8476

Outreach to Immigrant Communities: Teaching Pediatric Residents about Access to Health Care

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Summary: Twenty-seven pediatric residents were assessed for knowledge, attitudes, and behaviors regarding rights of immigrant families. A program documenting immigrant rights was reinforced in the clinic with posters and individual consultations on immigrant children's needs. This brief program was effective in instructing residents on health and nutritional services for immigrant patients.

Key words: Immigrant health, immigrant rights, resident education, Women, Infants and Children Program (WIC), food stamps, food supplementation programs.

Background

Pediatricians play a critical role in achieving access to health care and nutritional resources for the high-risk populations we serve.[1,2] As advocates, we ensure that services exist and are available. To be effective either as advocates or providers, pediatricians must believe that access to these resources is legitimate, know the laws governing access to resources, and be willing and able to explain rights to patients and the public alike.

Children in immigrant families are at highest risk for limited access to health care.[3–5] The risk extends through the spectrum of legal immigration, work permit (green card) eligibility, or illegal immigration. A substantial number of these families live in poverty and are affected by attendant problems, including uncertain access to health care and lack of health insurance (including 11% of U.S. children younger than 18 years old [8.4 million]).[3,4] Immigrant parents are unable to obtain health insurance for their uninsured children because of: 1) lack of knowledge about application processes and requirements, 2) legal and language barriers, 3) poverty, and 4) bureaucratic problems such as losing applications, perceived or actual discrimination, and excessive waiting or multiple visits.[5] A major fear of immigrants has been that, by applying for nutritional and health

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care support, they would make themselves into a public charge (one becomes a public charge, for example, by being on public cash assistance) and that this would deprive them of the right to apply for citizenship.[6–9] The original Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), which has transformed a welfare-based system for public support to a work-based system, prevented immigrants arriving after August 22, 1996 from receiving federally-funded benefits during their first five years in the US.[10] These benefits included Medicaid (except in the case of emergency medical care), food stamps, and income support.

Countering this barrier to health services, the American Academy of Pediatrics (AAP) has encouraged open access to care for immigrant children.[1,2,11] In 1999, the AAP Committee on Child health Financing recommended that, "New outreach efforts should be initiated to reach children who are potentially eligible for Medicaid but not enrolled, including but not limited to, legal immigrants and sets of other high risk children"[2] (p. 345). Efforts to educate residents about this issue have not been previously published.

Project Design

A proposal to educate pediatrics residents about immigrant rights and to improve the residents' skills in addressing the needs of immigrant families received funding from the American Academy of Pediatrics Child Access to Community Health (CATCH). The project grew out of a suggestion at an initial community meeting that a letter from the Immigration and Naturalization Service (INS) be circulated to assure immigrants in the community that applying for food and health programs would not affect their continued eligibility for citizenship. The letter was requested and obtained from the INS. Comprehensible print material for immigrants is an essential part of community intervention and resident education. Since the original language of the letter was confusing, the senior author (RJK) annotated it with explanatory bubbles prior to distribution.

The subsequent teaching project was a brief educational intervention to determine and improve pediatrics residents' clinical competence—their attitudes, reported behavior and knowledge—regarding immigration status and eligibility for government funded health and nutrition benefits. It addressed the full spectrum of immigration statuses noted above. Posters in the clinic and during individual preceptor sessions discussing patients reinforced these messages.

Twenty-seven pediatrics residents with varying levels of training participated in the study. These residents represented a diverse group both from the United States (20; 74%) and abroad (7; 26%). Eighteen of the 20 pediatric residents who were United States citizens either were immigrants themselves or had immediate family members who were immigrants. The ethnic backgrounds of the residents were as follows: Asian ancestry n=7, African ancestry n=9, European or Middle Eastern ancestry n=11 (total N=27). Five of the 27 residents were from Caribbean basin or South American countries, who might be identified in different ways (White or Black) by others. Two African American residents born in the United States did not have immigrants in their own family. Six residents engaged in community outreach or participated in the study design and were excluded from the study project.

Evaluation and Findings

Pediatric residents' attitudes, reported behavior, and knowledge were assessed regarding the Women, Infants and Children Program (WIC) and State Children's Health Insurance Program (SCHIP) eligibility and immigration status. The evaluation included: 1) social attitudes towards access to health care for children of immigrants, 2) behavior regarding immigration status of patients, and 3) knowledge of government-sponsored health/nutrition benefits, current immigration law, and government social programs.

Following baseline assessment, residents participated in a five-minute exercise to learn about program eligibility and immigration status. The exercise included presentation and discussion of the annotated letter obtained from the Commissioner of the INS. As shown in the figure, the letter reassures families of their unrestricted access to nutritional and child health services even if the parents are not legal immigrants. Upon completion of the training period, the figure was posted in the patients' waiting rooms and residents' conference rooms. The content was discussed with families individually whenever residents presented patients with possible problems with immigration issues.

The residents were resurveyed one and four weeks subsequent to the learner's exercise to assess the efficacy of this educational program. Outcome measures included changes in attitudes towards access to health care for children of immigrant parents (Likert agree/disagree scale of 1 to 5), reported changes in behavior regarding immigration status of patients (Likert always/never scale of 1 to 5), and changes in knowledge regarding government-sponsored health/nutrition benefits, current immigration law, and government social programs (true/false and multiple choice questions).

