



# NAVIGATING A PANDEMIC: WHEN "ENGLISH ONLY" THREATENS PUBLIC HEALTH



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## Introduction

Research on the COVID-19 outbreak has revealed that the novel coronavirus is highly contagious: current estimates show each infected person is likely to infect 2.2 other people.<sup>1</sup> Most experts agree widespread testing for the virus must be a core component of any successful public health effort to control the pandemic. As such, ensuring that everyone who might be infected has access to information about testing for the virus is a public health priority.

Recent reporting indicates that individuals with limited English proficiency (LEP) may be struggling to gain access to accurate information and potentially life-saving resources during the crisis.<sup>2</sup> Navigating healthcare can feel like a maze in the best of circumstances, but during this pandemic it can mean the difference between flattening the curve and creating a new hot spot of infection. For legal, moral, and public health related reasons, it is essential that these groups are not left behind in current efforts to control the pandemic.

The Equal Rights Center (ERC) is a civil rights organization that identifies and seeks to eliminate unlawful and unfair discrimination in housing, employment, and public accommodations in its home community of greater Washington, DC and nationwide. The ERC's core strategy for identifying unlawful and unfair discrimination is civil rights testing, an investigative tool used to gather evidence, usually in order to compare conduct to legal requirements or a policy. The ERC has conducted civil rights testing to evaluate language access in the District for many years.

In April and May 2020, the ERC used matched pair style testing to ascertain whether individuals with limited English proficiency in the Washington, DC region were able to obtain information about COVID-19 testing using resources published by local governments and major media outlets. Our findings raise concerns about whether the current state of language access to such healthcare resources is sufficient to yield a successful public health response to the threat that the novel coronavirus poses to our community. We hope that government leaders, healthcare providers, and even the media will take more steps to ensure that everyone can access necessary resources.

*Matched pair testing is one type of civil rights test that compares treatment between two people based on one variable because all other differences are controlled for.*

## Project Overview and Methodology

Based on Census data reported in 2018, 10.5% of people living in the DC Metropolitan Area speak a language other than English and speak English less than “very well”;<sup>3</sup> for the purposes of this publication, we will refer to this group as Limited English Proficient, or “LEP”. This project was designed to use phone testing to determine whether LEP people in the DC Metropolitan Area face language access barriers when seeking access to the healthcare system and accurate information regarding COVID-19.



### ***How did the testing work?***

The investigation resulted in a total of 37 phone tests conducted in late April and early May. During each phone test, three ERC trained testers called a target site: one tester only spoke English, one tester bilingual in English and Spanish posed as only being able to communicate in Spanish, and one tester bilingual in English and another, less commonly spoken language, posed as only being able to communicate in that language. Before each test, ERC test coordinators gave each tester detailed instructions about how to conduct the test.

During each call, bilingual testers, posing as LEP consumers, first communicated their need for language interpretation by stating “No English” and then their assigned language (eg., “No, English, Spanish”). The English-speaking testers and the bilingual testers who received language interpretation then stated that they were calling on behalf of a relative who was experiencing symptoms consistent with COVID-19, did not have a primary care provider, and wanted information about where to get tested for COVID-19. After each call, each tester submitted a detailed written report about their interaction. ERC test coordinators then closely analyzed test reports to determine the prevalence and nature of language access barriers.

### ***How did the ERC decide which sites to test?***

ERC staff chose test sites from two primary sources:

1. State and Department of Health Coronavirus resource pages for the District of Columbia,<sup>4</sup> Virginia,<sup>5</sup> Maryland,<sup>6</sup> and West Virginia<sup>7</sup> in the DC Metropolitan Area; and
2. A frequently updated list of COVID-19 testing sites published by the Washington Post.<sup>8</sup>

Once testing began, test coordinators added new test targets to the target list based on referrals provided by employees at the original testing sites. Ultimately, the ERC tested 37 sites in the Census defined DC Metropolitan region, including sites in the District of Columbia, Northern Virginia, Maryland, and West Virginia.

### ***How did the ERC decide which languages to test in?***

ERC staff looked to 2018 American Community Survey data in order to understand who makes up the LEP population in the metropolitan DC region. Overall, 10.5% of the DC Metropolitan Area speaks a language other than English and speaks English less than “very well”.<sup>9</sup> Of that number, 56.2% of the LEP population is made up of Spanish speakers and 43.8% of the LEP population is made up of people who speak foreign languages other than Spanish.<sup>10</sup> Some of the largest of these other LEP groups are Chinese, Korean, Vietnamese, Amharic,<sup>11</sup> French, and Arabic speakers.

Given past experiences with other language access testing projects, ERC staff suspected it would be more likely for people speaking languages other than English or Spanish to face challenges accessing interpretation. As such, in addition to English and Spanish, each test was also conducted in either Amharic or Korean.

