learn English, yet never enrolled in any class as she did not feel the need to speak English. She also had never used any interpretation service at the clinic.

Similarly, a couple shared that they had lived in the U.S. for more than 10 years without enrolling in any English class. They stated “we never had time and our children were able to help

with translation” Additional circumstances resulting in non-engaged participation were due to an individual’s status of health. Some participants presented to the clinic with relatively detrimental symptoms. These participants showed discomfort and were not able to communicate thus the instructors had to end the class early. Senior subsets declared that learning another language was quite difficult, as “it is hard to learn English when you are not very young,” or “at my age and being alone, it is hard to have an English conversation.” Other participants felt inadequate practicing English, and stated that “I have tried to learn English, but I am scared to have a conversation.”

## Discussion

This study examining implementation of English classes at a free clinic resulted in three main findings. First, free clinic patients with limited English proficiency do not necessarily report the need to learn English. Second, the study identified several reasons and potential barriers for participants not enrolling in any English class, including lack of desire to learn English, difficulty learning another language at an advanced age, and lack of time, confidence and resources. Third, analysis of the field notes reinforced the importance of offering similar classes in free clinic setting.

Congruencies of most individuals who partook in the research study included the following: limited English proficiency, no prior enrollment in any English class, feeling it was imperative that they learn English in order to communicate in their community. The second main finding, regarding not all patients with limited English proficiency have the desire to learn English, is consistent with the existing literature on immigrant’s health. Previous studies have found the majority of minorities do not report challenges with health information when adequate existed to provide in-language materials or formal interventions; such as interpretation services, or educating family/friend to make materials more comprehensive [12]. In relation to the English class participants, although they identified generic barriers to communicating in English, they can rely on the interpretation services provided or family/friend acting as an interpreter during their visit.

Foreign-born free clinic patients have impediments when attempting to learn English, thus bilingual communities have developed and thrived in large cities in the U.S. for several decades. Previous studies conclude strong enclave effects in the ethnic communities across the U.S. [17]. As a result, language-appropriate and cultural competency healthcare resources are readily available to incoming immigrants, thus some immigrants may not have the need of learning the destination-language [18]. Studies centered on learning English at an older age have indicated that older patients often did not perceive language barriers and were more reluctant to use interpretation services [19]. Another study found that the decision process to use interpretation services within the U.S. healthcare system are complicated due to the following: formation of trU.S.t, a sense of control, and power balance among providers, patients, and interpreters [13]. However, some studies alternatively argued that patients’ perception to their lack of language barrier was not always accurate in comprehension of detailed information

and disease management [19,20]. Healthcare providers have expressed concerns about how language barriers can impede quality of care and increase risks for malpractice [21]. These studies also clarified that seeking help with English translation from family/friends may not be an appropriate approach to improve quality of healthcare services and disease management. Indeed, utilization of a qualified interpreter should be promoted in healthcare settings, and providers can mandatorily request interpretation services if the services were deemed necessary [10,19].

A qualitative study conducted in a Russian-speaking community in California revealed that resources in Russian language were deemed inadequate and relatively unavailable compared to other non-English languages [22]. The intermountain metropolitan community housing the free clinic offers resources in Spanish but has limited materials for non-Spanish speaking foreign-born populations [16,23,24]. This barrier was identified in other studies with immigrants, especially those of older age, many expressing reluctance to learn the destination-language [25]. A minor subset attested to the final reason for not learning English, reporting that they had no time to learn English although they had been living in the U.S. for more than 10 years. This behavior could be explained by the strong enclave effect of a close-knit bilingual community that the participants lived in [17].

Effective communication between patients and healthcare providers determines the quality and safety of care [10]. Motivations to learn English were not limited to patient-provider communication in the clinic setting, rather communication in general. Participants identified that having small-sized and “conversation” classes were important to boost their confidence, communicate in the workplace, and join the mainstream culture. Indeed, it is crucial for immigrants to be proficient in the destination-country language, as it will lead to substantial economic returns and other social benefits [17,26].

