



Center for Deaf Health Equity

Arizona Commission for the Deaf – Age of Access Report

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Background

In order to better meet the needs of aging Arizonans who are deaf and hard of hearing, service providers need additional information. There is a large volume of research on aging in general, but less on deaf and hard of hearing individuals. As a result, this study sought to learn more about deaf and hard of hearing individuals' access to and anticipated needs of aging support and caregiving services. A brief, anonymous self-administered brief health survey included demographics, health indicators, and health service usage. This survey was made available in both American Sign Language (ASL) and English and took less than 15 minutes to complete. All Arizona respondents provided consent prior to taking the brief health survey.

Brief Health Survey

Within the signed or combined signed/spoken language subsample (n=130; mean age=66, SD=8), 97% reported being deaf in both ears, 42% had a college degree and 84% identified as White. A high majority (69%) self-identified as female. Over 89% had health care coverage, but 33% were covered by Medicaid and 57% were covered by Medicare. Only 8% reported receiving health care from a VA hospital or clinic. This sample had 53% of respondents who regularly saw a provider. When asked about communication with a healthcare provider, 75% of the subsample relied on interpreters or sign language communication. Within this group, 66% preferred interpreters in person and 13% preferred virtual remote interpreting, and the remaining 21% did not have a preference. About 57% of the sign language/combined sample used electronic means to communicate with a doctor or a doctor's office. When asked to rate the quality of healthcare received in the past 12 months, 53% rated it as excellent or very good. About 23% were admitted to the hospital in the past 12 months, and 49% went to an emergency room or urgent care. About 63% rated their providers highly in patient-centered care. A low percentage (11%) rated their health status as poor or fair, 7% rated their quality of life as fair/poor, 14% rated their mental health as fair/poor, and 19% rated their social health as fair/poor. 38% reported caring or making health care decisions for someone with a medical, behavioral, disability, or other conditions.

Within the spoken language subsample (n=181; mean age=73, SD=10), 94% of respondents reported being deaf in both ears, 62% had a college degree and 90% identified as White. A high majority (74%) self-identified as female. Over 98% had health care coverage, but 15% were covered by Medicaid and 68% were covered by Medicare. Only 7% reported receiving health care from a VA hospital or clinic. This sample had 88% of respondents who regularly see providers. When asked about communication with a healthcare provider, 95% of the subsample relied on spoken language communication. About 84% of the sign language/combined sample used electronic means to communicate with a doctor or a doctor's office. When asked to rate the quality of healthcare received in the past 12 months, 76% rated it as excellent or very good. About 20% were admitted to the hospital in the past 12 months, and 38% went to an emergency room or urgent care. Over 80% rated their providers as being high in patient-centered care. A low percentage (16%) rated their health status as poor or fair, 9% rated their quality of life as fair/poor, 11% rated their mental health as fair/poor, and 27% rated their social health as fair/poor. 19% reported

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caring or making health care decisions for someone with a medical, behavioral, disability, or other conditions.

In summary, the spoken language participants displayed higher access to healthcare in several areas. First, 98% had health care coverage compared to 89% of the sign language/combined sample. 88% of spoken language respondents regularly visited a provider; whereas 53% of the sign language/combined sample did. Urgent care or emergency department usage was higher for the sign language/combined sample (49%, compared to 38% of spoken language participants). The greater use of urgent care/ED among sign language/combined group is likely due to not having a regular provider (only 53% of this group reported having a regular provider).

Access to electronic communication was higher among the spoken language subsample (84%) compared to 57% of the sign language/combined sample. Regarding satisfaction of healthcare, about 76% of the spoken language subsample rated their healthcare as excellent or very good in contrast with 53% of the sign language/combined subsample who rated the same. About 63% of the sign language/combined participants rated their providers to be patient-centered compared to 80% of the spoken language participants. More sign language/combined participants (38%) reported currently caring for another person compared to the spoken language participants (19%) who cared for another person.

Overall, health and healthcare access was higher among the spoken language subsample. The exception to this is in the area of social health. A greater percentage of spoken language participants (27%) ranked their social health as fair or poor compared to 19% of the sign language/combined participants.

Interview: Awareness and Use of Caregiving Services in Arizona

A total of 26 participants between 55 and 84 years old (72% female; 88% White) were invited to participate in a 1:1 interview about their awareness and use of the existence if specific caregiving services in Arizona. Approximately 92% had a college degree or higher. 73% identified as deaf, 15% as hard of hearing, and 12% as hearing (caring for a deaf or hard of hearing senior).

About 88% were most aware of transportation services, personal caretaking (69%), meal services (69%), and fitness classes/equipment (62%). Participants were the least aware of heavy chore services (15%), prescription drug programs (27%), and legal assistance (35%). Of those with awareness of services, over half also knew how to access the services. A majority (69-100%) of the participants could envision using the services for themselves or for someone they cared for. Several participants expressed concerns about accessibility and whether services would provide accommodation for deaf and hard of hearing individuals.

Recommendations

Based on the data presented in these surveys, we recommend for attention to be focused on (not ranked by priority): 1) improving access to ongoing healthcare for deaf and hard of hearing individuals who primarily use sign language to communicate and 2) providing social supports for individuals who use spoken language. Though participants were aware of caregiving services in some areas, they also noted that the services were not always accessible to deaf and hard of hearing users. We recommend expanding the accessibility of caregiving services and promoting awareness of these services.