Language as a Barrier to Health Care for New York City Children in Immigrant Families:

Haitian, Russian and Latino Perspectives

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This is the first in a series of three reports on health care access for children in immigrant families. Subsequent reports will focus on out-of-pocket medical costs and barriers to public health insurance. To request copies of these reports, contact the Division of Health Policy at the New York Academy of Medicine or go to http://www.nyam.org/initiatives/sp-pub.shtml.

Reports are also available on line through the Foundation for Child Development at www.fcd-us.org. The Foundation for Child Development (FCD) is a national, private philanthropy dedicated to the principle that all families should have the social and material resources to raise their children to be healthy, educated and productive members of their communities. The Foundation seeks to understand children, particularly the disadvantaged, and to promote their well-being. FCD believes that families, schools, nonprofit organizations, businesses and government at all levels share complementary responsibilities in the critical task of raising new generations. More information about initiatives supported by the Foundation for Child Development is available at http://www.fcd-us.org/ourwork/n-index.html.

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INTRODUCTION

A growing body of literature has documented the impact of limited English proficiency (LEP) and patient-provider language discordance on access, use and quality of medical services. Limited English proficiency and language discordance are associated with under-use of primary and preventive services,[1-3] limited comprehension of medical[4, 5] and insurance-related[6] information, nonadherence to medical recommendations, and less cost-effective use of medical services, including a greater need for laboratory tests and longer medical visits.[7, 8] Limited English proficiency is also associated with inadequate insurance[9, 10] and inability to access needed information from health providers and to schedule appointments via telephone.[11]

New York City is now home to approximately 2.9 million immigrants, speaking well over 100 distinct languages.[12] In 2000, 52% of children born in NYC had a foreign-born mother; currently immigrants and their children account for nearly two-thirds of the City's population. Census data from 2000 show that nearly half of New York City's residents speak a language other than English at home,[13] and more than 12% of the City's population (or more than one in four adults) report that they do not speak English at all or do not speak it well.[11, 14] Although federal, state and local laws in New York (see figure 1) require that federal fund recipients, including hospitals, clinics, managed care organizations, and Medicaid offices, provide interpreters or take other steps to provide LEP individuals with meaningful access to their services, a number of recent reports and legal actions document significant shortcomings in practice.[11, 15-17]

This paper adds to and complements the existing literature on language access by focusing on the perspective of the consumer, including their own descriptions of how language affects enrollment in insurance and use of health care services and the strategies used to reduce the impact of limited English language skills.

FIGURE 1

Legislation Regarding Language Access in Health Care Settings

- **Title VI of the 1964 Civil Rights Act**, "Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons," 42 U.S.C. 2000d-2000d-4; 28 CFR 42.101, requires hospitals to ensure meaningful access to language services. Hospitals that receive federal money must provide non-English speaking persons with interpretation and translation services.
- **Executive Order 13166**, "Improving Access to Services for Persons with Limited English Proficiency," U.S. Department of Justice, mandates improved access to federally conducted and federally assisted programs and activities for persons who, as a result of national origin, are limited in their English proficiency.
- **New York State Patients' Bill of Rights**, N.Y. Public Health Law, Sec.2801-c (McKinney 1985), requires a hospital to provide interpreters and translators to non-English speaking patients, when such non-English speaking residents comprise at least 1% of the population of that hospital's service area.
- **New York City Emergency Room Interpreter Law**, N.Y. City Code, tit. 17, Sec 17-174 (2001), requires a hospital to provide interpretation services for non-English speaking patients seeking care in its Emergency Room, when such non-English speaking residents comprise at least 10% of the population of that hospital's service area.

STUDY DESIGN

Data reported here come from a study of New York City children in lower-income immigrant families who were uninsured or who had gaps in insurance during the prior two years. The focus of the study was on three immigrant populations: Latinos, Russian-speaking immigrants from the former Soviet Union,* and Haitians. These groups were selected for their notable size and the diversity, relative to one another, in immigration status, socioeconomic characteristics, and demographic characteristics. The study includes data from 74† qualitative interviews with parents (24 Haitian, 25 Latin American, and 25 Russian), conducted between August and December of 2003. The interviews, which took approximately 40 minutes to complete, followed a 30 question guide that focused on an index child's medical visits, as well as the parent's experiences enrolling the child in and using health insurance, their sources of health information, and home country health experiences. Each interview also included 20 short answer questions focused on demographic characteristics of participating families. Interviews were conducted in Haitian-Creole, Spanish and Russian by native speakers who were staff members of community-based organizations (CBO's)providing services to these three populations. The respondents each received a cash incentive for their participation. The open-ended portion of the interviews was audio-taped and professionally transcribed and translated. Coding and analysis of qualitative data was conducted using ethnographic software (Atlas.ti, Scientific Software Development, Berlin, Germany).

