

ABSTRACT

Health Care for Hispanic Immigrants: Improving the Accessibility and Quality of Preventive Services

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There are over 20 million foreign-born Hispanics currently living in the United States. Research shows Hispanic immigrants are healthier than U.S. natives upon arrival, yet their health deteriorates over time. Lifestyle changes coupled with lack of health care increase the prevalence of preventable chronic conditions. In the past three decades, U.S. federal and state policies defining the extent of preventive health services for immigrants have been inconsistent and controversial. Some experts have called for expansion of health insurance coverage for Hispanic immigrants; however, lack of insurance is not the only barrier to obtaining health care. Other difficulties include unfamiliarity with U.S. health care, discrimination, and sociocultural differences. When Hispanic immigrants do access preventive resources, the quality is threatened by the language barrier, misunderstanding in the patient-provider relationship, and a shortage of providers. Removing the obstacles to accessible and quality preventive care for Hispanic immigrants will require concentrated, culturally-specific efforts from community health workers, providers, medical educators, and government administrators. Prevention of

chronic disease in the Hispanic immigrant population is justifiable from public health, economic, and ethical points-of-view.

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HEALTH CARE FOR HISPANIC IMMIGRANTS: IMPROVING THE
ACCESSIBILITY AND QUALITY OF PREVENTIVE SERVICES

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CHAPTER ONE

Hispanic Immigrants in the United States: Trends and Characteristics

Past, Present, and Future Trends

In 2013, there were 19 million Hispanic immigrants living in the United States, representing 35% of the total Hispanic population and 6% of the entire U.S. population (Stepler and Brown). The Department of Homeland Security estimated that there were 12 million unauthorized immigrants alone living in the U.S., with over 60% coming from Spanish-speaking countries (Baker and Rytina). With these numbers in mind, it is reasonable to estimate that there are now over 20 million Hispanic immigrants, both legal and illegal, living in the United States.

Mass Hispanic immigration did not begin until the 1970s (Levine). Prior to 1965, federal immigration policies disfavored the entry of Spanish-speaking immigrants. The Immigration Act of 1924 established a quota system based on the 1890 census; only 2% of the number of each nationality in the census was allowed to enter the U.S. each year. This system favored immigrants from Western Europe far above any other immigrants (“The Immigration Act”). The 1965 Hart-Cellar Act revolutionized immigration policy by abandoning nationality quotas and allowing for immigration based on family reunification. In the years following this act, the number of Hispanic immigrants rose substantially and has continued to increase to the present day (Reyes and Hardy).

Current immigration procedures utilize the Diversity Visa Lottery, also known as the “Green-card lottery.” In this lottery, the U.S. government makes 55,000 visas

available annually. The government reserves 5,000 of these visas for immigrants who apply under the 1997 Nicaraguan and Central America Relief Act. The remaining 50,000 visas are made available to all nationalities. Those who win the lottery must receive approval to immigrate by providing proof of high school education or its equivalent, or alternatively, proof of having worked two of the past five years in a job that requires at least two years of training and experience. Lottery winners must also pass a medical exam and background check (Zong and Batalova).

In the past, immigration was the primary driving force for the growth of the U.S. population. Between 1980 and 2005, the U.S. population increased by 68 million. Immigration was responsible for 58% of that growth. From 2005 to 2050, 60% of the population growth will be due to the Hispanic population. However, Hispanic births in the U.S. will contribute more to the growth of the Hispanic population than will the arrival of new Hispanic immigrants (Taylor et al.). The proportion of the U.S. population that is Hispanic will rise from 18% in 2015 to 24% in 2065, while the proportion of immigrants who are Hispanic will fall from 47% to 31% (Cohn). With the slowing immigration rate from Spanish-speaking countries, the growth of the Hispanic population will be primarily driven by a rise in the U.S. Hispanic birth rate.

Countries of Origin

The majority of Hispanic immigrants are from Mexico. In 2013, there were 11.5 million immigrants from Mexico living in the United States, representing 28% of all immigrants and 61% of Hispanic immigrants (Brown and Stepler). However, the

proportion of Hispanic immigrants from Mexico is gradually decreasing due to the slowing immigration rate from Mexico (Stepler and Brown).

Countries of Origin of Hispanic Immigrants in 2013

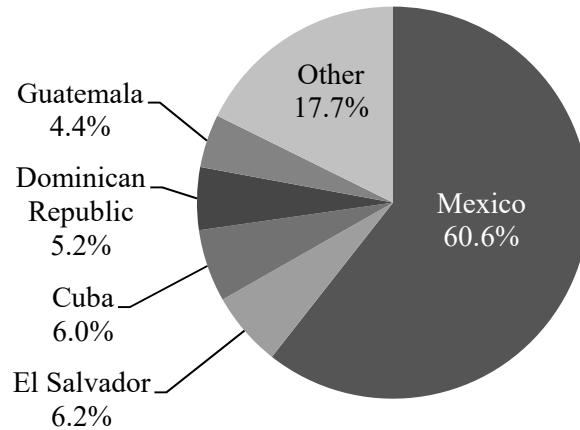


Figure 1: The top five countries of origin for Hispanic immigrants living in the U.S. in 2013. Other Spanish-speaking countries contributed less than 4% each (Brown and Stepler).

Age

The Hispanic immigrant population is very young, with 60.5% of Hispanic immigrants under the age of 20 (Brown and Stepler). In comparison, 26.4% of the total U.S. population is under the age of 20 (*Current Population Survey*). However, the proportion of immigrants that is elderly (65 years of age or older) is increasing across all nationalities. From 1990 to 2010, the number of elderly immigrants increased from 2.7 million to 4.6 million, a growth of 70% (Scommegna). By 2050, this population will nearly quadruple to 16 million (Treas and Batalova). Among elderly immigrants, 38% are from Latin America, the most prevalent region of origin for this population group (Wilmoth). Many immigrated before 1970 (Scommegna), thus having spent a majority of their lives in the United States.

Geographic Residence

As of 2014, the U.S. regions with the largest Hispanic immigrant populations were the West, Southwest, and East Coast. California's Hispanic immigrant population is by far the largest at nearly 5.4 million, followed by Texas at 3 million, Florida at 2.1 million, and New York at 1.3 million. All Midwestern states have Hispanic immigrant populations below 150,000 with the exception of Illinois, which has over 800,000 Hispanic immigrants.

