

Are You Listening?

**The Pursuit of High Quality Healthcare for Low-Income
Deaf and Hard of Hearing Children in Los Angeles County**



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Executive Summary

Deaf and hard of hearing (DHH) children have a unique set of needs and considerations concerning their healthcare. Low-income families, families of color, and recent immigrants require particularly extensive support, however the healthcare delivery system for low-income deaf and hard of hearing (DHH) children in Los Angeles currently falls short of meeting the needs of this unique population. Delivery is often disjointed, not all necessary services are covered, and bureaucratic delays inhibit the allocation process.

This study looks at the barriers that prevent service providers from providing the highest quality care to this group, and conducts a survey of private LA County Audiological services available to low-income DHH children who are publically insured. Research methods include interviewing several of the most influential and effective LA County entities that serve DHH children to find what policies and practices are destructive to their service delivery. Additionally, a phone survey of LA County Audiologists explores what role private practices play in serving low-income children.

My research has found that while both public and private healthcare institutions provide important resources for DHH children and their families, some significant gaps exist. One specific area that requires improvement is accessibility, both in the form of cultural relevancy, and in the number of available service providers. Coordination also emerged as an issue in terms of services as well as between public and private entities. Lastly the need for a shift in focus towards a more holistic health service model became apparent.

Important steps toward achieving these goals must be taken by all stakeholders including Federal and State governments, California Children Services, Medi-Cal and agencies, service providers, and families. Government entities must provide sufficient financial support for public entities to provide reasonable reimbursement amounts to providers, and for all necessary services to be available to patients. Entities with supervisory responsibilities such as Medi-Cal need to refocus their model to encourage collaboration and efficiency. Lastly, providers and families must join organizations that translate their concerns into political power.

1. Introduction

Several years ago, a friend of mine had a baby her freshman year of high school; a beautiful baby boy who was hard of hearing, and had several developmental disabilities. It felt exceedingly unfair that while she was attending one of the most underfunded and neglected schools in Oakland, a school that graduates less than half of its freshman class, she also had to navigate the world of disability services for her son. What hope was there for him to receive the services and support he needed when his mother had been systematically excluded from these same opportunities?

There is no simple answer to this question, but there are some clear factors that contribute to the challenges my friend, and many other low-income families with deaf and hard of hearing children, face in accessing resources. Deaf and Hard of Hearing (DHH) children, along with other children with disabilities, face a unique set of challenges in many areas of life including education, discrimination in employment, independent living, transportation, and social stigmatization, among others. This research paper will focus on healthcare issues and policies related to low-income deaf and hard of hearing children and their families, a group that has a very unique set of needs and abilities.

It will firstly look at the various entities that provide health services and management to low-income families with DHH children, exploring their overlaps, service gaps, and successes. It will then survey the private healthcare providers in LA County that accept Medi-Cal and serve deaf and hard of hearing children. Next,

it will explore the existing barriers and challenges that inhibit service providers from providing the highest quality and healthcare to DHH children on Medi-Cal. LA County DHH advocates and other relevant groups will also be included in the study. The overarching goal is to discover specific issues and establish clear steps that Los Angeles service providers and advocates, as well as local, state, and federal agencies can take to better serve and support DHH children and their families.

2. Research Approach

The information included in this study was gathered in a variety of ways. Data pertaining to policy, history, and services offered was largely collected from public websites, private research databases, and publically distributed fliers and brochures. Qualitative information was primarily assembled from interviews (either in person or over the phone) with doctors, advocates, and administrators from relevant stakeholders.

A. Introduction to Client

The portion of my research that surveys available resources is shaped by the current work of my client organization, The Disability Rights Legal Center. The DRLC has been operational since 1975 and is located on the Loyola Law School campus in downtown Los Angeles. The first cross-disability law office in the nation, its mission is “to promote the rights of people with disabilities and the public interest in and awareness of those rights by providing legal and related services.”¹

¹Disability Rights Center website. Accessed Feb 16, 2010. <
<http://www.disabilityrightslegalcenter.org/>>

They utilize the legal advocacy model in addition to self-empowerment education, and all of their services are free of cost to clients.

I am collaborating with the DRLC on one of their current projects; the creation of a comprehensive guide to Los Angeles County healthcare resources that serve Medi-Cal recipients with disabled children. This is a joint project between DRLC and the Local Initiative Health Authority for Los Angeles County, otherwise known as LA Care. LA Care coordinates healthcare for close to 1,000,000 LA residents, (versus the fee for service method where Medi-Cal patients independently solicit care). LA Care is working with DRLC to locate all of the health services that work with Medi-Cal and cater to children with disabilities, as to better serve their client base. My research has the same goal with a more specific focus on children that are deaf and hard of hearing.

B. Note Worthy Omissions

Because this study focuses on a narrowly defined population, there are some important issues that while certainly relevant, will not be covered in-depth throughout the course of this paper. The following topics are intimately related to low-income DHH children, but are also linked to other divergent issues, which would detract from the focus of the paper if included.

Firstly, many deaf and hard of hearing children have multiple disabilities, meaning they are DHH in addition to having autism, or mental retardation, for example. However because cognitive and developmental disabilities are linked to a distinct set of services and health policies, this paper will focus solely on issues directly relating to auditory disorders. While it is important to recognize the high

rates of children with multiple disabilities, it brings up a unique set of challenges that reach beyond the scope of this paper.

Another important issue that this study does not explore comprehensively is the phenomenon known as “aging out” of the public healthcare system. There presently exists a gap in Medi-Cal coverage for single adults that are over the age of 21. Many of the benefits that DHH children and youth receive throughout their lives suddenly become unavailable once they pass this benchmark. The 2009 state budget cuts to Medi-Cal intensified the drop off in coverage for this population. On the same note, youth that are DHH require specialized training and assistance to transition into adulthood, especially in relation to career and higher education goals. While not directly related to health, these services are an important part of creating the opportunity for DHH individuals to enjoy a full and healthy lifestyle. Unfortunately, youth experience a drop-off in both health and personal support after their twenty first birthday. Nonetheless, this research concentrates on access to healthcare for DHH children and youth only, and therefore does not delve deeply into the transition or adult period.

Lastly, undocumented families with DHH children face an especially difficult challenge in attaining necessary health care. Statistics show that there are high rates of DHH children born to undocumented parents, possibly because families hope to find greater support and services available for their child in the US, relative to their home countries. This population is especially vulnerable, and health care is far less accessible and consistent. This study does briefly address issues impacting

this group, but because there are a host of other legal matters are involved, it does not examine this issue deeply.

3. Background on Deaf culture and Issues

The following section will highlight some technical, quantitative, qualitative, and policy issues that impact deaf people and their families. The purpose of this section is to give some background and context on issues that effect DHH people, as well as to illustrate the vastness of the information that families with DHH children must research and understand in order to protect and support their child. The following data touches upon major issues and themes, but only represents small fraction of the concerns and choices that families with DHH children confront.

Some of the following issues are not directly relating to healthcare access, but shape the holistic needs of DHH children and their families. Because hearing loss impacts all areas of life, it cannot be understood within a strictly medical framework.

A. Technical parameters

What are the causes of hearing loss?

Hearing loss has a variety of causes and levels of intensity. Most hearing loss can be either classified as conductive (meaning that sound waves are blocked from entering the inner ear), sensorineural (damage to sensory structures or auditory nerve pathways), or a combination of the two. Some of the most prevalent causes for conductive hearing loss include ear infection, and obstruction of external ear canal, while sensorineural hearing loss is linked to congenital infections such as

rubella, herpes, and syphilis, childhood infections such as meningitis, exposure to loud noise, heredity, and aging.²

How many people are Deaf or Hard of Hearing (DHH) in the US?

Understanding the scope of the deaf community is important, however estimates of the DHH population in the US vary greatly depending on the methodological definition of hearing loss as well as distinction between deaf and hard of hearing. The US census no longer collects data on the prevalence of DHH, however there are several other surveys that gather population information on a national scale. Surveys that have a broad definition of DHH estimate upwards of 20 million Americans have “hearing problems.”³ According to the Survey of Income and Program Participation (SIPP), “1 in 20 Americans are currently deaf or hard of hearing” which equals roughly 20 million total, with 1 million being functionally deaf.⁴ However this survey judges hearing loss “in relation to an individual’s difficulty hearing normal conversation *with* the use of a hearing aid”, and therefore most likely excludes a sizable segment of the population.

B. Deaf with a capital D

² Robert J. Ruben, MD. “Hearing Loss and Deafness.” *Manual of Medical Information*. Merck & Co., Inc. 2007. 8 December, 2009. <<http://www.merck.com/mmhe/print/sec19/ch218/ch218a.html>>

³ Tom Harrington. “Deaf Population in the US.” *Deaf Research Help*. Gallaudet University, 2007. 8 December, 2009. <[http://library.gallaudet.edu/Library/Deaf_Research_Help/Frequently_Asked_Questions_\(FAQs\)/Statistics_on_Deafness/Deaf_Population_of_the_United_States.html](http://library.gallaudet.edu/Library/Deaf_Research_Help/Frequently_Asked_Questions_(FAQs)/Statistics_on_Deafness/Deaf_Population_of_the_United_States.html)>

⁴ Ross E. Mitchell, Michael A. Karchmer. “When Parents Are Deaf Versus Hard of Hearing: Patterns of Sign Use and School Placement of Deaf and Hard-of-Hearing Children.” *Journal of Deaf Studies and Deaf Education* 9.2 (2004).

Most people who belong to or are associated with the Deaf community would argue that being deaf is much more than an audiological deficiency. While diminished hearing may be the medical parameters for defining deafness, Deaf identity is far more complex and nuanced than a technological classification. According to an article about Nationalism and linguistic rights, “Over the last two decades, Deaf communities throughout the world have begun at last to achieve recognition by national and international authorities of the fact that they are cultural minorities with distinct languages.”⁵ The struggle to maintain a cohesive community and receive legal and social acknowledgment continues to be a major goal for Deaf people and their families.

However, an article in the *Journal of Deaf Studies and Deaf Education* cautions against categorizing the Deaf community as simply another linguistic population, given some important distinguishing characteristics. First, the majority of deaf people are not born into a deaf community, given that roughly 90% of deaf children have hearing parents.⁶ Members generally do not learn sign language from their family, but rather when they are introduced into the broader Deaf community. Additionally, there exists an inherent communication barrier that prevents full access to the English language, unlike other linguistic groups who can easily become bilingual given sufficient time and exposure. These attributes of the Deaf community create a dynamic where members are inevitably geographically

⁵ Jan Branson, Don Miller, “Nationalism and the linguistic rights of Deaf communities: Linguistic imperialism and the recognition and development of sign languages.” *Journal of Sociolinguistics* 3-34 (1998).

⁶ Jenny L. Singleton, Matthew D. Tittle. “Deaf Parents and Their Hearing Children.” *Journal of Deaf Studies and Deaf Education* 5.3 (2000).

dispersed; yet have an especially great need for a tightly knit community given their communicative isolation in the hearing world.

In many cases parents are either unconscious of the importance of their child realizing entry to the Deaf World, or they are unacquainted with methods to gaining access Deaf institutions and support systems. For this reason, many “deaf people may not be immersed in American Sign Language or have contact with Deaf adult members of the Deaf community until they are themselves young adults.”⁷ In order to circumscribe this postponed introduction into the community of which they are a member, and to satisfy their child’s social and emotional needs, parents of deaf children must bear the vital responsibility of locating an entry point into the “Deaf World” during childhood. To successfully fulfill this role, parents require the support of social networks and organizations, which have the potential to not only offer educational and medical advice, but also serve as a gateway in the deaf community. Service providers who interact with DHH patients must understand that deafness must be approached as more than a deficiency, to appropriately serve their clients.

C. Policy Affecting Deaf Americans

In the U.S. as in most other nations, the rights of deaf citizens are addressed under umbrella policies that prohibit exclusion and discrimination against people with disabilities. Therefore, despite many deaf people’s self-identification as linguistic minorities with a distinct culture rather than disabled, disability law has a

⁷ Jenny L Singleton, Mathew D. Tittle. Page 490.

heavy influence over their education, professional opportunities, access to public life, and healthcare.

Policy addressing the disenfranchisement of disabled Americans were all but nonexistent until 40 years ago when a broad coalition including citizens who were deaf, blind, had Down's Syndrome, and were HIV-positive organized to be recognized as a group being unjustly denied full citizenship.⁸ The movement for equal access was greatly influenced and inspired by the civil rights movement of the 1960's. The very notion that disabled people had the right to full access in their communities was a revolutionary assertion, and much like the civil rights movement, there was backlash to the destabilization of the status quo, particularly from businesses that would feel the financial repercussions of inclusionary policies.

However after years of rallies, sit-ins, marches, letter writing, public testimonials, private hearings, and lobbying, Congress passed the Rehabilitation Act in 1973.⁹ Section 504 states that "no qualified individual with a disability in the United States shall be excluded from, denied benefits of, or be subjected to discrimination" regarding programs receiving federal funding based solely on their disability.¹⁰ It was the first time in American history that prejudice against disabled people was illegalized. DHH individuals and other disabled groups would no longer be turned away from public schools, accommodations were mandated for

⁸ Arlene Mayerson. "The History of the ADA: A Movement Perspective." *Disability Rights Education & Defense Fund*. 1992. Disability Rights Education & Defense Fund. 15 October, 2009 <www.dredf.org/publications/ada_history.shtml>

⁹ Mayerson (2)

¹⁰ "A Guide to Disability Rights Laws." *Department of Justice Online Resources*. September 2005. U.S. Department of Justice. 22 October, 2009 <www.ada.gov>

government employees, and all public buildings were required to be physically accessible, among other changes.