To be eligible to participate in the study, a respondent had to be a Russian, Haitian, or Latino immigrant parent of at least one child under 18 years of age who was eligible for Medicaid or Child Health Plus. The index child had to be uninsured at the time of the parent's interview, or insured with Medicaid or Child Health Plus but with a period of uninsurance within the past two years. Respondents were recruited using purposive sampling through collaboration with community-based organizations serving the three populations. All participants were clients of the three collaborating organizations.

*** For the sake of brevity, respondents from the former Soviet Union are referred to as "Russians" throughout this report.**

† Seventy-five interviews were conducted. One interview was not included in the analysis because the audiotape was inaudible.

FINDINGS

Respondent Characteristics: Most respondents were limited English proficient and all were foreign-born. As shown in Table 1, 76% of respondents had at least a high school degree (although there was significant variation by ethnicity), 43% worked full- or part-time, and approximately 40% have been in the U.S. less than 5 years. Twenty percent of children in sample families were uninsured at the time of the interview (see Table 2); Latino children were least likely to be uninsured – in contrast to their parents who were most likely to be uninsured.

TABLE 1
Demographic Characteristics of Study Participants
(N=74)

Characteristic	Haitian (n=24)	Latino (n=25)	Russian (n=25)	Total
Gender of Respondent				
Female	100%	96%	100%	99%
Male	0%	4%	0%	1%
Age of Respondent (years)				
20 - 25	12%	4%	0%	6%
26 - 35	21%	37%	52%	37%
36 - 45	50%	42%	35%	42%
46 - 59	17%	17%	13%	15%
Education				
No high school	14%	16%	0%	10%
Some high school, no degree	9%	32%	0%	14%
High school degree/GED	54%	32%	21%	35%
Some college or college graduate	23%	20%	79%	41%
Employment Status				
Full time	25%	12%	29%	22%
Part time	17%	12%	33%	21%
Occasional	0%	4%	0%	1%
Student	4%	4%	4%	4%
Unemployed	54%	68%	33%	52%
Marital Status				
Married/living as married	60%	79%	64%	68%
Separated/divorced/widowed	12%	21%	32%	21%
Never married	28%	0%	4%	11%
Years in US				
< 5 years	56%	20%	44%	40%
5 -10 years	16%	24%	48%	29%
> 10 years	28%	56%	8%	31%
Household Composition*				
5 or more members in household	32%	50%	4%	28%
Child < 1 year in household	20%	8%	12%	13%
Child age 2 – 10 in household	84%	76%	52%	71%
Child age 11- 19 in household	32%	64%	52%	49%
Birthplace of Children				
US-born	61%	69%	34%	56%
Foreign-born	39%	31%	66%	44%
Reports speaking some English at home				
Yes	16%	28%	0%	15%
No	84%	72%	100%	85%

** does not add to 100% because categories are not mutually exclusive.*

Latin American respondents were primarily from Colombia (36%), Mexico (28%) and Ecuador (20%); Russian respondents were primarily from Russia (46%), Ukraine (38%), and Uzbekistan (12%). Over half (56%) of the children included in the study were born in the U.S., with the highest proportions among Haitians and Latin Americans. Sixteen percent of the index children had chronic health problems, which included asthma, allergies, diabetes, developmental delays, and vision-related problems. Participants sought medical care for these, as well as the typical range of childhood ailments, including broken bones and other injuries, respiratory infections, rashes, and high fever.

Language Access and Health Insurance: Study participants reported a number of barriers to sustained enrollment in and utilization of Medicaid and Child Health Plus, including difficulties accessing appropriate information on application procedures, eligibility guidelines, participating providers, and requirements regarding recertification. Long lines at Medicaid offices and administrative errors compounded their difficulties. Barriers to insurance led to gaps in coverage, which in turn resulted in delayed care, unfilled prescriptions, out-of-pocket medical costs, and medical debt.