### ***Why did the ERC conduct tests in English if it was interested in evaluating access to interpretation in languages other than English?***

Again, based on past language access testing projects that the ERC has completed, we suspected that there may be differences in the information provided to testers based on the language they spoke during the test. As such, it was important to collect information about the

experiences of English speakers seeking COVID-19-related healthcare resources to incorporate into our analysis.

### ***Isn't this a drain on the healthcare system during a time of crisis?***

This is an ethical consideration that the ERC took under very serious consideration when designing the investigation. There has been extensive reporting about the heavy toll that the pandemic has taken on healthcare workers in recent months, and the last thing we wanted to do was add to that burden. To figure out how to proceed in light of this concern, we spoke with healthcare workers and language access advocates, kept abreast of reporting about the toll of COVID-19 on local healthcare systems, and engaged in regular internal conversations about the topic. Test coordinators also conducted a small batch of calls to providers in advance of making test assignments in order to obtain a better understanding of how much time each call would likely require of the provider.

In the end, we decided that the question of whether non-English speakers can access healthcare resources necessary to comply with available guidance about “stopping the spread” of the coronavirus was too important to ignore. Given how contagious the virus is, ensuring that the region’s LEP residents can access vital information about the disease is a critical component in the success of public health efforts to control the outbreak.

That said, we conducted extensive advanced research and constructed the test methodology in ways designed to minimize the overall burden of the project on the healthcare system and the specific burden on individual healthcare workers. For example, test profiles were designed to communicate non-emergency symptoms so as not to raise undue alarm. There were conservative limits placed on how long testers were allowed to wait on hold for interpretation in order to minimize the time potential healthcare providers spent on each test. Our goal was to ensure the burden the project imposed on healthcare providers was minimal, but that the information we would be able to provide as a result could inform a better response to the threat.

## **Results**

Three testers, an English-speaking tester, a Spanish-speaking tester, and a tester speaking another language (Korean or Amharic), attempted to contact each site by phone until they reached a live employee.

As Table 1 below shows, non-English-speaking testers received interpretation in 48 out of a total of 74 calls (65%). Spanish-speaking testers received interpretation in 28 out of 37 calls (76%), while testers who spoke other languages (Amharic or Korean) received interpretation in 20 out of 37 calls (54%).

**Table 1: Was Interpretation Provided?**

<b>Name of site tested:</b>	<b>Korean or Amharic</b>	<b>Spanish</b>
Alexandria COVID-19 Hotline	✓	✓
AllCare Washington, DC	✗	✓
Arlington County COVID Hotline	✗	✓
Charles County COVID Hotline	✓	✗
Children's National Medical Center Corona Virus Hotline	✓	✓
DC COVID-19 "Human Needs Hotline"	✓	✓
DC Office of Unified Communications (DC 311)	✓	✓
DC Testing Triage Call Center	✓	✗
Fairfax County Health Department COVID-19 Hotline	✓	✓
Family and Medical Counseling Services	✗	✗
Farragut Medical & Travel Care	✗	✓
GW Hospital COVID Testing Line (GW Medical Associates)	✗	✗
Health Partners	✗	✗
HealthWorks for Northern Virginia Herndon	✗	✓
Howard University Hospital	✗	✗
Inova Health Systems	✗	✓
Inova Urgent Care North Arlington	✗	✓
Inova Urgent Care Dulles	✗	✗
Inova Urgent Care Tysons	✓	✓
Jefferson County Health Department	✗	✓
Johns Hopkins COVID Testing Line for University of DC-CC Bertie Backus Campus Testing Site	✓	✓
Kelly Goodman and Associates	✗	✓
Loudon County Information Line	✓	✓
Mary Washington Health Link Nurse Line	✓	✓
Maryland 211	✓	✓
Mary's Center	✓	✓
MedStar Health Adams Morgan Urgent Care	✓	✓
Medstar Health General	✓	✓
Montgomery County COVID Testing Line	✓	✓
Neighborhood Health	✓	✓
PM Pediatrics Fairfax	✗	✓
Prince George's County Health Department	✓	✓
Spotsylvania County Hotline, transferred to VA Dept of Health	✓	✓
United Medical Center	✗	✗
Unity Health Care	✓	✓
Virginia Hospital Center Arlington	✗	✗
Whitman Walker Health	✗	✓

Government hotlines provided interpretation in 22 out of 26 calls (85%), hospitals provided interpretation in seven out of 16 calls (44%), community health centers and private primary care practices provided interpretation in 11 out of 18 calls (61%), and urgent care centers provided interpretation in eight out of 14 calls (57%).<sup>12</sup> Testers received interpretation in 20 out of 32 calls to sites located in DC (63%), eight out of 10 calls placed to sites in Maryland (80%), 19 out of 30 calls placed to sites in Virginia (63%), and one out of two calls placed to sites in West Virginia (50%).<sup>13</sup>