The struggle was far from over after the historic 1973 legislation was passed, and the following several years were spent defining discrimination in tangible terms, and fighting for additional rights and physical accommodations to create a more inclusive environment. A person protected under this law is anyone who “has a physical or mental impairment that substantially limits one or more major life activities.”¹¹ Two years later in 1975, the landmark Education for All Handicapped Children Act was passed to support public schools in providing suitable education for children with disabilities. Before this time, only 1 in every 5 children with disabilities gained entry into US schools.¹²

The next major policy change affecting deaf people in America was the Americans with Disabilities Act of 1990, which once again involved massive organizing, lobbying, and educational campaigns. The ADA extended anti-discrimination law far beyond federally funded programs to a range of other areas that impact people’s everyday lives. The following table highlights key effected areas:

¹¹ “A Comparison of ADA, IDEA, and Section 504.” *DREDF.org*. 2009. Disabilities Rights Education and Defense Fund Online Resources. 15 November 2009 <www.dredf.org/advocacy/comparison.html>

¹² “History, Twenty-Five Years of Progress in Educating Children with Disabilities through IDEA.” *Office of Special Education Programs*. 2005. United States Department of Education. 8 December 2009 <www.ed.gov/offices/osers/osep>

Areas covered by the American With Disabilities Act (ADA)

Section	Title I Employment	Title II State and Local Government	Title III Public Accommodations	Title IV Telecommunications Relay Services
Impacted Bodies	Business with 15+ employees	State/local government programs and offices	Businesses and nonprofit service providers (restaurants, hotels, movie theaters, day care centers, zoos, recreation facilities, etc)	Telephone companies, public service announcements
Requirements	Offer equal opportunities in areas of pay, hiring practices, social activities, and to provide reasonable accommodation	Provide equal access to programs such as education, city buses and rail transit, social services, etc.	Comply with architectural standards for new and altered buildings, and make reasonable accommodations to existing buildings and policies	Common carriers must establish interstate and intrastate telecommunications relay services (enables callers with hearing and speech disabilities to communicate through a third party) Public service announcements must have captioning
Office that handles violators	US Equal Employment Opportunity Commission field office	U.S. Department of Justice Civil Rights Division	US Department of Justice Civil Rights Division	Federal Communications Commission

Information in table provided by “A Guide to Disability Rights Law”, US Department of Justice, 2006.

Other Important Policies that Mandate Inclusion of Persons with Disabilities

Policy	Requirements
Fair Housing Act (as amended in 1988)	Prohibits housing discrimination on the basis of disability (among other groups) and requires new multifamily housing with 4+ units to be accessible to persons with disabilities
Air Carrier Access Act (1990)	Airlines must provide boarding assistance and accessible aircrafts

Voting Accessibility for the Elderly and Handicapped Act (1984)	Polling places must be physically accessible to persons with disabilities
National Voter Registration Act (1993)	State-funded service programs for persons with disabilities must assist their members in registration and transportation to polling cites
Civil Rights of Institutionalized Persons Act (1980)	U.S. Attorney General has authorization to investigate conditions of confinement institutions (jails, juvenile correctional facilities, institutions for people with psychiatric or developmental disabilities)
Individuals with Disabilities in Education Act (1975)	Children with special needs must be offered a free and appropriate public education
Senate Bill 853 (2003) ¹³	Mandates all California health plans provide language assistance to enrollees with limited English proficiency

Information in table provided by “A Guide to Disability Rights Law”, US Department of Justice, 2006.

The wave of inclusionary bills passed in the 1980’s and early 1990’s elevated the legal climate and cultural consciousness relating to the rights of disabled individuals. However, very little legislation directly addressed issues of health access and equity. The recent Senate Bill 853 that calls for the presence of interpreters when needed by clients (among other accommodations relating to the language barrier), is often understood to only apply to spoken languages, and the need for ASL interpreter services are often overlooked.

Legislation relating to education has received more attention and made more progress in many cases. The most significant recent policy regarding education has been the Individuals with Disabilities Education Act or IDEA (previously Education for All Handicapped Children Act), which was most recently amended in 2004. The

¹³ “What is California Senate Bill 853?” *Dr. Tango* website. Accessed 5 April, 2010. <<http://sb853.com/>>

Disability Rights Education & Defense Fund describes IDEA as “an education act to provide federal financial assistance to State and local education agencies to guarantee special education and related services to eligible children with disabilities.”¹⁴ An important component includes the development of an Individualized Education Program (IEP) for children to determine their specific needs and educational goals, which must include parents, teachers, and special education experts. In the case of deaf students, this would take communication mode, severity of hearing loss, and social needs into account, among others.¹⁵ Additionally, parents must be notified and consent to changes in their child’s evaluation and placement, and the educational procedures regarding each child must be reviewed every three years.

Another crucial component of IDEA is the emphasis of the Least Restrictive Environment (LRE) as long as it complies with the requirement of children receiving a Free Appropriate Public Education (FAPE), which was originally outlined in the Education for All Handicapped Children’s Act of 1975.¹⁶ Least Restrictive Environment emphasizes the integration of disabled children into mainstream educational settings whenever possible. The philosophy of “inclusion” raises controversy, especially in regards to the education of deaf students given the intrinsic barriers to direct communication with teachers and peers, and a recent

¹⁴ “A Comparison of ADA, IDEA, and Section 504.”

¹⁵ Lamar Alexander. “Notice of Policy Guidance.” *Deaf Students Education Services*. 1992. Department of Education. December 6, 2009. <www.ed.gov/print/about/offices/list/ocr/docs/hq9806.html>

¹⁶ “History, Twenty-Five Years of Progress in Educating Children with Disabilities through IDEA”

notice of policy guidance from the Department of Education warns that “any setting, including a regular classroom, that prevents a child who is deaf from receiving an appropriate education that meets his or her needs including communication needs is not the LRE for that individual.”¹⁷ Despite critiques, the trend towards “mainstreaming” continues. Supporters point out that benefits of mainstreaming such as social inclusion with mainstream students, intellectually stimulating coursework, and the opportunity to gain coping and communication skills outweigh the negative aspects.

Through years of organizing, protesting, and lobbying, these policies have been put into place and deaf Americans, as well as all the other individuals who fall under the disabled category, have made considerable gains in attaining full access to their communities. Deaf students are now guaranteed the right to an appropriate education in their district, translators are provided upon request at public events, and alternative means of communication are provided by public entities. However, as is often the case, the lives of deaf peoples do not reflect the level of equality and inclusion that is expressed in the policies. Enforcement has lagged far behind mandate in many cases, especially in education related policies, with inspection often left to individuals or advocacy organizations. For example, the bill SB 580 calls for healthcare plans to provide interpreters when needed, but there is a lack of understanding and regulation regarding the inclusion of American Sign Language. The private organization Greater Los Angeles Agency on Deafness (GLAD) has taken

¹⁷ Alexander, Lamar.

on the role of enforcer and launched a program to assist healthcare providers in meeting these criteria.

D. Distinct Challenges Low-Income Families Face

When parents discover that their child is deaf or hard of hearing, they are thrown into a lifelong search for information and support. Parents need guidance in understanding their rights and navigating the programs and policies outlined above, obtaining the necessary healthcare for their child, accessing the deaf community for their child's future social and emotional wellbeing, as well as understanding the range of options and viewpoints concerning deaf children and students. For any family, this can feel like an overwhelming task, but when families are also living in poverty, an even greater amount of support is needed.

There are several important areas that present additional barriers for low-income families with deaf children. These include poor healthcare, physical accessibility/time, access to online information, and a lack of English proficiency.

Poor healthcare

Poor healthcare, especially in areas of preventative and prenatal care, has an adverse effect on families with deaf children from pregnancy onward. The official national poverty rate in 2008 was 13.2% (poverty level defined as \$22,025 for a family of 4) and 46.3 million Americans were uninsured.¹⁸ Impoverished families are less likely to have extensive healthcare coverage, and therefore less likely to

¹⁸ "Income, Poverty and Health Insurance Coverage in the United States: 2008." 2009. US Census Bureau News. 6 December, 2009 <www.census.gov/Press-Release>.

receive adequate care during pregnancy, and more likely to hold off on hospital and doctors visits until symptoms are severe because of excessive financial burden. A healthcare study in the *Journal of Health and Social Behavior* found that “segregation along socioeconomic lines also decreases likelihood of receiving adequate access to primary care”¹⁹ and “there are fewer primary-care physicians in low-income communities, where the physician-to-population ratio is less than a third the rate in middle-class communities.”²⁰ Because many communities are economically segregated in the U.S., these factors heighten medical issues.

A study cited on the Gallaudet University website asserts, “The prevalence of hearing impairment at all ages decreases as family income increases. Overall, those with a family income of less than \$10,000 are twice as likely as those with a family income of \$50,000 and over to have hearing impairment.”²¹ Deafness can be caused by treatable or preventable illnesses during pregnancy or infancy, and the systemic marginalization of health needs along economic lines puts low-income families at a disadvantage even before the child is born.

Physical accessibility/time

Another significant issue for families lacking sufficient financial resources is access to physical sites of information and resources. Many low-income families live in areas that are geographically cut off from social services, and without a car,

¹⁹ Kirby, James B., Toshiko Kaneda. “Neighborhood Socioeconomic Disadvantage and Access to Health Care.” *Journal of Health and Social Behavior*. 46.1 (2005).

²⁰ Rothstein, Richard.

²¹ Holt, Judith, Sue Hotto, Kevin Cole. “Demographic Aspects of Hearing Impairment: Questions and Answers.” *Center for Assessment and Demographic Studies Gallaudet University*. 1994. Gallaudet University. 5 December, 2009 < <http://gri.gallaudet.edu/Demographics/factsheet.html#Q6>>

are unable to reach resource centers on a regular basis. As a result, they may be unable to fully utilize the resources that are available. Even when considering families that do have cars, many families “living at or near poverty have many competing demands, chiefly finding and/or maintaining employment, and they do not have the time or money to negotiate the systems of care.”²² Single parent homes or parents regularly work beyond a 40-hour workweek, and the parental figure(s) do not have a sufficient amount of time to stay in steady contact with distant resource centers.

Access to and knowledge of the Web

The sociological concept of cultural capital comes into play when discussing inequity and access. Cultural capital is defined as the process through which “middle-class parents are able to endow their children with the linguistic and cultural competences that will give them a greater likelihood of success.”²³ Technology is an important area where working-class people lack cultural capital, which in turn impacts information acquisition and gathering, especially given the emergence of the Internet as one of the most highly utilized methods of information exchange.

In an Australian report on parents’ use of the Internet to find information about their deaf children, the author Ann Porter sites that 72% of parents with

²² Kathryn Smith, Laurie A. Soman, Juno Duenas, et al. “California’s Service System for Children and Youth with Special Health Care Needs.” *Lucile Packard Children’s Foundation*, December 2009.

²³ “Cultural Capital.” *A Dictionary of Sociology*. John Scott and Gordon Marshall. Oxford University Press 2009. *Oxford Reference Online*. Oxford University Press. 11 December 2009 <www.oxfordreference.com/views/ENTRY.html>

disabled children depend upon the Internet to learn about options for their child.²⁴ Of course, many low-income families do not have Internet access, or lack the cultural capital to efficiently utilize the Internet as a viable resource. Porter speaks about the “digital divide” and emphasizes the enormity of its negative impact on those that fall on the underprivileged side of the divide, given that “households with incomes of \$75,000 or more are 9 times as likely to have access to the Internet as are households at the lowest-income levels.”²⁵ This inequity sets low-income families behind in the process of discovering health care resources, and makes their necessity for outside assistance especially urgent.

E. The Intersection of Race and Class

People of Color in poverty

Because wealth and race in the United States are highly correlated, it is necessary to address racial implications amongst low-income families with deaf children. In 2008, the median household income for Latino and Black families in the U.S. was \$37,913, and \$34,218 respectively, compared to \$55,530 for white families.²⁶ Black Americans are 3 times as likely to be poor as whites,²⁷ and the

²⁴ Ann Porter, Sisira Edirippulige. “Parents of Deaf Children Seeking Hearing Loss-Related Information on the Internet: the Australian Experience.” *Journal of Deaf Studies and Deaf Education* 12.4 (2007).

²⁵ “Why Are Blacks Less Likely Than Whites to Use the Internet?” 2001. *The Journal of Blacks in Higher Education*, No. 30. 6 December 2009 <www.jstor.org/stable/2679074>

²⁶ “Income, Poverty and Health Insurance Coverage in the United States: 2008.” 2009. US Census Bureau News. 6 December, 2009 <www.census.gov/Press-Release>.

²⁷ “Why Are Blacks Less Likely Than Whites to Use the Internet?” 2001. *The Journal of Blacks in Higher Education*, No. 30. 6 December 2009 <www.jstor.org/stable/2679074>

assets of Black families are just 12% of white families.²⁸ Besides being a statically significant portion of low-income individuals, the host of obstacles for working class non-white families are more complex and often more severe than their white counterparts. Given that this paper seeks to address working class families specifically, examining the issues of non-white families with deaf children becomes particularly noteworthy.

Economic disparities exacerbate healthcare concerns, among other issues. One healthcare study sites that approximately “30 percent of Hispanic and 20 percent of Black Americans lack a usual source of health care compared with less than 16 percent of whites. Hispanic children are nearly three times as likely as non-Hispanic white children to have no usual source of health care.” Additionally, “African Americans and Hispanic Americans are far more likely to rely on hospitals or clinics for their usual source of care than are white Americans (16 and 13 percent, respectively, v. 8 percent).²⁹ The gap in quality of healthcare amplifies the obstacles previously outlined for working class non-white families with deaf children.

White people in the United States make up roughly 75% of the national population, but according to a study conducted in 2007 by Gallaudet University measuring demographics, white students make up only 47% of the total deaf

²⁸ Richard Rothstein. “Class and the Classroom.” *Article based on “Class and Schools: Using Social, Economic, and Educational Reform to Close the Black-White Achievement Gap.” Economic Policy Institute and Teachers College Press, 2004.*

²⁹ “Addressing Racial and Ethnic Disparities in Health Care Fact Sheet.” AHRQ Publication No. 00-PO41, February 2000. Agency for Healthcare Research and Quality, Rockville, MD. 6 December 2009 <<http://www.ahrq.gov/research/disparit.htm>>

student population. African-Americans account for 15.1% of deaf students, and Latin@s 28.3% (the remaining percent split between Asian, Native American, and multi-racial).³⁰ Economic disparities along racial lines are once again the primary cause for the imbalance.

F. Cultural Considerations

Beyond the economic disenfranchisement of people of color in the United States, evidence suggests that race also generally impacts information gathering, analysis, and decision-making. In recent years, the Internet has risen to be one of the most important sources of information, however an article in *The Journal of Blacks in Higher Education* asserts that surveys in all fields find, “the use of the Internet by blacks remains far below the level of use by whites”³¹ The article goes on to affirm that only 27% of black high school aged students have a computer at home, in comparison to 69% of white high school students. Given the importance of the web as a tool to gather information and connect to resources, this gap in access has important ramifications for families’ methods of attaining support for their child.

Additionally, the actual needs of non-white families with deaf children often differ to some degree. Physical and web-based resource centers provide information on schooling options, medical choices, etc. – but their secondary function as a gateway into the deaf community should be considered equally as

³⁰ Gallaudet Research Institute (December 2006). *Regional and National Summary Report of Data from the 2006-2007 Annual Survey of Deaf and Hard of Hearing Children and Youth*. Washington, DC: GRI, Gallaudet University.

