

Barriers to Health Care for Children on Medical Assistance

**A Case Study of Vietnamese and
Chinese Speaking Families**

**Philadelphia Citizens for Children and Youth
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Executive Summary

In the last decade, as more and more children of immigrant parents have come to or been born in the United States, there has also been significant growth in the availability of health insurance for children. In Pennsylvania, these positive trends have combined to provide health insurance, primarily Medical Assistance (Pennsylvania's Medicaid program), to many of the children of these new American families¹. All too often however, even with health insurance these children do not receive needed health care. The utilization of health insurance by these families whose children have been enrolled in Medical Assistance has not kept pace with the opportunity. In many instances, children who are insured are not regularly seeing a physician and are not as healthy as they should be. These families often turn to the emergency room for normal care, a costly response in economic as well as human terms. With the help of the Robert Wood Johnson Foundation, PCCY set out to listen to and learn from some of the families of immigrants from China and Vietnam with children who have settled in Philadelphia, to learn their perspective on the issue and to develop recommendations for improvement.

Not surprisingly, we learned that language and cultural issues were major barriers to accessing care and to understanding and complying with treatment plans, that transportation and interpretation services which should have been made available were either unknown by the families or communities or inaccessible when they were known. We learned that few families knew they should be able to access interpretation services and that providers were uncertain concerning how best to address language and cultural concerns.

In order to better meet the needs of the children of immigrant families on Medical Assistance, we recommend that many steps be taken, particularly but not exclusively, by the state. We recommend that Pennsylvania invest in and seek federal matching funds to assist with the cost of interpretation services, clarify the responsibility of health maintenance organizations for assuring that translation and interpretation services are known by and provided to families and improve Philadelphia's Medical assistance transportation system by simplifying the application process and diversifying the methods of delivery. We recommend that managed care organizations expand their interpretation services and develop new strategies to overcome language and cultural barriers among their practitioner panels. In addition, we recommend that hospitals, particularly children's hospitals, develop model language access strategies and support multi-language environments and services to respond to the needs of diverse communities.

We have the opportunity to improve the health of thousands of families, to provide the support needed to grow the next generation of Americans as healthy as possible. We should seize the chance to make real the laws which promise health care to Pennsylvania's immigrant children.

Study Methodology

With the assistance of two consultants, a native Mandarin speaker and a native Vietnamese speaker, PCCY was able to listen to and learn about the issues many of these families face in securing health care for their children. Both consultants were familiar with the Medical Assistance program and had contacts with families who were enrolled in public health insurance programs. Each consultant developed plans to reach families that included placing advertisements in local Chinese and Vietnamese newspapers and church bulletins, holding focus groups after other meetings that draw large numbers of parents and disseminating surveys through local social service agencies that help these families.

PCCY compiled data from: eight focus groups that reached 25 Vietnamese and 25 Chinese-speaking families; interviews with ten providers who see a large number of Chinese and Vietnamese-speaking families; intensive interviews with five Chinese-speaking families and 100 surveys (50 from Chinese-speaking families and 50 from Vietnamese-speaking families).

In addition, PCCY staff conducted site visits and interviewed representatives from each of the three children's hospitals and conducted site visits at each of the eight health centers. Finally, PCCY spoke with two nurses from the Philadelphia public schools, and representatives from the three physical health and the one mental health Medicaid managed care organizations.

The Population

Immigrant childrenⁱⁱ are the fastest-growing segment of child population in the United States. According to the 1997 Current Population Survey, immigrant children and U.S.-born children of immigrants account for nearly 20 percent of all children in the U.S, compared with 10 percent in 1990. In addition, the Population Survey indicates that Chinese and Vietnamese residents comprise the fourth and fifth largest foreign-born populations, respectively in the U.S.ⁱⁱⁱ.

According to the U.S. Census^{iv}, the total U.S. Asian and Pacific Islander population grew by 46 percent between 1990 to 2000. During that time period, the Chinese population in the U.S. grew by 41 percent and the Vietnamese population grew by 83 percent. These growth rates are compared to a 13 percent growth rate overall for the U.S. population during the same time period.

Similar to national trends, the Chinese and Vietnamese^v populations have been growing rapidly in Pennsylvania and in Philadelphia (see chart below). This population expansion is particularly striking in Philadelphia given that the overall city population decreased by four percent from 1990 to 2000.

	Growth Nationally from 1990 - 2000	Growth in Pennsylvania from 1990 - 2000	Growth in Philadelphia from 1990 - 2000
Chinese Population	41%	65%	49%
Vietnamese Population	83%	89%	104%
Asian & Pacific Islander Population	46%	62%	57%

Although we don't have specific data for the citizenship status of these children in Southeastern Pennsylvania, a 2001 national study found that 80 percent of children in immigrant families were citizens^{vi}.

