

Promising Practices to Improve Immigrants' Health and Well-Being

Health is a cornerstone of immigrant integration as much as education and learning English. If a family has health insurance for their children, then those children are in school learning and not home sick. Their parents don't have to miss work as often and can stabilize their family financially. Medical bills are the number-one cause for bankruptcy, so this is also about protecting the family against the financial difficulty that comes along with being uninsured."

—Laura Hogan, Program Director, Access to Health Services
The California Endowment

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INTRODUCTION

When immigrants arrive in the United States, they are generally healthier than native-born residents. However, over time, their health conditions converge with those of the general population. Acculturation to American lifestyles and dietary habits may account for part of this change, but immigrants also face a number of barriers to maintaining good health. As a group, they are much less likely than citizens to have health insurance, resulting in less access to preventive services, fewer regular check-ups, and ultimately poorer health outcomes.¹ Even when newcomers are eligible for health insurance, they

often face a variety of language, cultural, and immigration-related barriers that limit their access to quality care.

Maintaining good health is a critical element of immigrant integration. It is fundamental to newcomers' ability to find and keep jobs, learn English, and contribute to the vitality of their new communities.

Foundations can support programs that expand both eligibility and access, as well as reduce barriers to health care for newcomers, including:

- Policy and advocacy projects to expand health insurance coverage for immigrants and their children.
- Outreach and informational campaigns to educate immigrants about the U.S. health care system, their eligibility for health care services, and healthy behaviors.
- Efforts to deliver health services to immigrants in a linguistically and culturally competent manner.

By supporting these strategies, foundations will promote good health for immigrant families and enable newcomers to contribute to the overall well-being of the broader community.



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1. Grantmakers In Health. 2005. *For the Benefit of All: Ensuring Immigrant Health and Well-Being*. Washington, D.C.: Grantmakers In Health. Available at www.gih.org.

BARRIERS TO HEALTH AND WELL-BEING

This section provides a brief overview of the health care barriers faced by many newcomers, as well as promising practices to overcome these challenges.

LOWER RATES OF HEALTH INSURANCE

Immigrant families are much less likely than citizens to have health insurance for a number of reasons:

- **Less coverage from employers.** While over 80 percent of immigrants have families that include at least one full-time worker, a disproportionate number is employed by small firms or low-wage sectors which are less likely to offer health benefits.
 - **Ineligibility for federal health insurance programs.** The 1996 federal welfare and immigration laws bar most legal immigrants from Medicaid and the State Children's Health Insurance Program (SCHIP) in their first five years in the United States. (The few exceptions to this bar include refugees and political asylees). After five years, most remain ineligible due to "sponsor deeming," which adds the income of the person who sponsored the immigrant to that of the immigrant in determining eligibility.
 - **Very limited access to public health insurance for undocumented immigrants.** Although some states have begun to offer prenatal care and children's coverage to this population, federal and state laws generally bar undocumented residents from Medicaid and other programs except for emergency care.²
 - **Unfamiliarity with public health insurance programs.** This unfamiliarity results in low rates of participation even among those eligible, particularly the citizen or legal-resident children of immigrants.³
- For immigrants, this low rate of coverage means that they are less likely to have a usual source of care, have visited a doctor during the previous year, or receive immunizations and other

preventive services.⁴ Although few studies have examined the long-term effects of being uninsured among immigrant populations, research on Latinos participating in SCHIP and Medicaid consistently finds that enrollment, even for short periods of time, leads to better health outcomes.⁵

ACCESS BARRIERS TO HEALTH SERVICES

While providing health insurance is the first step to improving immigrants' health, the availability of insurance coverage, by itself, does not automatically lead to greater utilization of health services. Newcomers also face access barriers related specifically to their status as immigrants or their limited English proficiency. These include:

- **Confusion about program eligibility and how to use the U.S. health care system.** Health systems in immigrants' home countries often differ significantly from the U.S. system. Different eligibility requirements for various federal and state health programs add to the confusion, particularly in mixed-status families, in which some members may be eligible for coverage and others may not, depending on their immigration or citizenship status.
- **Fears about consequences for immigration status.** Many immigrants are reluctant to use any publicly funded health programs because they are afraid of adverse immigration consequences even though most of their concerns are unfounded. Common fears include:
 - *Being labeled a "public charge,"* which can result in difficulties obtaining permanent residency ("green card"), re-entering the country, or sponsoring a relative. This concern deters many from seeking care, despite the fact that receipt of non-cash benefits, such as Medicaid and other publicly funded health programs, are not a factor in public charge.⁶
 - *Making an immigrant's sponsor financially liable for the immigrant's use of public health programs.* No state has prioritized seeking reimbursement from sponsors in these situations.⁷

- *Providing sensitive information about family members that could lead to deportation or other negative immigration consequences.* The verification and reporting requirements in some states' application processes raise concerns that confidential information will be shared with immigration enforcement officials.

- **Language and cultural barriers.** Approximately half of all foreign-born adults in the United States speak English with some limitations,⁸ and many come from cultures that have very different attitudes toward illnesses and medicine. These differences can create barriers to applying for health coverage and communicating with health care providers.⁹

2. For details on health programs for which undocumented immigrants qualify, see National Immigration Law Center. 2004. *Guide to Immigrant Eligibility for Federal Programs*. Los Angeles, CA: National Immigration Law Center. Available at www.nilc.org.

3. Staudt, Kathleen and Randy Capps. 2004. "Con la ayuda de Dios? El Pasoans at the Border." In Philip Kretsedemas and Ana Aparicio, eds. *Immigrants, Welfare Reform, and the Poverty of Policy*. Westport, CT: Praeger.

4. Fremstad, Shawn and Laura Cox. 2004. *Covering New Americans: A Review of Federal and State Policies Related to Immigrants' Eligibility and Access to Publicly Funded Health Insurance*. Washington, D.C.: Henry J. Kaiser Family Foundation.

5. Shone, Laura, Andrew Dick, Jonathan Klein, Jack Zwanziger, and Peter Szilagyi. 2005. "Reduction in Racial and Ethnic Disparities After Enrollment in the State's Children's Health Insurance Program." *Pediatrics* 115(6): 697-705; Ku, Leighton. 2005. *Medicaid: Improving Health, Saving Lives*. Washington, D.C.: Center on Budget and Policy Priorities.

6. Fremstad and Cox, 2004.

7. National Immigration Law Center. 2005. *Overview of Immigrant Eligibility for Federal Programs*. Los Angeles, CA: National Immigration Law Center. Available at www.nilc.org.

8. Capps, Randolph, Michael Fix, Jeffrey Passel, Jason Ost, and Dan Perez-Lopez. 2003. *A Profile of the Low-Wage Immigrant Workforce*. Washington, D.C.: Urban Institute.

9. A more detailed overview of the impact of these barriers, related language access legal requirements, and strategies for overcoming these barriers can be found in the "Promising Practices in Language Access" section.



SECURING STATE-FUNDED SERVICES

California Immigrant Welfare Collaborative
Los Angeles, California
www.caimmigrant.org

The work of the California Immigrant Welfare Collaborative (CIWC), a partnership among four organizations, has made California a model for providing health and social service programs for low-income immigrants. The 1996 federal welfare and immigration laws restricting newcomers' access to public health and social service programs had a particularly harsh impact on California. While an estimated 40 percent of the immigrants affected by the new restrictions resided in the state, no single organization had the capacity to develop a statewide response. Funding from The California Endowment, The California Wellness Foundation, the Ford Foundation, and the David and Lucille Packard

Foundation made it possible for a core group of legal and community-based organizations (Asian Pacific American Legal Center, Coalition for Humane Immigrant Rights of Los Angeles (CHIRLA), National Immigration Law Center, and Northern California Coalition for Immigrant Rights) to form CIWC.¹¹ In its first years, CIWC documented the harmful effects of these federal restrictions and developed into a statewide network that successfully advocated for the continued provision of public health care and social services to immigrants.

Over the course of several years, CIWC played a pivotal role in securing what the Urban Institute has described as one of the most "generous" and "comprehensive" state-funded safety nets for immigrants who lost eligibility for federal programs.¹² With state funding, California's Medicaid and SCHIP programs have remained available to all immigrants who would have been eligible prior to 1996. In addition, the state

created new food and cash assistance programs for immigrants who lost eligibility for federal Food Stamps and Supplemental Security Income (SSI), as well as a state-only cash assistance program for legal immigrants who became ineligible for federal Temporary Assistance for Needy Families (TANF). CIWC also helped preserve prenatal care for low-income women regardless of immigration status.