³¹ “Why Are Blacks Less Likely Than Whites to Use the Internet?”

important. The need for a social network is especially relevant for non-white families since their children occupy the unique position of balancing two minority identities.

While there are few studies on the intersection of deaf and racial identity, one study published in *The Journal of Deaf Studies and Deaf Education* found that deaf Native American participants “experienced significant difficulties in maintaining their Native cultural identities within the deaf community, as well as barriers to full participation in the traditions and customs of hearing Native American cultures.” Consequently, many of the respondents “experience stress when they were unable to verify a dimension of their identity” and “maintained an ongoing search for peers who shared both their deafness and racial or cultural heritage.”³² Many deaf people of color are torn between the two because much like choosing to strongly identify as a racial minority, identifying as culturally Deaf has social and political demands that are not always harmonious with or inclusive of racial minority agendas. Because deaf institutions tend to be predominately white, there exists a strong need among deaf people of color for spaces that are inclusive of their racial identity in addition to their deaf identity.

Recent immigrants also face a host of additional challenges. It is not uncommon for families in less financially developed nations to immigrate to the US when they have a deaf child, in search of better resources and future opportunities.

³² Susan Foster, Waithera Kinuthia. “Deaf Persons of Asian American, Hispanic American, and African American Backgrounds: A Study of Intraindividual Diversity and Identity.” *Journal of Deaf Studies and Deaf Education* 8.3 (2003)

For these recent immigrants and families that speak a language other than English in the home, a host of specialized needs exist. Firstly, there may be communication barriers with professionals concerning health/education options. Unfortunately, a study prepared for the Lucile Packard Children's Foundation found that only 37.8% of families with children and youth with special healthcare needs that require an interpreter receive one.³³

One study in the *Journal of Deaf Studies and Deaf Education* found that "the deliberations of Hispanic parents are often complicated by the language and cultural barriers and by limited access to information, resources, and a full range of options."³⁴ Additionally, Spanish literature about deaf issues is often unbeneficial, since it is translated directly from English and does not always address issues that are specific to the Latino community. The authors assert "although parents have a strong desire for information and involvement in medical decisions, making informed choices involves access to culturally relevant information and resources."

Issues of communication are further complicated by the family's desire for the child to maintain their native language, the need for the child to learn American Sign Language, and the reality that learning to communicate in three languages at one time (ASL, Spanish, and English) may be an unrealistic expectation for many deaf children. However the study found that 63% of Latino families in their study

³³ Kathryn Smith, Laurie A. Soman, Juno Duenas, et al. "California's Service System for Children and Youth with Special Health Care Needs." *Lucile Packard Children's Foundation*, December 2009.

³⁴ Amy Steinberg, Lisa Bain, Yuelin Li, Gilbert Delgado, Vivian Ruperto. "Decisions Hispanic Families Make After the Identification of Deafness." *Journal of Deaf Studies and Deaf Education* 8.3 (2003)

“expressed hope that their children would be bilingual (English and Spanish) or trilingual (English, Spanish, and sign language).”

Beyond language, cultural values also influence need and decision-making. For example, 63% of Latino families in the study “indicated that their religious beliefs and faith influenced their decision-making process.” Latino families are also less likely to send their children to schools for the deaf partially because of the high traditional and cultural value placed on children remaining in the home, especially during younger years.³⁵ Families that are non-native English speakers require support from providers that understand these complex issues, can effectively communicate with them, and provide guidance with issues that do not affect white American families.

4. How the Health Delivery System Currently Operates

Taking into account the immense healthcare challenges facing low-income families with DHH children, the next questions is; what entities currently exist to support this population and provide the necessary medical services? The following section will explore this question, beginning with federal programs, then narrowing the focus to state and county services.

A. What is Medi-Cal?

Medi-Cal is the California’s Medicaid program and is defined as “a public health insurance program which provides needed health care services for low-

³⁵ Susan Foster, Waithera Kinuthia.

income individuals” by the California Department of Health Care Services.³⁶ It is the largest healthcare and most influential program serving underprivileged Americans. Medicaid is a joint state and federal healthcare program where in the Federal entity sets certain guidelines, and state offices create a set of specific requirements and eligibility standards. The federal entity matches at least 50% of the funds each state designates towards their healthcare program. Medicaid has been an important function of the federal and state government’s healthcare delivery system since it’s enactment in 1965 along with Medicare (for elderly and disabled Americans) in the Social Security Amendments.³⁷ Currently, Medicaid covers over 60 million people nationally, and 6.5 million Californians (17% of the population).³⁸

The federal “income-eligibility floor” for pregnant women and children is 133% of the federal poverty line (\$29,327 for a family of four) and in California the “income eligibility threshold” is 106% of the federal poverty level (\$23,373 for a family of four) for all other Medi-Cal recipients. When the national healthcare reform becomes operational, Californians up to 133% of the federal poverty level will be eligible (these changes will be explained in greater detail).

However, poverty is not the sole determining factor of Medi-Cal eligibility. Persons who are enrolled in programs such as Social Security Insurance, Refugee Assistance, and those who are age 65-plus, blind, disabled, under 21, or pregnant,

³⁶ “Medi-Cal - Apply for Individuals and Families.” *Department of Health Care Services*. Accessed Feb 18, 2010 <www.dhcs.ca.gov/services>.

³⁷ “Medicaid: A Program Overview.” *Almanac of Policy Issues*. Accessed Feb 18, 2010, <www.policyalmanac.org/health>.

³⁸ Rosenbaum, Sara. “Medicaid and National Health Care Reform.” *The New England Journal of Medicine*, Nov 19, 2009 (361; 21).

are also eligible.³⁹ These categories are linked to Medicaid’s traditional role of providing coverage for children and pregnant women. Today, significant gaps remain in both coverage and eligibility requirements, but its function has slowly expanded to address the health needs of other populations. The following table highlights some key services that are covered under Medi-Cal.⁴⁰ Services related to DHH individuals are in bold.

Federally mandated services	Additional Medi-Cal Services
Hospital inpatient and outpatient care Skilled Nursing care Doctor visits Lab tests Family planning	Prescription drugs Dental care Eye glasses Podiatry Hospice care Hearing Aids

Recipients of Medi-Cal are eligible to join a “managed care” health plan that coordinates services. The two major managed care providers that serve Los Angeles County are L.A. Care and Health Net. The alternative to joining one of these plans is to utilize the services of a private Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), or the regular “fee for service” mode of operation where patients individually locate service providers that accept Medi-Cal. Currently, 68% of Medi-Cal’s 0-21 population is enrolled in a managed care program.⁴¹ Benefits to joining a managed care plan include more streamlined and

³⁹ “Find Out if I Qualify – Medi-Cal Eligibility.” *Department of Health and Human Services*. Accessed Feb 18, 2010 < www.dhcs.ca.gov/services>

⁴⁰ Information in this table provided by : “Consumer Resources.” *California HealthCare Foundation*. Accessed Feb 18, 2010 <www.chcf.org>.

⁴¹ Kathryn Smith, Laurie A. Soman, Juno Duenas, et al. “California’s Service System for Children and Youth with Special Health Care Needs.” *Lucile Packard Children’s Foundation*, December 2009.

coordinated services. Drawbacks include reported difficulty in obtaining specialty care due to the somewhat limited network, and extended delays in service.⁴²

There are several other federally funded programs that provide healthcare services to people with disabilities. The following table illustrates the federal programs and their relevancy to deaf and hard of hearing children.

Federal Programs Utilized by Individuals with Disabilities

Supplemental Security Income (SSI)	Social Security Disability Insurance (SSDI)	Medicare
<p>Federal income supplement designed to assist aged, blind, or people with disabilities who have little or no income.</p> <p>*Children under 18 can qualify if they meet the federal definition of disability, and their family income and assets do not exceed a specified amount (Near 100,000 California children receive SSI).</p>	<p>Program pays benefits to adults with disabilities.</p> <p>*Minors cannot receive SSDI</p>	<p>Health insurance for elderly and disabled Americans</p> <p>Very limited scope for eligibility for children with disabilities</p> <p>*DHH children do not qualify</p>

Information in this table provided by: Smith, Kathryn, Laurie A. Soman, Juno Duenas, et al. "California's Service System for Children and Youth with Special Health Care Needs." Lucile Packard Children's Foundation, December 2009.

B. State Level Programs

⁴²Kathryn Smith, page 22.

At State levels, there are also several other programs that are important to children with special health care needs. The single most important program for DHH child is California Children’s Services or CCS, which is responsible for all specialty healthcare needs of children on Medi-Cal (other children may qualify as well). CCS was established in 1927 with the specific task of covering treatment of children with complex medical conditions, currently satisfying California’s Title V program for children with special health care needs. In counties serving larger populations, such as Los Angeles, the county program determines eligibility, covers the cost of diagnosis services, treatment planning, and all services related to the eligible condition, among other things.

CCS covers a range of conditions including “Sense organ disorders (loss of hearing or vision).” CCS covers services such as doctors visits, hospital stays, surgery, physical and occupational therapy, lab tests and x-rays, as well as orthopedic appliances and medical equipment. As of 2009, enrollment was around 175,000 with 75% of the children also being enrolled in Medi-cal, 15% in Healthy Families, and the remaining 10% enrolled solely in CCS.⁴³ CCS is primarily for low-income children (family income of under 40,000) however, exceptions are made for high cost health care conditions and families enrolled in Healthy Families.

In most counties, services operate under a “carved out” model where CCS addresses all healthcare related to the condition which qualifies the child for CCS care, and Medi-Cal or private care provider is responsible for primary care and

⁴³ Smith, Kathryn, page 37.

services unrelated to the condition. CCS must approve all providers, services, and equipment prior to visitation or usage.

Another important state run program is the Healthy Families program, which is California's version of the federal Children's Health Insurance Plan (CHIP). The purpose of this program is to assist families whose income or asset level is too high to qualify for Medi-Cal, but whose health needs outweigh their financial capabilities. Under this program, families pay low co-payments for services. The Child Health and Disability Prevention (CHDP) program focuses on early detection and prevention, and is responsible for the Medicaid mandated Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).

C. How are the healthcare Needs of Undocumented Immigrants Addressed Under Medi-Cal and CCS?

According to an article in the Guardian, "The Congressional budget office estimates that five years after the law [national healthcare reform] comes into effect there will still be 23 million people in the US without insurance. One-third of these will be illegal immigrants."⁴⁴ This population is especially significant in California, where 39.7% of children with special health care needs have parents who are immigrants.⁴⁵ However, since welfare reform and the passage of the 1996 Personal Responsibility and Work Opportunity Reconciliation Act, recent immigrants are not eligible for full Medi-Cal during their first five years in the United States. Most

⁴⁴ Chris McGreal. "US healthcare bill Leaves Illegal Immigrants Excluded." *The Guardian UK*, March 22, 2010. Accessed April 10, 2010. < <http://www.guardian.co.uk/world/2010/mar/22/us-healthcare-bill-illegal-immigrants>>.

⁴⁵ Smith, Kathryn, page 46.

immigrants are only able to receive emergency Medi-Cal services such as Emergency room treatment, and healthcare for pregnant women, but remain excluded from primary care services.

In states and counties that have a high percentage of undocumented immigrants, there are often regional programs that strive to attend to the medical needs of undocumented children. Los Angeles County has approximately 350,000 uninsured children, many of whom are either undocumented or whose parents are undocumented.⁴⁶ In LA, the Children's Health Initiative of Greater Los Angeles (a coalition of over 50 providers, advocacy groups, etc) strives to fill this gap by providing a healthcare option known as Health Kids to children that don't qualify for other forms of coverage.

D. Who are the Service Providers?

Service providers for children with special health care needs fall into the following general categories; Children's hospitals, California Children Services special care centers, Community hospitals and clinics, Pediatric subacute facilities (comprehensive inpatient care), private practices, and Home health care. There are eight children's hospitals in California that offer comprehensive care to children (up to 75% of which are Medi-Cal recipients) with a range of disabilities, and 698 CCS special care centers.

E. How Have Recent Budget Cuts Affected Medi-Cal?

⁴⁶ Jennifer Bihm, "School Board Endorses Children's Health Initiative of Greater L.A." *BNET*, August 12, 2004. Accessed April 10th, 2010. < http://findarticles.com/p/news-articles/sentinel-los-angeles-calif/mi_8174/is_20040812/school-board-endorses-childrens-health/ai_n50477608/>

Recent state budget cuts have eliminated the following services for Medi-Cal recipients age 21 and older: dental services, acupuncture, audiology services, speech therapy, chiropractic services, optometric and optician services, podiatric services, psychology services, and incontinence creams and washes.⁴⁷ Medi-Cal recipients, who are DHH and over the age of 20 will no longer be able to receive hearing exams, receive tests to make sure their hearing aids work, or receive replacement batteries. Services that remain unchanged include hearing aids, cochlear implant follow-up exams, and hearing aid repairs. DHH children and young adults under the age of 21 remain unaffected by decreases in services, presently.⁴⁸

F. How has the passage of National Healthcare Reform Impacted Medicaid?

The segments of the recent healthcare reform relating directly to Medicaid mostly address eligibility criteria. The new mandates call for the elevation of state Medicaid income criteria to include uninsured individuals and families making 133% of the federal poverty level or less (\$29,327 for a family of four). It also requires states to expand Medicaid to include childless adults starting in 2014. The federal government will be paying 100 percent of costs of newly eligible individuals through 2016. Lastly, undocumented immigrants will be definitively ineligible for any forms of Medicaid, even if they are able to personally cover the cost of health insurance exchanges.⁴⁹

⁴⁷ "Change in California State Law for Medi-Cal Benefits." *Department of Health Care Services*. Accessed Feb 18, 2010 <www.dhcs.ca.gov>.

⁴⁸ "Frequently Asked Questions – Audiology Benefits (Hearing Exam)." *Department of Health Care Services*. Accessed Feb 18, 2010 <www.dhcs.ca.gov/services>.

⁴⁹Jill Jackson, John Nolen. "Health Care Reform Bill Summary: A Look At What's in the Bill." CBS News. Accessed March 28, 2010. <http://www.cbsnews.com/8301-503544_162-20000846-503544.html>

5. Focus On Los Angeles County

A. State Impact

The circumstances and issues present in LA County are heavily influenced by State policies and budget priorities. However, according to a report about health services for children and youth with special healthcare needs (CYSHCN), “the state does not have a true system of care for these children. Instead, the services available are a patchwork of programs located in different state departments or in the private sector, often with little formal communication among them.”⁵⁰ Additionally, only 59.6% of families with CYSHCN have adequate private and/or public insurance to pay for the services they need, and only 42.2% receive coordinated, ongoing, comprehensive care with a medical home (defined as “a model of delivering primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective.”⁵¹ These issues are at least as severe in LA County where high levels of poverty and immigration compound issues.

