



CONNECTING LIMITED-ENGLISH PROFICIENT INDIVIDUALS TO HEALTH CARE SERVICES:

The Important Role of Community-Based Organizations

June 2017

TABLE OF CONTENTS

Introduction	4
LEP Populations and Challenges in Accessing Health Care	4
Challenges for Health Care Providers and Facilities in Providing Language Services	5
The Role of CBOs in Assisting LEP Individuals Access Health Care Services	6
The Role of Community Health Workers in Helping Individuals Access Care	8
Integrating CBOs into the Health Delivery System	10
Recommendations	12

This brief discusses the importance of integrating community based organizations (CBOs) into health care delivery systems. It describes the challenges facing hospitals, providers, and CBOs in assisting limited English proficient (LEP) individuals. It also provides a description of community health workers and their role in the healthcare delivery system and current funding models to support them. Finally, the brief presents recommendations for health care systems and providers to partner with and support CBOs to assist LEP individuals in utilizing health care services to improve their health.

INTRODUCTION

The Patient Protection and Affordable Care Act (ACA) passed in 2010 has provided millions of Americans with access to affordable health insurance and health care services. Many of those newly insured through the ACA now have access to much needed medical care, preventive services, and prescription drugs for the first time in their lives. However, despite the great increase in health insurance coverage, many individuals experience difficulties when attempting to utilize health care services. These challenges are most pronounced for certain groups, such as limited-English proficient (LEP) individuals (describing those for whom English is not their primary language and speak English less than “very well”), recent immigrants, ethnic minorities, and other underserved populations.

During the first four ACA enrollment periods that began in 2013, in-person assistance was crucial in helping people to navigate the process and enroll in health insurance coverage through private health plans and Medicaid. For LEP individuals, the in-language, in-person assistance provided by trusted community-based organizations (CBOs) was particularly important, as they faced many barriers throughout the enrollment process. For many Asian American, Native Hawaiian, and Pacific Islander (AA and NHPI) communities, these trusted CBOs helped individuals understand insurance plans, complete applications materials, and submit documentation in order to enroll in coverage.

CBOs have and will continue to play an important role in helping individuals understand how to “connect to care” and utilize their health insurance coverage. They are helping people understand the services covered by their plans, explaining how to select a primary care provider, assisting with scheduling appointments, and helping them obtain prescription drugs.

LEP POPULATIONS AND CHALLENGES IN ACCESSING HEALTH CARE

While only 8.6% of the entire U.S. population is limited English proficient (LEP) (about 25 million people), certain racial and ethnic groups have much higher rates of LEP than others. In the U.S., about one-third of both the Hispanic or Latino population and the Asian population are limited English proficient. When looking at subgroups, some Asian American groups such as Nepalese (51.5%), Vietnamese (49.2%), and Marshallese (45.5%) have even higher LEP rates.

Table 1: Limited English Proficiency (LEP) In the United States by Race

Race	Estimate of population 5 years and over with LEP	% of population 5 years and over with LEP
Asian	5,782,549	30.4%
American Indian and Alaska Native	300,883	6.0%
Black or African American	1,275,526	3.1%
Hispanic or Latino	15,985,791	31.1%
Native Hawaiian or Pacific Islander	98,387	8.3%
White	13,741,187	6.0%

Source: U.S. Census Bureau, 2015 American Community Survey 1-year Estimates

With the passage of the ACA, many more individuals with LEP now have health insurance. The expansion of Medicaid to adults with incomes under 138% of Federal Poverty Level, the availability of tax credits through the health insurance marketplace, and cost-sharing to make health insurance plans more affordable have all contributed to the decrease in the uninsured population. Additionally, the ACA included specific non-discrimination provisions to protect the rights of LEP individuals.¹ Before the ACA was passed, LEP individuals had three times the uninsured rate (49%) compared to those who were English proficient (18%).²

Although more LEP individuals have coverage, language continues to present a significant barrier when accessing health care services. Spoken language differences between patient and provider, the lack of appropriate interpretation services, and inadequate translated materials for patients all contribute to communication barriers that adversely affect health outcomes and contribute to the existence of health disparities. Patients who are LEP are less likely to seek care, even when insured, and experience lower quality of care and more adverse health outcomes, such as longer hospital stays and a greater chance of hospital readmission for certain chronic conditions, compared to those who speak English well.³ Many of those who need interpretation services are not aware of their rights to receive language assistance at a hospital or clinic.