Access to Health Care

According to national reports, 22 percent of children of immigrants are uninsured, more than twice the rate for children of native born adults. Fourteen percent of children of immigrants lack a usual source of health care, and nine percent are in fair or poor health. Compared with children of those who are native born, children of immigrants are more than three times as likely to lack a usual source of care, and they are more than twice as likely to be reported in fair or poor health^{vii}. According to The Commonwealth Fund's *2001 Health Care Quality Survey*, Americans of Asian heritage in the United States had comparatively higher socioeconomic status (measured as income and education), than other Americans, yet they reported poorer quality of health care than the overall population^{viii}. These Asian-Americans also reported greater difficulty communicating with physicians and accessing preventative services. The survey highlighted particularly high uninsured rates among Vietnamese families.

The Vietnamese respondents were also less likely than the general population to report having a regular source of care and were less likely to report being in excellent or very good health.

Although children generally have much greater access to health insurance than their parents, their access is influenced by the insurance, socioeconomic, and employment status of their parents. Complicating the picture further for these children are other factors, including language and cultural barriers which have to be better understood and responded to if we are to improve their condition.

Insurance Status

Children who are born in the United States, or who have documented immigrant status, qualify for public benefits, such as Food Stamps, Medical Assistance or CHIP, and TANF (welfare), if their families are income eligible. However, many of them do not take advantage of the supports that can help them. In fact, national data suggests that 36 percent of children eligible for, but not enrolled in, Medicaid live in immigrant families^{ix}.

Over the last 10 years, Pennsylvania has seen large increases in the number of children enrolled in publicly-funded health insurance. But, following national trends, most estimates suggest that a large number of those children who do not have publicly funded health insurance are from immigrant families. In spite of the increasing number of insured children, there are still many children who do not receive needed health care. Health coverage – free or reduced-cost – is available to the great majority of low and moderate income children in Pennsylvania. A typical family of four in Pennsylvania qualifies for free health coverage for their children if their income is under \$36,800; the same family qualifies for reduced cost coverage if their income is below \$43,200. Often, families can earn even more and still qualify, as working parents are able to take deductions from their income in order to enroll their children. For instance, some child care expenses can be deducted from family income to help families qualify. Furthermore, children with severe disabilities in Pennsylvania usually qualify for Medicaid, irrespective of parental income. But generally people have to be well informed and often assisted in applying for these benefits.

In addition to public insurance for children, other health resources in the community, such as federally qualified health centers, can provide care to uninsured children. There are also hospital programs that respond to children's serious health needs.

While securing health insurance is an important first step in improving the health care of children, coverage by itself does not assure treatment. Even among those immigrant families whose children are enrolled in publicly funded health insurance programs, there appears to be inadequate utilization of this critical service. This report is a beginning effort to better understand and hopefully decrease the barriers to health care faced by insured children from immigrant families.

I. Barriers to Accessing Health Care: Transportation

Although transportation is a covered benefit for Medicaid recipients, we found that lack of transportation was consistently cited as a primary reason Vietnamese and Chinese-speaking families do not access health care for their children insured through Medical Assistance. Most of the families with whom we spoke were unaware of the transportation benefit.

Getting There: The reality

“It would be a lot easier if we could afford transportation to doctor appointments. Because we can’t, I cannot get to the appointment.” – A Vietnamese-speaking mother.

Transportation difficulties led many respondents to cancel or miss appointments. Eighty four percent of Vietnamese-speaking and 65 percent of Chinese-speaking families with whom we spoke reported missing at least one appointment in the last year because of transportation problems. The problems reported by families included:

- Having to wait for a family member or friend to bring them to the doctor’s office. One respondent said, *“My husband or sister drives me because we live far away from the doctor. But I have to wait to see when they are available.”*
- Taking taxis to see their child’s doctors which can become prohibitively expensive.
- Having to bring all of their children on the bus to get to the doctors office which makes it difficult to afford and to arrive on time to appointments. One respondent said, *“I cannot afford child care when we have doctor appointments, so I have to bring them, but it is very difficult to do.”*
- Not understanding the public transportation system. One respondent said, *“I never understand what bus to take and so I walk with my children.”* Although walking to the doctor was easy for some family members who lived near their child’s pediatrician, many respondents report walking over 45 minutes to see a Chinese-speaking or Vietnamese-speaking doctor.
- Busses not coming on time or missing the needed bus. *“If I am one minute late for my bus, I cannot make it on time to my appointment, and it will be cancelled.”*

Although transportation was consistently reported as a barrier to accessing health care services for their children, few people knew about the Medical Assistance Transportation Program (MATP). In fact, 70 percent of Chinese-speaking families and 60 percent of Vietnamese-speaking families with whom we spoke had never heard of the Medical Assistance Transportation Program.