CIWC's success is especially striking in that it came shortly after the passage of the anti-immigrant state ballot measure Proposition 187,¹³ which proposed to restrict immigrants' access to education and public benefit programs. However, rather than allowing Proposition 187 and federal welfare laws to paralyze immigrant communities, CIWC and other advocates used these harsh measures to build and mobilize support for newcomers. A key strategy was to increase the visibility and involvement of affected communities in policymaking. Several factors contributed to CIWC's success:

- **Rapid response and multi-year support by funders.** Early recognition by funders of the developing crisis created by the 1996 laws made it possible for CIWC to launch a rapid, large-scale response. And multi-year foundation support gave CIWC the opportunity to advocate for incremental expansions of replacement programs that, over time, came to cover most immigrants who were no longer eligible for federal programs.

- **Combining policy analysis with community-based advocacy.** CIWC has been effective because its members have diverse and complementary skills, include broad-based immigrant rights

11. The current organizational members of CIWC have changed slightly with Services Immigrant Rights and Education Network (SIREN) joining in the early 2000s after the Northern California Coalition for Immigrant Rights discontinued operations.

12. Zimmerman, Wendy and Karen Tumlin. 1999. *Patchwork Policies: State Assistance for Immigrants under Welfare Reform*. Washington, D.C.: Urban Institute.

13. Proposition 187 was an initiative approved by California voters in 1994 that, among other things, prohibited undocumented immigrants from attending public schools and limited their access to public benefits programs. Proposition 187 never took effect; it was immediately enjoined by a federal court, which eventually ruled that the measure violated the U.S. Constitution.



coalitions in Northern and Southern California, and have access to a wide range of institutions and communities that can mobilize public support.

- **Extensive outreach to affected populations.** In its first three years, CIWC project staff traveled throughout the state and provided training on legislative changes to over 1,000 community organizations, ranging from large service providers to small, emerging immigrant groups. Staff also conducted workshops and presentations to more than 10,000 immigrants, where they both educated community members and brought them into the policymaking process.

- **Empowering community groups and immigrant leaders to participate in policymaking.** This began in 1997 with an annual “Immigrant Day” that brought up to 1,000 people to the state capital to share their concerns directly with policymakers. “The large size of these initial events,” recalls Susan Drake, then executive director of the National Immigration Law Center, “made a deep impression on policymakers, as many were only beginning to recognize that newcomers were a growing part of their constituencies.”

These activities, combined with growing representation of minority communities in the state legislature, created opportunities to build long-lasting support for increasing immigrants’ access to public health and economic security programs.

Ten years after its inception, CIWC continues to protect access and services for immigrants. With its extensive network and policy advocacy experience, CIWC emerged as the leading pro-immigrant voice in the state capital.

RESTORING HEALTH INSURANCE FOR LOW-INCOME IMMIGRANTS

Children’s Alliance
Seattle, Washington
www.childrensalliance.org

In 2002, the Washington State legislature responded to a budgetary crisis by cutting some of its health care programs, including eliminating three insurance programs for low-income individuals whose immigration status made them ineligible for Medicaid. These cuts affected over 28,000 people, 90 percent of them children. While individuals who lost coverage were eligible for the state’s Basic Health program, less than half enrolled because the program required monthly premiums and significant co-pays, offered fewer medical services, and provided few language access services.¹⁴

Although the cuts initially caught health advocates by surprise, they quickly developed a campaign to restore coverage for tens of thousands of children. Recognizing that Washington State has traditionally been a leader in expanding public health insurance coverage and

that the public was generally supportive of providing children with health services, Children’s Alliance and other advocacy groups developed a multi-year campaign to restore the cuts through the following strategies:

- **Developing a broad coalition of organizations and institutions** that supported restoring health insurance for immigrants, including local governments, community-based organizations, clinics, hospitals, and private businesses.

- **Working with health providers to identify individual stories that put a human face to the cuts.** These stories included children who were no longer able to receive preventive care or could not afford needed medical procedures.

- **Providing legislators and government officials with analysis of the cuts’ impact.** Children’s Alliance began publishing policy bulletins immediately after the cuts took effect, showing high numbers of children losing coverage. It also worked with researchers on a report (supported by the Henry J. Kaiser Family Foundation) that provided detailed analysis of the cuts’ harmful effects and true costs.¹⁵ The report showed that the “cuts” actually resulted in substantial cost shifting to county public health agencies and local clinics.

- **Developing public messages that promoted coverage for immigrant children as part of an overall campaign to increase health care coverage for all children.** Children’s Alliance found that its message resonated better with policymakers and the public as part of an effort to help all children, including U.S. citizens, who were losing health insurance because of recent budget cuts.

As a result of this campaign, the legislature and the governor restored the previously cut health insurance coverage for all children, including programs for immigrant children, regardless of immigration status. Research and advocacy played a key role in convincing

14. Gardner, Mark and Janet Varon. 2004. *Moving Immigrants from a Medicaid Look-Alike Program to Basic Health Insurance in Washington State: Early Observations*. Washington, D.C.: Henry J. Kaiser Family Foundation.

15. *Ibid.*

policymakers to reverse these cuts. As Liz Arjun of Children’s Alliance observes, “They may have initially thought their cuts would have minimal effect. But when we showed them that tens of thousands of children were no longer receiving regular medical care and the cost savings were minimal, they realized that taking health insurance away from immigrant children and children in general was a bad decision.”

PROMOTING COVERAGE FOR ALL CHILDREN

County and Statewide Approaches in California
www.insureallkids.org

“In polling, we’ve discovered that people understand that health coverage for all children is both the right thing to do and the smart thing to do.”

—Laura Hogan, Program Director,
The California Endowment

In 2000, government and community leaders in California’s Santa Clara County came together to determine the best way to allocate new monies that would be arriving from the Tobacco Settlement Fund. After considering various options, they identified a key priority: to make fundamental changes in the fragmented and confusing system that prevented many eligible children from enrolling in publicly funded health insurance programs.

The system was especially difficult for immigrant families, the majority of which have mixed immigration status. Depending on the children’s citizenship or immigration status, an immigrant family could have one child eligible for Medicaid, one child eligible for the State Child Health Insurance Program (SCHIP), and one child eligible for no publicly funded health coverage at all.

It became clear to these leaders that the County needed to create a more efficient, better coordinated system to increase both coverage and enrollment of qualified children. After more than a year of planning, the Children’s Health Initiative (CHI) was launched in 2001. CHI has three components: (1) health coverage for all children in Santa Clara County whose family income was under 300 percent of the federal poverty level and who were not currently eligible for existing Medicaid or SCHIP coverage; (2) expanded and coordinated outreach to increase enrollment; and (3) significant streamlining of enrollment processes across multiple public programs.

“What people inside the health system saw was that a lot of children who were eligible for programs were not enrolling because the system was so tough to navigate. They felt they had a responsibility to simplify the system and create an enrollment program that would really work,” says Laura Hogan, director of Access to Health Services at The California Endowment. In December 2005, The California Endowment awarded \$7.5 million in grants to local Children’s Health Initiatives in counties throughout California as part of its ongoing support of such efforts.

The initial idea in Santa Clara County originated at the grassroots. Two local advocacy groups—Working Partnerships USA, a labor-based research group, and the faith-based People Acting in Communities Together (PACT)—knew



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that the tobacco money would be coming in and quickly drew up a plan to provide health coverage to children whose family income and immigration status left them uninsured.

Although Medicaid and SCHIP cover children under 250 percent of the federal poverty level, there was nothing for children in families who earned more than that threshold yet too little to afford private health insurance. Ineligible for any publicly funded health coverage, undocumented children also fell through the cracks.

To implement the program, Working Partnerships USA and PACT partnered with the County Health Department, the First Five Commission, the Social Services Agency, the Santa Clara Health Plan, and officials at both the county and city levels. From the very beginning, the Children’s Health Initiative in Santa Clara has been a partnership between the private and the public sectors. While the proportion varies from county to county, all counties with a Children’s Health Initiative are public-private partnerships, supported by public funds as well as foundation grants and other private donations.