1 Section 1557 of the ACA prohibits discrimination on the basis of race, color, national origin (including primary language), sex, age or disability in any health program or activity that receives funding from the U.S. Department of Health and Human Services (HHS). "Covered entities" under Section 1557 are required to provide meaningful access to LEP individuals. In May 2016, HHS issued final regulations to implement Section 1557 which included standards for interpreters and translators.

2 Overview of Health Coverage for Individuals with Limited English Proficiency. Kaiser Commission on Medicaid and the Uninsured, August 2012.

3 Flores G. "The Impact of Medical Interpreter Services on the Quality of Health Care: A Systematic Review," *Med Care Res Rev*, 62(3): 255-299.

CHALLENGES FOR HEALTH CARE PROVIDERS AND FACILITIES IN PROVIDING LANGUAGE SERVICES

While hospitals and health care providers are required to offer interpretation and translation services if they receive any type of federal funding, they face many challenges in providing adequate language services. These include significant costs to provide interpretation services and translated materials and a shortage of qualified interpreters to serve their respective patient populations. A recent study analyzing the American Hospital Association’s Annual Survey of Hospitals databases showed that while about 70% of hospitals across the country provided language services, there are great differences in need and provision of language services by hospitals, with large variation by location and type of ownership (private not-for-profit, private for-profit, or government).⁴

The direct and indirect costs of providing language interpretation services are major considerations for providers and hospitals. This includes the costs of salaries and fringe benefits for interpreters, training costs, and equipment costs for items such as speaker phones, video conferencing equipment, computers, and costs associated with developing translated written materials. Opportunity costs also exist, but may be more difficult to estimate. For example, a provider may spend more time with a patient when using an interpreter, which might result in the provider seeing less patients during a clinical session and reduce the revenue billed. Only a few states provide reimbursement for interpretation services through Medicaid and hospitals are prohibited from billing patients for language services.

Research indicates that trained professional interpreters provide better quality language services. Some hospitals and providers utilize certified interpreters to provide language assistance, but there are a limited number of certified medical interpreters in the U.S. who are specifically trained to provide interpretation services for LEP individuals in the healthcare setting. Certified medical interpreters have received medical interpreter training and have passed exams covering ethics, cultural competence and responsiveness, medical terminology, and best practices for working with healthcare teams. Certification and testing is administered by the National Board of Certification for Medical Interpreters (“National Board”) or Certification Commission of Healthcare Interpreters (CCHI). Unfortunately, there are only about 2,000 medical interpreters certified by the National Board and 3,700 healthcare interpreters certified by CCHI in the entire U.S.

*Patients who are LEP... experience lower quality of care and more adverse health outcomes, such as **longer hospital stays and a greater chance of hospital readmission** for certain chronic conditions, compared to those who speak English well.*

In California, which has great language diversity and the highest concentration of LEP individuals in the country (about 6.8 million people), there are only about 900 healthcare interpreters certified by CCHI in the entire state. The current CCHI list of certified healthcare interpreters indicate that there are only 24 Vietnamese-speaking interpreters to serve the approximately 49% of Vietnamese in California who are LEP (about 318,000 people).⁵ For some less commonly-spoken languages, there may be no certified healthcare interpreters available.

4 Schiaffino, M.K., Nara, A, & Mao, L. “Language Services in Hospitals Vary by Ownership and Location,” Health Affairs 35, No. 8 (2016): 1399-1403.

5 U.S. Census Bureau, 2013 American Community Survey 3-year data.

Because of the limited number of available certified health care interpreters, hospitals and health systems use a combination of bilingual providers, on-site bilingual staff and volunteers (trained and untrained in interpretation), over-the-phone interpreters, and patients' family members to provide interpretation services. However, these options are not ideal for providing interpretation services. Bilingual staff and volunteers may not have adequate training to effectively interpret complex medical concepts. They may not also have the appropriate cultural awareness even if they do speak a language adequately. Bilingual staff providing interpretation assistance note that physicians do not always understand the difficulties interpreting medical concepts and often assume that staff interpreters understand all areas of medicine. Use of a family member introduces bias and family dynamics as well as cultural intricacies into the process. One study found that women were uncomfortable discussing gynecological symptoms when male relatives served as interpreters, which resulted in them not discussing important problems with their physicians.⁶ Family members may also not accurately convey complex medical terminology and concepts when interpreting for family members.