Most of these families were shocked when told that they were entitled to transportation services necessary to secure medical care. This might be in part because there is no information

regarding MATP in Vietnamese or Chinese and the English brochure describing the program is not widely distributed. Of those families who reported knowing about MATP, only two (out of one hundred respondents) reported ever using the service. When asked why they did not utilize MATP to assist with transportation, families reported the following barriers:

- They did not understand how to access the transportation benefit;
- They did not understand how to fill out the separate application, which is not available in Chinese or Vietnamese;
- They were unaware of the different transportation options offered through MATP;
- They did not know how to make a reservation;
- They were confused by the system for token reimbursement;
- They could not receive reimbursement for siblings on public transportation.

The problems: not knowing about, not understanding, not being able to apply for the benefit, are familiar to many families living in poverty. But they are more frequent and more difficult for families who are new to the community and whose language and culture are different from the majority language or culture.

There are federal rules that should decrease the barriers: Federal Medicaid regulations require all states that receive federal Medicaid funds to provide or pay for transportation for Medicaid beneficiaries who cannot obtain transportation to and from medical appointments.^x The rationale for this benefit is that providing health coverage for low income children and families is of little use if families cannot access medical appointments. According to a report by the Community Transportation Association of America, states spend approximately one percent of their Medicaid budgets on transportation programs. These programs transport approximately four million people (or ten percent of the Medicaid population) to medical appointments^{xi}. Although states have great flexibility in designing their transportation benefit, they are required to utilize the least expensive, most appropriate mode of transportation for beneficiaries.

Pennsylvania receives (“draws down”) federal matching dollars to fund transportation services. The federal government provides fifty cents for every dollar the state spends on health care transportation. Similar to all Medical Assistance benefits, transportation services are available to all enrollees as long as it is medically necessary (meaning that the patients need transportation in order to access health care services).

Most states include the transportation benefit as part of their Medicaid application; Pennsylvania does not: Pennsylvania is one of very few states that requires a separate MATP application. Families self declare their need for the service on the application. The application varies by county with Philadelphia’s application being especially lengthy and requiring information which is already recorded and readily available through the Medical Assistance program’s electronic eligibility verification system.

Few Medicaid recipients’ use the service and, a very small share of those who do, are children: In Philadelphia, the exclusive Medical Assistance Transportation Program (MATP) provider is Wheels of Wellness, which reimburses eligible families for tokens or mileage costs and

provides van service (paratransit) to transport persons to and from medical appointments. According to Wheels of Wellness, they provide approximately 5,000 van trips and 6,000 reimbursed trips (this includes rides on public transportation as well as mileage reimbursement for a private car) each day. The majority of the van trips, approximately 60 percent, are for adults being transported to and from mental health appointments. Approximately 800 children with caregivers (16 percent of total users) utilize MATP vans to get to health care appointments in the Philadelphia area each day.

The Cost of Providing Medical Assistance Transportation

Statewide Medical Assistance Transportation Program expenditures have increased 65.07 percent from \$36,708,703 in 98-99 to \$60,595,081 in 02-03. In the same time period, MATP clients have increased 18.05 percent from 63,260 to 74,677 and the number of trips has increased 53.33 percent. In Pennsylvania as a whole, the percent of all eligible Medicaid recipients using MATP has been increasing from 2.92 percent in 96-97 to 4 percent in 02-03.

We were not able to obtain reliable data for Philadelphia, but The Department of Public Welfare estimates are that approximately four percent of Medicaid recipients in Philadelphia use the Medical Assistance Transportation Program. Expenditures for Philadelphia's Medical Assistance Transportation Program have increased from \$18,792,149 in '98-99 to approximately \$26,000,000 in '04-05. Philadelphia accounts for 37 percent of all MATP dollars in Pennsylvania.

The Process of Accessing Medical Assistance Transportation

In most regions of Pennsylvania, Medicaid recipients in need of transportation assistance must rely on van service or paratransit because there is little to no public transportation system. Philadelphia, however, has a vast public transportation system. Yet 45 percent of all MATP trips are on paratransit. Paratransit trips cost MATP approximately \$40 roundtrip while roundtrip reimbursed trips on public transportation cost a maximum of \$5.20. Monthly passes for unlimited use of public transportation would cost \$70.00.

Although many disabled and senior Medicaid recipients are in need of paratransit services, people we interviewed from The Department of Public Welfare believes that many recipients are choosing to use paratransit rather than public transportation because the process for token reimbursement is arduous.

After completing the MATP application Medicaid recipients are then required to complete a claim form with the date of treatment, name of the medical provider visited, public transportation route and fare (or miles per round trip, if using a privately owned vehicle) and signatures from the medical provider. This form must then be turned in to the MATP office for reimbursement, after which a check will be mailed to the Medicaid recipient. By contrast, accessing paratransit only requires Medicaid recipients to have their health care provider complete a form stating that they need van service to and from medical appointments. The Medicaid recipient then just calls the Philadelphia MATP provider to schedule rides.

In response to these findings, we recommend steps be taken to improve outreach and information, simplify the application process and improve the transportation system.