“In just about every county, it’s been a cooperative and collaborative effort on the part of a lot of different sectors, and that’s what makes it so powerful,” notes Rebecca Stark, program coordinator at PICO California, which is working to promote statewide health coverage for children.



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"It's a program for all kids, so immigration status doesn't become an issue."

**—Linda Baker, Program Officer
David and Lucile Packard
Foundation**

Under the CHI guidelines, all children up to the 300 percent of the federal poverty level are guaranteed health coverage, meaning that in 2006, a household of four can earn up to \$60,000 and still qualify. CHI, unlike the state's Medicaid and SCHIP programs, also covers undocumented children. "It's a program for all kids, so immigration status doesn't become an issue," says Linda Baker, program officer at the David and Lucile Packard Foundation.

The Children's Health Initiatives that many California counties have adopted also streamline a daunting application process. Under such programs, all income-eligible families, even those that include children in mixed-status families, fill out a single application with the assurance that all of their children will be enrolled in a health care program. Moreover, children in one family are able to see the same providers regardless of the program in which they are enrolled.

"When Santa Clara gave families a simple message that they could enroll in one place with one application, families did come in and enroll," Hogan says.

This strategy eliminated the confusion and intimidation that prevented many families from applying in the first place, significantly increasing enrollment in all three public health insurance programs. In its first two years alone, Santa Clara's Children's Health Initiative increased enrollment in Medicaid and SCHIP in the county by 28 percent.

Santa Clara County's success helped spur the creation of similar programs in 17 other counties, including, significantly, Los Angeles County which started an initiative in 2003 and already has enrolled 43,000 children. In all, these initiatives have provided coverage to more than 80,000 children in California

and assisted in enrolling another 80,000 in Medicaid and SCHIP. As of 2005, 90 percent of all children in California were insured, either through public or private insurance programs. In pioneering Santa Clara County, this statistic reached an impressive 98 percent.

Planning of similar initiatives in a number of other counties is underway. "The most important thing for a county to do when starting an initiative is to build the right coalition of people, and it has to be a broad coalition that includes business, teachers, health providers, and others," advises Hogan. "You have to have champions who really want to achieve this goal and believe in what's happening."

Hogan further explains, "In polling, we've discovered that people understand that health coverage for all children is both the right thing to do and the smart thing to do. Issues related to immigration status do not weigh heavily

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in the public's mind when considering the benefit of this policy change. The feeling is that they didn't come here of their own choosing, they are in society now, and they are here to stay."

In addition to addressing ethical and societal responsibility, having a Children's Health Initiative provides practical economic benefits.

"Investing in insurance for children, especially undocumented children, provides them with greatly improved access to care. And, the fact that CHI brings insurance to nearly all children pulls into the system many children who have been eligible for insurance but were not previously enrolled. This is smart fiscal policy," Baker says. She also notes that in 2001 and 2002, the evaluation of the Santa Clara initiative showed that the 28 percent increase in enrollment in the state's Medicaid and SCHIP programs has brought nearly \$25 million in federal and state dollars into the county, which local officials appreciate and need.

Although the initiatives vary slightly from county to county, they remain largely similar for pragmatic and long-term fiscal reasons. But their comprehensive approach to coverage—and the high level of demand for coverage—means that the initiatives cannot be sustained in the long term by local dollars alone. Funding, especially for small rural counties, is a major challenge.



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“Each county has used a different strategy for funding,” Baker explains. “They all use First Five, tobacco settlement money, county general funds, private donations, and foundation dollars, but at this point, the demand for services is so high that waiting lists are forming, and fundraising has become a challenge. It’s not easy.”

The hope, says Baker, is that eventually all the programs in each county can become one statewide initiative.

A coordinated advocacy effort is underway to make this hope a reality. This effort is led by PICO California and the 100% Campaign, which is a coalition of three children’s advocacy organizations: Children Now, The Children’s Partnership, and Children’s Defense Fund.

Two strategies are simultaneously in play: working through the budget and legislative process in the California General Assembly and passing a statewide tobacco-tax ballot initiative. If either the legislation or the initiative were to pass, statewide universal health insurance for low-income children would become a reality. California would join six other states in the country that offer such coverage.

Supporters of universal health coverage for children in California continue their efforts to win public support for the ballot initiative and the bill under consideration in the General Assembly, while also advocating for state funding for county-level initiatives. This multi-strategy approach is particularly important because several counties have started to freeze their Children’s Health Initiative enrollment due to insufficient funding.

In 2006, Illinois became the first state in the nation to provide universal health coverage for all children through age 18, with graduated premiums based on family income. The All Kids program, effective July 1, 2006, provides coverage for preventive care, dental and vision services, hospital costs, and prescription medicine.

With the number of uninsured and the cost of health care skyrocketing, affordable health coverage is vital to the well-being of low-income families. Hogan sums it up this way, “Health is a cornerstone of immigrant integration as much as education and learning English. If a family has health insurance for their children, then those children are in school learning and not home sick. Their parents don’t have to miss work as often and can stabilize their family financially. Medical bills are the number-one cause for bankruptcy, so this is also about protecting the family against the financial difficulty that comes along with being uninsured.”

DVD

Watch the DVD California Healthy Kids

Most of us agree that all children, regardless of their immigration status, deserve to be healthy. Be inspired by an energetic and wide cross-section of grassroots and grass-tops stakeholders as they raise the long-term implications—and the short-term urgency—of universal health care for every child.

OUTREACH AND EDUCATION PROGRAMS

Helping immigrants become more familiar with the U.S. health care system and the services for which they are eligible is an important first step toward self-sufficiency.

ELEMENTS OF PROMISING PRACTICES

Successful health outreach and communication campaigns that target newcomers require addressing the immigrant-specific barriers discussed above (e.g., language, culture, and perceived and real immigration consequences), helping them understand how to access and receive medical services, and communicating the information through multiple sources that are trusted by the targeted community. General elements of an effective health outreach effort targeting newcomers include:

- **Culturally appropriate materials and messages.** Simply translating materials into other languages is not enough; messages and materials need to be developed specifically for the targeted audience. Public health campaigns are increasingly using market research, focus groups, and community discussions to identify appropriate messages and messengers. “

- **Targeted campaigns that utilize ethnic or foreign-language print and electronic media.** Many immigrant families rely upon media sources in their native language for information and news. Research suggests that health outreach efforts conducted through ethnic media can be less costly and more effective in reaching newcomers than mainstream media campaigns.¹⁶

- **Community-based strategies.** Effective strategies include distributing information at neighborhood fairs, making presentations at community meetings or churches, and going door-to-door in immigrant enclaves. Combining a targeted media campaign with community-based outreach is an especially promising approach.¹⁷

- **Provider-based outreach.** Trusted and accessible clinics and health center workers can be very effective in communicating information and encouraging enrollment in public health programs. In Los Angeles, for instance, 40 percent of all applications to the state SCHIP program come through health providers, more than twice the number from any other single source.¹⁸

- **School-based strategies.** Promising practices include programs that link enrollment of children in public health programs with the application process for subsidized school lunches.

Although these general strategies can be utilized with most immigrant populations, differences in beliefs and background need to be taken into account. For instance, focus groups reveal that some ethnic groups are less likely to enroll in health programs because of immigration concerns, while the primary barriers for others are language capacity or misunderstandings of eligibility requirements.¹⁹ Outreach needs to take into account these differences and should incorporate media outlets and community-based groups that are trusted by each targeted group.

MULTIMEDIA HEALTH OUTREACH CAMPAIGN

North Carolina Division of Public Health and North Carolina Healthy Start Foundation
Raleigh, North Carolina
www.ncpublichealth.com
www.nchealthystart.org

In 2000, North Carolina officials launched an outreach campaign to promote awareness of the state’s publicly funded children’s health insurance programs among Latino families. Rather than simply translating materials into



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16. USC Division of Community Health. 2006. *Reaching Out and Reaching In: Understanding Efforts to Identify and Enroll Uninsured Children into Health Insurance Programs*. Los Angeles, CA: The California Endowment.

17. USC Division of Community Health. 2006. *Reaching Out and Reaching In: Understanding Efforts to Identify and Enroll Uninsured Children into Health Insurance Programs*. Los Angeles, CA: The California Endowment.

18. Ibid.

19. Ibid.



Spanish, the state's Division of Public Health entered a unique public-private partnership with the North Carolina Healthy Start Foundation to develop appropriate messages and strategies targeting Latinos through a broad media and community outreach campaign.