In 31 calls, employees used a telephonic interpretation service such as Language Line Solutions to connect the tester to a professional interpreter. These subscription services provide quick access to interpretation in almost any language and can usually help employees identify the language of a caller if needed. Though some sites were able to provide interpretation through bilingual employees rather than an interpretation service, 16 out of the 17 calls in which this occurred involved a Spanish-speaking tester, and employees relied almost exclusively on professional interpretation services to provide interpretation in languages other than Spanish.<sup>14</sup>

The ERC identified three main ways in which testers had difficulty accessing healthcare resources due to language access barriers: explicit refusal of interpretation services, failed attempts by employees to access interpretation resources, and overly complex automated menus. Each of these barriers is outlined in greater detail below. Quotations included in the following sections come directly from test reports testers filed after completing each call.

### ***Explicit Refusal of Interpretation Services:***

In 21 out of the 74 calls (28%), such as those in the following examples, an employee explicitly told the tester that they would not provide interpretation, though testers clearly indicated their test language and implied their need for interpretation.

*“She said ‘this would not be a good setting for someone who does not speak English.’”*

*“I said once more, ‘No English, Amharic.’ [The employee replied] ‘I’m not sure what it is you’re asking. No Spanish here.’ After a brief pause I said once more, ‘No English, Amharic please.’ She says, “I don’t know Spanish. Get somebody to translate for you.”*

*“I said, “No English. Korean?”, and the employee said in English, “We don’t speak Korean at this location.” I asked again, “No Korean?”, and the employee said, “No ma’am.” ...*

*“I said, ‘No English. Spanish.’ She said, ‘NO! I don’t speak Spanish.’ I said, ‘No English.’ Then she said in clear Spanish, ‘No hablo Español.’ I said, ‘No hablo Ingles.’ She then lowered her voice and spoke quickly in a confidential, hushed tone: ‘We don’t have anybody who speaks Spanish here.’”*



### ***Failed Attempts to Access Interpretation Resources:***

In some cases, such as those noted in the examples below, employees attempted to provide interpretation but were unsuccessful. As the examples illustrate, this sometimes happened because the employee could not identify the caller's language, could not reach a telephonic interpretation service, and/or could not locate an available bilingual employee at the time the tester happened to call. The examples show how even agencies who have well-meaning employees and bilingual staff sometimes failed to provide interpretation if they did not have a system in place to efficiently access professional interpretation services.

*“Would you mind calling back at 1:30 for a Spanish speaker?” ‘Amharic,’ I replied. She said once more, ‘call back at 1:30 for Spanish.’”*

*“I said, ‘No English. Spanish.’ She said, ‘No Spanish. But I am going to try to hook you up with a translator.’ Then, I waited for 7 minutes and 30 seconds. Then she said, ‘I am not able to connect you with an interpreter. Call back again once you get another person who can speak English. So sorry!’”*

*“I don’t think we’ll find someone speaking that language...” The representative claims that she knows someone that speaks the language but doesn’t know where he is. The other person in the room says, ‘they’re not giving us any resources, so I don’t know what to do at this point...’”*

*"I replied, ‘No English, Amharic.’ ‘Spanish?’ ‘Amharic,’ I said. ‘What language? Arabic?’ I replied again, ‘Amharic.’ ‘I’m sorry I don’t understand,’ he replied. I said ‘Okay’ and ended the call."*

### ***Automated Menus***

In 28 out of the 37 sites tested, testers had to navigate automated menus in order to speak to a live employee. Eighteen of these automated menus offered options only in English while nine offered options in English and Spanish, and one offered options in English, Spanish, and Amharic. Some menus required testers to select one of several menu options provided only in English before they could speak to a live employee. There were also instances in which testers had to call back multiple times in order to reach a live employee because of faulty menus that would disconnect the caller. Someone who does not speak English may not be able to figure out if they made the wrong menu selection or if the line they called disconnected on its own. This indicates callers seeking information about COVID-19 testing must navigate complicated, multi-step automated menus in order to speak to a live employee. LEP consumers, in particular, face a difficult if not insurmountable barrier to COVID-19 testing resources in those instances.

## ***Differences in referrals***

In addition to the barriers to interpretation outlined above, the ERC also found LEP testers, even when they received interpretation, received different information. Referrals rarely remained constant between testers at the same site, and testers could not access reliable information about whether interpretation would be available for their relatives at physical testing sites. Because of this, the ERC suspects it takes LEP consumers, on average, more phone calls to access testing resources available in their native language than it takes English-speaking consumers

During each test, all three testers called the same site and asked for the same information, but they only received the same referrals in four out of 36<sup>15</sup> test locations (11%). There were differences in both the amount of referrals provided and the quality of the referrals provided.