Community health centers (CHCs) provide linguistically accessible and culturally appropriate comprehensive health care services to many medically-underserved communities regardless of insurance status and ability to pay. CHCs often serve communities with a high proportion of LEP individuals who are best served in languages other than English.⁷ However, CHCs face difficulties recruiting and retaining bilingual providers, interpreters, and staff to represent the increasing diversity of the populations they serve. In order to cover some of the less widely spoken languages they encounter, health centers must sometimes rely on remote video interpretation. The costs required for the equipment and access to remote interpreters are expensive and require significant financial resources.

THE ROLE OF CBOS IN ASSISTING LEP INDIVIDUALS IN ACCESSING HEALTH CARE SERVICES

CBOs have always played an essential in helping people enroll in health insurance coverage and continue to assist communities in understanding recent changes to the health care system. With the passage of the ACA and the subsequent changes in health insurance coverage and the Medicaid program, many community members expressed confusion about what health reform meant for them. They had questions about the health insurance marketplace and exchanges, their eligibility for coverage and tax credits, the services covered under health insurance plans, and monthly premiums and costs.

The expansion of the Medicaid program, allowing all eligible adults under certain income levels to access Medicaid, led to many questions about eligibility from community members. Those who had never had health insurance before, particularly recent immigrants and LEP individuals, needed assistance understanding how to apply and what documents to submit to confirm their eligibility. CBO staff helped explain health insurance concepts and terms that were unfamiliar to many, such as "deductible" and "co-pay". They also helped individuals understand the various costs associated with the specific plans they chose. One survey found that large numbers of new enrollees did not know the

6 Shah S, Ayash C, Pharaon N, and Gany F. "Arab American Immigrants in New York: Health Care and Cancer Knowledge, Attitudes, and Beliefs," *J Immigr Minor Health*, October 2008; 10(5): 429-36.

7 "Serving Patients with Limited-English Proficiency: Results of a Community Health Center Survey", National Association of Community Health Centers (2008), available at <http://www.nachc.org/wp-content/uploads/2015/06/LEPReport.pdf>.

amount of their deductible (37%) or the amount of subsidy they received (47%).⁸

Trusted CBOs Serve a Vital Role in the AA and NHPI Community

CBOs serving AA and NHPI communities often focus on providing services to specific AA and NHPI ethnic subgroups that are most represented in the community. Others provide services for segments in a community, such as immigrants and refugees, that often have a large proportion of individuals who came to the U.S. from an Asian or Pacific Island nation. Many of these individuals are LEP, and therefore CBOs frequently have multilingual staff and volunteers who come from the community with the necessary cultural understand to competently provide in-language assistance to the individuals they serve.

During the first four enrollment periods of the ACA, APIAHF helped to establish the *Action for Health Justice (AHJ)* network, a collaborative of over 70 CBOs and CHCs in 22 states serving primarily AA and NHPI individuals and helping them enroll in health coverage, many of whom were LEP with varying immigration statuses.⁹ The CBOs and CHCs were selected to make up the *AHJ* network due to their roles in providing services to local AA and NHPI communities and standing as trusted sources of information and assistance for the community. These entities engaged in multiple strategies to help consumers enroll in coverage, from staff spending multiple one-on-one sessions with community members to help them complete applications and explain complex health insurance terms and concepts, to hosting in-language information sessions to explain health insurance options.

AHJ organizations also created their own translated easy-to-read educational materials for community members, as many materials created by Federal and state marketplaces were not available in Asian and Pacific Island languages or were not translated appropriately for community members to understand. CBO staff provided assistance submitting enrollment documentation, such as identity and immigration status verification documents, which many LEP consumers needed assistance with. Initially, the identity verification vendor used by the federal marketplace did not provide interpretation services over the phone. CBO staff also helped clients identify the relevant documents and submit them in the correct format. Many legal permanent residents who were eligible for coverage mistakenly believed that applying for coverage would negatively impact their immigration status and CBO staff helped to allay these concerns.