The success of this on-going campaign is due in large measure to the partners' collective vision, cooperation, and willingness to build on each partner's strengths and expertise. The project began by convening an advisory panel of Latino advocates, holding consumer focus groups, and hiring one of the state's first Latino public relations firms. The result was a multi-faceted campaign to promote a state-run,

toll-free, bilingual hotline that provides information and referral on material and child health. The campaign included print materials, advertisements, and radio programming featuring "Ana Maria," a trustworthy Mexican woman and her family.

One highlight of the campaign is a colorful "fotonovela," or picture book, featuring Ana Maria's family. The book explains complicated information in a format that is familiar to the intended audience. Bilingual state and Foundation staff held focus groups to understand what information could help "bridge" Latinos from their previous health care systems to the one in the United States. This research was used to design and distribute the fotonovela and other bilingual materials to communities across the state through a network of community service providers, clinics, businesses, and outreach workers. Nearly 500,000 copies of Spanish outreach materials were distributed in 2005. The materials were reinforced through the placement of news stories and advertisements in Spanish media.

The popular "Ana Maria" now appears in materials on other health topics, such as obtaining preventive health care for children, reducing the risk of Sudden Infant Death Syndrome, the dangers of secondhand smoke, and the importance of folic acid for women of childbearing age.

To expand its efforts, the Foundation launched a Spanish website (www.nchealthystart.org/enespanol) in early 2006 with information on child health insurance, the state's health care system, infant mortality reduction, women's health, pregnancy, and infant care. All materials can be easily downloaded or ordered from the site.

Although the program's impact is still being assessed, observers note that the Latino community's contact with public health programs has increased significantly. More than 25 percent of the calls to the state's health resource hotline in 2005 were made by Spanish-speaking individuals, and 77 percent of these callers inquired about the state's child health insurance program.

¿Tiene Seguro Médico Su Hijo?

Seguro médico gratuito (Medicaid) o de bajo costo para niños y adolescentes.

Límites de ingreso familiar
(Válidos hasta el 31 de marzo, 2007)

TAMAÑO DE LA FAMILIA	INGRESO MENSUAL*
2 personas	\$2,200
3 personas	\$2,747
4 personas	\$3,334
5 personas	\$3,900
6 personas o más	Añada \$567 por cada miembro adicional

* Antes de la deducción de impuestos. Los miembros de familias con ingresos por arriba de los límites pueden tener derecho al programa si tienen gastos de guardería infantil, gastos relacionados con el trabajo o gastos de cuidado para menores.

Incluye beneficios

- Exámenes rútmicos del niño sano
- Medicamentos
- Consultas por enfermedad
- Servicios dentales
- Hospitalización
- Análisis de laboratorio y del oído
- Consejería
- Terapias
- Cirugía
- Equipo y suministros médicos
- Inmunizaciones (Vacunas)
- Servicios para la vista y del oído

Es posible que existan otros beneficios para niños con necesidades especiales de salud.

¡Es fácil presentar una solicitud!

Para obtener más información o para obtener una solicitud, póngase en contacto con el Departamento de Servicios Sociales local, o llame a la Línea de Recursos de Salud Familiar de Carolina del Norte. 1-800-367-2229. 11-800-976-1922 para personas con problemas de audición que tengan equipo TTY.

¡Manténgase inscrito!

Si su hijo ya está cubierto por estos seguros, no olvide RE-INSCRIBIRSE cada año para que continúe recibiendo los beneficios.

1-800-367-2229

La Línea de Recursos de Salud Familiar de Carolina del Norte

www.nchealthystart.org/enespanol

INFORMACIÓN LOCAL

INCREASING ENROLLMENT IN PUBLIC HEALTH INSURANCE PROGRAMS

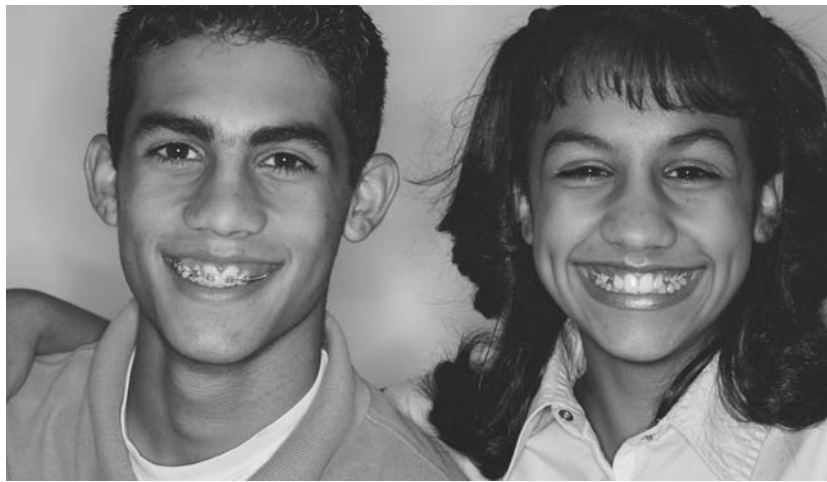
GEM: Get Enrollment Moving
A project of Citrus Valley
Health Partners
Covina, California
www.cvhp.org/gem

Another approach to increasing immigrants' enrollment in public health programs is face-to-face outreach. Although this type of outreach can be labor intensive, it can help alleviate fears, build trust, and provide accurate information to families who otherwise would be hard to reach.

Over the last five years, Citrus Valley Health Partner's Get Enrollment Moving (GEM) project has successfully utilized this approach to enroll nearly 30,000 people into California's Medicaid, SCHIP, and public health programs for children and pregnant women. GEM estimates that approximately 85 percent of the enrollees are Latino, three-quarters have limited English skills, and nearly 35 percent live in a family headed by at least one undocumented adult.

GEM started in 2001 in response to the growing number of immigrant families in the San Gabriel Valley that lacked health insurance. GEM recognized that a successful outreach program required not only educating immigrants about their health insurance options but also addressing deep-rooted fears and misperceptions about the immigration consequences of using public programs.

The result was the creation of a program of volunteer health educators, "promotoras de salud," who go door-to-door in low-income neighborhoods to personally urge eligible families to enroll in public health programs. The volunteers, trained and supervised by GEM staff, visit families, provide health care information, and identify individuals who are eligible for coverage. At GEM's central office, multilingual staff members provide application assistance. As of early 2006, GEM had over 300 volunteers in the promotora program covering 27 zip codes



east of Los Angeles. The promotoras also work with GEM staff to provide information and enrollment opportunities at churches, schools, health clinics, community centers, nonprofits, and businesses. GEM estimates that its outreach program makes contact with approximately 18,000 families each year.

Several factors have contributed to the success of GEM's promotora program:

- **Recruiting volunteers from the community.** Volunteers share the culture and language of community members and face some of the same challenges (e.g., limited English skills, poverty, and undocumented immigration status). Volunteers can build trust with residents and help them overcome fears of enrolling in public health programs.

- **Making volunteers partners in program development.** GEM looks to the promotoras for leadership in developing outreach strategies. The coordinator of the promotora program describes her approach as "helping to lead the program from beside." The GEM staff meets with the volunteers weekly to gather and incorporate feedback, ideas, and concerns. GEM also holds an annual retreat with volunteer leaders to discuss challenges facing the program, as well as to offer an opportunity for respite, education, and camaraderie.

- **Providing volunteers with an appropriate level of training and encouraging collaboration with health workers.** GEM provides all volunteers training on the U.S. health care system and eligibility requirements

for public health insurance programs. According to Silvia Rodriguez, executive director of GEM, "The promotoras play a critical role in outreaching and identifying people who are eligible. Our staff has a complementary role in answering the technical questions and helping identified individuals enroll in a health plan."

- **Providing personal support and professional development opportunities for promotoras.** The promotora program helps volunteers develop health care knowledge and communication skills, build self-esteem, gain work experience, and access professional training courses. In fact, several current GEM staff originally started as promotoras. Rodriguez notes that being supportive of volunteers encourages long-term participation and strengthens the program. "These women are becoming empowered and are taking it as their mission to start addressing other issues in their community," she says. "Their activities will not only make a huge difference in their own lives but ultimately, it will benefit their communities."

The GEM's promotora program is being evaluated by researchers at the USC Division of Community Health. GEM receives funding from The California Endowment, Kaiser Permanente, First 5 LA, and L.A. County Department of Health Services.