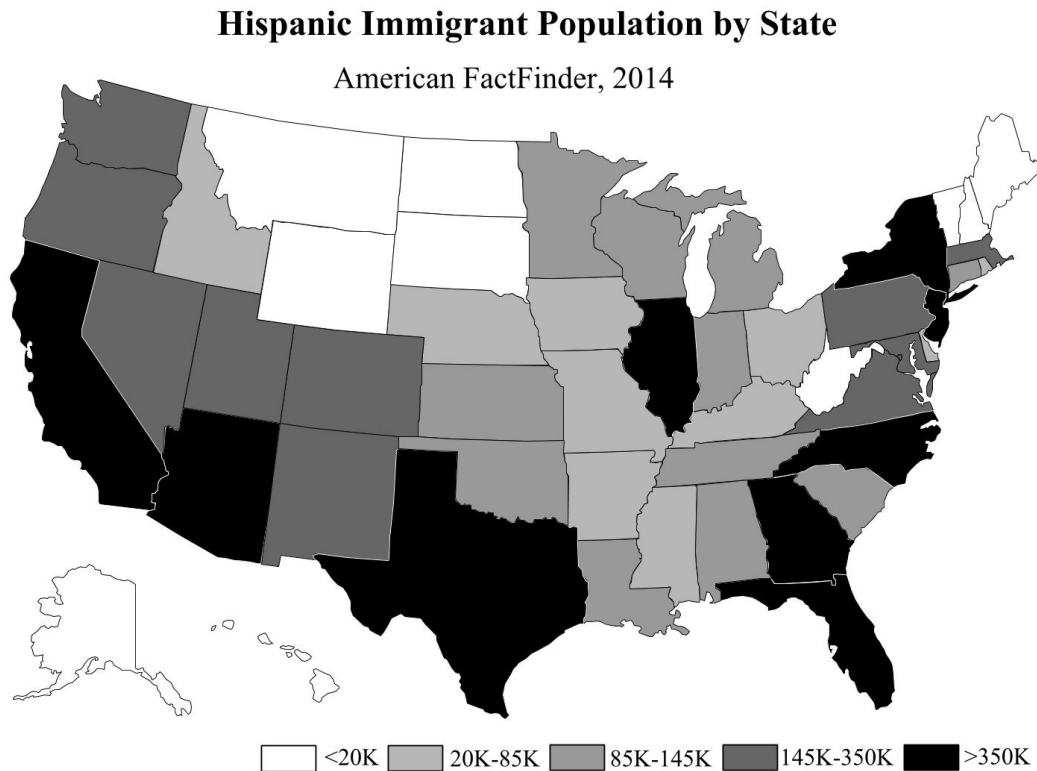


Figure 2: A density map comparing Hispanic immigrant populations between states (*ACS Demographic and Housing Estimates*).

The location where Hispanic immigrants settle depends on a number of factors, especially nationality and citizenship status. Mexican immigrants settle primarily in California and Texas. Central American immigrants settle largely in California, but also

have large numbers in Texas and Florida. South American immigrants tend to populate states on the East Coast, mainly Florida, New York, and New Jersey (Brown and Stepler).