The type of differential treatment in the example below—in which a tester speaking a non-English language received interpretation but got less information or fewer resources than their English-speaking counterpart—occurred at nine out of 36 (25%) of test locations. In total from 36 tests, the English-speaking testers received 49 referrals, the Spanish-speaking testers received 36 referrals, and the testers speaking other languages (Korean/Amharic) received a combined 24 referrals.<sup>16</sup>

*Spanish speaking tester: “[She] started speaking in Spanish...she said... to look online...and that the Arlington County website had resources too...She told me to get the number from the back of the insurance card, and to call them, that they have people that speak Spanish and can help her get a doctor...”*

*Korean-speaking tester: “I said, ‘No English. Korean?’ and the employee asked, ‘Sorry?’. I repeated, ‘No English. Korean?’, and the employee said in English, ‘I’m sorry. I don’t have anyone who can help you in Korean. I do apologize.’...”*

*English-speaking tester: “He said we could get in contact with urgent care and offered to give a phone number. He gave the following information: Inova Urgent Care, 571-492-3080, 4600 Lee Highway, Arlington, VA 22207.”*

## ***No interpretation available for relative***

In calls when LEP testers were able to access interpretation and were given a referral, their test coordinators instructed them to ask whether interpretation services would be available for their relative at the referral location. Many employees at the test sites did not know if translation would be available at physical testing sites, had a limit on when their access to interpretation would be available, or did not know if the online platforms they suggested would be available in other languages. For example:

*“She said ‘No, she would need an interpreter, or you would need to call in and translate for her...The main hospital has those services but we don’t.’”*

*“After the interpretation, I asked if my uncle will be able to get help in Korean. The employee responded in English, ‘I’m not sure. She can ask the facility, but we can’t provide that for her.’”*

*“I told her that my cousin only spoke Spanish, and [asked] if she could make the appointment in Spanish. She said it was not a problem but that she was the only person there that spoke Spanish, and that she usually left by 4 PM.”*

## Discussion and Recommendations

Our civil rights testing investigation reveals significant concerns about language barriers to COVID-19 testing information for LEP individuals in the greater Washington, DC region. Overall, non-English-speaking testers only received language interpretation in 65% of calls they made to obtain information about COVID-19 testing. Non-English-speaking testers who speak a language other than Spanish faced the most pronounced difficulties in obtaining language access and received interpretation in only 54% of their calls. We are especially alarmed that hospitals only provided interpretation in 44% of the calls we conducted.

The good news is that fixing the problems with language access that ERC testing uncovered is a lot easier than “fixing” the pandemic! There are many resources available at a reasonable cost and plenty of regional expertise to draw from in crafting solutions. We also know that the problems are solvable because testing revealed that many healthcare and information resources are already providing effective language access to constituent groups that need it.

We offer the following three recommendations to entities likely to receive inquiries from the public about COVID-19 in order to meet the language access needs of our community and in turn foster the most effective equitable response to the threat the virus poses.

- 1. Commit to a culture that values language access:** Our investigation indicates providing language access may not be a priority for many of the entities we tested. For example, during one call, an employee at a private medical practice that offers COVID-19 testing stated, “This would not be a good setting for someone who does not speak English.” This is an unacceptable position in the face of a public health emergency originating from a contagious disease: one person’s inability to access testing resources could affect an entire community. In order to effectively respond to the outbreak, all responsible entities must remain committed to providing important information about the disease to anyone who may contract and spread it. Such a commitment needs to be present at all levels of the organization, and in various facets of its work. *A commitment to providing effective language access should be displayed in materials available to the public, such as websites, and in the willingness of frontline employees such as phone operators to provide interpretation resources.*

2. **Ensure that employees have the appropriate resources and training to provide effective language access:** Several times, testers encountered an employee who very much appeared to want to provide interpretation but seemed to lack the resources and/or training necessary to do so. *Services such as Language Line Solutions allow employees to quickly connect to an interpreter in almost any language and can help identify the language a caller is speaking if needed.*

However, just having access to this type of service is not enough - hotline operators and healthcare providers must ensure their staff are trained in how to use it. In addition, organizations need to prioritize providing high quality interpretation so that the quality of the information exchanged is appropriately safeguarded. *For example, in general, employees should opt to use a professional interpretation service over unreliable interpretation that a semi-fluent coworker may be able to offer.*