TABLE 2
Insurance Status of Study Families (N=74)

Characteristic	Haitian (n=24)	Latino (n=25)	Russian (n=25)	Total
Insurance Status of Study Children				
Medicaid/Child Health Plus	66%	90%	83%	80%
Private	0%	0%	0%	0%
Uninsured	34%	10%	17%	20%
Insurance Status of Respondent				
Medicaid/Family Health Plus	24%	20%	64%	36%
Private	12%	0%	16%	9%
Uninsured	64%	76%	20%	54%
Respondent unsure	0%	4%	0%	1%
Insurance Status of Spouse/Partner				
Medicaid/Family Health Plus	14%	22%	50%	29%
Private	7%	5%	25%	13%
Other	0%	6%	0%	2%
Uninsured	79%	64%	25%	56%
Families with at least one uninsured child	32%	16%	16%	21%

Because study participants were all clients of CBO's that employ bilingual health advocates and/or facilitated enrollers, most LEP study participants received linguistically appropriate assistance from these organizations. However, many described difficulties resulting from language barriers that occurred prior to their connection to the CBO's. Lilia, a Ukrainian mother of a 12-year-old, described her experience first enrolling in Medicaid. Her daughter's school entry was delayed by three months, as Lilia waited for her Medicaid to be activated before taking her for a physical and to get the required vaccinations.

> *We had just come to this country. We didn't know any English; we didn't understand what was asked of us. And we always had to ask strangers for help. Not everybody had time for us. We asked one friend to come with us, then the second friend, then the third friend. We went to this office three or four times. Every time we had to fill out a different application. We were communicating with the representative through our friends, because we didn't understand a word he was saying… I saw all Russian-speaking people coming with their friends for interpreting. —Lilia*

Alejandra, from Colombia, also faced a language barrier in the Medicaid office. Her son needed expensive dental work due to an accident. He was enrolled in Child Health Plus at the time, but his plan covered only routine dental care. It was suggested that Alejandra switch him to Medicaid, but when she went to the Medicaid office, she was discouraged from applying and, in her opinion, treated inappropriately.

> *A lot of times they treat you like if you were nobody. Just because we don't understand English and because we don't have our documents in order or whatever, they think we are nobody, so then they treat us badly… They tell you like this: 'and why don't you speak English, you have to know how to speak English, I'm not supposed to find you an interpreter. You live here in the United States and you are supposed to learn how to speak English.' Like that. 'If you don't understand then we can't continue, so find yourself someone who can translate for you because I can't.' That's how they tell me; they are very rude. —Alejandra*

Problems with enrollment were, however, less often mentioned than problems maintaining insurance once enrolled. In the view of participants, insurance plans focused their language access resources on recruitment so as to increase enrollment, but cared relatively little about providing linguistically appropriate services to members once enrolled. Malaya, from Colombia, described a recent recertification encounter:

> *I don't know what is going to happen. As I said, they didn't provide an interpreter, nothing! She would ask me and I would tell her I didn't understand. She also asked my son if he spoke and understood English … well, the child speaks a little, but only what he hears from my other nephews, because I don't speak English to him. He is barely three years old. She asked him if he understood English, if he spoke English, and he kept saying, 'yes.' It was funny because she was asking him… like for instance, if it was true I was taking care of a child, what was his name… the father, etc., and he would ask me, 'how mom?' And she would repeat the same question… and she thought it was funny as well. What he could tell her was his name and that the other boy was his friend. —Malaya*

Bilingual phone support was not necessarily available for matters that ordinarily could be dealt with over the telephone. In some instances, therefore, participants were required to travel far from their home neighborhood to Medicaid offices employing bilingual staff. Because participants had work and/or childcare responsibilities, such travel represented a significant burden.

Bilingual staff, including facilitated enrollers, health care advocates, and other staff from CBO's, health care providers, and insurance plans, helped a number of participants navigate the insurance system in their own language. Participants mentioned being approached and directed to appropriate assistance at health fairs, in waiting rooms at doctors' offices and hospitals, during English classes, and on the street.

> *While I was waiting, this lady approached me. I was speaking Creole to the child and she asked me if I was Haitian, and she asked me if I had an insurance card. I said no. I told her that I have not been here long, I just have a problem with the child and I came to the hospital with her. Then she asked me if I was interested. I said yes. She asked me for my name and address. I gave her my name and… my daughter's name. That's how we enrolled the child. Then some time later, the card came to the house. —Francoise*

LANGUAGE ACCESS AND MEDICAL CARE

Participants with limited English proficiency described a number of medical encounters with satisfactory language services. In these encounters, the provider or another staff member spoke the participant's language, or the respondent brought along a family member – usually a sibling or spouse – who was able to communicate with the provider. More often, however, language barriers were reported by LEP participants, reducing access, quality, and satisfaction with care.