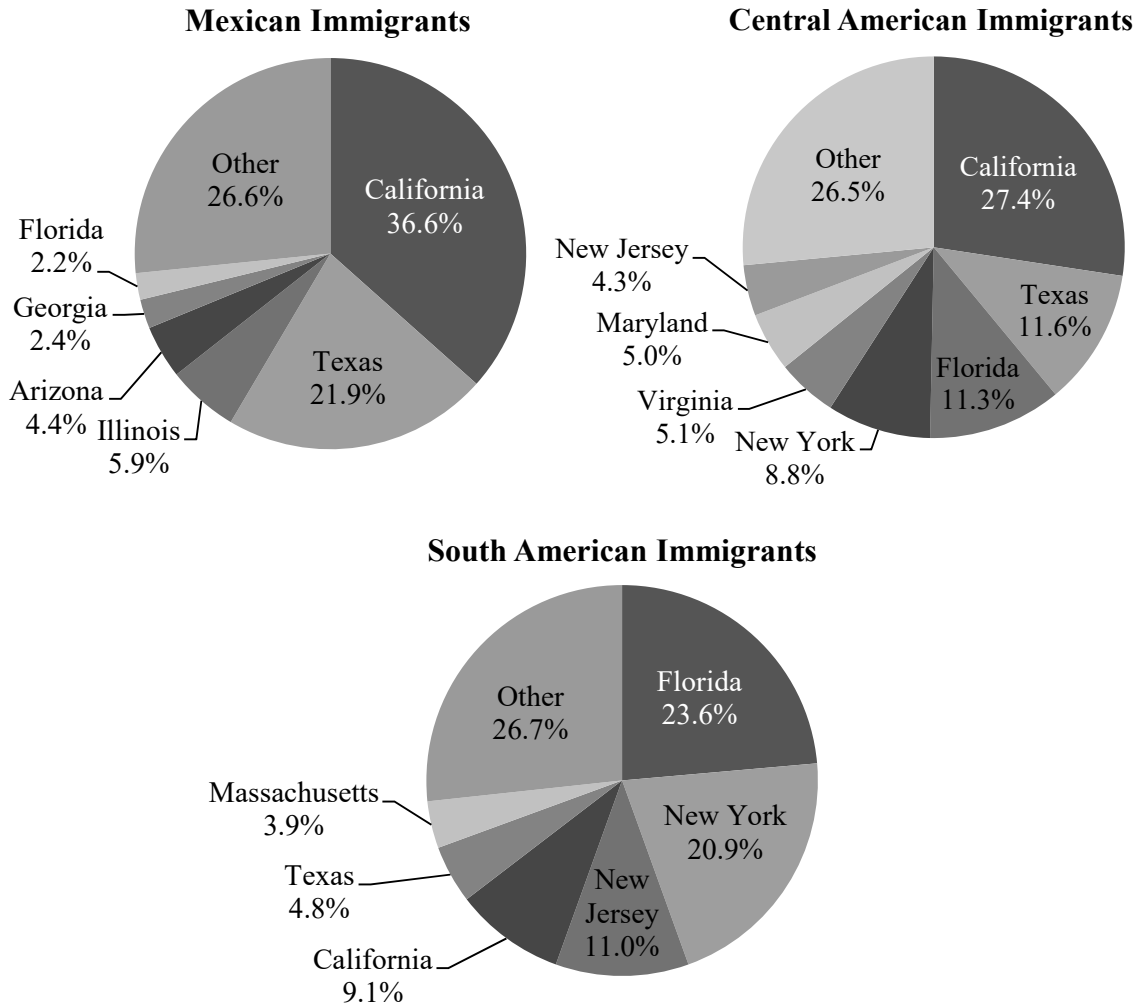


Figure 3: Most prevalent U.S. states of residence for immigrants from Mexico, Central America, and South America (Brown and Stepler).

Interestingly, Hispanics who are legal permanent residents (LPRs) are more geographically dispersed. They have the highest presence in California (25.6%), but 12.5% live in New York, 9.9% live in Texas, and 9.7% live in Florida (Rytina).

Unauthorized immigrants have a similar presence in California (25%), but have a greater presence in Texas (16%) (Baker and Rytina).

The geographic distribution of Hispanic immigrants is changing. Regions of the U.S. with a historically low presence of Hispanic immigrants are experiencing new growth. Since 2000, states that are not typically immigrant destinations have grown more rapidly than states like California, Texas, New York, Florida, and Illinois. These “new growth states” are heavily concentrated in the Southeast, but also include the Dakotas, Nebraska, Oklahoma, Iowa, Indiana, West Virginia, and Maine.

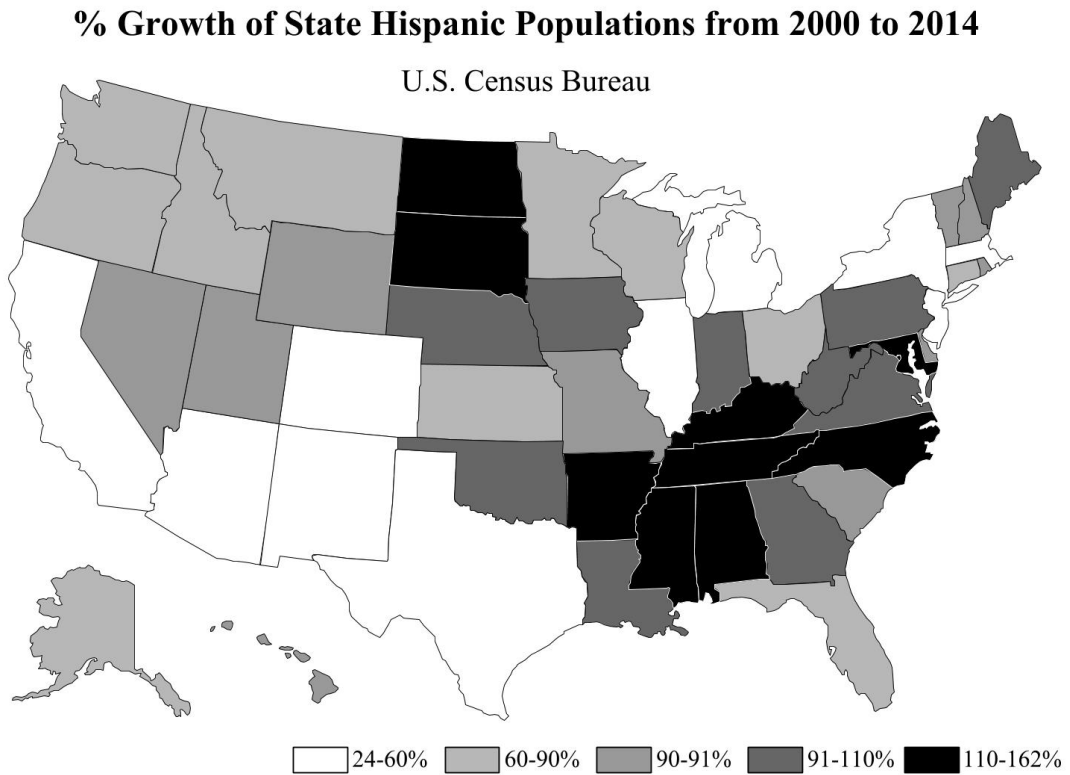


Figure 4: A density map comparing the growth rate of Hispanic populations over a 14-year period between states (Ennis, Ríos-Vargas, and Albert) (*ACS Demographic and Housing Estimates*).

Two-thirds of the recent Hispanic immigrant population growth is occurring in communities that are historically less than 20% Hispanic. As of 2006, more than half of the Hispanic population lived in communities that are less than 20% Hispanic (Cunningham et al.). Recent immigrants who are older, termed “late-life immigrants,” are more likely to settle outside of historical immigrant communities (Leach). These late-life immigrants are driving the growth of immigrant populations in rural and small town areas (Scommegna).

Language

In assessing the language preferences of Hispanic immigrants, one 2013 study found that 61% are predominantly Spanish-speaking, 33% are bilingual, and 6% are predominantly English-speaking (Taylor et al.). Spanish-speakers (both citizen and non-citizen) accounted for 64% of the limited English proficient (LEP) population in the U.S. in 2013 (Zong and Batalova). According to a 2013 study, 68% of Hispanic immigrants speak English “less than very well” (Stepler and Brown).

Use of English improves with length of residence, but the extent of improvement may be small. Among those who immigrated in the last five years, 81% spoke English “less than very well.” Among those who immigrated at least 20 years ago, 61% had not improved their English past this level (Stepler and Brown). However, another study found that only 31% of long-term immigrants felt that they did not speak English well (Taylor et al.). Mexican and Central American immigrants have much higher proportions of individuals with limited English proficiency – 71.6% and 67.9%, respectively. South American immigrants have the lowest proportion of individuals with limited English

proficiency at 45.6%, which is lower than the proportion of immigrants across all nationalities at 51.0% (Stepler and Brown).