Recommendations:

Outreach Recommendations

- The Philadelphia MATP provider should develop and distribute MATP brochures in appropriate languages.
- The Department of Public Welfare should send out MATP information or brochures to all families at enrollment.
- The Department of Public Welfare should require Medicaid managed care organizations (MCOs) to send out MATP information to all enrollees.
- The Philadelphia MATP provider should place informational kiosks around the city to provide information on MATP (similar to what has been done in other cities such as Pittsburgh).

Usage Recommendations

- The Philadelphia MATP provider should simplify the process of receiving reimbursement for tokens and explore offering the option of monthly public transportation passes to Medicaid recipients who utilize paratransit on a regular basis.
- The Philadelphia MATP provider should work with the state to develop a system for reimbursing families for tokens for siblings to travel to medical appointments where necessary.
- The Philadelphia MATP provider should allow siblings to travel to medical appointments when needed.
- The Philadelphia MATP provider should undertake the following pilot projects:
 - Allow providers to give tokens to families eligible for MATP (providers would then be reimbursed rather than families).
 - Allow a children's hospital to oversee the transportation program for its patients in order to decrease their no-show rate.
- The Philadelphia MATP provider should simplify its phone message so families can better understand how to make a reservation, file a reimbursement claim etc. The provider should also add prompts in other languages.

Application Recommendations

- The Department of Public Welfare should add a MATP check off box to the Medical Assistance application to eliminate the current MATP application^{xii} OR
- The Department of Public Welfare should add a requirement that MATP providers have applications available in other languages which correspond to the requirements placed on HealthChoices managed care plans AND
- The Philadelphia MATP provider should simplify Philadelphia's MATP application.

II. Barriers to Accessing Health Care: Language Barriers

“Understanding what’s going on, being able to ask for help, being able to comply with treatment – I need my patients to do all of that. But, when they do not speak English well, they usually can’t and we run into difficulties.” - A Pediatrician with many Chinese-speaking patients.

English proficiency has a significant impact on disparities in insurance coverage, access to care, and quality of care. One study found that a language barrier is as significant as lack of insurance in predicting non-English speakers’ use of health services^{xiii}. Language barriers impact families’ health care experience in terms of the patient/physician relationship, leaving many parents uncomfortable with their children’s health care providers. In addition, parents with no or limited English proficiency are less likely to be aware of other kinds of medical services and how to access them. They are likely to have difficulty making appointments and communicating with medical support staff, and are less likely to access preventative services. And health care is avoided or postponed in many instances because the families do not feel welcome or understood when they need health care.

“No doctor has ever told me I can get an interpreter.” - A Vietnamese-speaking father.

“I was never told I could get someone to interpret. I thought I always had to bring someone.” – A Chinese-speaking mother.

Most families reported that interpreters were never provided. Of the 100 families we surveyed, 48 percent of Vietnamese-speaking families and 50 percent of Chinese-speaking families said they had never been offered an interpreter at their child’s pediatric office. Not only was an interpreter not offered, 62 percent of Vietnamese-speaking families and 47 percent of Chinese-speaking families reported sometimes or always being asked to bring an interpreter. Few of the respondents in PCCY’s surveys, focus groups or interviews knew that interpretation services should be made available by their health care provider.

Although there is consensus that children should not be used as interpreters for families, too many parents continue to ask children to interpret at medical appointments. Because parents are the health care decision-makers, effective communication between parents and medical providers is vital to the quality of care and subsequent outcomes for children. Miscommunications with limited-English proficient parents or the use of untrained interpreters can lead to a host of serious issues including: privacy violations, misdiagnosis, medical errors, misunderstandings about medical instructions and prescription labels, and even death.

In one study, parents with limited English proficiency cited language barriers as the cause of misdiagnoses, poor medical care, and inappropriate medications and hospitalizations of their children^{xiv}. Although there are many problems with using children as interpreters, we found the practice all too common. In fact, 37 percent of Chinese respondents and 32 percent of Vietnamese respondents reported sometimes or always using a child as an interpreter at medical appointments.

Most of the Chinese and Vietnamese-speaking families interviewed for this report stated that finding a practitioner who speaks their native language is a top priority when choosing a doctor. One mother said, *“I first had an American doctor who took care of my child but I could not talk to him or understand him. Many times I have to ask other Vietnamese friends or my older children who can speak English to help me with the interpretation but I also found a very difficult time when none of them were available to help me. Also they often said that they were not familiar with medical terms. Then I changed to a Vietnamese doctor.”* Many respondents sought, but were unable to find a physician who spoke their language. But some families were successful. Our survey results showed that 66 percent of Chinese-speaking parents have a Chinese-speaking pediatrician and 45 percent of Vietnamese-speaking parents have a Vietnamese-speaking pediatrician.