B. Los Angeles Features

⁵⁰ Kathryn Smith, Laurie A. Soman, Juno Duenas, et al. “California’s Service System for Children and Youth with Special Health Care Needs.” *Lucile Packard Children’s Foundation*, December 2009.

⁵¹ Kathryn Smith, et al. Page 16.

Several national surveys of deaf and hard of hearing populations found that approximately 1 in 20 Americans are DHH. Applying this statistic to the population of Los Angeles County, which is nearing 4 million, it is reasonable to assume there are roughly 200,000 hearing impaired Angelinos. Additionally, this number may be inflated by the high percentage of undocumented immigrants. Given, many of these DHH individuals are senior citizens, a significant proportion are also children and youth. These hearing impaired children and their families must negotiate an immense and complex system to acquire the needed health services.

Los Angeles has some unique characteristics that impact healthcare delivery. Firstly, being a large metropolitan, a full spectrum of audiological specialists are available to DHH clients, unlike rural or suburban areas where there may not be a large range of options within a reasonable distance. Additionally, the LA County CCS office is independently run, creating the opportunity for a greater level of autonomy and communication.

There are also many factors that create additional obstacles to attaining quality service. Firstly, LA is notorious for its broken transportation system. While middle and upper class Angelinos generally rely on private vehicles for their transportation needs, low-income communities are often isolated along geographic lines. Another issue, which intersects transportation limitations, is the intense concentration of poverty characteristic of LA County. According to a study by the UCLA School of Public Affairs, 17.9% of Angelinos were categorized as living in

poverty in the 2000 census.⁵² An economic report prepared for the City of Los Angeles found that many of these impoverished Angelinos live in geographically segregated tracks. Eight percent of all LA tracts are considered to have concentrated poverty (wherein 40% of residents are below the poverty level). Over 270,000 residents live in these neighborhoods.⁵³ As mentioned earlier in this paper, areas with high levels of low-income individuals contain fewer healthcare providers and other resources needed to maintain a healthy community.

Lastly, LA County has constantly changing ethnic demographics, with an increasing number of non-native English speaking families and undocumented immigrants. The 2000 census reports that over 50% of families speak a language other than English in the home in LA County.⁵⁴ These populations require additional support throughout the entire healthcare acquisition process. These combined factors make Los Angeles a distant environment for healthcare providers and patients. Low-income families in search of specialty audiological services have some significant support systems in place, but also face tremendous adversity.

C. Los Angeles Healthcare Resources

The health related resources available to low-income families with DHH children in LA County are mainly provided by the following entities: California Children's Services (CCS), Los Angeles Unified School District (LAUSD),

⁵² Ong, Paul, & McConville, Shannon. (2004). Four: Trajectory of Poverty in Los Angeles. UC Los Angeles: UCLA School of Public Affairs. Retrieved from: <http://escholarship.org/uc/item/9gr8h4tc>

⁵³ Michael Matsunaga, "Concentrated Poverty In Los Angeles." Prepared in 2008 for the City of Los Angeles. Accessed April 10, 2010. <http://www.economicrt.org/download/cons_pov.html>

⁵⁴ "Languages Spoken at Home Persons 5 Years of Age and Older." *Los Angeles Almanac*. Accessed April 10th, 2010. <www.laalmanac.com/population/po47.htm>

comprehensive service centers, and private audiologists. The following sections will highlight the aforementioned resources, then expand upon the role and perspectives of comprehensive centers and private audiologists.

I. California Children's Services (CCS)

9320 Telstar Ave.

Suite #226 El Monte

CA 91731

Phone: (800) 288-4584

Fax: (800) 924-1154

Email: CCS@ph.lacounty.gov

Parents can acquire CCS services (outlined earlier) by submitting an application available online or at the LA County CCS office. If the family is unsure if the child has an eligible condition, CCS will cover the cost of diagnostic testing in many cases. While the application process is extensive and time consuming, it is the first step low-income families (Medi-Cal recipients *and* families making under \$40,000) of DHH children must take to acquire needed services.

II. Los Angeles Unified School District

333 South Beaudry Avenue

Los Angeles

CA 90017

Phone: 213-241-2460

The majority of services offered by LAUSD to children with special healthcare needs and their families related to educational accommodations. However, the low incidence disability office employs Audiology specialists that are very involved, often accompanying families to their audiological appointments, and working with schoolteachers and staff to establish the best structure for the child. Additionally,

LAUSD may provide loaner hearing aids to children during the lengthy CCS application and authorization process.⁵⁵

III. Comprehensive Centers

This study has identified five centers in Los Angeles County that deliver comprehensive services to low-income DHH clients. The services provided span from resource and referral programs, wide-ranging medical services, to advocacy and education. These comprehensive centers comprise some of the most valuable resources for LA county DHH children and their families of all income brackets, and their collective knowledge bank provides important insight into the current issues associated with providing quality healthcare to low-income DHH children.

IV. Private Audiologists

Private audiologists also play a vital role in meeting the needs of low-income hearing impaired children and youth. Facilities such as county and children's hospitals that were in part designed to meet the needs of low-income patients, no longer have the capacity in terms of physical space, staff, or equipment to be the sole source of medical attention. Private audiologists fill this significant gap for DHH children.

⁵⁵ Allison Grinds, UCLA Audiology. Interview conducted April 2nd, 2010.

D. Comprehensive Center Profiles

(Full organizational profiles available in Appendix)

Organization	Mission	Main Services Offered	Funding	Medi-Cal/CCS Policy
Greater Los Angeles Agency on Deafness, Inc. (GLAD)	Equal access for the deaf and hard of hearing community	<ul style="list-style-type: none"> • Advocacy • Health Education • Referral services • Community Education & Outreach 	Privately funded	Services are free to all constituents
HEAR Center	Providing DHH individuals with auditory and oral communication skills	<ul style="list-style-type: none"> • Pediatric Audiology • Conditioned Orientation Response • Conditioned Play Audiometry 	Non-profit that is privately funded, and charges both private and public insurance	Accepts Medi-Cal fee for service patients, and within certain networks
House Ear Institute (HEI)	Advancing hearing science through research and education to improve quality of life.	<ul style="list-style-type: none"> • Outpatient Infant Screenings • Diagnostic Audiology • Auditory Rehabilitation • Developmental Psychological Examination 	Non-profit that is privately funded, and charges both private and public insurance	Accepts Medi-Cal fee for service patients, and within certain networks
John Tracy Clinic (JTC)	Parent-centered services to young children with a hearing loss	<ul style="list-style-type: none"> • Parent Resources • Diagnostic Testing • Comprehensive Audiological Services 	Non-profit that is privately funded	All services are free of charge
UCLA Audiology	To provide excellent patient care	<ul style="list-style-type: none"> • Hearing Testing • Play Audiometry • Cochlear implant services • Hearing aid dispensin 	Mixed funding sources	All forms of Medi-Cal are accepted with authorization.

6. Findings

The primary research cited in this study was carried out using two separate target groups and methodological approaches. Firstly, members from each of the five comprehensive centers previously identified were interviewed (either in person or via phone). The purpose of these interviews is to gain insight into the healthcare needs of DHH low-income children from professionals who work closely with patients. Secondly, to identify effective practices from some of the most impactful DHH healthcare entities in LA County, and lastly to determine what policies and practices are detrimental to the delivery of high quality care.

The subsequent research findings are based on a survey of private Audiology practices. The survey sought to reach all LA County Audiology practices whose contact information is readily available on line. While the survey may not include every practice in LA County, it represents the majority of Audiology offices, and certainly includes centers that serve larger numbers of clients. The purpose of this study was to discover which practices accept public insurance, as well as gain an understanding of the ratio of offices that do work with low-income children, versus those that do not. Lastly, 3 practices from each camp (those that do accept Medi-Cal/CCS and those that do not) were randomly selected and asked to anonymously identify the factors that determined their decision.

A. Comprehensive Centers

The following section presents the viewpoints and opinions from the five organizations of special interest, as well as an interview with Marcia Blank, a practicing doctor in a private clinic, who has been working in Audiology for three

decades. The responses are categorized according to content rather than by individual center/organization so that viewpoints may be compared and contrasted for various sub-topics. The responses are not direct quotes, but recount the responses of each participant using many of their own words. The speaker and their organizational affiliation are identified below each response.

I. What do DHH Children Need to Be Healthy?

According to the directors and doctors from the five organizations of special interest that I spoke with, the following services should be considered necessary for a deaf or hard of hearing child to live a healthy life:

- Baby check (audiological testing to catch issues early)
- Regular health services from a pediatrician
- Regular Audiological services (from a pediatric approach)
- Speech therapy
- Access to an Otologist (specialist in ear, nose and throat)
- Appropriate educational services
- Appropriate therapy services
- Access to a developmental specialist
- Access to a speech and language pathologist
- The inclusion of parents and family members

Vice President of Programs at John Tracy Clinic Jill Muhs also points out that hearing loss is often an indication of other serious health issues, and comprehensive in-depth monitoring should be considered essential.⁵⁶

II. Challenges Facing low-income Families with DHH Children

Some of the major challenges that families face in accessing health care include a language barrier (for families where English is a second language), transportation,

⁵⁶ Vice President of Programs at John Tracy Clinic Jill Muhs. Interview conducted March 1st, 2010.

childcare, and not understanding the healthcare system. Navigating the nuances of coverage and services of the healthcare system stands out as the most significant barrier, and Dr. Grinds comments, “I’ve been a CCS provider for 30 years and *I* don’t understand the system.” Families of children that have multiple disabilities have various systems to navigate, but even when the child only requires auditory care, the family still has to figure out where to go for the various health needs of their child. All of these issues are exacerbated when the parents of the child are undocumented, and afraid to come in for service.

UCLA Audiology and Speech Pathology
Allison Grinds, Clinic Audiologist

The largest issue is that undocumented (and therefore uninsured) families with DHH children have difficulty in receiving treatment, and often only go to the emergency room when their child has a serious health issue.

Additionally, doctors’ offices may not provide ASL interpreters and parents end up serving as makeshift interpreters, but because of limited ASL knowledge, the information that comes across is not full and accurate. Also, many families don’t know that managed care providers like LA Care can coordinate and cover the cost of ASL interpreting services for families.

Lastly, a large need for sexual health and education exists within the teen DHH population that isn’t being addressed. Parents often don’t have the ASL skills to communicate complex subject matter like sexual health, and the youth may not pick up all of the necessary details and facts in the classroom.

Greater Los Angeles Agency on Deafness (GLAD)
Paul Stuessy, Health Care Access Case Manager

There are families who fall through the cracks because they do not qualify for CCS, or they qualify for CCS only for certain services and are required to go through their insurance for other services, and there may not be any pediatric hearing specialists on their insurance plan, for example.

For families that are not fluent in English, communication becomes a major challenge. Dr. Winter asserts, “It is time consuming and sometimes difficult to communicate effectively using a telephone translation service when we are explaining highly technical and often emotionally loaded information to parents who do not speak English, but we do our best.”

House Ear Institute
Margaret Winter, Audiology Coordinator

The tedious and drawn out CCS authorization process can span a period of six months and includes identification of need, documentation, proof of financial qualification, and authorization. The process can be even more complex if the child is privately insured, and applying for CCS as supplementary insurance. Because hearing loss results in the loss of critical language acquisition time, this delay presents a significant difficulty for the child and their family.

Gardena Hearing Center
Marcia Blank, Audiologist

III. Gaps in CCS/Medi-Cal Coverage

There are some serious gaps in the services provided by Medi-Cal and CCS. Social work assessment, as well as psychological assessment and counseling should be considered vital for DHH patients, but are not a reimbursable service. Having an auditory deficiency typically puts a great deal of mental and emotional strain on a child and their family, and with no outlet or support, it can cause harm to the child over time. For example, one little boy was understandably upset about having a hearing loss, and took out and threw away his hearing aid multiple times.

Psychological counseling to help the child learn how to cope emotionally with having a hearing loss was necessary, but CCS responded that the hearing aid should just be replaced. In this case it was clear that the child was not receiving the medical services he required.

*UCLA Audiology and Speech Pathology
Allison Grinds, Clinic Audiologist*

There are complex ramifications of hearing loss. It is more than an audiological impediment, but also impacts social ability, mental stress, and communication. Medi-Cal doesn't cover the cost of the services that address these diverse needs.

*John Tracy Clinic
Jill Muhs, VP of Programs*

Sometimes the child needs a more advanced hearing aid that doesn't fit into that pay schedule. Also for children that are privately insured, most private insurers don't cover hearing aids, and hearing aids often one of the first benefits to be cut.

Consequently, a large group of children that are not eligible for CCS due to parents' income and insurance are not actually receiving the audiological services they need.

*Gardena Hearing Center
Marcia Blank, Audiologist*

IV. Issues Working with CCS

It is not a lack of caring or compassion on the part of CCS, but nonetheless they're extremely difficult to bill and receive reimbursement from. They work with very particular billing, coding, and authorizing system that is not provider or patient friendly. UCLA medical center has an entire CCS unit created expressly to handle paperwork, claims billing, and reimbursement with CCS. For smaller practices that don't have access to these services, it would be unfeasible to serve a high number of CCS patients.

*UCLA Audiology and Speech Pathology
Allison Grinds, Clinic Audiologist*

The most prominent issue is long delays in provider reimbursement, which in turn makes doctors reluctant to pay for interpreters. This decreases options for Medi-Cal patients with DHH children to a small and overworked pool, which lowers the quality of service.

*Greater Los Angeles Agency on Deafness (GLAD)
Paul Stuessy, Health Care Access Case Manager*

Medi-Cal "makes it a very difficult environment to provide service in because they keep threatening to cut [the funding of certain services]." If services have already been delivered, Medi-cal might retroactively announce that they do not cover that specific service and the provider will not receive reimbursement. This presents a high level of financial risk for service providers when working with Medi-Cal

patients. Additionally, there is very little recourse when benefits are retroactively eliminated.

There is also a general lack of coordination between CCS and the Medi-Cal billing system that accounts for a large proportion of the problems. For example, CCS approves claims based on a much more comprehensive list of services, whereas Medi-Cal only guarantees coverage of more basic services. Children with disabilities are supposed to be held to the CCS standards of medical necessity, since their health needs are much greater. However, there are many cases where CCS will approve a service, and the provider will carry out that service, at which point the Medi-Cal billing system will deny reimbursement based on their definition of what is medically necessary.

“They are not user friendly, and it creates an adversarial relationship where you’re trying to provide the best service, and they’re trying to spend the least they can.”