Many Hispanic immigrants have a positive view of the English language. A survey found that 87% of Hispanics believe it is important for immigrants to learn English in order to succeed in the U.S. Interestingly, the number of Spanish-speakers in the U.S. is projected to increase from 24.4 million in 2009 to 39-42 million in 2020 (Lopez and Gonzalez-Barrera), yet the number of Spanish-speakers in the Hispanic population is expected to decrease from 75% in 2010 to 66% in 2020. This decrease is driven by a decrease in the number of immigrants under 45 years of age; those older than 45 are actually expected to increase in their use of the Spanish language (Lopez and Gonzalez-Barrera).

Reasons for Immigrating

There is no universal reason for why Hispanic immigrants decide to come to the United States permanently. Two ways of assessing the possible reasons for immigrating are (1) surveying Hispanic immigrants and (2) surveying Spanish-speaking countries with high emigration to the U.S.

One study following the first method found that 55% immigrate for economic reasons and 24% immigrate for family reasons. When the participants were asked about their attitudes on various aspects of U.S. society, 72% said that the U.S. is better for raising children and 69% believed that the poor are treated better in the U.S. compared to their home country. Only 44% agreed that the moral values of the U.S. are superior to those of their home country. Nevertheless, 79% affirmed that, if they had to do it all over

again, they would still immigrate to the U.S. (Taylor et al.), indicating that the view held by Hispanic immigrants of the U.S. remains quite positive.

A study following the second method surveyed citizens of Mexico. The majority identified crime (81%), economic problems (75%), illegal drugs (73%), and corrupt political leaders (68%) as big problems in Mexico. Of the 39% who had friends and/or family in the U.S., 70% believed those friends and family members had achieved their goals. The U.S. image among Mexicans is improving: 69% have a positive opinion of the U.S. (up from 47% in 2008), and 57% say that people who move to the U.S. enjoy a better life (up from 51% in 2007). Moreover, 33% say that they would move to the U.S. if they had the means and opportunity; this percentage increases to 43% amongst those who have traveled to the U.S. before. Nevertheless, the immigration rate from Mexico has decreased in recent years, in part due to economic trouble in the United States. The study found that 40% of Mexicans know someone who moved to the U.S., only to return because they could not find a job. Though 69% say the Mexican economy is also bad, 61% expect it to improve over the next 12 months. Only 14% expect it to get worse, meaning that many are likely to stay in Mexico and await improvements in the economy (*Most Mexicans See Better Life in U.S.*).

Education

The current education status of Hispanic immigrants varies based on nationality. Immigrants from Mexico have the lowest levels of education, while immigrants from Central America have slightly improved numbers. Immigrants from South America

consistently demonstrate higher education levels compared not only to other Hispanic immigrants, but also to the general U.S. population.

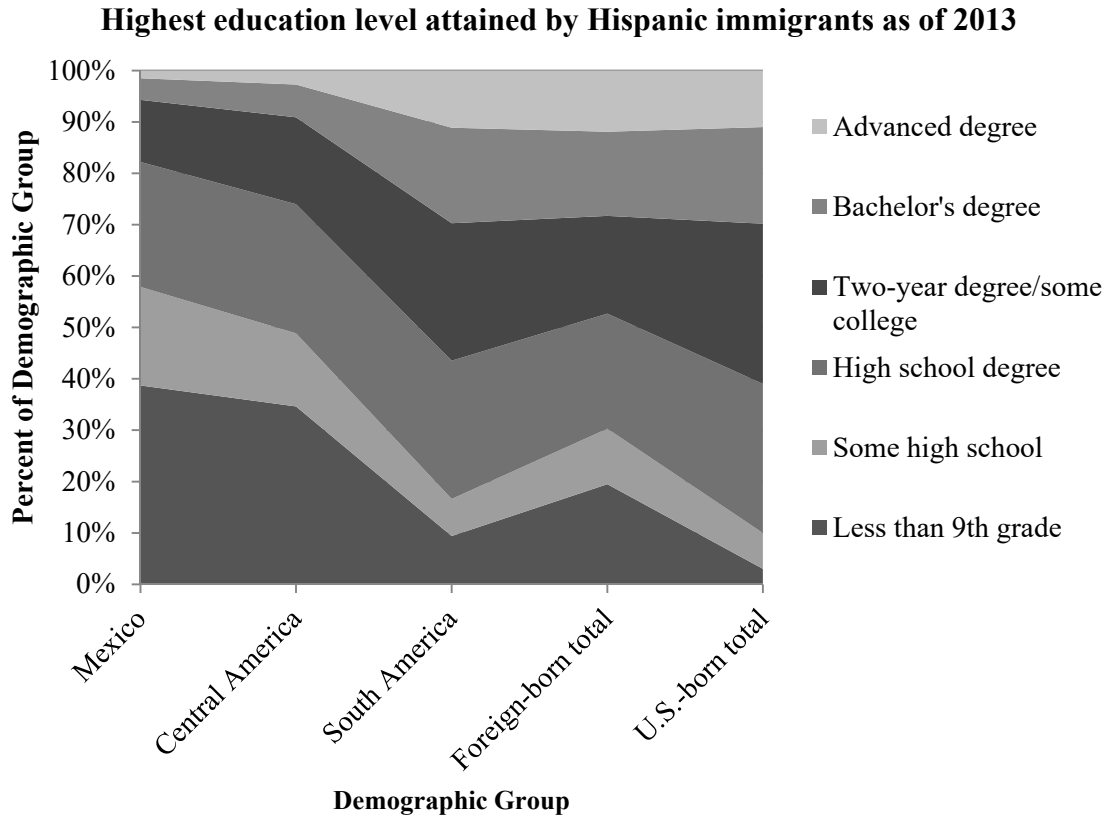


Figure 5: The education levels of U.S. residents born in Mexico, Central America, South America, any foreign country, and the U.S. in 2013 (Brown and Stepler).

Mexican and Central American immigrants have the highest high school dropout rates (10.7% and 18.3%, respectively). These rates are substantially higher than the average rate for all foreign-born high schoolers (7.1%). The high school dropout rate is lowest for South American immigrants (4.7%) and is similar to the dropout rate for U.S. natives (4.0%) (Stepler and Brown). Likewise, college enrollment rates were lowest for Mexican and Central American immigrants (18.3% and 15.3%, respectively), compared

to 41.0% for all immigrants and 42.4% for U.S. natives. South American immigrants had the highest college enrollment at 49.2% (Stepler and Brown).