When asked whether or not they understand what their doctors who do not speak their native language say to them regarding their children’s diagnosis and treatment plan, only 16 percent of Vietnamese-speaking and 33 percent of Chinese-speaking families said they always understand. Eighty-six percent of Vietnamese-speaking and 67 percent of Chinese-speaking families said they rarely or never understand what their children’s doctor is telling them. While speaking about this problem, one mother said, *“My daughter has a liver problem and needs to have care at the hospital, but I never really understand what they are doing or what the problem is. It makes me very scared.”*

Respondents also expressed concern about understanding their doctor’s orders as they relate to medications. Because it is difficult to find a Chinese or Vietnamese-speaking pharmacist in Philadelphia, and medication labels are printed in English, many families were unsure of how to administer their prescriptions. In fact, 17 percent of Chinese-speaking and 16 percent of Vietnamese-speaking families said they rarely or never understand how to give their children the medications they are prescribed.

As of 2000, 47 million U.S. residents, approximately 17 percent of the population, spoke a language other than English at home^{xv}. According to the 2000 U.S. Census, almost 13,000 Philadelphians do not speak English at all and another 66,000 are living in households classified as linguistically isolated^{xvi}.

Entities (including hospitals) that receive Federal money have a responsibility to provide interpretation assistance to all patients with limited English proficiency (LEP) under Title VI of the Civil Rights Act of 1964, but the provision of interpreters is not standard practice. In many cases, providers have relied on patients’ English-speaking children or on non-medical personnel for translation. In fact, the Commonwealth Fund’s 2001 Health Care Quality Survey^{xvii} found that of those nationally who needed an interpreter, only half reported that they always or usually received one^{xviii}.

The survey found that when an interpreter was provided, it was usually a family member or friend (43 percent) or a staff person (56 percent) at the health care facility. Only 2 percent of respondents reported that they received a trained interpreter.

The costs and difficulties of developing an adequate response to the health care access barriers presented by language and culture are many. While ideally specially trained interpreters

would be available when needed, this practice appears to be under-utilized even in large health care settings. The cost of providing professional interpreters for a number of languages in many instances has resulted in either using other employees who speak the needed language, often without training, or family members- particularly children, or other inadequate and makeshift responses. And there are no statewide standards or certification programs for medical interpretations. This results in medical interpreters with varying degrees of experience and expertise.

Recommendations:

There are not easy answers for this complex issue but there are some things that we as a community should do to improve the likelihood of children of immigrants securing the health care they need. Basically, our recommendations fall into several categories: employing different strategies to increase the availability of interpretation and translation services, including increasing the funding available for these services; improving outreach to families with limited English proficiency; clarifying the responsibilities for informing and providing language appropriate services; and developing more welcoming environments for language minorities.

- Pennsylvania should apply for federal matching dollars to help pay for interpretation services (see attachment for fact sheet on drawing down federal matching dollars).
- DPW should modify the contracts with MCOs to clarify roles and responsibilities in providing language appropriate services^{xix}.
- DPW should monitor the implementation of interpretation/translation requirements in MCO contracts
- DPW should require that MCOs develop comprehensive written LEP plans
- DPW and MCOs should provide information to consumers in their primary language about access to interpreter services.
- DPW and MCOs should provide information to health care providers about their responsibility to provide interpretation. .
- The state should develop a plan to increase the number of medical interpreters.
- DPW and MCOs should provide information to families and providers about reasons not to use children as interpreters.
- MCOs and other providers should coordinate the delivery of interpretation services.
- Pennsylvania should develop standards and a certification program for medical interpreters.
- MCO's and the state should pilot strategies such as using technology for translation assistance or developing networks to support interpreter services.

The Role of Children's Hospitals

“The sea is so big and my boat is so small”
- The Children's Defense Fund

Hospitals are generally large institutions- and your child is small. The act of taking your child to be cared for in such a big, complex place can be daunting. If you don't speak the same

language as the majority of people there speak, if you don't see signs or cultural expressions that welcome you in your language - you and your child feel even smaller. With few exceptions, Philadelphia's hospitals do not make an overt effort to create a welcoming climate to non-English speakers

As part of this project, we spoke with staff at Philadelphia's three children's hospitals to better understand the practices, policies, and programs in place to address the needs of patients and families with limited English proficiency. Although all three hospitals expressed concern about addressing the needs of increasing numbers of families with limited English proficiency, they have each utilized different strategies, with varying levels of success, to meet these needs.

All three children's hospitals have written policies regarding language interpretation services. These policies provide guidelines for employees about appropriate practices for interpretation services (ie. that patients and other minors should not be used as interpreters). In addition, all three hospitals have some in-person interpretation available as well as contracts with one of the phone interpretation services. It is important to note, however, that utilization rates of the phone interpretation services vary widely. In other words, just because a hospital has interpretation services, does not mean they are being used – this is often due to staff and patients not knowing about these services.