The study successfully conducted English classes for patients with limited English proficiency and examined their needs, motivations, and barriers to learning English. However, the study was prone to some limitations. The study was cross-sectional, descriptive, and limited to a small sample size of patients who were interested in learning English thus, the findings were not eligible to draw any causation, and cannot be generalized to other populations. Since the research cohort did not conduct any follow-up study with the class participants, the long-term impacts of whether the participants utilized course materials or enrolled in another English class were unknown.

Although three quarters of the returned satisfaction surveys stated that the quality of the English class was “good” or “excellent,” results from the field notes also implied several approaches for quality improvements in future classes. Many classes were distracted by background noise in the clinic’s waiting room or participants’ caring for their children. Therefore, future classes should be conducted in another setting, such as a separate meeting or classroom. If possible, child care services should be provided at the clinic. Having the option of childcare during clinic appointments would improve quality of healthcare services provided and future classes offered. Another implication for future class offerings would

include specific group formats. Since these English classes were based on voluntary enrollment, it was nearly impossible to separate participants into different English proficiency levels. Future courses should include options for individuals to learn at their proficiency level (beginner or intermediate) so that beginners would feel more confident and stay engaged in the class. This option will also help participants who speak English at intermediate levels to improve upon communication skills for healthcare and other purposes. Although most of the class participants were predominantly from Spanish-speaking countries, participants originally from other countries or regions also shared the need for learning English. Future classes should consider providing separate classes for people who speak the same language. This approach will promote learning among peers, and increase class participation and performance.

### Conclusion

Existing literature suggests that linguistic resources offered by local organizations in receiving communities play a key component in determining the immigrant integration process [27, 28]. Thus, the free clinic would benefit their patients by advocating and promoting English classes and similar resources in the community. This can be delivered via print materials in various languages and distributed to patients in the waiting room. These print materials will help with class structure and recruit appropriate participants for each type and level of class being offered. Since participants mentioned distance and lack of availability to resources as barriers of learning English, the clinic and research cohort should also consider collaborating with local organizations already providing services to immigrants in the area. Partnerships and referral networks help with raising awareness of available resources, and providing comprehensive care for patients in community-based free clinics.

### Conflict of Interest

The author(s) declared no potential conflicts of interest with respect to the research, authorship and/or publication of this article.

### Ethical Approval

The University of Utah Institutional Review Board (IRB) approved this study.

### Funding

This study was partially supported by the College of Social and Behavioral Science at the University of Utah.

### Acknowledgement

The authors would like to thank the patients who participated in this study and acknowledge the contribution of the staff and volunteers of the Maliheh Free Clinic. In addition, the authors would like to acknowledge the contribution of Guadalupe Aguilera for translation. This study was supported by the Undergraduate Research Opportunities Program (UROP) (Sayro Paw and Sullivan Howard) at the University of Utah.

### References

1. McNeely C.A, Lyn M, Benjamin D, Laurie L.M, Summer A, et al. (2017) How schools can promote healthy development for newly arrived immigrant and refugee adolescents: Research Priorities. *J School Heal* 87:121-132.
2. Watkins P.G, H Razee, J Richters (2012) 'I'm Telling You... The language barrier is the most, the biggest challenge: Barriers to education among karen refugee women in Australia. *Aus J Educ* 56: 126-141.
3. Akresh I.R, R. Frank (2011) At the intersection of self and other: English language ability and immigrant labor market outcomes. *Soc Sci Res* 40:1362-1370.
4. Nguyen E.T, J.M. Hale (2017) "You Just Don't Understand Me!" Determinants of second generation asian and latino youth self-esteem. *Intern Mig* 55: 44-61.
5. Fryer C, Shylie M, Frances B, Keith H, Catherine S (2012) The effect of limited English proficiency on falls risk and falls prevention after stroke. *Age Ageing*: 104-107.
6. Ponce N.A, R.D. Hays, W.E. Cunningham (2006) Linguistic disparities in health care access and health status among older adults. *J Gen Intern Med* 21: 786-791.
7. Kim G, Worley CB, Allen RS, Vinson L, Crowther MR, et al. (2011) Vulnerability of older Latino and Asian immigrants with limited English proficiency. *J Am Geriatr Soc* 59: 1246-1252.
8. Haviland A.M, Elliott MN, Hambarsoomian K, Lurie N (2011) Immunization disparities by Hispanic ethnicity and language preference. *Arch Intern Med* 171: 158-165.
9. Teitler J, M. Martinson, N.E. Reichman (2017) Does life in the United States take a toll on health? Duration of residence and birthweight among six decades of immigrants. *Intern Mig Rev* 51: 37-66.
10. Attard M, McArthur A, Riitano D, Aromataris E, Bollen C, et al. (2015) Improving communication between health-care professionals and patients with limited English proficiency in the general practice setting. *Aust J Prim Heal* 21:96-101.
11. Schyve PM (2007) Language differences as a barrier to quality and safety in health care: The joint commission perspective. *J Gen Intern Med* 22: 360-361.
12. Sentell T, Braun KL, Davis J, Davis T (2015) Health literacy and meeting breast and cervical cancer screening guidelines among Asians and whites in California. *Springerplus* 4: 432.
13. Brisset C, Y. Leanza, K. Laforest (2013) Working with interpreters in health care: A systematic review and meta-ethnography of qualitative studies. *Patient Educ Couns* 91: 131-140.
14. Watt K, P. Abbott, and J. Reath, (2016) Developing cultural competence in general practitioners: An integrative review of the literature. *Bmc Fam Prac*: 17.
15. Higham R, Samin P, Sullivan RH, Emely P, Maison AE (2018) Stress management classes for uninsured free clinic patients in the United States. *Divers Equal Health Care* 15: 184-189.