Income

Mexican and Central American immigrants have similar income distributions, with 46.9% and 45.9%, respectively, having incomes below \$20,000. On the other hand, South American immigrants have more individuals in the \$20,000-\$49,999 range than above or below (Stepler and Brown).

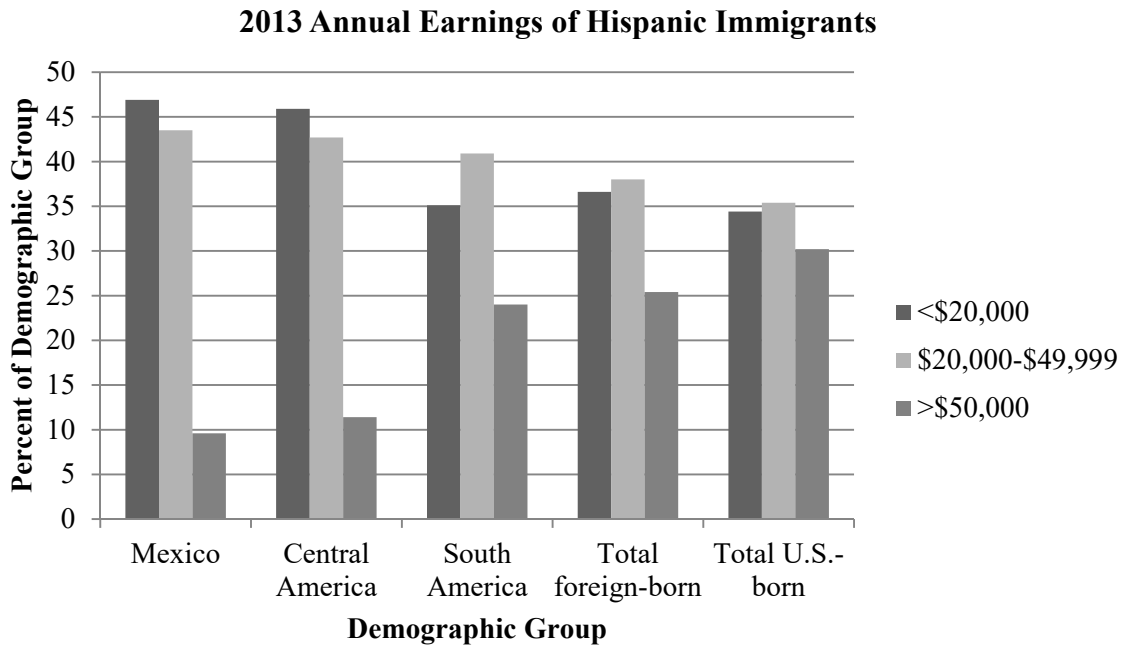


Figure 6: Annual earnings of U.S. residents born in Mexico, Central America, South America, any foreign country, and the U.S. in 2013 (Brown and Stepler).

Mexican immigrants have the highest rate of poverty at 26.0%, followed by Central American immigrants at 21.4%. South American immigrants have a lower poverty rate at 14.5%. Immigrants in general have a poverty rate of 18.6%. The poverty rate of the U.S.-born population is 15.3%. (Stepler and Brown).

Unemployment

Hispanic immigrants have a lower unemployment rate than that of U.S. natives. In 2013, the unemployment rates for Mexican, Central American, and South American immigrants were 8.0%, 7.8%, and 7.4%, respectively. The unemployment rate of all immigrants was 7.6%, and that of U.S. natives was 8.6%, the highest rate of all. Those not in the labor force include 30.7% of Mexican immigrants, 24.3% of Central American immigrants, and 28.8% of South American immigrants. These rates are all lower than that of the general immigrant population, of which 33.3% are not in the labor force. The native U.S. population had the highest percentage not in the labor force at 37.1% (Stepler and Brown).

Identity

Hispanic immigrants are more likely to identify with the American culture than U.S.-born Hispanics. In a survey asking whether they consider themselves to be “very different from the typical American,” 34% of Hispanic immigrants agreed compared to 66% of U.S.-born Hispanics. However, U.S.-born Hispanics are more likely to use the term “American” to describe their identity than Hispanic immigrants. The use of the identifier “American” increases with each successive generation, from 8% to 35% to 48% in the first, second, and third generations, respectively (Taylor et al.).

Health Trends

The health trends of Hispanic immigrants are unlike those of any other racial or ethnic group in the United States. Studies consistently show that recently-arrived

Hispanic immigrants are generally healthier than the U.S.-born population. One of the best ways to observe this trend is by comparing the body mass index (BMI) of immigrants versus U.S. natives. The BMI is a measurement of body fat and is calculated based on one's height and weight. A lower BMI indicates less body fat and is associated with better overall health. Both female and male Hispanic immigrants enter the U.S. with BMIs that are 2-5% lower than women and men born in the U.S., respectively (Holmes, Driscoll, and Heron). Those who immigrated within the past four years are less likely to perceive themselves as having poor health, health conditions, or limitations on their daily activity compared to U.S. natives (Antecol and Bedard). Studies also show that foreign-born Hispanics have a longer life expectancy than the U.S.-born population and the U.S.-born Hispanic population, although this mortality advantage seems to appear only in those who immigrate after age 24 (Holmes, Driscoll, and Heron).

The better health of Hispanic immigrants compared to U.S. natives is so well-established in the literature that it is termed the "healthy immigrant effect." Some experts attribute this phenomenon to positive selection, the idea that immigration naturally favors the translocation of healthier individuals. There are several explanations for how positive selection could occur: 1) U.S. border control health screenings weed out immigrants with infectious diseases, 2) higher-income immigrants are more likely to remain in the U.S. permanently, and 3) unhealthy immigrants are more likely to return to their home countries (Antecol and Bedard). On the other hand, some experts argue that there is no significant difference in the health of those who do immigrate versus those who do not immigrate (Williams and Sternthal). Though the causes remain unclear, the data strongly indicates that Hispanic immigrants are initially healthier than U.S. natives.