3. **Consult with the experts:** Decisionmakers who choose to act in response to language access concerns have a wealth of resources at their fingertips. The DC area has already benefited from the expertise of language access advocates for decades. For example, the DC Language Access Coalition (DCLAC), formed in 2002, is an alliance of community-based and civil rights organizations that advocates for language access rights locally. There is also a wide array of community-based organizations that represent the interests of specific constituent groups who have language access needs, such as the Ethiopian Community Center, La Clínica del Pueblo, and Multicultural Community Service. Finally, the DC Office of Human Rights' Language Access Program provides a multitude of resources online,<sup>17</sup> many of which remain relevant to organizations considering how to increase their commitments to language access outside of the District. *Those tasked with the critical job of providing access to healthcare and healthcare-related information, especially during the pandemic, should seek insight and technical assistance from language access experts and be prepared to compensate them for their expertise. Finally, members of the media should think through the language access implications of their pandemic related reporting and consult local experts for their perspectives about this important topic.*

Though anyone, regardless of the language they speak, should be able to access healthcare resources, the language access barriers we've identified raise heightened alarm due to the dramatic public health implications: we ignore them at our own peril. COVID-19 testing is a key aspect of an effective public health response to the pandemic. If LEP individuals are unable to obtain information about COVID-19 testing, we're all at greater risk.

## Endnotes

1. Morgan McFall-Johnsen and Aria Bendix, “An average coronavirus patient infects at least 2 others,” *Business Insider*. April 18, 2020. <https://www.businessinsider.com/coronavirus-contagious-r-naught-average-patient-spread-2020-3> (Accessed May 13, 2020).
2. See, for example:
  - a. Monica Samayoa, “Some immigrant groups struggle to get facts about COVID-19,” *WBUR Here & Now*, April 2, 2020. <https://www.wbur.org/hereandnow/2020/04/02/immigrant-communities-coronavirus> (Accessed April 13, 2020).
  - b. Natalie Delgadillo, “Why do latinos have the highest rate of coronavirus infection in D.C.?” *DCist*, May 11, 2020. <https://dcist.com/story/20/05/11/why-do-latinos-have-the-highest-rate-of-coronavirus-infection-in-d-c/> (Accessed May 13, 2020).
3. U.S. Census Bureau, “Language spoken at home by ability to speak English for the population 5 years and older,” 2018 American Community Survey 1-year estimates, 2018. <https://data.census.gov/cedsci/table?q=B16001&hidePreview=true&tid=ACSDT1Y2018.B16001&vintage=2018&y=2018&g=310M400US47900> (Accessed May 13, 2020).
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6. Maryland Department of Health, “Coronavirus Disease 2019 (COVID-19) Outbreak,” 2020. <https://coronavirus.maryland.gov/#FAQ> (Accessed May 13, 2020).
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8. Patricia Sullivan and Antonio Olivo, “Need a coronavirus test?,” *Washington Post*, Updated May 5, 2020. [https://www.washingtonpost.com/local/getting-tested-for-coronavirus-in-virginia-maryland-dc/2020/03/26/5e19f608-6de9-11ea-a3ec-70d7479d83f0\\_story.html](https://www.washingtonpost.com/local/getting-tested-for-coronavirus-in-virginia-maryland-dc/2020/03/26/5e19f608-6de9-11ea-a3ec-70d7479d83f0_story.html)
9. U.S. Census Bureau. “Language spoken at home by ability to speak English,” 2018.
10. Ibid.
11. Amharic is a language spoken in Ethiopia and Eritrea. It is spoken by 8.6% of the LEP population in the DC Metropolitan Area. (Source: U.S. Census Bureau, “Language spoken at home by ability to speak English,” 2018.)
12. See Appendix, Table 2
13. See Appendix, Table 3
14. See Appendix, Table 4

15. Although we tested 37 test sites, we were only able to compare referrals in 36 test sites, because the English-speaking tester was not able to reach a live employee for one of the test sites.
16. See Appendix, Table 5.
17. District of Columbia Office of Human Rights, “Language Access program information Portal,” 2020. <https://ohr.dc.gov/service/language-access-program-information-portal> (Accessed May 13, 2020).

## Appendix:

**Table 2: Shows which test sites provided interpretation on each test, arranged by type of test site**

<b>Type of Target</b>	<b>Name of Site Tested</b>	<i>Korean or Amharic (number of calls in which tester received interpretation)*</i>	<i>Spanish (number of calls in which tester received interpretation)</i>	<b>Total Number of Calls Conducted</b>	<b>% of Calls in which tester received interpretation</b>
Government Hotline	DC COVID-19 "Human Needs Hotline"	1	1	2	100%
	DC Office of Unified Communications (DC 311)	1	1	2	100%
	DC Testing Triage Call Center	1	0	2	50%
	Charles County COVID Hotline	1	0	2	50%
	Maryland 211	1	1	2	100%
	Montgomery County COVID Testing Line	1	1	2	100%
	Prince George's County Health Department	1	1	2	100%
	Alexandria COVID-19 Hotline	1	1	2	100%
	Arlington County_COVID Hotline	0	1	2	50%
	Fairfax County Health Department_COVID-19 Hotline	1	1	2	100%
	Loudoun County_Information Line	1	1	2	100%
	Spotsylvania County Hotline/VA Department of Health	1	1	2	100%
	Jefferson County Health Department	0	1	2	50%
<b>Government Hotline Total</b>		<b>11</b>	<b>11</b>	<b>26</b>	<b>85%</b>