What is a Community-Based Organization (CBO)?

Community-based organizations are non-profit groups in local communities that provide services and work toward improving conditions for members of the community. Some may be focused on a specific topic area and/or a specific community. They provide a variety of services (job-training, social services, etc.) and often assist marginalized communities. Staff usually live in the local communities they serve, understand their culture, and speak the same languages as the community.

⁸ Survey of Non-Group Health Insurance Enrollees, Kaiser Family Foundation, June 19, 2014, available at <http://kff.org/health-reform/report/survey-of-non-group-health-insurance-enrollees/>.

⁹ For more information about the work of Action for Health Justice, see the report "Improving the Road to ACA Coverage: Lessons Learned on Outreach, Education, and Enrollment for Asian American, Native Hawaiian, and Pacific Islander Communities," September 2014, available at <http://www.apiahf.org/resources/resources-database/improving-road-aca-coverage-lessons-learned-outreach-education-and-enro>

Helping Connect to Care: Navigating for the Newly Enrolled

CBOs continued to help AA & NHPI individuals even after they had enrolled in coverage. Once individuals had coverage through qualified health plans and/or Medicaid, they needed assistance understanding how to use their coverage and access health care services. They needed assistance understanding their provider network to see if it included providers that might speak their language in close proximity to them, or what out-of-network services were covered under the plan they selected. Results from a 10-state study found that AAs and NHPIs had the highest percent of those using health clinics or hospitals for primary care vs. individual physicians (78% compared to 70% for Native Americans or Alaska Natives and 56% or less for all other racial groups).¹⁰ In a California-specific survey, 88% of AAs and NHPIs reported going to a hospital or clinic instead of a physician for primary health care needs, compared to 43% for White and 63% or less for all other racial groups.¹¹ While this may in part be due to high deductibles when seeing primary care providers, many individuals likely continued to use these trusted community health centers and clinics for care, where they had previously received adequate language assistance and culturally appropriate care and where they went for care before they had any insurance coverage.

CBOs also helped AA & NHPI individuals understand the services in their health plans. In the same 10-state study, less than 20% of AAs and NHPIs knew which services were included in their insurance coverage, compared to over 40% of all other race groups. Another study on the state of health in New Mexico showed that Asian Americans had a much higher percentage than all other major race groups of not knowing if their coverage included access to free preventative services.¹² CBOs assisted individuals by describing the value of prevention to community members, discussing the preventive services covered under their plans, and explaining how to access those free or very low-cost services.

THE ROLE OF COMMUNITY HEALTH WORKERS IN HELPING INDIVIDUALS ACCESS CARE

Community Health Workers (CHWs) play increasingly important roles in helping individuals access health care services. CHWs often reflect the cultural and socioeconomic diversity of the local population. Some work in the community independently, while others are integrated members of primary care and prevention teams. Many have built trust with the community, and this enables them effectively work with community members and assist them in accessing health care services. They have a broad range of roles and responsibilities, including helping patients in navigating the health care system and increasing usage of primary and preventive care services.¹³ They also work with providers to help them better understand a patient's background, limitations, and expectations.

10 "Breaking Barriers: Improving Health Insurance Enrollment and Access to Health Care," April 2015, pg. 12, available at http://allianceforajustsociety.org/wp-content/uploads/2015/04/BreakingBarriers_Natl_sm.pdf.

11 "Breaking Barriers: Improving Health Insurance Enrollment and Access to Health Care in California," March 2015, pg. 9, available at http://allianceforajustsociety.org/wp-content/uploads/2015/04/BBReport_CALIF.pdf.

12 "Breaking Barriers: Improving Health Insurance Enrollment and Access to Health Care in New Mexico, April 2015, pg. 10, available at <http://strongfamiliesmovement.org/assets/files/Breaking-Barriers.pdf>.

13 "Community Health Workers in California: Sharpening our Focus on Strategies to Expand Engagement," California Health Workforce Alliance, January 2015.