16. Kamimura A, Clayton B, Kai S, Mu P, Alla C (2017) Home Dental Care Education for Refugee Background Adults in the United States. *Divers Equal Health Care* 14: 277-282.
17. Isphording I.E. and S. Otten (2015) Linguistic barriers in the destination language acquisition of immigrants. *J Econ Beh Organ* 105: 30-50.
18. Alba R, Logan J, Lutz A, Stults B (2002) Only English by the third generation? Loss and preservation of the mother tongue among the grandchildren of contemporary immigrants. *Demography* 39: 467-484.
19. Fryer C.E, Mackintosh S.F, Stanley MJ, Crichton J (2013) 'I understand all the major things': How older people with limited English proficiency decide their need for a professional interpreter during health care after stroke. *Ethn Health* 18: 610-625.
20. Gray B, J. Hilder, H. Donaldson (2011) Why do we not use trained interpreters for all patients with limited english proficiency? Is there a place for using family members? *Aus J Prim Heal* 17: 240-249.
21. Gadon M, G.I. Balch, E.A Jacobs (2007) Caring for patients with limited english proficiency: The perspectives of small group practitioners. *J Gen Intern Med* 2: 341-346.
22. Dohan D, M. Levintova (2007) Barriers beyond words: Cancer, culture, and translation in a community of Russian speakers. *J Gen Intern Med* 22: 300-305.
23. Trinh H.N, Meng H.W, Mitch J, Kai S, Naveen R, et al. (2018) Physical activity education for adults with refugee background in the United States. *Divers Equal Health Care* 15: 158-163.
24. Hubenthal, W (2004) Older russian immigrants'experiences in learning english: Motivation, methods, and barriers. *Adult Basic Edu*:14.
25. Duff P, P. Wong, M Early (2000) Learning language for work and life: The linguistic socialization of immigrant Canadians seeking careers in healthcare. *Canadian Modern Language Rev* 57: 9-57.
26. Nawyn S.J, Linda G, DeBrenna LaFa A, Breanne G (2012) Linguistic isolation, social capital, and immigrant belonging. *J Contem Ethnog* 41: 255-282.
27. Kaeser M.A, Cheryl H, Michelle LA, Richard R (2016) Community-based free clinics: Opportunities for interprofessional collaboration, health promotion, and complex care management. *J Chiropr Educ* 30: 25-29.

**ADDRESS OF CORRESPONDENCE:** Akiko Kamimura, PhD, Department of Sociology, University of Utah, 380 S 1530 E, Salt Lake City, Utah 84112, U.S.A, Tel: 18015855496; Fax: 18015853784; E-mail: akiko.kamimura@utah.edu

*Submitted: September 04, 2018; Accepted: September 18, 2018; Published: September 25, 2018*