*HEAR Center
Ellen Simon, Executive Director*

Medi-Cal is difficult to communicate with, difficult to get a straight story from, and frequently give advice that conflicts with that from another Medi-Cal administrator. Additionally, they take forever to pay, don’t always pay what they say they will pay, and it is laborious to track their decision and decipher why they have not paid or paid properly. Their appeals process is laborious as well, and the amount they pay is sometimes not worth the trouble. The paneling process is frustrating and it takes an appallingly long time for new staff to be approved as a

provider, even when they are clearly well qualified and those qualifications are clearly documented.

House Ear Institute
Margaret Winter, Audiology Coordinator

The main problem is low reimbursement rates. The payment remains the same for children but there is much more paperwork and effort involved– children may require 2 hours versus 45 min with an adult.

Gardena Hearing Center
Marcia Blank, Audiologist

V. Desirable Policy and Practice Modifications to Medi-Cal/CCS

A single payer system would be ideal and would lay the groundwork for coordinated high quality care, however in the meantime, “There needs to be infrastructure, there needs to be reimbursement that is reasonable enough so that you don’t have audiologists discontinuing participation.”

UCLA Audiology and Speech Pathology
Allison Grinds, Clinic Audiologist

Director of HEAR Center Ellen Simon makes the following suggestions:

- More direct communication between Medi-Cal offices and providers
- Development of a clear and user-friendly problem solving process that quickly and effectively solves payment or coverage discrepancies
- A centralized informational center where providers could find answers to questions that all other parts of Medi-Cal would honor
- Collaboration and synchronization between the various departments and offices under the Medi-Cal umbrella

If Medi-Cal were more accessible to providers, the quality and availability of healthcare for children with disabilities would greatly increase. Additionally, the possibility for a greater degree of collaboration between providers would be possible, and the organizations and clinics that do serve Medi-Cal patients would be less overwhelmed.

HEAR Center
Ellen Simon, Executive Director

“In short, communication should be easier, faster, clearer, better. Reimbursement should be more straightforward, more timely, and easier to monitor.”

House Ear Institute
Margaret Winter, Audiology Coordinator

CCS designates some providers as “communication disorder centers,” if providers meet certain criteria such as types of service, and ages served, and office hours. When an Audiology office is designated as a communication disorder center, their role expands to include different facets of service, meaning can be audiologist and hearing aid dispenser for example, and service is less disjointed.

In the case of Audiologist Marcia Blank’s office, this designation would be advantageous for both provider and patient. Currently the Gardena Hearing Center essentially functions as a hearing aid “vendor” that serves patients referred to them by other hospitals or clinics. Each time a patient needs a minor adjustment or service, Dr. Blank must engage in a lengthy application process where the primary provider must authorize each individual service. Efficiency, coordination, and

timely delivery of care would improve if more practices were included in the service “center” model.

*Gardena Hearing Center
Marcia Blank, Audiologist*

VI. Desirable Policy and Practice Modifications unrelated to Medi-Cal/CCS

It would be beneficial to the communities served if there were more providers from cultural and linguistic backgrounds of the patients (currently almost no cultural/linguistic diversity exists in Audiology). Secondly funding to expand the transportation services that CCS offers would have a positive impact on access for low-income families.

*UCLA Audiology and Speech Pathology
Allison Grinds, Clinic Audiologist*

In an ideal situation, doctors wouldn’t be burdened with the responsibility of contracting an interpreter service, and there would be a much higher number deaf or ASL fluent doctors. Additionally, there would be a large-scale systematic training process for doctors and other service providers so that the ability to work effectively with DHH patients would be institutionalized, rather than occurring sporadically on an individual basis.

*Greater Los Angeles Agency on Deafness (GLAD)
Paul Stuessy, Health Care Access Case Manager*

Ideally there would more centers set up that followed the House Ear model of comprehensive care offered by a group of collaborating specialists. Additionally, mandating private insurers to cover hearing aids would address the privately

insured DHH children that fall through the cracks, but on the other hand may result in payment hikes that could ultimately harm families.

*Gardena Hearing Center
Marcia Blank, Audiologist*

VII. Response to Federal Healthcare Changes

The historic passage of the national health reform bill in March 2010, will undoubtedly impact healthcare providers that serve Medi-Cal patients. At UCLA Audiology, they may be receiving a higher volume of new patients as a result of healthcare reform, but according to Dr. Grinds, 'we're already at capacity with our patient population. If we had room to grow, I would say that it would help us provide quality care to more patients. However, we physically don't have enough equipment or audiologists to serve a significantly larger number of patients.'

*UCLA Audiology and Speech Pathology
Allison Grinds, Clinic Audiologist*

More children will fall through the cracks, because more people will be on Medi-Cal and providers will have to handle greater caseloads.

*Gardena Hearing Center
Marcia Blank, Audiologist*

VIII. Existing Collaboration Efforts

The UCLA center is a fairly good model for coordination, at least within an individual unit. There is a team of specialists, who can collaborate and serve patients all at one site, making service more time efficient and streamlined. However, the

implementation of medical homes may not be realistic on a larger scale without a major shift in healthcare policy (such as a single payer system).

UCLA Audiology and Speech Pathology
Allison Grinds, Clinic Audiologist

House Ear Institute works closely with the physicians of the House Clinic, and employs an educational liaison to stay in contact with schools and therapists; in addition the individual audiologist communicate regularly with the children's teachers and therapists. There is a great deal of collaboration in our clinic between us and various other providers of service, including otologists, schools, and private therapists. We do not however, have a great deal of contact with primary care physicians.

House Ear Institute
Margaret Winter, Audiology Coordinator

One of GLAD's current projects is the GLAD Health Care Access Coalition – a regional network of health care providers, language advocates and other stakeholders that are working to develop a strategic plan to improve access to quality health care services for deaf and hard of hearing consumers in Los Angeles County in the following areas:

Health Care Providers: To assist health service providers to become knowledgeable and sensitive to deaf culture and make resources available to increase deaf and hard of hearing patients' access to health care.

Health Plans: to assist health plans and insurance companies with compliance with

laws including SB853 and to provide technical support to maintain quality assurance between health plans, insurance and medical providers (for instance, who pays for interpreter services – doctors or insurance companies?).

Deaf and Hard of Hearing Consumers: to educate deaf and hard of hearing consumers about their rights and responsibilities so they can access quality health care.

Sign Language Interpreters: to provide professional medical-related training for sign language interpreters to be able to interpret fluently in medical settings.

Legislative: to educate lawmakers about the need for sign language to be added to the SB853 bill so that medical providers and health plans will comply. Funded by The California Endowment.

Information taken from the GLAD website.

B. Private Audiologists Findings and Analysis

The experiences and opinions of private audiologists are also included in this study. The goal is to assess the role of private sector of DHH services by; determining the ratio of audiologists that do accept Medi-Cal and CCS versus those that do not, establishing a list of private providers that are open to public insurance, and understanding the factors that determine each provider's Medi-Cal/CCS policy. The list of Audiologists that do accept Medi-Cal is included in appendix.

I. Presentation of Data

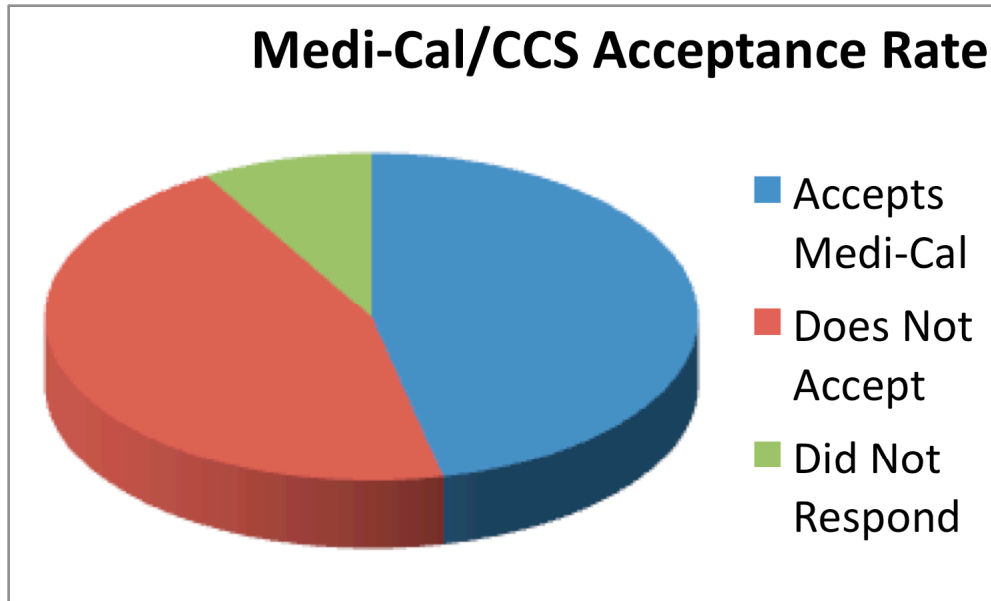
71 LA County Audiology offices included in survey

6 (8%) did not respond

32 (45%) responded that they do NOT accept Medi-cal

33 (46%) responded that they DO accept Medi-cal

6 (8%) offices were randomly selected to anonymously respond to survey questions



II. Discussion of Data

Roughly half of all private audiological offices serving LA County opt out of working with patients covered by Medi-Cal or CCS, a ratio that mirrors national trends. Of those that do accept public insurance, many have a set number of Medi-Cal/CCS slots, meaning that they only serve a very limited number. One office mentioned that their appointment availability was much scarcer for Medi-Cal patients, the nearest opening was not for over a month. Others mentioned that they were “at capacity” in terms of publically insured patients and could not afford to take on new clients. According to Audiologist Marcia Blank who has been practicing for 30 years, the rates of audiologists that work with CCS have always been low, but have dropped notably lower in recent years.⁵⁷ The low rate of acceptance coupled

⁵⁷ Marcia Blank, Gardena Hearing Center Audiologist. Interview conducted April 1, 2010.

with publicly insured patient limits creates a situation where audiological services can be difficult to access in a consistent and timely manor.

The majority of the offices asserted that the recent state budget cuts to audiological benefits within the Medi-Cal program had significantly impacted their population of low-income patients. Several weren't fully aware of the specifics of what services had been cut, and had stopped seeing Medi-Cal patients all together. One office expressed concern for their Medi-Cal patients whose services had been cut and continue to offer the services at a discounted price to these patients, if they are able to pay independently. While the cuts did not impact children and youth, they were very serious for adult DHH Medi-Cal recipients.

III. Explanation of Determination

Several of the audiologists who do not accept Medi-Cal/CCS patients in their practices voiced their opinions about the influential factors in their decision-making process. The following list includes their responses:

- Unreasonably low fees
- Long delays in the reimbursement process
- Overwhelming amounts of time-consuming paperwork, especially when CCS was involved
- Inconvenient audits by the state of California (mandated to monitor billing practices)
- Lack of patient cooperation/understanding in billing
 - The Medi-Cal reimbursement system calls for patients to complete and submit paperwork independently before payment is processed, and many patients either neglect this post-visit task, or do not fully understand the paperwork
 - If the patient does not submit their portion of the necessary paperwork before the stated deadline, the process must start over

Audiologists that do accept Medi-Cal patients uniformly work with these patients strictly on moral grounds. They believe that low-income patients deserve the right to healthcare and are well aware that if all private providers denied service, they would have nowhere to turn. While some of the offices found Medi-Cal to be less of a burden than others, all expressed that working with Medi-Cal reimbursement rates is “bad business” and at times the cost of delivering the service outweighs the reimbursement amount. Some coping mechanisms they use include:

- Balance the number of Medi-Cal patients with higher paying private patients
- Ensure that referrals from non Medi-Cal audiologists are spread between the various offices that do accept Medi-Cal, so that impact is minimized

7. Lessons From LA

A. Defining Quality Healthcare

Private healthcare organizations, practicing doctors, and government agencies all agree that deaf and hard of hearing children should receive high quality care regardless of family income. The response becomes more complex and varied when the question shifts to – what specific components define high quality care and how should these components be achieved? Drawing from literature reviewing patient feedback and provider input, coupled with the opinions of the professionals included in this study, the following factors stand out as key in the delivery of high quality care to DHH children: It must be accessible, coordinated, holistic.

The notion of *Accessibility* must be further broken down to understand what steps are necessary to create healthcare that is regarded as accessible by DHH children and their families. The most obvious indicator of accessible healthcare is

the ease with which clients can move between home and provider, as well as the doctor availability. Patients must be able to obtain an appointment within a reasonable timeframe, and be capable of reaching the doctor's office without excessive effort.

Another less apparent factor is that healthcare should be culturally and linguistically accessible. Like most doctors, audiologists and other professionals involved in hearing loss treatment tend to be from white, English speaking, middle to upper class upbringing. Needless to say, families whose children receive CCS funded care generally don't share a similar background. Additionally, medical information relating to hearing loss is complex and emotionally sensitive. Families benefit from having this information transmitted to them in a form that responds to their unique cultural and linguistic needs.

The concept of *Coordination* also contains multiple connotations. For the purpose of this paper, it speaks to collaboration between all appropriate stakeholders to achieve streamlined and synchronized delivery of services and payment/reimbursement systems. Stakeholders include Medi-Cal and CCS, healthcare providers, managed care providers, and families. A pivotal element to coordinated care is open lines of communication between patients and healthcare providers, managed care providers and all other stakeholders, within CCS and Medi-Cal entities, and particularly amongst healthcare providers.

Holistic healthcare seeks to address the root problem of medical issues, while recognizing the interdependence of all elements of health. The overall wellness of an individual is the goal, not merely the eradication of surface level conditions. For

low-income DHH children, a holistic health delivery system must first acknowledge and respect that hearing loss is intrinsically connected to other issues relating to the wellbeing of the child that must be addressed simultaneously. Additionally, holistic healthcare recognizes that family involvement is critical to the auditory, mental, and communicative health of the child, and offers a reasonable level of support, so that families can be active and engaged participants.

B. Logistical Practicality

This study has found *logistical practicality* to be a pivotal missing element preventing healthcare providers from delivering fully coordinated, accessible, and holistic healthcare to low income DHH children and youth. The primary logistical issue is the unrealistically low reimbursement rates that providers receive for treating low-income patients. This issue coupled with extended delay in reimbursement makes serving low-income patients a financially unsound decision. Ultimately, all service delivery systems must be financially sustainable, and a reimbursement system that forces providers to choose between serving a significant number of low-income patients and financial sustainability is inherently flawed.