Funding for CHWs

CHWs are funded in a variety of ways. CHWs can be funded through the use of State Plan Amendments for reimbursing preventive services, Section 1115 Medicaid demonstration waivers, and reimbursement through managed care contracts. However, the scope of services that CHWs can be reimbursed for is limited. For example, preventive services that are recommended by a physician or licensed provider, but potentially provided by a non-licensed provider such as a CHW, can be reimbursed. This can include services provided by a CHW, such as group health education and diabetes prevention programs. CHW services can also be reimbursed if a State Plan Amendment is filed adding CHWs and identifying which preventive services they can provide.

What is a Community Health Worker (CHW)?

Community Health Workers are defined by the American Public Health Association as “a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served.”

CHWs have also been funded through Centers for Medicare & Medicaid Services (CMS) State Innovation Model (SIM) grants. CMS developed the SIM initiative to fund states to test new delivery system models that would result in better quality care, lower costs, and improved health for populations. Some included patient-centered medical homes, health home models, and accountable care models, and CHWs were incorporated into some of these state models.

Some states that have created Medicaid Health Homes and other similar coordinated care mechanisms have encouraged the inclusion of CHWs in care teams. Health Homes are used to coordinate care for Medicaid beneficiaries with chronic conditions and utilize community care teams comprised of a variety of participants, including hospitals, home health agencies, health centers, primary care practices, social service organizations, and community-based entities. In Maine, reimbursement is provided for CHWs as part of the Community Care Teams. Other states, including New York, Oregon, and Washington also use similar models in which CHWs function as integral parts of the multidisciplinary teams.¹⁴

Effectiveness of CHWs

Studies have shown the effectiveness of CHWs by helping community members enroll in health insurance programs and navigate health care systems. Other studies have identified the cost effectiveness of CHWs, as they help patients manage chronic conditions, and increase the utilization of preventive services and primary care, thereby reducing use of costly emergency care and hospitalization.

For example, the use of CHWs as part of care coordination teams by Hennepin Health in Minnesota resulted in significant reductions in patient utilization of emergency department and hospital visits,

¹⁴ Katzen A. and Morgan M. “Affordable Care Act Opportunities for Community Health Workers: How Medicaid Preventive Services, Medicaid Health Homes, and State Innovation Models are Including Community Health Workers,” May 2014, available at <http://www.chlpi.org/wp-content/uploads/2013/12/ACA-Opportunities-for-CHWsFINAL-8-12.pdf>. For more information on state funding for CHWs, see the Families USA issue brief “How States Can Fund Community Health Workers through Medicaid to Improve People’s Health, Decrease Costs, and Reduce Disparities”: http://familiesusa.org/sites/default/files/product_documents/HE_HST_Community_Health_Workers_Brief_v4.pdf

while increasing outpatient primary care utilization.¹⁵ This health system is continuing to explore CHW impact on outcomes, cost savings, and revenues. In another example, Molina Healthcare of New Mexico identified higher users of health resources, such as the Emergency Department, in a Medicaid managed care system and assigned CHW services to these users for six months.¹⁶ This group was compared to a similar group of high utilizers of services who did not receive CHW services. Study results showed a significant reduction in numbers of claims and payments, number of emergency department visits, and number of inpatient admissions for those who received CHW services.

INTEGRATING CBOs INTO THE HEALTH DELIVERY SYSTEM

Just as CHWs have become more integrated and utilized in the health care system to support the health of individuals and communities, CBOs provide another mechanism to improve the patient experience, particularly for LEP individuals. CBOs can function as a hub for LEP individuals who want to access care, but who need culturally and linguistically appropriate assistance to navigate the health care system. Although CBO staff may not be certified CHWs, they still provide culturally competent in-language enrollment assistance and assistance in helping people access care and navigate the health care system. CBOs can serve as important members of a care coordination system designed to improve health care access and quality for LEP individuals and receive compensation for services provided by staff, just as CHWs are compensated for helping individuals navigate the health care system. This compensation could come in the form of contracts between CBOs and hospitals, insurers, and provider networks in which CBO staff provide interpretation and health system navigation for LEP individuals. Health plans could contract with CBOs to help their LEP members find providers, describe services covered under their plan, make appointments with providers, and provide interpretation assistance during clinic visits.

15 Islam N., Nadkarni S., Peretz P., et. al. "Integration of Community Health Workers into Primary Care Health Systems: The Time for New York is Now!" NYU-CUNY Prevention Research Center, October 2016.