<b>Type of Target</b>	<b>Name of Site Tested</b>	<i>Korean or Amharic (number of calls in which tester received interpretation)*</i>	<i>Spanish (number of calls in which tester received interpretation)</i>	<b>Total Number of Calls Conducted</b>	<b>% of Calls in which tester received interpretation</b>
Hospital	Children's National Medical Center_Corona Virus Hotline	1	1	2	100%
	GW Hospital COVID Testing Line (GW Medical Associates)	0	0	2	0%
	Johns Hopkins COVID Testing Line_University of DC--CC Bertie Backus Campus & Sibley Memorial Hospital	1	1	2	100%
	United Medical Center	0	0	2	0%
	Inova Health Systems	0	1	2	50%
	Mary Washington Health Link Nurse Line	1	1	2	100%
	Virginia Hospital Center Arlington	0	0	2	0%
	Howard University Hospital	0	0	2	0%
Hospital Total		3	4	16	44%
Community Health Center/Primary Care Practice	Mary's Center	1	1	2	100%
	Unity Health Care	1	1	2	100%
	Whitman Walker Health	0	1	2	50%
	Neighborhood Health	1	1	2	100%
	Family and Medical Counseling Services	0	0	2	0%



<b>Type of Target</b>	<b>Name of Site Tested</b>	<i>Korean or Amharic (number of calls in which tester received interpretation)*</i>	<i>Spanish (number of calls in which tester received interpretation)</i>	<b>Total Number of Calls Conducted</b>	<b>% of Calls in which tester received interpretation</b>
	MedStar Health_General	1	1	2	100%
	Kelly Goodman and Associates	0	1	2	50%
	Health Partners	0	0	2	0%
	HealthWorks for Northern Virginia Herndon	0	1	2	50%
Primary Care Practice Total		4	7	18	61%
Urgent Care	AllCare_Washington, DC	0	1	2	50%
	Farragut Medical & Travel Care	0	1	2	50%
	MedStar Health_Adams Morgan Urgent Care	1	1	2	100%
	Inova Urgent Care North Arlington	0	1	2	50%
	Inova Urgent Care_Dulles South	0	0	2	0%
	Inova Urgent Care_Tysons	1	1	2	100%
	PM Pediatrics_Fairfax	0	1	2	50%
Urgent Care Total		2	6	14	57%
<b>Grand Total</b>		<b>20</b>	<b>28</b>	<b>74</b>	<b>65%</b>

\*Includes 20 calls in Korean and 17 calls in Amharic.

**Table 3: Shows which testers received interpretation at each test site.**

**Test sites are arranged by state.**

<b>State</b>	<b>Name of Site Tested</b>	<i>Amharic or Korean (Number of calls in which tester received Interpretation)*</i>	<i>Spanish (Number of calls in which tester received interpretation)</i>	<b>Total Number of Calls Conducted</b>	<b>% of calls in which tester received interpretation</b>
DC	AllCare _Washington, DC	0	1	2	50%
	Children's National Medical Center_Corona Virus Hotline	1	1	2	100%
	DC COVID-19 "Human Needs Hotline"	1	1	2	100%
	DC Office of Unified Communications (DC 311)	1	1	2	100%
	DC Testing Triage Call Center	1	0	2	50%
	Family and Medical Counseling Services	0	0	2	0%
	Farragut Medical & Travel Care	0	1	2	50%
	GW Hospital COVID Testing Line (GW Medical Associates)	0	0	2	0%
	Howard University Hospital	0	0	2	0%
	Johns Hopkins COVID Testing Line_University of DC--CC Bertie Backus Campus & Sibley Memorial Hospital	1	1	2	100%
	Mary's Center	1	1	2	100%
	MedStar Health_Adams Morgan Urgent Care	1	1	2	100%
	MedStar Health_General	1	1	2	100%
	United Medical Center	0	0	2	0%