Secondly, the exorbitant amount of paperwork involved with serving underprivileged clients presents another logistical pitfall. Smaller practices in particular often do not have sufficient personal or available time to spend hours filling out paperwork for each service that a client receives. The bureaucracy involved in the Medi-Cal and CCS application and reimbursement systems impede the delivery of quality healthcare on several levels. Firstly, they deter providers from participating, thusly shrinking the pool of available providers and drastically

increasing the patient to doctor ratios in practices that continue to work with underprivileged patients. Furthermore, each individual patient requires much more time and energy than necessary, which in turn slows down the delivery of care, and restricts the number of patients that can be helped. Until these issues are addressed, coordinated, accessible, and holistic healthcare for low-income DHH children will remain out of reach.

8. Models of Improvement

While the federal healthcare reform excitement has come and went, there have been important advances towards a more efficient and higher quality healthcare delivery system on a smaller scale. Many of these examples especially focus on the concept of operating under a streamlined collaborative model.

A. The Canadian Model

In the United States the concept of broad implementation of medical homes is only recently receiving widespread attention, however over 1 million patients in Ontario are currently being served by Family Health Teams (FHTs), the Canadian counterpart to medical homes⁵⁸. The system was first implemented in 2004, and while comprehensive evaluation has yet to be completed, thus far feedback from both patients and physicians has been overwhelmingly positive. The main goal of the FHTs is to expand the capacity of primary care by creating network of interdisciplinary teams of healthcare providers. In essence, “Not every physician

⁵⁸ Walter W. Rosser, Jack M. Colwell, et al. “Patient Centered Medical Homes in Ontario.” *The New England Journal of Medicine*, January 6th, 2010. The New England Journal of Medicine online database. 29 March, 2010 < <http://healthcarereform.nejm.org/?p=2612#more-2612>>.

delivers every service, but each group must be organized to do so. The patient's physician sees to it that appropriate services are provided."⁵⁹

Some important aspects include:

- Clear standards as to what services must be included in each team
- Autonomy and flexibility for each FHT to determine the details of their implementation practices to a reasonable extent
- Coordinated electronic health records for providers to share information, as well as for reimbursement purposes
- Primary care providers are the link between patients and specialty care
- Coordinated efforts to emphasize preventative care

B. US Examples

There have been small pockets of reform in the United States as well. A publication of the National Academy For State Health Policy found some unique approaches in the states of New York, Arizona, and Pennsylvania. Their key functions and characteristics are outlined below:

- **New York Project:** Several national health plans are collaborating to create a pilot project in the Mid-Hudson region of New York
 - Key aspects
 - The project will include approximately one million covered lives and 500 providers
 - Participating practices will employ electronic health records, ePrescribing, online provider portals, and adopted standards for continuity of care and care coordination per PPC-PCMH™ guidelines.

⁵⁹ Walter W. Rosser, Jack M. Colwell, et al.

- The practices receive their regular reimbursement for the services they provide to patients in addition to reimbursement based on their performance and the outcomes they produce.

Funded by the New York Department of Health and the health plans.

- **Arizona Project:** Implementing health information exchange (HEI) using health information technology (HIT) to encourage the collaboration of providers and support an integrated medical home
 - Objectives:
 - Integrate health care delivery
 - Increase transparency of health care cost and quality
 - Promote productive interchange between provider and patient
 - Enable consumers and patients to make informed decisions and actively participate in their own care
 - Enable health care providers to provide cost effective care management and use clinical decision support tools to reduce cost and improve quality
- **Pennsylvania Project:** Coordination Program for Children with Special Health Care Needs -Assists families with children with special health care needs navigate the health care system to obtain services that are available but not readily or easily accessible through the SCHIP program – pilot project began 2005
 - *(Created in response to large numbers of children in the CHIP program that had special health care needs, but did not qualify for Medicaid)*
 - Key Aspects:
 - Supports providers by informing them if the children is enrolled in the Caring Program, sharing care plans with

physician practices, providing appropriate (non-medical) referral information, coordinating care and communication among multiple practitioners and facilities

- Provides family-centered education to the family to support adherence to the physician medical care plan

These projects seek to address some of the fundamental deficiencies associated with healthcare services for low-income individuals, such as lack of communication and coordination, and time consuming bureaucratic delay. Like the Canadian example, extensive analysis has yet to determine the level of success, but initial reviews have been very supportive. These smaller scale examples shed light on possible solutions for LA County and the state of California. The use health exchange information technology, and a two-tier reimbursement system are particularly transferable concepts.

Another important lesson is that highly organized projects have the potential to make rapid and considerable impact when their funding and infrastructure mirror their target constituency. While this goal is far more attainable for smaller scale projects, well-executed programs shed light on effective ideas and the capacity for systemic change.

C. Legislation

Pennsylvania Representative Allyson Schwartz introduced a bill in 2009 known as the Healthcare Innovation Zone that calls for the Secretary of Health and Human Services to establish pilot programs that focus on collaborative care. The basic tenets of the bill include,

A regional alliance consisting of an academic medical center, local hospitals, physicians and other health-care organizations coordinates and delivers the full spectrum of care in ways that reward quality. These Innovation Zones

could also test new, more patient-centered models of care, such as the medical home and "accountable care organizations," as well as new payment models that have the potential to vastly improve care and reduce costs.⁶⁰

While the bill awaits further review from Committee (where the majority of bills die), it represents innovative strategizing, and if passed would present the opportunity for a more patient centered healthcare model to be tested.

9. Recommendations

The following section will examine what accessibility, coordination, and holistic healthcare looks like in reference to healthcare for DHH low-income children. It will address what specific policy and practice changes would most effectively translate these concepts into reality.

- ***A. Medi-Cal and California Children's Services*** are the most influential entities in determining the standards and delivery mode of healthcare services for low-income DHH children. They have the power to hugely impact accessibility and collaboration, and increase holistic care for this population. While their existence tremendously improves the lives of these children today, there are many changes that, if adopted, would magnify their impact in the future. The following recommendations are geared toward the creation of government agencies that are transparent, accessible, responsive, and communicative. The California Department of Healthcare Services (CDHS) requires additional funding and restructuring to implement these changes.

⁶⁰ "H.R. 3134--111th Congress: Healthcare Innovation Zone Program Act of 2009." [GovTrack.us \(database of federal legislation\)](http://www.govtrack.us/congress/bill.xpd?bill=h111-3134). 2009. April 15, 2010 <<http://www.govtrack.us/congress/bill.xpd?bill=h111-3134>>

- *Increase reimbursement amounts* – Granted this recommendation is only possible with additional monetary support from state and federal governments, Medi-Cal policy must also modify its reimbursement calculations to become a reasonable option for healthcare providers. Reimbursement amounts for both primary and specialty doctors should (at the minimum) match Medicare amounts.
- *Commission of an outside task force that evaluates their billing methods in order to streamline and accelerate the process* – All healthcare providers included in this study listed the excessive paperwork and delay involved in their billing process as a major hindrance to providing quality care. The Medi-Cal/CCS billing system necessitates immediate and in depth analysis and revamping by an outside agency. The objective being to identify key problems and create a model of billing that produces efficient and results, rather than alienating and discouraging participating providers. The ultimate goal would be to cut down on unnecessary paperwork as well as cutting reimbursement wait-time to match private insurance agencies. The desired outcome would be increasing the desirability of public insurance to attract more private practices.
- *Cover supplementary services such as psychological and family therapy services* – Most healthcare professionals who work with DHH children argue that the health effects related to hearing loss extend far beyond what audiological services offer. Given that deafness greatly hinders

communication and social interaction with family and friends, children often suffer from psychological effects. To meet this holistic need, CCS should include psychological assessment and services as part of the care deemed appropriate and necessary for DHH children.

- *Open lines of communication within the Medi-Cal/CCS entities –*
Incongruity between administrators within Medi-Cal and CCS has led to confusion and distrust for the integrity of the payment system. A formalized structure to create unity within these entities should be developed that includes a method for the various offices to meet and discuss payment regulations, procedures, and policy updates.
- *Expansion of supportive services such as transportation and childcare –*
Currently CCS does offer some transportation services to low-income families without means to travel to doctors' appointments, and these services should be expanded and widely advertised. Transportation without a vehicle is especially difficult in Los Angeles, and a well structured and publicized assistive transportation service would remove some of the barriers to accessibility for very low-income patients. Additionally, childcare offered on the site would enable single parents to participate in meetings with doctors without the additional burden of securing childcare.
- *Incentivize collaboration by increasing reimbursement to practices that incorporate multiple services –* Medi-Cal/CCS should also actively encourage providers to serve clients in a model that synchronizes

their multiple health needs related to hearing loss. The most direct way to nurture these types of delivery models is to increase reimbursement amounts for practices that operate under a collaborative model. For example, because the House Ear Institute employs a team of specialists that offer comprehensive care to children with hearing loss, they would receive additional reimbursement to reward their superior service.

- ***B. State and Federal governments*** also have a large degree of control over the healthcare available to low-income populations. Much of that control is derived from the power to fund, or underfund, all public programs. However, state and federal policy decisions also have significant ramifications for healthcare. The subsequent suggestions highlight some specific ways that state and federal governments can support quality healthcare for DHH children.
- ***Actions that Apply to Both State and Federal Governments***
 - *Tax breaks for private practices that accept Medi-Cal/CCS patients* - tax breaks or other forms of preferential incentives should be instituted in order to balance the extra time and lower pay involved in serving low-income patients. This additional encouragement may tip the scale for private primary and specialty providers that are hesitant to work with public insurance.
 - *Allocate additional funding specifically for Medi-Cal/CCS to increase reimbursement amounts* – The unrealistically low reimbursement

rates allocated for Medicaid services are the primary reason why many providers do not work with Medicaid patients. Both state and federal budgets must be adjusted to place greater priority on the health needs of the low-income populations served under Medicaid. Until rates are raised, at least to match Medicare rates (approximately 70% of private insurer rates), Medicaid consumers will have little hope of receiving satisfactory care from private practices.

- *Institute a schedule of pay increases for Medicaid that takes inflation and the rates of private insurers into account* – Because state and federal governments co-fund Medi-Cal, both entities would need to jointly institutionalize a system where Medicaid fees are regularly increased to account for inflation, and prevent the formation of an immense gap between public and private insurance reimbursement fees in future years.

- ***C. California State Government***

- *Reinstate the auditory cuts that were made to adult recipients of Medi-Cal* – The 2009 budget cuts to Medi-Cal created a situation where DHH children receive basic coverage, but their young adult counter parts are left without many services that are vital to their basic health maintenance. Even with the recent federal healthcare reform expanding coverage to single adults, DHH patients would not be receiving the full range of auditory coverage they require. Vital

services such as hearing exams, and maintenance of hearing aids should be immediately reinstated.

- *Actively address the needs of Linguistic/cultural minorities/families in extreme poverty* – These populations have been identified as high-risk Medi-Cal/CCS recipients who require additional support. The majority of doctors and healthcare professionals included in this study asserted that meeting the unique needs of these groups as a major issue. The state of California is one of the most culturally and linguistically diverse regions of the country, and must put forth particular effort towards addressing the needs of these groups of people. Some particular steps that should be taken are outlined below:

- Fund medical associations to begin active recruitment within cultural and linguistic minority communities and minority pre-medical school students to pursue a career in Audiology
- Fund DHH institutions such as GLAD to begin active recruitment of ASL interpreters that are fluent in multiple spoken languages
- Fund DHH institutions such as GLAD to carry out Deaf Cultural sensitivity training sessions and communication guides for primary care physicians
- Fund health organizations to outreach within cultural/linguistic communities to increase knowledge of

resources for DHH children (preferably lead by members of those communities)

- *Establish an Institutionalized Relationship with Private Sector* – The private sector does a considerable amount of work with DHH children and youth, and in many cases has developed effective programs and practices. The state should take advantage of the lessons learned by the private sector and aim to work in coordination with these providers. Some specific approaches include:
 - Replicate models of service delivery that work well in the private sector
 - Provide additional financial support for private programs that effectively serve high numbers of publically insured children
 - Establish open lines of communication to collectively explore improved practices and support a more coordinated care delivery system that incorporates both public and private entities
- ***D. Federal Government*** – There are several policy and funding modifications on the federal level that would benefit low-income DHH children. The US Department of Health and Human Services (HSS) should implement the following adaptations to improve the quality of care for children, as well as the professional environment for providers.

- *Incentivize collaboration* – Increasing federal matching amounts for states that institutionalize collaborative methods of healthcare delivery.
- *Incentivize streamlined Medicaid paperwork* – Provide additional funds to states that are instituting task forces to increase Medicaid payment efficiency
- **E. DHH Healthcare Providers**
 - *Collectivize power to influence policy* – Healthcare providers have the potential to carry significant political clout when they unite with a specific goal in mind. To have more power over the policy decisions that influence their ability to offer exceptional healthcare, providers should:
 - Join organizations such as Patient-Centered Primary Care Collaborative (PCPCC) or Physicians for a National Health Program (PNHP) that focus on systematic change to healthcare delivery
 - Establish a set of common goals and targets
 - Increase links with other providers outside of the formal structure with the intent of increasing collaboration (for example, a practice that just administers audiological tests connect with a practice that provides hearing aids to collaborate over patient health records, and cut back on unnecessary paperwork)

- *Aim to create a collective provider model* - Upcoming practices in particular should aim to create service centers modeled after the House Ear Institute model – where patients are served by a team of specialists, rather than dividing the various audiological services among disparate providers
- *Incorporate patient perspective* - Regularly seek out and incorporate patient opinions and concerns in respect to healthcare delivery and evaluation through surveys, interviews, etc
- **F. Families** - While the process of obtaining healthcare alone overwhelms most families, their involvement in the political arena is crucial to advancement of a more equitable and effective healthcare delivery system. To be a part of systemic change families would benefit from the following actions:
 - *Firstly, stay informed* about the presence of current healthcare policies so that they can support the passage of bills that would benefit them
 - There are a number of groups that assist parents in advocating for policy changes. Some examples include Family Voices of California, the American Association of People with Disabilities (AAPD), and the California Association of the Deaf
 - *Join coalitions* with providers and other stakeholders that share a common interest of improving healthcare for low-income children/children with special healthcare needs. Families and

providers each bring a unique pool of knowledge and assets to the table, and open communication about common goals is key to moving towards creating change.