Although the hospitals have written policies and all have some interpretation services available, we found that not all employees know how or when to use interpretation services. In addition, many employees still do not know that interpretation should be available to all patients regardless of the language spoken. The hospitals are working to raise employee awareness about the telephone service, and educating employees about language access services in general. One hospital has placed language service information stickers on all hospital phones. This sticker explains that patients can access an interpreter or language assistance and outlines how to connect to the language line. This hospital has also offered trainings for physicians, department heads, and resident physicians about interpretation services and all new employees receive information about interpretation services during orientation. All three children's hospitals recognize the need to increase provider awareness of the availability of language interpretation services

In addition to informing providers about the interpretation services offered at the hospital, patients need to be educated about their right to language assistance. Recognizing that patients should not have to ask for an interpreter every time they come to the hospital, one hospital is developing a plan to put stickers in patient files that would indicate the language spoken and provide the appropriate telephone service phone number.

Educating patients about their right to language assistance is just the first step. Patients also need vital information translated into their primary language. While all three hospitals have created handouts to inform patients before being admitted to the hospital about their right to language assistance, much more needs to be done. All three children's hospitals lack adequate signage in languages other than English. While some signs are translated into Spanish in two of the hospitals, signage explaining how to navigate the hospital needs to be more prominent and widespread.

The largest children's hospital in the region has recently undertaken a large initiative to decrease barriers for families with limited English proficiency. This initiative includes having full time interpreters on staff, increasing staff awareness of the availability of telephone interpretation services, translation of vital documents and patient education information into the six primary languages spoken by patients and developing "I Speak" cards for patients to hand to any hospital employee for assistance in connecting to an interpreter.

"We know we have to give patients interpreters, but it is not cheap."
- An administrator at a local children's hospital.

In order to work around the high costs of providing interpretation services, one of the children's hospitals has developed a language bank with employees who complete a self-assessment. There is concern among patient advocates about this type of program because the interpreters are not being trained in medical interpretation. Recognizing this problem, another one of the hospitals is developing what they call a "high-quality employee language bank system." They are developing a language proficiency test to screen employees who wish to volunteer for the language bank. They are also planning to train qualified employees in medical interpretation and then pay employees a minimal fee when they provide interpretation assistance.

According to federal law, entities that receive federal funds must offer and provide language assistance services at no cost to each LEP patients. The most recent HHS guidance recognizes the need for flexibility in the provision of language services but calls on recipients of federal funds to: (1) assess the language needs of their patient populations; (2) develop written policies on how these populations can obtain language services (oral and written); (3) avoid using minor children, friends, and family to interpret; (4) have methods for notifying persons of their right to language services; (5) monitor the policies; and (6) train staff for effective implementation of these policies.

Section 601 of Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d, provides that no person shall "on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance^{xx}. One type of national origin discrimination is discrimination based on a person's inability to speak, read, write, or understand English. Department of Health and Human Services regulations forbid recipients from "utilizing criteria or methods of administration which have the effect of subjecting individuals to discrimination because of their race, color, or national origin, or have the effect of defeating or substantially impairing accomplishment of the objectives of the program with respect to individuals of a particular race, color, or national origin." Recipients of Federal funding are required to take reasonable steps to ensure meaningful access to their programs and activities by LEP persons. While designed to be a flexible standard, the starting point is an assessment that balances the following four factors: (1) The number or proportion of LEP persons eligible to be served or likely to be encountered by the program or grantee; (2) the frequency with which LEP individuals come in contact with the program; (3) the nature and importance of the program, activity, or service provided by the program to people's lives; and (4) the resources available to the grantee/recipient and costs. The intent of the guidance is to ensure meaningful access by LEP persons to critical services while not imposing undue burdens on small business, small local governments, or small nonprofits. When considering the number or proportion of LEP individuals in a service area, Federal fund recipients should consider whether the minor children

their programs serve have LEP parent(s) or guardian(s) with whom the recipient may need to interact.

HHS suggests that Federal fund recipients carefully explore the most cost-effective means of delivering quality language assistance services before limiting services due to resource concerns. Large organizations and those entities serving a significant number or proportion of LEP persons should ensure that their resource limitations are well-substantiated before using this factor as a reason to limit language assistance.

Most experts agree that hospital language assistance programs will only work if there is an organization-wide commitment and comprehensive, written policies on language access procedures^{xxi}. Hospital policy should outline procedures for publicizing the right to and availability of free language assistance; identifying and assessing the language needs of all patients; determining the types of language interpretation models the hospital will use in various situations (e.g., determine if in-person interpretation will be used for specific languages); guiding staff in providing the appropriate type of interpreter service; assuring proper documentation of LEP patient encounters; communicating with LEP patients by telephone; translating written material; training and assessing staff; and collecting data about language needs.