Clinic Administration: Access to medical care can be influenced by the administrative staff and administrative procedures within a health care setting. Participants were particularly frustrated by language barriers in administrative matters. Similar to their experience in insurance offices, some participants felt they were treated rudely by administrative staff because of their limited English language skills and told "go and learn English." According to participants, even bilingual staff working in physician offices did not always provide linguistically appropriate services to LEP patients.

> *There are some Haitians who won't speak Creole. I don't know why but they won't. There is one at [my daughter's] clinic; I always speak Creole to him, but he never speaks to me in Creole. I know he is Haitian. Every question he asks me in English, I reply to in Creole. He writes the information down, but he still won't speak to me in Creole. —Nadege*

Sourette, another Haitian mother, commented:

> *As for me, the language is a little heavy, I'm stuttering when I'm speaking English. They tend to stay away from me. They're really not around for you. Neither do they look for someone that knows your language and would speak to you in your language. They'd rather ask you the question three or four times and you don't understand what they're telling you… Anywhere I went, I had to force myself to speak the [English] language. There are even certain Haitians there, and they act as if they don't speak your language so they won't have to help you. Whenever the person sees that you cannot speak the language they don't even bother with you. [When that happens], I feel humiliated, I don't feel comfortable, I feel embarrassed. —Sourette*

For other participants, it was merely the lack of linguistically appropriate services that frustrated them. Vera, from Belarus, was unable to enroll her daughter in school because the child was not fully vaccinated. Vera took her daughter to a vaccination clinic in a largely Russian neighborhood.

> *When you finally entered that office, you had to go through tons of papers. Most of the patients were Russians, but nobody from the staff spoke Russian. They gave us applications and started explaining something, but we didn't understand anything they said. We were just consulting each other, and finally, half of the papers we filled out were filled out incorrectly. And the staff actually accused us of not being capable to write our children's health histories in English. And we were wondering why they couldn't provide us with Russian-speaking interpreters, so we could communicate on equal terms. —Vera*

Esperanza takes her children to a clinic with Spanish-speaking physicians and nurses. They require that she make an appointment prior to bringing her children in but have limited Spanish speaking staff to schedule appointments.

> *When I have to make an appointment, I put [my nine year old daughter] on the phone and sometimes she can't say all the things I would like for her to say… because when I call the clinic they always tell me that there's no one who can speak Spanish and they put me on hold and then I wait on the phone for 20 to 30 minutes so instead of waiting I put my daughter on the phone to make the appointment. —Esperanza*

The medical encounter: Overall, 55% of study participants complained of language barriers in one or more medical encounters, including 66% of Haitians, 40% of Latinos, and 12% of Russians. Although several LEP participants spoke highly of their English-speaking physicians, praising their skill, concern, and the patience required to repeat information multiple times – and their willingness to pull staff from their regular responsibilities to help with translation – there was a universal preference for providers who spoke their own language.

> *Actually, it is very convenient when you can come, and in spite of your limited knowledge of [the English] language, tell your doctor everything about your problems in your native tongue. This is natural for every ethnic group. This creates more trust… especially when there is some medical problem. —Julia, Russian mother*

> *When you have a child you can't take too many chances. When you live in this country you think you can speak English but sometimes you really can't. You may say something that is not correct and the doctor ends up giving the child something that does not make her feel well. So I made sure that I found a doctor who specializes in this so that no matter how I speak to him, he will provide me with the proper answers. That's why I have chosen [this Haitian doctor].*
> *—Yolaine, Haitian mother*

Access to language concordant providers varied, however, by language and by provider type. The Russian immigrant community in NYC includes a relatively large number of physicians; Russian study participants tended to have little trouble identifying Russian pediatricians. Latino and Haitian participants were somewhat less likely to have a pediatrician with whom they shared a language, and all three populations were unlikely to find specialists, including dentists, who spoke their own language.

Language discordant medical encounters were handled in a number of ways within this sample, including remote simultaneous translation (in one instance); translation by spouses, siblings, or friends brought (or phoned) for that expressed purpose; translation by other parents in the waiting room or clinic staff (often nursing or administrative staff); translation by the children needing care; and no translation at all. One participant relied on her bilingual pharmacist to explain medication information after her medical visits, because she did not understand her English-speaking physician's attempt at a Spanish explanation. Although few of these solutions were entirely satisfactory, medical encounters without any interpretation were most troubling. The immediate consequences of a language discordant medical encounter without translation are obvious – minimal communication and insufficient comprehension. Participants reported that language barriers caused under-utilization of services, as they sought to avoid uncomfortable and frustrating encounters, and over-utilization of services, attending a second visit for clarification of information provided in the first visit.