10. Further Research

There are some important areas relating to the topic of improving healthcare for low-income DHH children in Los Angeles that call for investigation beyond what was included in this study. The following issues were either too extensive to include in this study or there was a general lack of information available and were therefore not examined in depth, however further research would advance the understanding of healthcare access for low-income DHH children:

- The services available to undocumented children and what policy changes would more adequately meet the needs of this population
- More extensive examination of best practices in other states/counties concerning quality of care for children with special healthcare needs
- Research into what happens to low-income DHH children when they age out of CCS benefits
- The impact of the recently passed federal healthcare reforms (as the impact of the bill begins to take effect)
- Further research into what work is currently being done to address these healthcare issues and what policies are being pushed that would benefit low income DHH children

11. Conclusions

This research paper has explored the intersection of poverty, healthcare access, and disability, and found that low-income children with special healthcare needs comprise one of the most difficult groups to effectively serve in terms of healthcare delivery. This population faces a host of unique challenges from physical access, to language barriers, and minimal amounts of time and energy to devote towards navigating complex healthcare systems. However, the implementation of a functional, time and money efficient system that delivers high quality holistic care is not outside of the realm of possibility.

Strategic adjustments and a tactical restructuring of the health delivery system combined with a more logical prioritization of the state and federal budgets would bring about swift and far reaching change. These improvements would reach far beyond the limited category of DHH low-income children. When functional and efficient delivery methods are developed to serve this population, lessons learned from the process would be invaluable in the improvement of services for all levels of need.

Improving access to healthcare for any population, and especially low-income high-risk groups, ultimately decreases the cost placed on taxpayers. When a DHH child does not receive the services they need throughout childhood and adolescence, they require additional and costly assistance in every academic setting, and throughout their adult lives. Without consistent quality health care, conditions accelerate and develop into severe or chronic issues that are distressing for the patient, and costly for the public that foots the Medi-Cal bill. Early and consistent

quality healthcare creates the opportunity for DHH individuals to become healthy and competent members of society.

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1. Glossary of Acronyms

- **ASL** – American Sign Language; language which utilizes hand movements and facial expressions (used by majority of deaf Americans to communicate)
- **CCS** – California Children’s Services, a statewide program that provides medical services to children under age 21 with CCS-eligible medical conditions.
- **DHH** – Deaf or Hard of Hearing; all encompassing term that refers to individuals with any level of hearing loss
- **FAPE** – Free and Appropriate Public Education; a stipulation of the IDEA Act that requires disabled students receive an education that meets their unique needs at no extra cost to parents
- **IDEA** – Individuals with Disabilities Education Act; federal law that governs how education and related services are provided to children with disabilities from birth to age 21
- **LRE** – Least Restrictive Environment; a stipulation of the IDEA Act that calls for children with special learning needs be placed in the least segregated environment possible while receiving appropriate instruction

2. Federal Poverty Level Guidelines

**The 2009 Poverty Guidelines for the
48 Contiguous States and the District of Columbia ⁶¹**

Persons in family	Poverty guideline
1	\$10,830
2	14,570
3	18,310
4	22,050
5	25,790
6	29,530
7	33,270
8	37,010
For families with more than 8 persons, add \$3,740 for each additional person.	

⁶¹ "The 2009 HHS Poverty Guidelines." *U.S. Department of Health and Human Services*. Accessed March 1, 2010. <<http://aspe.hhs.gov/poverty/09poverty.shtml>>

3. Audiology Centers in LA County that Accept Medi-Cal/CCS

Alhambra Audiology Inc

49 S Garfield Ave
Alhambra, CA 91801
(626) 284-4633
(no children)

American Hearing & Balance

633 N Central Ave
Glendale, CA 91203
(818) 500-0662

American Hearing & Balance

20911 Earl St
Torrance, CA 90503
(310) 370-0007

Arcade Hearing Aid Center

1318 2nd St Ste 1
Santa Monica, CA 90401 Map
(310) 395-5426 or (310) 393-4232

Audio Rx Hearing Aids

18238 Prairie Ave
Torrance, CA 90504
(310) 371-0034
(Older children only)

Audio RX Hearing Services

6333 WILSHIRE BLVD STE 409
LOS ANGELES, CA 90048-5722
323-651-5107
(NO children)

Audiology Center Of Los Angeles

1728 Laurel Canyon Blvd
Los Angeles, CA 90046
(323) 851-6556

Burbank Hearing Clinic

127 N San Fernando Blvd
Burbank, CA 91502
(818) 842-4069

(NO children)

Central Hearing Center Inc

633 N Central Ave Ste 106
Glendale, CA 91203
(818) 246-4839

Dr. Davis, Audiology and Hearing Aids

8135 Painter Ave Ste 200
Whittier, CA 90602
(562) 945-6134

Fidelity Hearing Center

13079 Artesia Blvd., B-104
Cerritos, CA 90703
Phone: 562-926-6066
(children 5 and up)

Gardena Hearing Center

1300 W 155th St
Gardena, CA 90247
(310) 327-5001

Glendale Professional Hearing Center

372 Arden Ave Ste 101
Glendale, CA 91203
(818) 243-0680
(With referral from doctor)

Hearing Aid Professionals

960 E Green St
Pasadena, CA 91106
(626) 793-1179

Hearing Aid Professionals

8540 S Sepulveda Blvd
Los Angeles, CA 90045
(310) 348-4700

House Clinic

Nicole Green

330 N. Maple St, Unit M
Burbank, CA 91505
Phone: 213-483-9930
(With doctors' referral)

International Hearing Aid Center

Adele Zaretsky
6225 Wilshire Blvd
Los Angeles, Ca 90048
Phone: 323-954-1388
(Children 6+)

Jays Hearing Aid Center

3740 E. 7th St, Long Beach
(562) 433 6701

Mayo Hearing Clinic aka Affordable Hearing Aids

2511 N Orchard Dr
Burbank, CA 91504
(818) 843-2415
(Mostly located in Torrance, only house visits in Burbank)

Otonix Inc.

1700 E Cesar E Chavez Ave #2300 A
Los Angeles, CA 90033
(323) 260-7404

Physicians Hearing Center

3640 Lomita Blvd Ste 200
Torrance, CA 90505
(310) 378-7070

Riverview Hearing Speech And Language Centers-long Beach Ca

(562) 439-9539 (800) 432-7456
5842 Naples Plaza, Long Beach

Sonus Hearing Care Centers

416 W Las Tunas Dr
San Gabriel, CA 91776
(626) 281-9889

Salisbury Audiology

3235 E Colorado Blvd

Pasadena, CA 91107
(626) 568-1800

Sonus Hearing Care Professionals

612 W Duarte Rd
Arcadia, CA 91007
(626) 445-2844

Sonus Hearing Care Centers

1911 Wilshire Blvd
Santa Monica, CA 90403
(310) 828-1055

Sonus Hearing Care Center

741 Atlantic Ave, Long Beach
(562) 427-5889

Sonus Hearing Care Center

3816 Woodruff Ave, Long Beach
(562) 982 0050
(Children 5+)

Sonus Hearing Care Center

1127 Wilshire Blvd
Los Angeles, CA 90017
(213) 481-1295

Sonus Hearing Care Center

11600 Wilshire Blvd
Los Angeles, CA 90025
(310) 477-1519

Towers Audiology Center

8631 W 3rd St Suite 312E
Los Angeles, CA 90048
(310) 652-4327

Union Hearing Aid Center

5520 Whittier Blvd
Commerce, CA 90022
(323) 721-6424

Whittier Hearing Center

13121 Philadelphia St
Whittier, CA 90601
(562) 945-9321 Or (562) 698-0581

4. Comprehensive Centers Full Organizational Profiles

Greater Los Angeles Agency on Deafness, Inc. (GLAD) Organizational Profile

www.gladinc.org
2222 Laverna Avenue
Los Angeles, CA 90041

(323) 478-8000 Voice/TTY
(323) 550-4226 TTY
(866) 932-8553 Videophone (VP)
(323) 550-4205 Fax

Mission

To ensure equal access of the deaf and hard of hearing community to the same opportunities afforded their hearing counterparts. The organization's general purposes and powers are directed around the promotion of the social, recreational, cultural, educational, and vocational well-being of its deaf and hard of hearing constituents.

GLAD's specific and primary purpose is to act as a coordinating agency that addresses the broad social service needs of deaf and hard of hearing people through direct service provision, advocacy, research and dissemination of information regarding deafness to parents, professionals and consumers.

Medi-Cal Policy

GLAD's health related services are free to constituents, and are non medical so do not require health insurance

Funding: The organization receives grants from the California Endowment, ***Public Health (specifically a teenage pregnancy prevention program that addresses the lack of total communication between DHH teenagers and their hearing parents in regards to sexual health) funded by Public Health, and UCLA (specifically funds a program that creates and distributes informative DVDs about breast cancer in ASL).

GLAD Services

Health Services

HIV Prevention Program
HIV Interpreting Services
Breast Cancer Research and Education
Teen Pregnancy Prevention Program

Advocacy

Independent Living Skills
Employment Assistance
Information & Referral
Community Education & Outreach
Parent Connections
LIFESIGNS, Inc. is a non-profit
interpreting service

Human Services

Communication Assistance
Peer Counseling

HEAR Center Organizational Profile

www.hearcenter.org

Phone: (626) 796-2016

301 East Del Mar Boulevard

Fax: (626) 796-2320

Pasadena, CA 91101

Email: info@hearcenter.org

Mission

To help individuals with hearing loss or speech and language impairments enrich their lives by providing them with auditory and oral communication skills.

Medi-Cal Policy

HEAR Center is not able to provide Audiology and speech pathology services free of charge, however they do accept clients with “straight” Medi-Cal (meaning that patients within certain HMOs may be Medi-Cal recipients, but cannot receive service because their coverage is outside of their network). HEAR Center does serve fee-for-service Medi-Cal recipients, in addition to those within the LA Care network, and several other private HMOs.

Funding

HEAR Center is a non-profit organization, receiving all of its funding from private sources.

Main Services Offered to DHH Children

Pediatric Audiology:

The cornerstone of our auditory services is the evaluation of a child's hearing. At the HEAR Center we perform age-appropriate diagnostic testing to obtain the most accurate audiological results possible.

Conditioned Orientation Response (COR):

Used for babies up to three years of age, COR uses visual stimulation partnered with auditory stimulation to elicit a conditioned response.

Conditioned Play Audiometry:

For children over two years of age, play audiometry is performed by playing a listening game with the child to determine audiological and speech thresholds.

House Ear Institute Organizational Profile

www.houseearclinic.com
2100 W. 3rd Street
Los Angeles, CA 90057
Email: info@hei.org

Phone: (213) 483-4431
In US: (800) 388-8612
TDD: (213) 484-2642
Fax: (213) 483-8789

Mission

House Ear Institute (HEI) is an organization dedicated to advancing hearing science through research and education to improve quality of life.

Medi-Cal Policy

Accept Medi-Cal/CCS pay for service or within certain plans

Funding

HEI is a non-profit that is privately funded, and charges both private and public insurance

Children's Center Mission

The House Ear Institute's Children's Auditory Research and Evaluation (CARE) Center is devoted to improving the communication ability of infants and children with auditory disorders through research, clinical services and education of professionals and families.

Children's Center Clinical Services

Outpatient Infant Screenings

Infant re-screenings and diagnostic evaluations for babies identified through the California Newborn Hearing Screening Program.

Diagnostic Audiology

Testing for children of all ages to determine what parts of the auditory system are functioning normally and why.

Auditory Rehabilitation

Helping children with hearing aids, cochlear implants, FM systems, and other assistive listening devices. Refer children to educational programs and therapy services.

Developmental Psychological Examination

Evaluations to determine cochlear implantation candidacy.

Speech/Language Evaluations and Therapy

Pre-evaluations for cochlear implant candidacy, post-therapy, on-going therapy for children with hearing impairment who have speech/language problems.

Considering a Cochlear Implant?

Providing necessary information for families who are considering Cochlear implants.

Cochlear Implant Services

Describes the evaluation process and qualifications for implantation and post-surgical services.

John Tracy Center Organizational Profile

www.jtc.org
806 West Adams Blvd,
Los Angeles, California, 90007

Los Angeles Tel: (213)748-5481
TTY: (213)747-2924
Long Beach Tel: (562)426-2257
Fax: (562)426-8437

Mission

John Tracy Clinic provides, worldwide and without charge, parent-centered services to young children with a hearing loss offering families hope, guidance and encouragement.

Medi-Cal Policy:

All services are free of charge so insurance is not needed

Funding:

Completely privately funded

Main Services Offered

- Parent Resources –classes and resources that inform and empower parentsFriday family school – support group, education class, playtime, community building
- Parent participation preschool (appx.. 100 families usually enrolled)
- Education department – where parent learning how to gather information, learn how to communicate with their child
- Distance education for parents (international correspondence course)
- Diagnostic testing
- Baby program
- Graduate program (training in DHH education)
- Counseling

Comprehensive audiological services include:

- Newborn Hearing Screening
- Hearing Screening (6mo.-5yrs.)
- Tympanometry
- Acoustic Reflexes
- Otoacoustic Emissions
- Auditory Brainstem Response (ABR) Natural Sleep
- Behavioral Observation Audiometry (BOA)
- Visual Reinforcement Audiometry (VRA)

*John Tracy Clinic audiologists do not dispense hearing aids but will discuss amplification needs, testing methods and troubleshooting with parents

Outside Services/Collaborative Efforts

- *The Clinic audiologists confer regularly* with pediatricians, hospital personnel, implant centers, otolaryngologists (ENT) and the coordination centers of the

California State Newborn Hearing Screening Program to ensure the best possible services to families.

- *Free community hearing screenings* are provided for children in preschools and daycare centers throughout Los Angeles, San Bernardino and Orange counties, as well as the Coachella Valley area of Riverside County. The program is designed to identify children with mild and moderate losses, so that they can receive appropriate medical, audiological and educational services long before school begins (strong model for collaboration).
- *Baby Sound Check* - On May 11th, 2007 John Tracy Clinic launched a model program called Baby Sound Check® designed to fill critical gaps in the early detection and treatment of hearing loss in collaboration with Los Angeles area community healthcare clinics. The program is funded by a gift from Monica and Philip Rosenthal.
 - The first year of the three-year pilot project was implemented in partnership with five community clinics owned by AltaMed Health Services Corporation, a leading Federally Qualified Health Center in East Los Angeles, and now works with a total of 11 clinics. Baby Sound Check® will assess and monitor the hearing health of over 10,000 children in the first three years and thousands more thereafter as the program becomes a self-sustaining model that will be extended throughout the Los Angeles area, and disseminated and replicated nationally.
 - The program provides materials, equipment, and training for the local staff to check for hearing loss when families bring their babies in for normal checkups
 - Young children suspected of hearing loss are referred to JTC for comprehensive diagnostic evaluation. If significant hearing loss is confirmed, the families will be given guidance and information by JTC counselors and audiologists. Every identified child will be invited to join JTC's free Parent/Infant Program and assigned a case manager for continued educational, psychological and audiological support.