However, the “healthy immigrant effect” does not last. As length of residence in the U.S. increases, the health of Hispanic immigrants worsens, becoming more similar to the health of U.S. natives. The BMI of Hispanic immigrant women converges to the BMI of U.S.-born women within 10 years. The BMI of Hispanic immigrant men also converges, though more gradually, closing one-third of the gap within 15 years. Hispanic immigrant health not only converges, but eventually becomes worse than the health of U.S. natives. Hispanic immigrant women who have lived in the U.S. for more than 15 years have a higher average BMI than that of U.S.-born Hispanics (Antecol and Bedard). As length of residence increases, the prevalence of diabetes in the Hispanic immigrant population also increases (Oza-frank, Stephenson, and Venkat Narayan). Mental health is no exception to this trend; immigrants who have lived in the U.S. for at least 13 years have a higher prevalence of mental disorders than those who immigrated more recently (Vega et al.). The decline in immigrant health starts soon after immigration. Hispanics who have lived in the U.S. for more than five years have more obesity, hypertension, and heart disease than those who have lived in the U.S. for less than five years (Sanchez-Birkhead et al.).

Surprisingly, the gradual worsening of health occurs simultaneously with a gradual improvement in socioeconomic status, a trend that contradicts the well-established correlation between socioeconomic status and health (Syme and Berkman). As such, this phenomenon is commonly referred to as the “Hispanic paradox.” Experts attribute this paradoxical decline in Hispanic immigrant health to acculturation, the process through which an immigrant adopts elements of their new surrounding culture into their own identity and lifestyle. Acculturation is not the same as assimilation, which

involves complete abandonment of one's heritage cultural identity in exchange for the host cultural identity. Instead, acculturation typically involves integration of the heritage and host identities, resulting in a "bicultural orientation." Immigrants may exhibit greater preference for one culture over another. Some immigrants exhibit "separation," or complete refrain from adopting the host cultural identity (Fox et al.). Acculturation as a blending of cultures is far more common than both assimilation and separation.

One explanation for the effect of acculturation is the "cultural-buffering hypothesis," which proposes that the social networks of recent immigrants are primarily with individuals of the same ethnicity. The coethnic environment may reinforce positive health behaviors and prolong the "healthy immigrant effect." Over time, however, immigrants may form social relationships and explore cultures beyond their ethnic communities, leading to the adoption of new habits (Akresh).

Across numerous studies, greater acculturation is associated with worsening health. More acculturated immigrants demonstrate decreased nutrition, indicated by increased fast food consumption and decreased fruit and vegetable consumption; increased smoking, alcohol consumption, and illicit drug use; insufficient and low-quality sleep; loss of social support; and higher levels of stress. Exposure to these harmful health influences explains why increased length of U.S. residence is also associated with increases in blood pressure, cholesterol, proinflammatory proteins, and the stress hormone cortisol. Over time, these factors lead to the development of chronic conditions such as obesity, diabetes, cardiovascular disease, and depression (Fox et al.).

Native U.S. citizens are exposed to these same negative health influences and develop the same chronic conditions. The last century has seen a dramatic shift in the

causes of mortality from infectious diseases to chronic diseases due to improved sanitation, public health measures, and advances in the medical field. Public health experts call this the “epidemiologic shift.” With a longer lifespan, the U.S. population is now living long enough to see the detrimental effects of exposure to risk factors for chronic diseases such as a high-fat diet and smoking. The same shift is seen in all subgroups of the U.S. population and in other developed nations. Hispanic immigrants are no exception to this trend. However, the strategies currently implemented to combat chronic diseases in the general U.S. population are not effective toward the Hispanic immigrant population because Hispanic immigrants have a much lower rate of healthcare utilization, the reasons for which will be discussed in Chapter Three. Healthcare utilization among Hispanic immigrants increases with age (Ku and Matani), but it is actually the young Hispanic immigrants who are in the greatest need of health care, specifically in the form of services to prevent chronic disease. Young Hispanic immigrants are highly vulnerable to future chronic conditions, yet are the least likely to access health resources.

Conclusion

Following the immigration reform of 1965, the composition of immigrants in the United States was no longer dominated by those of Western European origin, but by those of Spanish-speaking origin. Hispanics have continued to dominate the immigrant landscape to the present day and will continue to dominate it for the next 50 years. The rise in the Hispanic immigrant population has prompted concerns regarding the burden

that will be placed on the U.S. healthcare system. These concerns have led to various policy initiatives in federal and state legislatures.

CHAPTER TWO

Immigrant Healthcare Policies and Their Consequences

Introduction

For several decades, U.S. policymakers and healthcare experts have wrestled with the question of whether and how to meet the health needs of the rapidly growing Hispanic immigrant population. Concerns about the burden of immigrants on the U.S. healthcare system prompted a series of twelve federal policies between 1985 and 2012. This chapter provides a historical overview of these policies and examines their consequences. Collectively, the literature indicates that federal immigrant health policies were inconsistent and even contradictory, with some restricting immigrant health coverage and others expanding it. Due to inconsistencies and gaps in federal policies, each state, hospital, clinic, and provider can determine whether and how health services are provided to their respective immigrant populations. The lack of a national standard for meeting immigrant health needs has concerning medical, financial, and ethical implications that must be addressed.

Review of Federal Policies

The first major policy initiative from the federal government was the 1985 Emergency Medical Treatment and Active Labor Act (EMTALA), which required that all hospitals receiving Medicare payments from the government treat anyone who enters with an emergency or is in labor until that person is ready for discharge or stable transfer,

regardless of ability to pay or citizenship status. Since the vast majority of U.S. hospitals receive Medicare payments, the act opened up nearly every emergency department (ED) nationwide to foreign visitors, temporary or permanent, including all undocumented immigrants (Footracer). This system is called “Emergency Medicaid.”