> *If I am going to take my children to the doctor, it's because it's something important so I need for them to understand what I want and I want to understand what they are saying… If you are talking to the doctor, they don't understand what you are saying, maybe they understand half of the things we are saying… You don't understand what they are telling you about the children, and then they get upset because you tell them that you don't understand and that we need interpreters and they tell you there's none. —Alejandra, mother of 4 from Colombia*

Francoise, who is Haitian and speaks limited English, worried that she hasn't fully comprehended the information provided to her but has been too embarrassed to request special assistance:

> *Sometimes it's very upsetting when someone's telling you something, and you don't really understand them. You understand a few words and you hope that what you've heard is correct, but you're not really sure that you understood all the information given to you, unless there's an interpreter there that can tell you exactly what's being said. —Francoise*

She continued:

> *Sometimes they say something and I respond yes, but I know I did not understand. It just seems that sometimes you hear a word that makes sense. You think you understand the word but you don't. Most often I want to hurry-up and finish, because I don't want them to see that I don't understand. —Francoise*

Gertha, another LEP Haitian, has had to bring her daughter to the emergency room four or five times. She explained:

> *An interpreter was never provided to me in the emergency room; sometimes I have other people who accompany me who understand English better then I do, but I did not have an interpreter [that time]… It was difficult … because sometimes I may want to tell the person something specific that I saw in the child, but I end up not telling them everything because they don't speak my language. There are some things that I sometimes do not tell them, because I can not explain it well enough. —Gertha*

The absence of interpreters in the emergency department was likely to be particularly distressing due to the nature of the medical complaints (including, in this study, anaphylactic shock and suspected suicidality) and the invasiveness of treatment. Sourette, a Haitian mother of three, was upset that she could not understand the emergency care her daughter received.

> *I did not know what they were doing… They were speaking, but I did not know what they were doing because I don't speak English. I did not understand. The only thing I noticed was that they were stinging the child [with a syringe] a lot [to find a vein]. They inserted this long instrument in her private part and I did not like that. —Sourette*

Translation: Participants reported a number of interactions where their children (commonly as young as 9 or 10 years old) were asked to serve as interpreters at their own medical appointments. Parents expressed discomfort with the role reversal and lacked confidence in their children's ability to translate essential medical information. Although the children of immigrants often speak more English than their parents, they seldom command the specialized vocabulary required for a medical encounter; nor are they likely to have an adequate understanding of health problems or treatment issues. Roselore is referring to her ten year old daughter in the quote below. She mentioned later in the interview that her daughter also helps her to complete medical forms.

> *Her head was hit, then I took her to the doctor. I have to tell you they're American… Because I only speak Creole and I don't know a lot in English, this child is really my interpreter… I don't feel good [about that]. I should have been the one to speak on behalf of the child, not the other way around. I am the one that brings her there, and she's the one speaking for me. —Roselore*

Raquel's daughters also translate for her, because the doctors they see rarely have interpreters available.

> *The girls understand English very well, what the doctor is saying to them, but in Spanish they cannot explain it to me very well. One of them asks me 'how do you say it?' but how can I tell them? I don't speak English. —Raquel*

Several participants mentioned asking other parents sitting in the waiting room to translate; this seems to have occurred primarily in hospital settings where staff are unfamiliar and may seem unapproachable. Although some participants were comfortable with such arrangements, Alejandra, the Colombian mother quoted below, was embarrassed to have a stranger involved with her child's medical care. She explained:

> *Yes of course, there are times I feel uncomfortable to tell someone everything that is going on with me and to have someone else know about it. [Interviewer: "And what would you do then?"] Keep on going because of your children. Sometimes you have to put your ego aside. —Alejandra*

Many participants reported that language interpretation was provided by staff identified by their providers at the time of the visit. In some cases, the participants clearly stated that these interpreters were nurses, administrative staff, or had some other responsibility. In other cases, the broader role and training of interpreters was unclear. Participants were satisfied with such arrangements.