PROVIDING ACCURATE HEALTH INFORMATION

Immigrant Health Access and Advocacy Collaborative
A project of the New York Immigration Coalition
New York, New York
www.thenyic.org

Addressing barriers to low-income immigrants' access to health care in New York City is the mission of the Immigrant Health Access and Advocacy Collaborative. Begun in 2000, the Collaborative involves the New York Immigration Coalition, New York Lawyers for the Public Interest, and eight community organizations that serve newcomers. Together, these organizations provide outreach, training, individual assistance, and systemic advocacy on public health care.²¹

According to Project Director Adam Gurvitch, nearly two-thirds of uninsured adults in New York City are immigrants, and the rate of uninsured immigrant children is five times higher than the city average, even though all children are eligible for the state's SCHIP program. These disparities are due in large part to conflicting messages about immigrants' rights to public health care and the risks of using such services. Since September 11, 2001, newcomers have only become more fearful of the immigration consequences of using public health resources. As *The New York Times* observed, "More and more immigrants are delaying care or retreating into a parallel universe of bootleg remedies and unlicensed practitioners."²²

The Collaborative has been successful in addressing these misunderstandings because the partners are trusted community groups that have longstanding



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relationships with specific communities, provide services and advocacy in neighborhood centers, and have the language and cultural expertise to communicate effectively. All eight community organizations receive training and technical assistance from the policy and legal organizations, and each employs at least one part-time bicultural, bilingual health advocate. The Collaborative's activities include:

- **Conducting community education and outreach to raise the awareness and confidence of immigrants and refugees interacting with the health care system.** Community workshops, public education materials, and outreach through the ethnic media inform immigrants of their rights to health care, their eligibility for insurance and affordable payment options, and any potential immigration consequences.

- **Providing direct assistance to immigrants and refugees who have been unable to access or pay for health care.** With technical assistance provided by the policy and legal organizations, the community health advocates help address problems involving lack of access to services, health coverage, hospital payments, or discrimination. The initial four community groups in the Collaborative assisted over 1,100 clients annually. The numbers have increased with the addition of four new community groups in 2005.

- **Using knowledge gained from interaction with individual immigrants to develop recommendations for policy reform.** With the information provided by the community partners, the Collaborative has been able to provide feedback to hospitals and other public agencies on improving their services (as well as file civil rights complaints when agencies have been unresponsive). The Collaborative is also bringing immigrant voices to health policy debates at the state and national levels.



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- **Developing the skills of immigrant-serving organizations through ongoing capacity-building partnerships.** This project has developed the capacity of relatively small immigrant-based organizations to provide accurate and timely health information to community members. The community partners, in turn, are able to implement broad public education in multiple languages and can mobilize their communities to support public policy reforms.

The Collaborative has an annual budget of approximately \$250,000, with funding from Elebash Fund, United Hospital Fund, Alman Foundation, New York Community Trust, Long Island Community Foundation, and Westchester Community Foundation. "All of the organizations in the Collaborative are responding to their communities' need for accurate health information and advocacy, and they devote considerably more resources to health care work than what they receive through these grants," Gurvitch points out. "But what the grants have done is allow them to go deeper on these issues, work together, learn from each other, and develop a coalition that has addressed shared challenges far beyond what any single group could do by itself."

21. The eight community organizations are Haitian Americans United for Progress, Korean Community Services of Metropolitan New York, Latin American Integration Center, Shorefront YW-YMHA of Manhattan-Brighton Beach, Council of Peoples Organization, Filipino American Human Services, Make the Road by Walking, and Reconciliation and Culture Cooperative.

22. Bernstein, Nina. 2006. "Recourse Grows Slim for Immigrants Who Fall Ill," *The New York Times*, March 3.

INCREASING ACCESS TO REPRODUCTIVE HEALTH CARE

La Promesa and Adult Role Models Planned Parenthood Southeastern Florida www.plannedparenthood.org

Responding to the fast-growing Latino and immigrant communities in southeastern Florida, Planned Parenthood of Greater Miami, Palm Beach, and Treasure Coast Area (Planned Parenthood)²³ established two programs, La Promesa and Adult Role Models, to increase these communities' awareness and access to reproductive health.

La Promesa's goal is to "break down barriers to reproductive health care for the Hispanic population," says Maria Kulp, vice president of education of the local Planned Parenthood. The program uses bilingual community health workers, known as "promotoras de salud," to conduct outreach and communicate with Spanish-speaking individuals, primarily women, served by its health centers. Reflecting the area's ethnic diversity, the promotoras include women from the Caribbean, Mexico, and Central America.

In addition to increasing the access of Latina immigrants to Planned Parenthood services, La Promesa works to heighten their awareness of reproductive and family health issues, promote early detection of and reduce the mortality rate for breast and cervical cancer, and assist families in communicating effectively about sexual and reproductive health.

La Promesa promotoras typically connect with their Spanish-speaking clients at outreach events, including health fairs, after-school programs, and presentations at faith-based organizations. They also go door-to-door to homes, markets, and businesses in Latino communities.

To encourage Latina women to seek health services, La Promesa offers free Pap smears and linguistically and culturally appropriate services. "We started this knowing that Latina women probably are one of the worst groups at seeking care for themselves. We wanted to do outreach to promote the health center, let them know that this was affordable. The program just took off and became a lot larger than anyone had anticipated," Kulp says.

When women call to make an appointment at a Planned Parenthood health center, they are asked for their language preference. If their response is Spanish, a La Promesa staff person will usually greet the person on arrival to the office, help with the completion of forms, and follow-up with the individual after the medical appointment as needed. Kulp estimates that about 3,000 women are served through La Promesa each year, and the program has increased requests for contraception at Planned Parenthood offices in southeastern Florida by 129 percent.

Planned Parenthood also operates Adult Role Models (ARM), a unique trilingual program that utilizes parent volunteers to educate youth and the broader community about sexual health and teen pregnancy. It works with three agencies

that primarily serve Latinos, Haitians, and African-Americans to recruit parents from those communities to participate in the program and organize trainings in English, Spanish, and Creole. ARM also provides 75 hours of training to parent volunteers on information about sexuality. Topics include contraception, puberty, sexual orientation, prenatal care, HIV/AIDS, and more.

"The curriculum is designed to provide the Adult Role Models with current, accurate information on these topics. There is a pre- and post-test completed at each session to let us know if they have increased their knowledge... Additionally, at the end of the training sessions, the [role models] have to design and present a workshop to the group that is taped to be able to give them feedback," Kulp explains.

After their training, these parents return to their communities and train other parents on how they can talk to their children about sex. These sessions can be either formal or informal in nature, depending on the experience of the parents who have finished their ARMs training. While some, particularly those who were professionals in their native countries, teach at churches and community groups, others prefer to teach in their homes. In 2005, the project trained over 70 parents, who in turn have reached another 5,000 parents.

Although the ARM program, which has a staff of three, is funded solely by the Children Services Council of Palm Beach County, La Promesa has received foundation support, including grants from the Quantum Foundation and the Picower Foundation. The success of these programs has led funders to urge that Planned Parenthood expand them to nearby counties. Planned Parenthood chapters in St. Lucy County and Martin County have both adopted La Promesa programs. St. Lucy County also has an ARM program, and Martin County is considering launching one as well.



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23. Planned Parenthood of Greater Miami, Palm Beach, and Treasure Coast Area operates eight health centers in six counties. In 2005, the eight centers served more than 30,000 individuals, approximately 17 percent of whom were Latino.

LANGUAGE ACCESS AND CULTURAL COMPETENCE



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Providing newcomers with access to high-quality health care requires that service providers and insurance programs be able to communicate with them effectively. Because nearly half of all immigrant adults speak English with some limitations²⁴ and 40 percent have resided in the United States for less than 10 years,²⁵ reducing language and cultural barriers is critical to increasing access to good health care.

The “Improving Language Access in Government Services” section of this toolkit provides a general overview of the language barriers faced by new immigrants, describes the legal obligations of federal contractors and grantees (including public health agencies and medical service providers) to provide linguistically accessible services, and highlights promising practices. The general elements of a successful language access policy for assessment, plan development, bilingual staffing, translation of written materials, training of staff, evaluation, and outreach apply in the health care setting as well. Health care organizations that receive federal funds are required to make reasonable efforts to offer free language assistance services to limited English proficient (LEP) individuals.²⁶

In addition to language, culture plays an important role in determining the quality of an individual’s interaction with the health care system. Recent immigrants often bring traditions and practices unfamiliar to U.S. health care professionals, and they often have limited experience with Western medicine.