Critics pointed out that the term “emergency” was poorly defined and that EMTALA would increase the number of patients using EDs for primary care needs. Treating non-emergency needs is more costly in the ED setting than in the primary care setting. Unfortunately, the data on ED utilization is limited, with the earliest data sets going back to 1990; thus, it is difficult to know whether non-emergency ED use increased following EMTALA, especially amongst immigrants. However, a systematic literature review found no consistent association between non-emergency ED visits and Medicaid expenditures between 1990 and 2010 (Uscher-Pines et al.). Even California, with its significant Hispanic immigrant population, showed no annual change in ED visits between 1990 and 1999. In fact, visits to California public hospitals decreased by an average of 1,085 visits per ED per year during that time. Non-emergency ED visits decreased by 8% overall (Lambe et al.). North Carolina reported an increase in Medicaid spending for ED visits, but over 80% of the associated cases involved urgent conditions such as childbirth (DuBard and Massing).

Arguably the most important piece of legislation came in 1996 with the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA). Signed by President Clinton on August 22, 1996, it is primarily known as the Welfare Reform Act, but it also shifted the financial burden of meeting immigrant health needs from the federal government to the individual states (DuBard and Massing). Each state was left to

determine if and to what extent it would supplement certain health services beyond Emergency Medicaid. Prior to PRWORA, lawfully present immigrants had the same eligibility as U.S. citizens for means-tested benefit programs, which are programs that provide benefits to individuals with incomes below a certain amount. With the passage of PRWORA, only those who were “lawfully residing” prior to August 1996 remained eligible for these programs (Hasstedt).

One of the most important PRWORA conditions stated that immigrants entering after August 1996 must be lawfully present for five years in order to become eligible for federally-funded programs such as Medicaid. If an immigrant had a legal U.S. sponsor – a U.S. citizen who agreed to financially support the immigrant – the sponsor’s income could play a role in determining the immigrant’s eligibility. The sponsor could also be held financially liable for public benefits used by the immigrant. In response, there was widespread confusion regarding eligibility criteria, leading many immigrants to simply avoid public coverage programs (Mohanty et al.). Additionally, PRWORA ended a cash assistance program administered by local governments to unauthorized immigrants (Angel).

On the same day that President Clinton signed PRWORA into law, he also signed the Illegal Immigrant Reform and Immigrant Responsibility Act (IIRIRA), which placed additional restrictions on immigrant eligibility for Medicaid and other public benefit programs (Mohanty et al.). With each state left to formulate a response to immigrant health needs, great variation resulted; some chose to extend coverage beyond Emergency Medicaid while others placed further restrictions on top of those in federal policy. The most notable section of the IIRIRA was section 287(g), which allowed law enforcement

agencies to enforce federal immigration laws during daily law enforcement activities.

This section caused immigrants to avoid accessing health services for fear of deportation (Rhodes et al.).

The following year, Congress passed the 1997 State Children's Health Insurance Program (SCHIP), now commonly known as CHIP, which provides health insurance to children under 19 with family incomes above the Medicaid eligibility ceiling but below 200% of the federal poverty level (Dailard). However, it applied the same five-year waiting period installed by PRWORA to immigrant children under 19 (Hasstedt). Some states did not extend coverage to all immigrants during the five-year waiting period but did extend coverage to children and pregnant women after the passage of CHIP.

In 2002, the Bush administration responded to nationwide concerns regarding health care for pregnant immigrant women, given that their children would be born on U.S. soil. A ruling extended CHIP eligibility to the unborn children of low-income immigrant women, regardless of their documentation status. As a result, prenatal care became nationally available. Nevertheless, it was up to the states to determine whether or not they would offer this coverage option; as of January 2013, it was available in only 15 states (Hasstedt).

Considerable criticism followed the 2002 ruling due to its medical and ethical implications. The ruling made the unborn child the sole beneficiary so that all services provided to the mother had to benefit the child. An epidural for the mother to relieve pain during delivery was potentially not covered because it benefited the mother and not the child. Postpartum care was not covered, which some health professionals believed contradicted long-established standards of pregnancy care. Under Medicaid and private

insurance programs, women typically receive a comprehensive benefits package encompassing prenatal, delivery, and postpartum care. The 2002 ruling placed providers in a tough situation: providing uncompensated postpartum care represented a great financial risk, yet not providing such care was unethical and contradicted basic standards of care. In response to this outcry, the administration issued a guidance allowing the 28 states that reimbursed providers for a comprehensive pregnancy package through a single “bundled” payment to continue providing reimbursements (Dailard).

Though the 1996 PRWORA pushed the financial burden of uncompensated care for immigrants to the states, a 2004 federal provision dedicated \$1 billion over four years to hospital reimbursements for uncompensated emergency treatment of undocumented immigrants. Unfortunately, less than one-third of the funds were dispersed (DuBard and Massing) and the provision was withdrawn less than a year later due to concerns that inquiring about documentation status would cause undocumented immigrants to delay seeking treatment (Footracer), increasing their risk of spreading disease and developing more serious medical problems.

Policies concerned specifically with documentation began in 2005 with the Deficit Reduction Act (DRA), which mandated that those applying for or renewing their Medicaid coverage provide proof of citizenship. Eight states subsequently reported dramatic declines in enrollment, presumably due in part to the withdrawals of undocumented immigrants. Some experts claimed that the DRA caused children to lack immunizations and medical care (Okie). Furthermore, some argued that the DRA was a cumbersome policy that caused delays and declines in healthcare delivery among individuals who were still qualified to receive care (Hasstedt).

Several bills were also proposed in 2005 and 2006 that would make it a felony to provide medical care to undocumented immigrants. The bills were met with criticism, even outrage, and did not pass. The outcry from professional medical societies was tremendous. The American Medical Association (AMA) published a policy titled “Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients,” and the American Association of Physician Assistants (AAPA), among many other societies, passed a similar resolution, opposing “the establishment of local, federal, or state initiatives that require health care providers to refuse care to undocumented persons or to report suspected undocumented persons to authorities” (Footracer).

In 2009, the federal government resolved the controversial 1997 CHIP policy by passing the Children’s Health Insurance Program Reauthorization Act (CHIPRA). It allowed states to remove the five-year waiting period for pregnant immigrant women so that they could receive care in their own right, not just care that would benefit their unborn children. Furthermore, it removed the five-year waiting period for immigrant children, allowing them to become eligible for Medicaid and CHIP upon immigrating. As of January 2013, 20 states offered this coverage to pregnant women, and 25 offered it to children (Hasstedt).