Recommendations

We recognize that providing language access services is costly and that there are many complexities involved, but there are many steps that the three children's hospitals could take to improve language access for patients and families. We recommend that:

- The hospitals have prominent signs present in intake and other entry areas that state, in multiple languages, that interpretation services are available.
- The hospitals have "I speak" cards available in multiple languages that allow patients and families to point to the language they speak and to request an interpreter.
- All important signs and documents, such as consent forms, are to be translated and available in the most commonly encountered languages (HHS recommends translation of documents for each language group that constitutes five percent or 1,000, whichever is less, of the population of persons eligible to be served or likely to be encountered)
- The three hospitals consider hiring in-house interpreters for the most commonly encountered languages.
- Hospitals require employee language bank participants to be proficient in the language they will be interpreting and to be trained in medical interpretation
- Hospitals develop appropriate ways to identify who needs translation services and ensure that once a person has been identified as having LEP or requested an interpreter or translated material, the person does not need to request assistance again
- Employees be continuously trained and reminded regarding patient's rights to language assistance
- The hospitals support efforts to draw down federal matching funds to help pay for interpretation and translation services
- Hospital staff at the three children's hospitals visit and seek advice from institutions that are recognized for ensuring access for families with limited English proficiency such as Delaware County Memorial Hospital's Cultural Connections Collaborative Program.

Where Do We Go From Here With Language Access?

The problem is apparent – without high quality interpretation and translation services, immigrant children and their families are less likely to access health care and are more likely to be in poor health. If we are to adequately address the problem, we need to work together to ensure that families with limited English proficiency have access to translated materials and interpreters in the health care setting.

Recommendations:

We recommend that:

- Advocacy agencies work together to strengthen and clarify local, state and national policies to support and enhance interpretation and translation services
- Hospitals and other large health care institutions create model programs to provide a positive, welcoming environment for language minority patients.
- Local and State agencies, health care providers, hospitals and advocates work together to secure additional funding and pilot strategies for broader use and access to interpretation and translation services
- States develop mechanisms for collecting and reporting information on performance of MCOs in providing interpretation and translation services
- MCOs develop ways for small and medium size providers within their networks to access interpreter services (perhaps allowing providers access to the MCO's language lines)
- States better advertise information pertaining to families' rights to language assistance in health care settings
- States should develop programs to increase the pool of trained medical interpreters
- MCO's and states should explore utilizing technology (such as internet interpretation) to increase access to interpretation services.

Advocacy Report

During the research for this report, Philadelphia Citizens for Children and Youth (PCCY) undertook advocacy to improve the Medical Assistance Transportation Program and increase interpreter and translation services to families insured through Medicaid. In October, 2004 PCCY conducted a forum entitled *Barriers to Health Care for Children on Medicaid*^{xxii}, which drew over 150 attendees, including speakers from each of the three children's hospitals, the Pennsylvania Department of Public Welfare and the Pennsylvania Department of Health.

In addition, we are pleased to report the following advances:

- The Philadelphia MATP provider simplified their phone message and added prompts in one language (Spanish) which connects callers directly to someone who can assist them in applying for and utilizing the transportation benefit.
- The Philadelphia MATP provider applied for a waiver from the Department of Public Welfare to reimburse families for tokens for siblings to travel to medical appointments.

- The Philadelphia MATP provider simplified the MATP application for Medicaid recipients requesting token reimbursement.
- The Philadelphia MATP provider developed a policy to allow siblings to travel on paratransit trips as long as there is room on the van.
- The Department of Public Welfare is completing a comprehensive brochure describing the Medical Assistance Transportation Program
- The Department of Public Welfare has urged The Philadelphia MATP provider to begin utilizing monthly public transportation passes for regular users of MATP services.
- The Department of Public Welfare adopted most of our recommendations to simplify the Medical Assistance Transportation Program in Philadelphia and used the recommendations to draft a Request for Proposals for a new transportation contract for the City.
- The Pennsylvania Health Law Project with assistance from PCCY drafted sample contract language for use between the Department of Public Welfare and Medicaid managed care companies (see attachment). This contract language is currently under review by the Department of Public Welfare, which has indicated that the concepts, if not the precise language, will be incorporated into the next managed care contract.
- The Department of Public Welfare wrote its first policy statement on services to families with limited English proficiency.

Conclusion

The children of Pennsylvania’s increasing non-English-speaking populations are entitled to many important public benefits including Food Stamps, Medical Assistance or CHIP, and TANF (welfare), providing that their families are income eligible. We know, however, that many of these families do not access the supports that would help them. The problem of uninsured children in our region and state does not result exclusively from the lack of available health coverage. Health coverage – free or reduced-cost – is increasingly available to low and moderate income children in Pennsylvania, and throughout the nation. And yet we know that compared with children of those who are native born, children of immigrants are more than three times as likely to lack a usual source of care, and they are more than twice as likely to be reported in fair or poor health^{xxiii}.

This study was conducted to begin understanding why children from families with limited English proficiency, particularly families who speak Vietnamese or Chinese, are not accessing health care at the same rate as native born, English-speaking families. In focus groups and surveys, families cited two important barriers to accessing health care for their insured children – language and transportation. Many families reported not understanding how to access care, not being offered language assistance and being unsure of their child’s diagnosis and treatment plan. In addition, we learned that transportation barriers often keep families from accessing health care for their children. Unfortunately, few families know about Medicaid’s transportation program, and, of those families who are aware of the program, few are using it because of difficulties accessing the benefit.