While new immigrants frequently experience communication problems in their daily lives, language and cultural barriers can be much more harmful when immigrants are seeking medical services. Miscommunications between medical personnel and patients can have costly and tragic consequences for both individual immigrants and the broader community. A report by Grantmakers in Health identifies some of the harmful effects of language barriers in health care:²⁷

- Reduced access to health insurance, preventive care, and specialty services.
- Compromised patient understanding of diagnosis and treatment plans.
- Lower patient satisfaction.
- Lower quality of care, which can lead to serious complications and adverse clinical outcomes.
- Higher costs to the health care system through unnecessary testing as well as medical complications resulting from the lack of treatment or misdiagnoses.

Conversely, there are a number of studies showing the positive health effects of providing LEP patients with language services. A review of these studies found that:

...[P]atients with limited English proficiency who are provided with... interpreters make more outpatient visits, receive and fill more prescriptions, do not differ from English proficient patients in test costs or receipt of intravenous hydration, have outcomes among those with diabetes that are

TITLE VI OF THE 1964 CIVIL RIGHTS ACT

This federal law requires states, counties, and private health providers receiving federal funds to make reasonable efforts to provide language assistance to limited English proficient individuals. This longstanding requirement gained significant public attention after President Clinton issued Executive Order 13166 in 1999, requiring federal agencies to develop procedures for

improving language access to their programs, as well as issuing specific guidance on how recipients of federal funding should implement Title VI’s language access requirements. This order has been affirmed by the Bush administration, which has set up a website to provide guidance, best practices, and resources at www.lep.org.

24. Capps, Fix, Passel, et al., 2003.

25. Moran and Petsod. 2004. *Newcomers in the American Workplace: Improving Employment Outcomes for Low-Wage Immigrants and Refugees*. Sebastopol, CA: Grantmakers Concerned with Immigrants and Refugees and Neighborhood Funders Group.

26. For a detailed analysis of relevant federal laws requiring language access, see: Perkins, Jane, Mara Youdelman, and Doreena Wong. 2003. *Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities*, 2nd Edition. Los Angeles, CA: National Health Law Program.

27. Grantmakers In Health. 2003. *In the Right Words: Addressing Language and Culture in Providing Health Care*. Washington, D.C.: Grantmakers In Health.

28. Ku, Leighton and Glenn Flores. 2005. “Pay Now Or Pay Later: Providing Interpreter Services In Health Care.” *Health Affairs* 24: 435-444.

superior or equivalent to those of English-proficient patients, and have high satisfaction with care. LEP patients with bilingual providers ask more questions, have better overall information recall, and are more comfortable discussing sensitive or embarrassing issues; those with hypertension or diabetes have less pain and better physical functioning, psychological well-being, and health perceptions and have high patient satisfaction...²⁸

ELEMENTS OF PROMISING PRACTICES

The health care sector has been a leader in developing promising practices to reduce language and cultural barriers. There is federal funding available to support language assistance in health programs serving low-income families. In addition, several foundations have funded projects that provide advocacy, technical assistance, and research support to help states seek federal matching funds and develop long-term funding streams for this purpose.²⁹ The health care sector has also been well ahead of other fields in developing standards for providing linguistically and culturally competent services.

Improving communications between health care providers and recent immigrants in the service delivery setting has been the focus of most efforts to increase access. Because of the diversity of health care providers (ranging from small clinics to large public hospitals), varying demographics of local communities, and differences in culture and language among immigrant communities, a wide range of practices have been developed over the years. They include:

DVD

Watch the DVD Hold Your Breath: The Doctor's Office

Health care is a challenge for many Americans, and particularly problematic for immigrants who may lack English skills, access to care, and familiarity with Western medicine. Hear from both "sides," as an immigrant family faces confusing, possibly devastating information, about their cancer-stricken father, and as their American-born physician struggles with his own cultural limitations.

- **Assessing community needs and developing administrative infrastructure for providing language services.**

Each agency begins with an assessment of the language needs of its service population and its capacity to serve these individuals. This is followed by the development of a plan for communicating both verbal and written information. Providing funding for these initial steps can encourage health care institutions to make the changes needed to serve LEP individuals.

- **Increasing the number of bilingual/bicultural medical staff members.** Research suggests that the best way to provide medical services to newcomers is through bilingual medical providers who are familiar with the culture of their patients. Foundation-supported projects in this area include (1) language and cultural training to existing medical staff; (2) resources to recruit bilingual health workers, nurses, and physicians; and (3) programs to train immigrants to become health workers.³⁰

- **Increasing interpretation resources.** In recent years, a number of third-party interpretation models have emerged, including (1) dedicated staff interpreters at a specific hospital or clinic; (2) private or non-profit in-person contract interpreters; and (3) remote, third-party interpretation. Support for research in using innovative new technologies has helped make remote interpretation services—telephonic, videoconferencing,³¹ and remote simultaneous medical interpreting using wireless technology³²—increasingly viable. Initial research suggests that these approaches can enhance access to medical interpretation because there is no wait for interpreters to be physically present, and they may be more cost-efficient than in-person interpretation.

- **Supporting translation of written documents.** Written materials are critical to communicating health-related information. Patient care instructions, consent forms, medical history forms, and health education materials are all vital documents that should be language-accessible. Health care organizations need to identify and prioritize the most important documents for translation into languages commonly spoken by



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patient populations. Ideally, translated written materials should reflect the cultural nuances of the target population and be at the appropriate educational and literacy levels.

- **Promoting advocacy and policy reform.** As with efforts to expand immigrant eligibility for state public health programs, advocacy is important in developing policies that lessen language and cultural barriers to health care. Foundation-funded advocacy efforts have included projects to urge federal agencies to enforce existing language access laws, advocate that states seek federal reimbursement for language service costs, educate policymakers on the importance of language access, and negotiate with state or local health agencies to develop effective access plans. In some communities, foundations can also play a convening role in bringing various stakeholders together to address language and cultural barriers.

29. See examples discussed in Grantmakers In Health, 2003.

30. See profiles of the International Institute of Minnesota's Medical Careers Project in the "Promising Practices in English Acquisition" section and the Welcome Back Initiative in the "Promising Practices in Economic Mobility" section.

31. Health Access. 2002. *Videoconferencing Medical Interpretation: The Result of Clinical Trials*. Oakland, CA: Health Access.

32. Youdelman, Mara and Jane Perkins. 2002. *Providing Language Interpretation Services in the Health Care Settings: Examples from the Field*. Los Angeles, CA: National Health Law Program.

HEALTH INTERPRETATION SERVICES IN RURAL AREAS

El Puente (The Bridge) Jackson, Wyoming

Like many rural communities, Teton County, located on the Wyoming-Idaho border, is undergoing dramatic demographic changes. The availability of agricultural and service jobs has drawn newcomers to the region, and the mostly Latino immigrant population has grown fourfold since 1995, to 2700 residents. And these newcomers are seeking services from the local health care system. In 1990, the primary local hospital—St. John Medical Center—did not deliver a single Latino baby. By 2005, over 24 percent of the babies born there were Latino.³³ Local health care providers have struggled to make their services accessible to this fast growing population.

El Puente was started in October 2003 to help address these challenges by providing interpreter services and health care education for immigrants. El Puente offers medical interpreting services at hospitals and medical offices free of charge to both patients and health care providers. It also works with individual patients to help them navigate the local health care system, enroll in insurance programs, and receive care as needed. With an annual budget of only \$200,000 and a staff of four full-time trained medical interpreters and six part-time interpreters, El Puente provides almost 400 hours per month of in-person and



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telephonic interpretation for doctors, dentists, nurses, and other medical staff. In 2004-05, its staff provided interpretation for approximately 5,150 medical appointments.

By all accounts, El Puente provides a critical service to both the local Latino community and health agencies. Although providers have increased hiring of bilingual personnel and use of contract interpreters, El Puente continues to play a major role in making health services accessible. “The interpretation services provided by El Puente for our non-English speaking patients are extremely important for safe and effective patient care,” explains Becky Kimmel, executive director of St. John Medical Center. “Both patients and the medical community benefit from increased understanding, which enables us to deliver efficient and compassionate care.”