<b>State</b>	<b>Name of Site Tested</b>	<i>Amharic or Korean (Number of calls in which tester received Interpretation)*</i>	<i>Spanish (Number of calls in which tester received interpretation)</i>	<b>Total Number of Calls Conducted</b>	<b>% of calls in which tester received interpretation</b>
	Unity Health Care	1	1	2	100%
	Whitman Walker Health	0	1	2	50%
DC Total		9	11	32	63%
MD	Charles County COVID Hotline	1	0	2	50%
	Kelly Goodman and Associates	0	1	2	50%
	Maryland 211	1	1	2	100%
	Montgomery County COVID Testing Line	1	1	2	100%
	Prince George's County Health Department	1	1	2	100%
MD Total		4	4	10	80%
VA	Alexandria COVID-19 Hotline	1	1	2	100%
	Arlington County_COVID Hotline	0	1	2	50%
	Fairfax County Health Department_COVID-19 Hotline	1	1	2	100%
	Health Partners	0	0	2	0%
	HealthWorks for Northern Virginia Herndon	0	1	2	50%
	Inova Health Systems	0	1	2	50%
	Inova Urgent Care North Arlington	0	1	2	50%
	Inova Urgent Care_Dulles South	0	0	2	0%
	Inova Urgent Care_Tysons	1	1	2	100%
	Loudoun County_Information Line	1	1	2	100%

<b>State</b>	<b>Name of Site Tested</b>	<i>Amharic or Korean (Number of calls in which tester received Interpretation)*</i>	<i>Spanish (Number of calls in which tester received interpretation)</i>	<b>Total Number of Calls Conducted</b>	<b>% of calls in which tester received interpretation</b>
	Mary Washington Health Link Nurse Line	1	1	2	100%
	Neighborhood Health	1	1	2	100%
	PM Pediatrics _Fairfax	0	1	2	50%
	Spotsylvania County Hotline/VA Department of Health	1	1	2	100%
	Virginia Hospital Center Arlington	0	0	2	0%
VA Total		7	12	30	63%
WVA	Jefferson County Health Department	0	1	2	50%
WVA Total		0	1	2	50%
<b>Grand Total</b>		<b>20</b>	<b>28</b>	<b>74</b>	<b>65%</b>

\*Includes 20 tests in Korean and 17 tests in Amharic

**Table 4: Shows what form of interpretation testers received at each test site**

<b>Test Language</b>	<i>Received interpretation from a professional interpreter through a telephonic interpretation service (Number of Calls)</i>	<i>Received interpretation from employee who spoke test language (Number of Calls)</i>	<i>Received voicemail in test language* (Number of Calls)</i>	<i>Did not receive interpretation (Number of Calls)</i>	<b>Total Number of Calls</b>	<b>Interpretation Rate: (% of Calls)</b>
Amharic	8	1		8	17	53%
Korean	11			9	20	55%
Spanish	12	14	2	9	37	76%
<b>Grand Total</b>	<b>31</b>	<b>15</b>	<b>2</b>	<b>26</b>	<b>74</b>	<b>65%</b>

\*At these test sites, testers did not receive interpretation during their initial call or receive a call back within the 20-minute time period after their call during which they were required to monitor and answer any calls to their tester phone number. However, later in the day, the testers who conducted these two tests received a voicemail in their test language from the test site they had called.

**Table 5: Shows how many resources or referrals testers received at each test site**

<i><b>Name of Test Site</b></i>	<i><b>Same Referrals* (Y/N)</b></i>	<i><b>English (Number of Referrals Provided)</b></i>	<i><b>Amharic or Korean (Number of Referrals Provided)</b></i>	<i><b>Spanish (Number of Referrals Provided)</b></i>	<i><b>Total Number of Referrals</b></i>
Alexandria COVID-19 Hotline	N	2	1	1	4
AllCare _Washington, DC	N	1	0	1	2
Arlington County_COVID Hotline	N	1	0	2	3
Charles County COVID Hotline	N	2	0^	0	2
Children's National Medical Center_Corona Virus Hotline	N	2	0^	1	3
DC COVID-19 "Human Needs Hotline"	N	2	2	2	6
DC Office of Unified Communications (DC 311)	Y	1	1	1	3
DC Testing Triage Call Center	N	1	1	0	2
Fairfax County Health Department_COVID-19 Hotline	N	3	3	2	8
Family and Medical Counseling Services	N	1	0	0	1
Farragut Medical & Travel Care	N	1	0	1	2
GW Hospital COVID Testing Line (GW Medical Associates)	N	1	0	0	1
Health Partners	N	1	0	0	1
HealthWorks for Northern Virginia Herndon	N	1	0	1	2
Howard University Hospital	N	1	0	0	1
Inova Health Systems	N	3	0	1	4
Inova Urgent Care North Arlington	N	3	0	1	4
Inova Urgent Care_Dulles South	N	1	0	0	1
Inova Urgent Care_Tysons	Y	1	1	1	3
Johns Hopkins COVID Testing Line_University of DC--CC Bertie Backus Campus & Sibley Memorial Hospital	Y	1	1	1	3