We found residents to be quite comfortable asking parents and patients about immigrant status at baseline. As expected, their comfort levels remained high post-intervention. With respect to attitudes at baseline, the residents generally agreed that children should be eligible for WIC benefits regardless of immigrant status. Their level of agreement increased significantly at one-week post intervention, and this increase was sustained at four weeks. At onset, most residents believed that children of illegal immigrants should be eligible for those government-subsidized health benefits offered to children of legal immigrants. There were no statistically significant increases of scores at one and four weeks.

Reported behaviors regarding immigrant rights and use of health and nutrition benefits were measured by assessing the frequency with which residents reported discussing immigration status. At baseline, residents rarely reported discussing participation in government-sponsored programs with patients. Frequency of reported discussion increased significantly at 1 week and was sustained at 4 weeks. Improvements in knowledge of current immigration law and government social programs improved significantly after 1 week (a p level of .012 using McNemar's test) but diminished at the four-week assessment ($p=.063$).

Stop worrying! You can apply for WIC, Food Stamps, and Medicaid programs.

You may have received a letter or other important documents which contains language or terms that may not be clearly explained. This is what they mean.

"Applying for these benefits will NOT affect your immigration status."

U.S. Department of Justice
Immigration and Naturalization Service

Office of the Executive Associate Commissioner

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Dear Dr. Karp:

In response to your inquiry, I am enclosing a copy of the Immigration and Naturalization Service's (INS) "Quick Guide to Public Charge and Receipt of Public Benefits." This document represents official INS policy concerning public charge.

As the Quick Guide describes in more detail, using health care benefits generally has no effect at all on a non-citizen's immigration status. This is true for both lawful permanent residents – those who already have their "green card" – and those people who hope to obtain a "green card" in the future. In particular, non-citizens will not be considered a "public charge" if they use programs such as Medicaid, the Children's Health Insurance Program (CHIP), prenatal care, or other free or low-cost medical care at clinics, health centers, or other settings (other than long-term care in a nursing home or similar institution).

I hope that this information is useful to you and others in your community. We appreciate your assistance in helping to inform people about INS policies and in reducing unfounded fears about using health care programs for which non-citizens and their family members are eligible.

Sincerely,

Barbara L. Strack
Special Assistant
Office of Policy and Planning

"Public Charge" → *Are you on welfare?*

"will not be considered a Public Charge" → *Applying for Medicaid or Child Health Plus, is **NOT** welfare. (Neither is applying for WIC or Food Stamps)*

"who hope to obtain a 'green card'" → *You can still get a 'green card' after you apply for Medicaid, Child Health Plus, (WIC or Food Stamps).*

Health Insurance and WIC

- All children with Social Security numbers or who are born in the USA are eligible for health insurance through Medicaid programs depending on your family's income level. This insurance has different names in different states, but the rules are about the same. Ask your doctor!
- The WIC (Women, Infants and Children) program gives low income families checks for infant formula, baby cereal, and other foods for mothers and children. WIC was started to prevent child malnutrition. WIC and Food Stamps provide foods of high nutritional value and relieve your family of the cost for purchasing a substantial portion of your daily food. You can use the extra money to purchase food with a higher nutritional value — better food — than is possible without WIC and Food Stamps.

The INS is never informed and parents' citizenship status is not required for Medicaid programs, WIC, or Food Stamps. Parents may be asked for Social Security numbers but they are not required to have one in order for their child to get health insurance or food support.

- Remember, health insurance for children is a right. No matter what the situation, your child will be able to see your doctor. Remember, the Immigration and Naturalization Services (INS) is banned from seeing this application.

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The social/Community Pediatrics Initiative of SUNY Downstate Medical Center. Copyright 2003.

Figure 1. Using a letter from the Immigration and Naturalization Service to good advantage. The material used in our educational program originated with a request from the community, a critical element in projects supported by the American Academy of Pediatrics program for Community Access to Child Health.

Conclusions and Recommendations

Data from the present study show that a short educational program using an authoritative source affects resident attitudes, knowledge, and reported behavior with respect to the needs of an immigrant population, consistent with recommendations of the AAP.[1,2,11] This educational intervention was successful in positively changing the social attitudes, reported clinical behaviors, and short-term knowledge of our pediatric residents concerning immigration status and government-funded health and nutrition benefits. These findings have two important implications. First, relatively brief educational interventions are effective and viable methods to introduce material affecting the health of children. Second, and more specifically, we can encourage advocacy by educating residents about government benefits for underserved immigrants.

Study limitations include a sample size of 27 residents highly representative of an urban multi-ethnic training program. Only the two native-born African-American residents were without a living memory of interaction with an immigrant in their own family. The response to training could be different in a more homogeneous residency without participation of immigrant and international residents. The knowledge level did diminish over time. Several of the residents either forgot what they knew or rushed through the post-intervention protocol. Long-term effects were not measured.

This short teaching module, constructed around a letter sought by the community, was effective in achieving the goals of the study. The learning was reinforced either subtly (posters within sight) or individually in the context of patient care. The training program and material equipped these pediatric residents with the knowledge and awareness necessary to serve as resources and advocates for children of immigrant families.

An essential component of health care is to provide multiple levels of support to the families we serve. Calvin Sia calls this the medical home.[12] Comprehensive care includes building access to resources such as WIC, school-feeding, and federal food stamp programs. Availability of social workers, health educators, and dieticians are part of the Medical Home model.[12] The figure presented can be used in the medical home to educate immigrant families themselves about their rights consistent with efforts of the American Academy of Pediatrics to insure quality health care for all.[1,2,11]

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Notes

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