El Puente’s success suggests that it could serve as a model for other immigrant communities located in regions where bilingual medical resources are scarce and health care providers have little experience serving newcomers. The project has also played a role in easing potential tensions between native-born residents and the growing Latino community. According to El Puente executive director Vida Day, the rapid growth in the Latino population had caused some residents to perceive new immigrants as a “drain” on the local health care system. “The nonprofit model allows us to demonstrate the Latino community’s commitment to finding a solution to this challenge, while also drawing resources from local foundations and individuals.” As of 2005, El Puente received about half its revenues from over 10 local foundations, with the remaining coming from individual donors. “Funders should understand that their support is absolutely critical in rural communities,” says Day, “where resources are scarce and their contributions can make a tremendous difference in improving the health of immigrants.”

EFFECTIVE HEALTH INTERPRETATION SYSTEMS

Cambridge Health Alliance Cambridge, Massachusetts www.challiance.org

Providing language access in large hospital settings requires more than qualified interpreters. Well-designed systems are needed to enable providers and patients to utilize interpreters quickly and effectively. Research indicates that patient and provider satisfaction with language services depends in part on how easily interpreters are available. When requests for interpretation lead to delays, providers and LEP patients often try to communicate without assistance, and over the long-term may be discouraged from requesting interpreters altogether.

Cambridge Health Alliance (CHA), which operates three large hospitals and 20 primary care sites in the area north of Boston, has developed an innovative system of language services. Key elements include (1) development of a centralized dispatch system; (2) training of medical staff on how to best utilize interpreters; (3) outreach to hospitalized LEP patients; and (4) ongoing monitoring and evaluation of the program.

In May 2005, almost three decades after it first started providing language assistance to LEP patients, CHA adopted new “one number calling” for all interpretation requests. Providers can request face-to-face or telephonic interpretation in the three languages provided by CHA staff (Portuguese, Spanish, and Haitian Creole), as well as in over 40 languages that are provided by “per diem” interpreters.³⁴ If staff or per diems are unavailable, the system refers providers to the telephonic interpretation services of a third party contractor. Prior to this system, CHA medical staff had to call different numbers

33. All of the demographic information was provided by El Puente.

based on their location and the language needed. The new system, which utilizes automatic call distribution queues staffed by Portuguese, Spanish, and Creole interpreters at 10 sites, not only makes it easier for providers to request assistance, it also helps CHA utilize its interpreter staff more efficiently. Interpreters at the three hospitals and seven health centers provide telephone interpreting to all 23 CHA sites, as well as face-to-face interpreting at their own sites. The new system automatically connects a caller to an available interpreter. These changes have resulted in significantly less waiting time for LEP patients and more efficient use of CHA's resources.

To implement the new system, CHA has provided orientation and training to its medical personnel. Equally important, CHA's interpretation unit and the nursing staff have worked to identify situations in which interpretation is underutilized. For instance, requests for interpreters are less likely to occur for hospitalized patients, who may then have difficulty communicating discomfort, symptoms, or other important information to inpatient care providers.

With support from the Blue Cross Blue Shield of Massachusetts Foundation, CHA is installing dual handset speaker phones in its inpatient facilities near each patient bed. CHA will train nursing staff to identify situations that require interpretation, address the reluctance of some staff to utilize telephonic interpretation, and provide orientation to patients on how and when to request an interpreter. Staff interpreters will also conduct daily visits to each inpatient-care facility, speak directly with LEP patients, and record relevant information in the individual's medical records.

According to Director of Multilingual Interpreting Loretta Saint-Louis, the new system's centralized nature allows managers to monitor performance and identify and respond to problems. "Overall," says Saint-Louis, "the changes have made the system easier to use and have maximized our productivity." The average wait time for interpreter services in the three most common non-English languages is now less than one minute. CHA's interpreting volume grew by 14 percent in the first six months of



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the program, while expenditures increased by less than half that amount. Telephonic interpretation expanded by an astounding 82 percent, suggesting that providers were becoming more comfortable with the service. "While we still have a lot to learn and evaluate," Saint-Louis notes, "the bottom line is that these changes have made it easier for LEP patients to obtain accessible health care."

INCREASING WORKFORCE DIVERSITY

Welcome Back Initiative
San Francisco, California
www.e-welcomback.org

Providing accessible medical services to newcomers requires hiring providers with relevant cultural backgrounds and language skills. An innovative approach is the Welcome Back Initiative, which builds on the skills of internationally trained immigrant health professionals. This California-wide project has helped thousands of immigrant health workers become oriented to the U.S. health care system, enroll in English classes and health care courses, obtain required licenses and credentials, and find jobs in the health field. The project is helping immigrants improve their economic situations, while also making health services more accessible to newcomers. The Welcome Back Initiative is described in detail in the "Promising Practices in Economic Mobility" section.

34. "Per diem" staff members are on-call employees who only come in when there is need for their services.

RESPONDING TO DEMOGRAPHIC CHANGE, DRIVEN BY COMMUNITY NEEDS

WHITE MEMORIAL MEDICAL CENTER WWW.WHITEMEMORIAL.COM

“White Memorial is a story of how an institution that was increasingly becoming irrelevant in the neighborhood transformed itself by reaching out to the immigrants and refugees that are now there. The way indigenous leadership emerged to broker relationships between the hospital and the community in all different kinds of ways could be applied to integration strategies beyond the health arena.”

**—Ignatius Bau, Program Director
The California Endowment**

Opened in 1913 in East Los Angeles by the Seventh Day Adventist Church, White Memorial Medical Center started as a medical clinic and slowly grew into a major teaching hospital. Today, it is the flagship facility for Adventist Health, a nonprofit that operates a number of health facilities on the West Coast.

More importantly, White Memorial has emerged as a powerful example for how integrating newcomers into the health care system—as patients, health professionals, vendors, leaders, and stakeholders—can reap enormous benefits for the receiving community.

White Memorial, says Ignatius Bau, a program director at The California Endowment, is a story of “how an institution that was increasingly becoming irrelevant in the neighborhood transformed itself by reaching out to the immigrants and refugees that are now there. The way indigenous leadership emerged to broker relationships between the hospital and the community in all different kinds of ways could be applied to integration strategies beyond the health arena.”

Over the course of its history, White Memorial experienced both lean times and periods of expansion. In the decades after World War II, the hospital flourished as a pioneer in open-heart surgery

and other specialty procedures. But by the 1980s, White Memorial, like other safety-net hospitals that provided a sizable amount of uncompensated care, was facing a financial crisis and the possibility of closure.

One reason for the hospital’s financial decline was its slowness to adjust to the area’s changing demographics. Before World War II, East Los Angeles was predominantly home to immigrants of Japanese and European descent. But by the 1980s, working-poor Latino immigrants, most of whom spoke Spanish as their primary language, made up the vast majority of the area’s population. Largely uninsured patients began using the hospital primarily for emergency services, leaving its specialty service underutilized. And despite the increase in Latino patients, the hospital had very few Latino or Spanish-speaking staff who could effectively serve its new patient population.

A STRATEGY FOR SURVIVAL

In the wake of its financial crisis, White Memorial recognized that its future existence depended on its ability to adapt to this new demographic reality. It devised a strategy to build a closer relationship with the growing Latino community by becoming a community-based hospital focused on the area’s most critical health need: the severe shortage of primary care providers, especially for Spanish-speaking patients.

White Memorial eliminated several of its specialized residency programs and shifted its focus to building the capacity to provide culturally competent primary care to Latino patients. Over time, the hospital recruited a diverse professional staff, instituted effective training and retention programs, and learned how to incorporate neighborhood residents into all aspects of the medical center’s activities—as patients, employees, vendors, board members, and future health professionals. In developing this successful strategy, White Memorial transformed itself into an invaluable community health resource whose services and contributions go well beyond providing traditional medical services.