<i><b>Name of Test Site</b></i>	<i><b>Same Referrals* (Y/N)</b></i>	<i><b>English (Number of Referrals Provided)</b></i>	<i><b>Amharic or Korean (Number of Referrals Provided)</b></i>	<i><b>Spanish (Number of Referrals Provided)</b></i>	<i><b>Total Number of Referrals</b></i>
Kelly Goodman and Associates	N	1	0	1	2
Loudoun County_Information Line	N	1	1	1	3
Mary Washington Health Link Nurse Line	N	0^	1	2	3
Mary's Center	N	1	1	3	5
Maryland 211	N	1	1	1	3
MedStar Health_Adams Morgan Urgent Care	N	1	1	2	4
MedStar Health_General	N	2	2	1	5
Montgomery County COVID Testing Line	N	3	2	0^	5
Neighborhood Health	Y	1	1	1	3
PM Pediatrics _Fairfax	N	1	0	1	2
Prince George's County Health Department	N	2	1	1	4
Spotsylvania County Hotline/VA Department of Health	N	2	2	3	7
United Medical Center	N	1	0	0	1
Unity Health Care	N	1	1	2	4
Virginia Hospital Center Arlington	N	0^	0	0	0^
Whitman Walker Health	N	1	0	1	2
<b>Total Number of Referrals</b>		<b>49</b>	<b>24</b>	<b>36</b>	<b>109</b>

\*Indicates whether all three testers who participated in each test received the same resources and/or referrals.

^Indicates that a tester spoke to an employee or interpreter who spoke their test language but did not receive any specific recommendations or referrals. A value of "0" indicates that a tester did not receive interpretation or speak to an employee who spoke their test language.

**Table 6: Shows where testers reached automated menus during their test calls and what language options were provided by each automated menu**

<i>Test Site</i>	<i>Automated Menu Language: English</i>	<i>Automated Menu Language: English &amp; Spanish</i>	<i>Automated Menu Language: English, Spanish &amp; Amharic</i>
AllCare _ Washington, DC	X		
Arlington County _ COVID Hotline		X	
Children's National Medical Center _ Corona Virus Hotline		X	
DC COVID-19 "Human Needs Hotline"	X		
DC Office of Unified Communications (DC 311)		X	
DC Testing Triage Call Center	X		
Fairfax County Health Department _ COVID-19 Hotline	X		
Family and Medical Counseling Services	X		
HealthWorks for Northern Virginia Herndon		X	
Howard University Hospital			X
Inova Urgent Care _ Dulles South	X		
Inova Urgent Care _ Tysons	X		
Jefferson County Health Department	X		
Johns Hopkins COVID Testing Line _ University of DC--CC Bertie Backus Campus	X		
Mary Washington Health Link Nurse Line	X		
Mary's Center		X	
Maryland 211		X	
MedStar Health _ Adams Morgan Urgent Care	X		



<i><b>Test Site</b></i>	<i>Automated Menu Language: English</i>	<i>Automated Menu Language: English &amp; Spanish</i>	<i>Automated Menu Language: English, Spanish &amp; Amharic</i>
MedStar Health_General	X		
Montgomery County COVID Testing Line	X		
Neighborhood Health		X	
PM Pediatrics _Fairfax	X		
Prince George's County Health Department	X		
Spotsylvania County Hotline/VA Department of Health	X		
Unity Health Care		X	
Whitman Walker Health		X	
<b>Number of Automated Menus Offered in Each Language:</b>	<b>16</b>	<b>9</b>	<b>1</b>

**Table 7: Lists calls during which an employee explicitly refused to provide interpretation to a tester:**

<i><b>Test sites</b></i>	<i><b>Amharic or Korean (Number of Calls)</b></i>	<i><b>Spanish (Number of Calls)</b></i>	<i><b>Total (Number of Calls)</b></i>
AllCare _Washington, DC	1	0	1
Arlington County_COVID Hotline	1	0	1
Charles County COVID Hotline	1	0	1
Farragut Medical & Travel Care	1	0	1
Inova Urgent Care North Arlington	1	0	1
Jefferson County Health Department	1	0	1
Kelly Goodman and Associates	1	0	1
Loudoun County_Information Line	1	0	1
PM Pediatrics _Fairfax	1	0	1
Whitman Walker Health	1	0	1
Family and Medical Counseling Services	1	1	2
Health Partners	1	1	2
Howard University Hospital	1	1	2
Inova Urgent CareDulles South	1	1	2
United Medical Center	1	1	2
<b>Total Number of Calls:</b>	<b>15</b>	<b>5</b>	<b>20</b>