> *They have an interpreter that speaks Spanish. He works there. He is the one the doctor calls on when our regular [Spanish-speaking] doctor is not there….He always calls him. I've never had any problems. —Hermosa*

> *The doctor does not speak Creole, but there is someone in his staff that speaks Creole. Whenever I do not understand what he is saying he would call the other lady who works there to provide me with an explanation in Creole… When that woman is there I don't have a problem, but when she's not there I have a problem. —Dieudonne*

Although preferable to no translation and translation by a child, research has shown that *ad hoc* translators who lack specific training as medical interpreters are likely to make numerous errors, including errors with potential clinical consequences.[18, 19] Errors may be due to language deficiencies on the part of the translator in either the patient's or the provider's language (particularly the specialized medical terminology), as well as lapses in memory of exactly what was said and errors in judgment regarding what information needs to be communicated. Staff with other responsibilities who are eager to return to their own work may try to rush through the translation process.

One participant in the study described a medical encounter in which remote simultaneous translation was used. Consistent with other reports on this translation method,[20, 21] her assessment was positive.

> *I tell them that I do not speak English and they look for [an interpreter] really fast… They translate well, and that is what I like. They gave me headphones so that I could understand the doctor." [Interviewer: "And you could hear the translation through the headphones, did you like that method?"] "Yes I did like it. And the girl that was translating was very fast and she would translate into English to the doctor." —Manuela*

SUMMARY AND RECOMMENDATIONS

Over half (55%) of the parents in this study reported that language barriers affected utilization, quality or satisfaction with care – notwithstanding federal, state and city laws that require language access by federal fund recipients including Medicaid offices and health care providers. Participants reported that limited English language skills resulted in discourteous treatment, partial disclosure of symptoms, as well as partial comprehension of medical information and instructions provided by physicians. Participants reported approaching medical encounters with trepidation, hurrying through them in an effort to hide their limited English language skills. Some reported underutilization of services to avoid these discomforting situations, others over-utilized care as they sought in a second encounter to clarify information provided at a first.

The foreign-born and the limited English proficient population of the U.S. has increased and diversified dramatically in recent years. To improve their access to health care services, we recommend the following:

1. **Inform LEP New Yorkers about their right to an interpreter and to translated documents:** Information on legal rights to language access in health care should be made available in immigrant communities and multilingual signs should be posted in health care settings. Signs should indicate that free translation services are available, and explain how to access those services. Informational materials and forms should be translated and readily available to LEP patients.

2. **Educate staff in public insurance and health care settings regarding the right of LEP New Yorkers to interpreter services and translated documents:** Staff should proactively seek interpreters and translated materials for LEP consumers and patients. Bilingual administrative staff should be encouraged to provide administrative services and information in the language most appropriate to the consumer or patient's linguistic skills. Personal opinions regarding "the need for everyone to learn English" should not interfere with patients rights for accessible services.
    - In New York City, the 2003 Equal Access to Human Services Act requires that language access services be provided in Medicaid, Food Stamps and welfare offices citywide by the end of 2006.

3. **Increase the availability and utilization of interpretation and translation services for medical encounters:** Bilingual staff should be offered training as medical interpreters. Interpreters should be easily identifiable to patients (e.g. wearing "I speak…" buttons in the appropriate language). Use of dual headset remote translation, such as the "TEMIS" simultaneous translation service used at Bellevue Hospital or the ATT phone interpretation line, should be expanded. Staff should be informed about the availability of such services and trained on their use. Patients' needs for interpreter services should be clearly marked in the medical record.

4. **Use federal Medicaid matching funds to reimburse for interpretation services:** New York should join the nine states, which include Massachusetts, Maine, New Hampshire, and Washington, that already obtain federal Medicaid matching funds to reimburse costs associated with the provision of language services to Medicaid beneficiaries.22 Although reimbursement may not fully cover the costs of services, obtaining federal funds will offset a portion of the required expenditures.

5. **Monitor and enforce compliance with existing laws:** Recent civil rights investigations by the New York State Attorney General have led to promising settlements with two NYC and two upstate hospitals. Among other provisions, the settlements require appointment of a language assistance coordinator at each of the hospitals; translations of forms and informational materials; documentation of language preference, need, and acceptance of interpreters in patient medical records; restrictions on the use of friends, strangers and family members (particularly underage children) as interpreters; and recruitment and training of bilingual staff.
    - Legal documents can be accessed at: *http://www.nylpi.org/mdrmain.html* and *https://www.thenyic.org/templates/documentFinder.asp?did=257*.

6. **Support proposed New York State regulations that clarify hospital responsibilities regarding meaningful access to hospital services for LEP patients.** Consistent with the provisions set forth as a result of civil rights investigations (see number 5 above), these regulations provide guidance to hospitals regarding steps they should take in order to effectively meet the needs of limited English proficient patients.

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