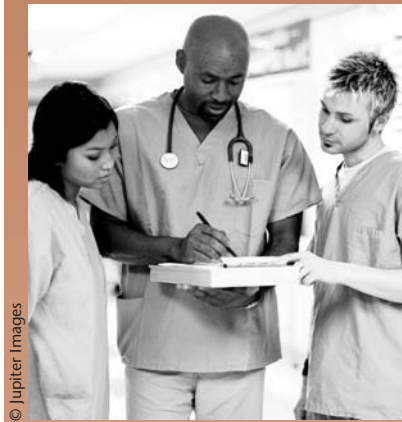
DIVERSIFYING THE HEALTH CARE WORKFORCE

Developing a diverse workforce, White Memorial recognized, would be critical to meeting the area’s health care needs. To increase the number of qualified health professionals, the hospital established the Family Medicine Residency program to (1) recruit medical residents from East Los Angeles, as well as others who plan to practice in underserved areas; (2) provide them with the skills and understanding to be successful in working with the health problems they encounter in underserved areas; and (3) equip them with the knowledge and networking needed to have a successful practice.

Developing local talent is a top priority for the residency program. Four of the seven founding members of the private family practice group, who also serve as faculty for the Family Medicine Residency program, grew up uninsured in East Los Angeles. With their leadership, White Memorial developed a multi-faceted strategy to prepare and recruit neighborhood residents to work at the hospital. By expanding primary care services to meet local needs, for example, the hospital also created an opportunity to hire a number of new physicians who were local residents or had the necessary language and cultural skills to serve Latino patients.

According to Dr. Hector Flores, co-director of Family Medicine Residency, these changes “immediately increased the hospital’s opportunity to connect with the community. It opened the door to the immigrant population. They began to feel that not only was [White Memorial] a good place to go if you needed emergency care, but it was also a good place to go for all your medical needs, for keeping yourself well, managing a chronic condition, and so on.”

As part of its long-term strategy, the private family practice group also supports pipeline programs to provide mentoring and increase interest in higher education, especially the health



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professions, among local high school students. It also developed partnerships with two science magnet schools that bring students and residence staff together regularly. Cultivating the interest of area students serves multiple goals: It increases the number of physicians interested in working in underserved areas; creates career paths and expands economic opportunity for young people in the community; and increases minority representation and cultural and linguistic competency in the health field over the long term.

As of early 2006, the Family Medicine Residency Program had 86 graduates: 70 percent are working in underserved areas, and 40 percent have remained in East Los Angeles.

BUILDING CULTURAL COMPETENCE

Although many young physicians have a personal commitment to serving low-income communities, they may shy away from the work because they are not trained in the skills those environments require. With funding from The California Endowment, White Memorial's Family Practice Residency program created the Cultural Competence Initiative to broaden the understanding of cultural competence beyond language and ethnicity. Through the initiative, medical residents learn about cultural, gender, educational, and economic issues that have an influence on patients' health and the challenges the residents may face in delivering care to such patients. White Memorial's family medicine clinic has served as a "living laboratory" for developing this curriculum, drawing on the real-life challenges that health professionals experience on a daily basis.

Significantly, all hospital departments are now easily accessible to Spanish speakers onsite, via telephone, and on the Web. All hospital staff receive training in cross-cultural interaction; many more community residents are on staff; and the hospital has increased community representation on its governing board.

RESPONDING TO COMMUNITY NEEDS

In the same spirit of responsiveness, White Memorial has looked to community needs to drive its service priorities. For example, it expanded its maternal and child health care facilities and services to reflect the needs of the area's demographics, even though some of these services, like neonatal care, are very expensive. The hospital also put in place other programs that provide community members with information about how to access health and related services that may be available to them. Such programs, delivered in Spanish, demystify an otherwise complicated medical system for both immigrant and U.S.-born Latinos.

THE HEALTH INDUSTRY AS AN ECONOMIC ENGINE

The family medicine practitioners at White Memorial understand that the health care industry can be an engine for neighborhood economic growth, and they strive to benefit the community when they hire employees and contract out services.

For example, local residents account for over half of hospital's 1500-person workforce—from physicians and health educators to clerks and janitors. Within the family practice group, which serves 45,000 patients annually, about 95 percent of the employees are women, many of whom are from immigrant backgrounds and about half of whom are single heads of households. For many nonprofessional employees, working for the family practice group is their first job, and the group is deliberate about providing support to help them achieve financial stability. For example, it provides training in financial literacy and offers access to interest-free loans that employees have used to pay off debt, purchase homes, or send their children to college. As the practice has grown, it has also offered educational scholarships to employees and their family members who want to improve their careers.

Beyond their work within their practice group, family practitioners also have worked to direct the \$100 million that White Memorial contracts with vendors to businesses in East Los Angeles. Not long ago, the hospital did no business with any East Los Angeles vendors, but as of 2004, between \$22 and \$25 million a year of White Memorial contracts was staying in East Los Angeles. This has had an unexpected positive impact on increasing health coverage for community residents. As local businesses thrive, they began to offer employees health care benefits, and increasing numbers of local employees are going to White Memorial for their health care needs.

A VALUED COMMUNITY RESOURCE

Nearly 20 years ago, White Memorial changed with its patient population. The choice has required the dismantling of barriers, active outreach, and an infusion of ingenuity. Today, White Memorial is thriving in the midst of the immigrant community it serves. For Ignatius Bau of The California Endowment, this success was due to "a pretty unique confluence of factors, but the lesson for others is how the organizational transformation happened."

On April 9, 2006, White Memorial celebrated the opening of a brand-new \$200 million state-of-the-art facility. Among those celebrating the event were the mayor of Los Angeles, a congressional representative, a city councilmember, the consul general of Mexico, and a number of local celebrities. They had gathered to celebrate not just a hospital but the lifeblood of the community itself.

"The beautiful \$200-million state-of-the-art building we now have makes a statement to the community that they are welcome and that they deserve the best of care, even if they are poor. It is also a tribute to the physicians who work here. And it is all about this community and its demographics."

**—Dr. Hector Flores, Co-Director
Family Medicine Residency
White Memorial Medical Center**

EVALUATING HEALTH PROGRAMS

Family health and well-being play an important part in the successful integration of immigrants. However, it is sometimes difficult to achieve due both to the structural barriers discussed in this section and the stress caused by the migration and the integration process itself.

Therefore, evaluating efforts to promote health and well-being should focus both on program design and implementation and the physical and mental health outcomes for immigrant families.

In order to determine if a health initiative leads to outcomes illustrated in the chart below, foundations can collect the following data:

- Number and percent of immigrant adults and children participating in benefit programs (e.g., Food Stamps, SCHIP, Medicaid, other publicly funded health insurance programs).
- Number and percent of immigrants who get regular blood pressure and cholesterol screenings, mammograms, Pap smears, and dental check-ups. Such data can be obtained at health fairs and/or from local clinics.
- Number and frequency of visits to the emergency room. Data can be obtained from the Agency for Healthcare Research and Quality's Medical Expenditure Panel Survey and the National Health Interview Survey.
- Recruitment and retention of staff and/or volunteers who are familiar with the immigrant's culture and language.
- Number of agencies and services that provide translation and interpretation assistance. Samples of assessment questionnaires are available from:
 - Andrulis, D., Delbanco, R., Avakian, L., Shaw-Taylor, Y. "Conducting a Cultural Competency Self-assessment."
 - Dana, R.H., Behn, J.D. & Gonwa, T. 1992. "A Checklist for the Examination of Cultural Competence in Social Service Agencies." *Research on Social Work Practice*, 2, 220-233.
 - Goode, T.D. 2005. *Promoting Cultural and Linguistic Competency: Self-assessment Checklist for Personnel Providing Services and Supports in Early Intervention and Early Childhood Settings*. Washington, D.C.: Georgetown University National Center for Cultural Competence.

OUTPUTS

- Analysis of health-related policies.
- Community-based advocacy for improved health access and services.
- Increased allocation of local and state funds for health programs.
- Culturally and linguistically appropriate outreach, education, and services for immigrant families.



These outputs lead to the following outcomes, which in turn encourage these outputs to become more widespread.



OUTCOMES

Newcomers:

- Increased access to effective health education and services.
- Increased food security.
- Improved physical and mental health outcomes.
- Improved child well-being.
- Improved familial relationships (e.g., reduced intergenerational tensions).
- Increased economic security.

Receiving community:

- Culturally and linguistically competent services.
- Accessible, affordable, quality systems and services.
- Healthier communities.
- Increased benefit from the contributions of immigrants.



These outcomes encourage integration, and as integration gradually occurs, these outcomes will also become more widespread.



IMMIGRANT INTEGRATION

SOURCE:

Annie E. Casey Foundation. "Family Economic Success: Building Strong Financial Futures for Families and Communities." Retrieved from www.aecf.org/initiatives/fes/fes/ on March 17, 2006.