16 Johnson D., Saavedra P, Sun E., et. al. "Community Health Workers and Medicaid Managed Care in New Mexico," J Community Health. September 28, 2011.

CBO Perspectives on Connecting LEP Individuals to Care

Staff representing 17 CBOs in California serving primarily AA and NHPI communities provided feedback to APIAHF on the assistance they provide to LEP individuals in accessing health care services and suggestions on how they might work more closely with the health care system.

These CBOs provide a variety of services, such as health education, assistance applying for public benefits, legal assistance, interpretation, and job placement assistance. They shared their perspectives from working directly with community members helping them enroll in coverage and accessing health care services. Questions asked included the following: What types of assistance do you provide to LEP individuals? What challenges do you face in providing interpretation services to community members and hiring staff to provide interpretation services? What resources would be most helpful?

Some of the feedback they shared included the following:

- The importance of the **quality** of in-person interpretation that they provide. They mentioned that many hospitals and clinics use telephone interpretation services, which may cost less than providing in-person interpretation, but decreases the quality of communication between provider and patient. One respondent mentioned the importance of non-verbal communication, especially in a clinic setting and discussed how in-person interpretation is preferred by both patient and provider over telephone interpretation.
- The **cultural competency** and ability to **understand nuances** in language (sometimes differences in the ways the older and younger people speak a language) which are important in explaining health care concepts. Some CBO staff discussed challenges they face in translating some medical terms into certain Asian languages. They talked about the need for training in medical terminology and concepts to provide adequate interpretation.
- **Inadequate translated materials** provided by health plans. They described how clients bring in materials, translated by their health plan, that do not read well or do not make sense to the consumer because of inaccurate or purely literal translations and how CBO staff must explain this information to clients. Some talked about the need for funding to help develop their own translated materials that the community can understand about how to access health care services through private insurance or Medi-Cal (California's Medicaid program).
- **Patient Navigation.** Bilingual CBO staff often help to make appointments for LEP individuals because of the challenges they face making appointments with their provider over the phone.

Overall, CBO staff described ways that they are providing language assistance services to health plan members but not getting reimbursed for this work. They are doing it because community members need help, many of whom are LEP, and come to the CBO as the **trusted source** of information in the community.

RECOMMENDATIONS

CBOs, health insurers and providers can work together in the following ways to address the language barriers that greatly contribute to health disparities facing LEP individuals, particularly in AA and NHPI communities:

- 1. Health plans and health systems can provide a better experience for their LEP members by contracting with CBOs to assist LEP members, especially for those who speak less common languages.** Health plans could refer LEP clients to local CBOs that they have contracted with to provide these services. For example, a health plan could provide a LEP Hmong-speaking member with a list of local CBOs with qualified Hmong-speaking staff that it has contracted with to provide in-language patient navigation services. A local CBO could contract with a local health care facility to provide language services. For non-emergency appointments, clinics could schedule patients who speak certain languages to come on certain days and work with CBOs to provide staff who speak less common languages to local clinics on those days.
- 2. Insurers, health plans, and health systems should provide funding to CBOs to work with them to review translated materials for consumers.** CBOs can assist with the review of written materials to ensure that they are culturally appropriate and consumer friendly for the populations that the CBOs serve. Partnering with CBOs to develop translated materials will ensure that funds are spent efficiently and materials are useful for the intended audiences.
- 3. Health plans and providers should partner with CBOs on various training opportunities.** While CBO staff best understand the communities they serve and nuances in the languages spoken by community members, health plans can work with CBOs to provide training for some important medical terms and concepts. Local CBO staff can engage with interpreters servicing local health care facilities to share information on cultural and language nuances, and medical interpreters can discuss complex medical concepts and terms to help CBO staff with their interpretation accuracy. By combining the health plan/provider knowledge with the cultural and linguistic understanding of CBO staff, LEP individuals can receive the high quality interpretation, which will result in better access to care and better health outcomes.
- 4. Cost/benefit analyses and further testing of contractual relationships between CBOs and providers is needed.** Pilot testing could help to explore the feasibility and effectiveness of integrating CBOs into the health care delivery system. While paying CBOs to provide language services requires additional direct costs to providers, they must be weighed against other costs, such as those associated with medical errors, greater malpractice risk, and poor quality of care, which could be much greater than the costs for providing quality interpretation services.