We have highlighted many recommendations that can bring us closer to meeting the needs of Philadelphia families with limited English proficiency including securing more federal dollars to help pay for interpretation and translation services, increasing access and outreach, streamlining the Medicaid transportation program, increasing interpretation and translation services at the children’s hospitals and other large health practices and having managed care organizations play a larger role in providing interpretation services and translated materials.

We began assuming that families did not know that benefits were available to them; we found that to be true. But we learned more and substantiated that which we had assumed. Even among this selected group, i.e. children of families who had been reached and had their children enrolled in Medical Assistance, we found a need for better and clearer information and outreach. We also found that health care professionals, institutions and managed care organizations have not developed and put into place strategies to responsibly, yet practically, respond to the needs of language minority children. In the next several years, we hope that this country which is a nation of immigrants, a medical pioneer and a leader in innovation, will develop and support new ways to respond to old issues: helping new Americans adopt to and become a part of the fabric of their new home.

Endnotes

ⁱ The issue of insurance for immigrant children, who, because of immigration status do not qualify for Medical Assistance, is beyond the scope of our inquiry here.

ⁱⁱ The term “immigrant children” is being used to signify immigrant children and U.S. born children of immigrants. A major difference between the two groups is that U.S. born children of immigrants are U.S. citizens and citizenship affects access to health insurance. In the state of Pennsylvania, U.S. citizens and legal immigrants can be eligible for Medicaid and CHIP. Both groups are affected by parent’s citizenship, education, and income and face similar health access issues.

ⁱⁱⁱ 1997 Current Population Survey, U.S. Census Bureau.

^{iv} It is generally recognized that the U.S. Census numbers undercount immigrant populations.

^v We recognize that the Chinese and Vietnamese populations are not homogeneous and there is heterogeneity within and between the groups. There is a relative lack of studies that focus on disaggregated Asian subgroups, especially on populations that have arrived more recently.

^{vi} *Low Income Children of Immigrants More Likely to Live in Two-Parent Families*. The Urban Institute. 2002

^{vii} (<http://www.urban.org/Template.cfm?NavMenuID=24&template=/TaggedContent/ViewPublication.cfm&PublicationID=7349>)

^{viii} The Commonwealth Fund. 2001. Quality of Health Care for Asian Americans: Findings from the Commonwealth Fund 2001 Health Care Quality Survey.

^{ix} *Language Access: Helping Non-English Speakers Navigate Health and Human Services*. National Conference of State Legislatures. Jan 2003.

^x 42 Code of Federal Regulations Sections 431.53 and 441.62

^{xi} Managing Medicaid Transportation: A Manual Examining Innovative Service Delivery Models Under State Medicaid Managed Care Plans <http://www.ctaa.org/pubs/medicaid/fulltext.asp>

^{xii} The only information needed by the MATP program not currently captured on the Medical Assistance application is whether or not the applicant is in need of transportation assistance, and, if so, what type of assistance is needed (paratransit versus reimbursement).

^{xiii} Derose, K. P. & Baker, D. W. 2000. Limited English Proficiency and Latinos’ Use of Physician Services. *Medical Care Research and Review*, 57, p. 76.

^{xiv} Flores G, Abreau M, Olivar M, and Kastner B. 1998. Access Barriers to Health Care for Latino Children. *Archives of Pediatric and Adolescent Medicine*. Vol. 152, 119-1125.

^{xv} U.S. Census Bureau; “GCT-P1. Urban/Rural and Metropolitan/Nonmetropolitan Population: 2000. Census 2000 Summary File 1 (SF 1) 100-Percent Data.”

^{xvi} U.S. Census Bureau; “QT-P17. Ability to Speak English: 2000. Census 2000 Summary File 3 (SF 3) Sample Data.” Figures are for population five years of age and older. The Census Bureau defines a linguistically isolated household as one in which no member 14 years old and over (1) speaks only English or (2) speaks a non-English language and speaks English “very well.” In other words, all members 14 years old and over have at least some difficulty with English.

^{xvii} The Commonwealth Fund. 2001 Health Care Quality Survey.

^{xviii} National Conference of State Legislatures. January 2003. Language Access: Helping Non-English Speakers Navigate Health and Human Services.

^{xix} See attached Recommended Contract Language developed by Pennsylvania Health Law Project with input from Philadelphia Citizens for Children and Youth

^{xx} National Standards for Culturally and Linguistically Appropriate Services in Health Care, U.S. Department of Health and Human Services, Office of Minority Health, Washington D.C. <http://www.hhs.gov/ocr/lep>

^{xxi} Massachusetts Office of Minority Health. Best Practice Recommendations for Hospital-Based Interpreter Services. <http://www.state.ma.us/dph/bhqm/2bestpra.pdf>

^{xxii} Please see attachment for a copy of the forum Powerpoint Presentation

^{xxiii} (<http://www.urban.org/Template.cfm?NavMenuID=24&template=/TaggedContent/ViewPublication.cfm&PublicationID=7349>)