Interview subject: Sandy Mintz, Director of Baby Sound Check

Baby sound check is a program that works with 11 community clinics that are treating underserved communities in pediatrics.. If a baby is diagnosed with a hearing loss, they are then referred to the John Tracey Clinic. The program is made possible with a grant from a private funder, as Medi-Cal does not reimburse for this secondary auditory screening.

Presently, hospitals receiving CCS money are required to give newborns an auditory examination (covered by Med-Cal), but many doctors do not emphasize the importance of following up with additional tests. Because many forms of hearing loss do not develop until several months after birth, a large number of DHH babies are not diagnosed until much later. Baby Sound Check was developed to reach LA County infants that fall through the cracks of the early detection process.

UCLA Audiology Organizational Profile

Audiology Clinic

Peter Morton Medical Building
200 UCLA Medical Plaza
Suite 540 Los Angeles, CA 90095

<http://audiology-speech.ucla.edu>
(310) 825-5721

Mission

To provide excellent patient care in support of the educational and scientific programs of the Schools of the UCLA Center for the Health Sciences. In keeping with this mission statement, the Audiology clinic provides services to people of all ages and with any hearing related disorder.

Medi-Cal Policy

They accept Medi-Cal in all forms with authorization.

Mixed Funding Sources

Main Services Offered to DHH Children

- Basic hearing testing - to assess the presence of hearing or hearing loss
Advanced diagnostic procedures for the purpose of quantifying hearing loss in that population who cannot participate in a basic hearing test. This population includes:
 - Babies from birth to childhood
 - Developmentally delayed children and adults
 - Patients with functional hearing loss
- Brainstem Auditory Evoked Response (BAER/ABR) in babies, adults or children. This test is a physiological evaluation of the hearing pathways and can be used to assess hearing in children from as early as birth.
- Otoacoustic emission testing - to evaluate cochlear (inner ear) functioning
- Tympanometry - to assess middle ear functioning, usually to assist in the diagnosis of middle ear pathology such as otitis media or otosclerosis
- Play audiometry - used to assess children's hearing from ages 3 and older
- Visual response audiometry - to assess hearing in children prior to the age of 3 years.
- Electrocochleography (ECoG) - used to assist in the diagnosis of cochlear related pathologies such as Meniere's Disease.
- Electroneuronography (ENoG) - assesses the function of the facial nerve.
- Full Cochlear implant services - will assess the eligibility of a patient to receive a cochlear implant. The service provides information, counseling, testing, hearing aid evaluation, and preparation for further evaluations such as scan, medical visits etc. Following the implant the Audiology clinic provides all mapping and rehabilitation services necessary for cochlear

implant patients.

- Hearing aid dispensing - The Audiology Clinic dispenses most major brands of digital and non-digital hearing aids at competitive prices. All styles of hearing aids are available.
- Aural rehabilitation - for patients who have hearing loss or cochlear implants and need training on listening skills to improve communication abilities

5. Additional Organizations that Provide Support to Individuals that are DHH

LAUSD Resources

Division of Special Education
Los Angeles Unified School District
333 South Beaudry Avenue
17th Floor Los Angeles
CA 90017
(213) 241-6701
Fax: (213) 241-8915
TTY (213) 241-6854
email: spec-ed@lausd.k12.ca.us

- Online Informational Training for Parents of Children with Disabilities
- Parent and Community Support (provides trainings)
- Community Advisory Committee (meets monthly)
- Special Ed. Multicultural Advisory Committee (meets monthly)
- Complaint Response Unit/Parent Resource Network (meets monthly)

No Limits

9801 Washington Blvd
Second Floor
Culver City, Ca 90232
Phone: 310.280.0878 Fax: 310.280.0872
Email: NoLimitsTG@aol.com

The mission of No Limits is to meet the auditory, speech and language needs of deaf children and enhance their confidence through the theatrical arts and individual therapy as well as provide family support and community awareness on the needs and talents of deaf children who are learning to speak.

No Limits engage deaf children in a challenging and rewarding theater program that fosters growth in auditory skills and social development. Additionally, No Limits offers an Auditory and Speech Language Program, as well as Literacy Programs. All services are free of charge to clients.

Deaf Churches

Pilgrim Lutheran Church of the Deaf

1233 South Vermont Avenue
Los Angeles, CA 90006
(213) 389-9940

International Deaf Mission

2121 James M Wood Boulevard
Los Angeles, CA 90006-2219
(213) 382-5253

Los Angeles Deaf Church

1233 S. Vermont Avenue
Los Angeles, CA 90006
Video phone: (562) 569 – 3190

Holy Angels Catholic Church of the Deaf

4433 South Santa Fe Avenue
Vernon, CA 90058-2101
(323) 587-2096

Grace Bible Church for the Deaf

6819 N. Figueroa Street Highland Park, CA 90042
323-257-3868
TTY/V 323-257-6144
jhansen@biblicalministries.org

6. CCS Approved Hospitals in LA County

(Information take from Department of Healthcare Services website)

AHMC SAN GABRIEL
VLY MED CTR
GENERAL COMMUNITY (OVER 14
WITHOUT PEDIATRIC LICENSE)
Los Angeles 438 W Las Tunas Dr
San Gabriel CA 91776-1216

ANTELOPE VALLEY
HOSP MED
COMMUNITY
STANDARD 12/01/1982 Los Angeles 1600 W Avenue J
Lancaster CA 93534-2894

CALIFORNIA HOSP
MED CTR-
COMMUNITY
PEDIATRIC COMMUNITY 05/06/2009 Los Angeles 1401
S Grand Ave Los Angeles CA 90015-3010

CASA COLINA
HOSPITAL FOR
COMMUNITY
SPECIAL 07/01/1975 Los Angeles 255 E Bonita Ave
Pomona CA 91767-1933

CATHOLIC
HLTHCRE W SO CA
COMMUNITY
SPECIAL 01/19/2001 Los Angeles 1420 S Central Ave
Glendale CA 91204-2508

CEDARS-SINAI
MEDICAL CTR
COMMUNITY
HOSPITAL -
INPATIENT
TERTIARY 01/01/1977 Los Angeles 8700 Beverly Blvd
Los Angeles CA 90048-1804

CENTINELA
FREEMAN REG
COMMUNITY
HOSPITAL -
INPATIENT
STANDARD 01/01/1980 Los Angeles 555 E Hardy St
Inglewood CA 90301-4011

CHILDRENS
HOSPITAL OF LA
TERTIARY 01/01/1955 Los Angeles 4650 W Sunset Blvd
Los Angeles CA 90027-6062

CITRUS VALLEY
MED CTR-
COMMUNITY

HOSPITAL -
INPATIENT

PEDIATRIC COMMUNITY 12/29/2003 Los Angeles 1115
S Sunset Ave West Covina CA 91790-3940

CITRUS VALLEY

MED CTR
COMMUNITY
PEDIATRIC COMMUNITY 12/29/2003 Los Angeles 210
W San Bernardino Rd Covina CA 91723-1515

CITY OF HOPE
HELDFORD
STANDARD 07/01/1980 Los Angeles 1500 Duarte Rd
Duarte CA 91010-3012

DANIEL FREEMAN
MEMORIAL
COMMUNITY
SPECIAL 10/01/1994 Los Angeles 333 N Prairie Ave
Inglewood CA 90301-4501

GARFIELD MEDICAL
CENTER
INPATIENT
PEDIATRIC COMMUNITY 12/02/1997 Los Angeles 525
N Garfield Ave Monterey Park CA 91754-1205

GLENDALE
ADVENTIST MED
COMMUNITY
SPECIAL 01/19/1994 Los Angeles 1509 Wilson Ter
Glendale CA 91206-4007

GOOD SAMARITAN
HOSP
COMMUNITY
HOSPITAL -
INPATIENT
STANDARD 01/01/1989 Los Angeles 1225 Wilshire Blvd
Los Angeles CA 90017-1901

KAISER
FOUNDATION HOSP
COMMUNITY
HOSPITAL -
SPECIAL 01/05/1994 Los Angeles 5601 De Soto Ave
Woodland Hls CA 91367-6701

KAISER
FOUNDATION HOSP
COMMUNITY
HOSPITAL -
INPATIENT

TERTIARY 02/01/1962 Los Angeles 4867 W Sunset Blvd
Los Angeles CA 90027-5969

KAISER FOUND
HOSP-BELLFL
COMMUNITY
HOSPITAL -
INPATIENT
PEDIATRIC COMMUNITY 10/21/2004 Los Angeles 9400
Rosecrans Ave Bellflower CA 90706-2246

KAISER FOUND
HOSP WLA
COMMUNITY
HOSPITAL -
INPATIENT
STANDARD 03/01/1980 Los Angeles 6041 Cadillac Ave
Los Angeles CA 90034-1702

LAC/MARTIN
LUTHER KING
COUNTY HOSPITAL -
INPATIENT LONG 09/01/1975 Los Angeles 14445 Olive
View Dr Sylmar CA 91342-1437

LAC/MARTIN
LUTHER KING
COUNTY HOSPITAL -
INPATIENT PEDIATRIC COMMUNITY 02/03/2005 Los
Angeles 12021 Wilmington Ave Los Angeles CA 90059-
3019

LAC+USC MED CTRCOUNTY HOSPITAL -
INPATIENT TERTIARY 01/31/2002 Los Angeles 1200 N
State St Los Angeles CA 90033-1029

KAISER
FOUNDATION HOSP
COMMUNITY
HOSPITAL -
INPATIENT
SPECIAL 09/24/1992 Los Angeles 13652 Cantara St
Panorama City CA 91402-5423

LITTLE CO OF MARY
HOSP
COMMUNITY
HOSPITAL -
INPATIENT
STANDARD 08/01/1982 Los Angeles 4101 Torrance
Blvd Torrance CA 90503-4664

LOS ANGELES
COUNTY
COUNTY HOSPITAL -
INPATIENT TERTIARY 07/06/1978 Los Angeles 1000 W
Carson St Torrance CA 90502-2004

MEMORIAL
HOSPITAL MED

COMMUNITY
HOSPITAL -
INPATIENT
LONG 05/01/1980 Los Angeles 2801 Atlantic Ave Long
Beach CA 90806-1701

METHODIST HOSP
OF SO CAL
COMMUNITY
HOSPITAL -
INPATIENT
STANDARD 11/01/1991 Los Angeles 300 W Huntington
Dr Arcadia CA 91007-3402

NORTHRIDGE HOSP
MED CTR-
COMMUNITY
HOSPITAL -
INPATIENT
STANDARD 12/05/1961 Los Angeles 18300 Roscoe Blvd
Northridge CA 91325-4105

PASADENA HOSP
ASSN, LTD
COMMUNITY
HOSPITAL -
INPATIENT
PEDIATRIC COMMUNITY 12/04/2003 Los Angeles 100
W California Blvd Pasadena CA 91105-3010

POMONA VALLEY
HOSPITAL
COMMUNITY
HOSPITAL -
PEDIATRIC COMMUNITY 11/08/1974 Los Angeles 1798
N Garey Ave Pomona CA 91767-2918

PRIME
HEALTHCARE SVS II
COMMUNITY
HOSPITAL -
INPATIENT
SPECIAL 03/06/1992 Los Angeles 4929 Van Nuys Blvd
Sherman Oaks CA 91403-1702

PROVIDENCE
HEALTH SYSTEM
COMMUNITY
HOSPITAL -
INPATIENT
STANDARD 04/06/2009 Los Angeles 18321 Clark St
Tarzana CA 91356-3501

PROVIDENCE HOLY
CROSS
COMMUNITY
HOSPITAL -
INPATIENT
STANDARD 03/04/2005 Los Angeles 15031 Rinaldi St
Mission Hills CA 91345-1207

PROVIDENCE ST
JOSEPH MED
COMMUNITY
HOSPITAL -

INPATIENT
SPECIAL 04/08/1998 Los Angeles BUENA VISTA &
ALAMEDA ST Burbank CA 91505-4809

RANCHO LOS
AMIGOS
COUNTY HOSPITAL -
INPATIENT SPECIAL 01/01/1980 Los Angeles 7601 E
Imperial Hwy Downey CA 90242-3456

RONALD REAGAN
UCLA MED
COMMUNITY
HOSPITAL -
INPATIENT
TERTIARY 08/01/1962 Los Angeles 757 West Wood
Plaza Los Angeles CA 90095-8358

PRESBYTERIAN
INTERCOMM
HOSPITAL -
INPATIENT
STANDARD 08/01/1974 Los Angeles 12401 Washington
Blvd Whittier CA 90602-1006

ST JOHNS HOSP
HLTH CT
COMMUNITY
HOSPITAL -
INPATIENT
STANDARD 01/01/1985 Los Angeles 1328 22nd St
Santa Monica CA 90404-2032

ST MARY MEDICAL
CENTER
COMMUNITY
HOSPITAL -
INPATIENT
PEDIATRIC COMMUNITY 10/17/2003 Los Angeles 1050
Linden Ave Long Beach CA 90813-3321

ST VINCENT
MEDICAL CTR
COMMUNITY
HOSPITAL -
INPATIENT
LIMITED 03/29/1982 Los Angeles 2131 W 3RD ST Los
Angeles CA 90057-1901

TORRANCE
MEMORIAL MED CT
COMMUNITY
HOSPITAL -
INPATIENT
STANDARD 11/01/1986 Los Angeles 3330 Lomita Blvd
Torrance CA 90509-9977

UCLA HOSPITAL &
CLINICS
COMMUNITY
HOSPITAL -
INPATIENT
TERTIARY 02/09/2007 Los Angeles 10833 Le Conte Ave
Los Angeles CA 90095-3075

SANTA MONICA-
UCLA MED CT
COMMUNITY
HOSPITAL -
INPATIENT
PEDIATRIC COMMUNITY 09/08/2008 Los Angeles 1250
16th St Santa Monica CA 90404-1249

ST FRANCIS
MEDICAL CTR
COMMUNITY
HOSPITAL -
INPATIENT
STANDARD 04/01/1998 Los Angeles 3630 E Imperial
Hwy Lynwood CA 90262-2609

USC UNIVERSITY
HOSP
COMMUNITY
HOSPITAL -
INPATIENT
SPECIAL 04/26/2001 Los Angeles 1500 San Pablo St Los
Angeles CA 90033-5313

VALLEY
PRESBYTERIAN
HOSP
COMMUNITY
HOSPITAL -
INPATIENT
PEDIATRIC COMMUNITY 10/01/1971 Los Angeles
15107 Vanowen St Van Nuys CA 91405-4597

WHITE MEMORIAL
MED CTR
COMMUNITY
HOSPITAL -
PEDIATRIC COMMUNITY 09/01/1980 Los Angeles 1720
E Cesar E Chavez Av Los Angeles CA 90033-2481