The 2010 Patient Protection and Affordable Care Act, a massive and complex law, had varying consequences for Hispanic immigrants, depending on citizenship status. Naturalized citizens have access to more healthcare insurance options through the expansion of Medicaid and the creation of the Health Insurance Exchange (also known as the Health Insurance Marketplace). “Qualified non-citizens,” which include lawful permanent residents, or green card holders, must still wait five years before receiving

Medicaid or CHIP coverage, though they can purchase private Marketplace plans and receive subsidies if their income falls at or below 400% of the federal poverty level. Twenty-nine states and the District of Columbia have removed this five-year waiting period (“Health Coverage for Lawfully Present Immigrants”). Agricultural workers with H-2A visas, many of whom are illegal, are entitled to workers’ compensation, but this compensation only covers work-related illness or injury (Frank et al.). Because they are lawfully present in the U.S., they are required to enroll in a Marketplace plan or pay the tax penalty for not enrolling; however, they do not qualify for Medicaid (Farmworker Justice), which would cost less than a Marketplace plan (“Medicaid & CHIP Coverage”). Undocumented immigrants are prohibited from purchasing private coverage from the Health Insurance Exchange, even out of their own pocket and at full cost (Hasstedt). As a result, the ACA was criticized for entrenching the prohibitions already established against undocumented immigrants (Light). Furthermore, some criticized the ACA for making stipulations that are especially harmful to Hispanic immigrants, such as not providing financial assistance to the types of businesses that employ immigrants, establishing complex bureaucracies that are nearly impossible for the non-English speaker and the illiterate to navigate, and making employment history important for obtaining later life benefits (Reyes and Hardy).

Nevertheless, the ACA indirectly supported health care for undocumented immigrants by dedicating \$11 billion to Federally Qualified Health Centers (FQHCs) (Light). These centers provide integrated, comprehensive care to anyone regardless of legal status, insurance or income (Warner). FQHCs are even rewarded for reaching out to disadvantaged persons. Federal funding authorized by President Bush caused the

number of FQHCs to double to 1,200 between 2002 and 2008, reaching a total of 17 million people through a network of 7,500 sites (Light). In 2007, FQHCs were estimated to serve 1 in 9 Hispanics, 1 in 8 uninsured persons, and 1 in 7 U.S. residents living below the federal poverty line (*Health Centers: America's Primary Care Safety Net*). With the funding provided by the ACA, 20 million additional people were estimated to receive medical, dental, and mental health services (Light).

The most recent major policy development occurred in 2012 with President Obama's announcement of the Deferred Action for Childhood Arrivals (DACA) policy. DACA states that undocumented individuals ages 15-30 who immigrated with their families as children and go to work or school can remain in the U.S. for renewable two-year periods. Unfortunately, those with DACA status are prohibited from almost every type of public and private health coverage, including Medicaid and CHIP. Moreover, years spent with DACA status do not count toward the five-year waiting period to become Medicaid-eligible. Individuals with DACA status are also banned from purchasing private coverage through the Health Insurance Exchange (Hasstedt).

State-to-State Variation

Each state's response to federal policy gaps is influenced by its public and private healthcare resources, as well as its Hispanic immigrant population size and composition (Berlinger and Raghavan). Not surprisingly, public coverage of Hispanic noncitizens is three times higher in states that choose to fund immigrant coverage programs than in states that do not (Cunningham et al.). One example of how states have differed is in their response to the five-year waiting period enacted by the 1996 PRWORA. In 2007,

23 states used state funds to extend coverage beyond Emergency Medicaid to immigrants during the five-year waiting period, while the rest did not. That same year, only 11 states extended coverage to undocumented pregnant women and children (DuBard and Massing). Seven states used CHIP-funded coverage to provide prenatal care regardless of immigration status (Cunningham et al.). On the other hand, states such as Arizona, Colorado, Georgia, and Virginia passed laws that further restricted the ability of noncitizens to access health services (Okie).

The states that do not extend coverage are perhaps the ones that need to do so the most. States such as North Carolina, which does not provide extended coverage beyond Emergency Medicaid, are “new growth states,” so called because their previously small immigrant populations are now rapidly increasing. In 2006, only 27.4% of Hispanics and 15.6% of Hispanic noncitizens in new growth communities were in states with immigrant coverage programs (Cunningham et al.). Not only do new growth communities lack public coverage programs, but the few that exist are hard to access. Whereas the majority of Hispanics living in major Hispanic centers live close to a safety-net provider, only 50% of Hispanics in new growth communities live within 10 miles of a provider (Cunningham et al.).

New growth communities tend to be in rural or small urban settings. Compared to traditionally Hispanic areas, they may not be considered “poor enough” to receive federal funding for community health clinics. As such, Hispanics in these areas are more likely to rely on emergency departments for nonurgent needs, and medical providers may be less prepared to address linguistic and cultural barriers. In fact, the use of emergency departments by Hispanics in major Hispanic centers was 16.5%, whereas it was 21.5% in

new growth communities. These communities have fewer specialty providers and translation services, which may result in physicians referring more Hispanic immigrant patients to the ED (Cunningham et al.).

Site-to-Site Variation

When there are gaps in both federally- and state-funded coverage, the result is variation in how Hispanic immigrant patients are treated from hospital-to-hospital and clinic-to-clinic. The 1996 PRWORA welfare reform created a complex system of inclusions and exclusions, leading to great confusion and misinformation about immigrants' entitlement to certain benefits (Viladrich). Local healthcare systems responded to these complex reforms by creating their own benefits programs. For example, two very different systems are the Miami Jackson Health system and the New Jersey Charity Care program. Both set up clinics specifically to assist immigrants ineligible for Medicaid. However, the Miami Jackson Health system filtered immigrant patients by such strict documentation rules that half of those who needed medical attention did not qualify. In contrast, the Charity Care program allowed immigrant patients to simply initial a statement regarding their employment and income, given the high rate of illiteracy in the immigrant population (Light). These two systems are a prime example of how a lack of federal and state standards leads to a diversity of local policies, with some being more inclusive and others more exclusive.

The care available varies greatly depending on the structure of the health organization, whether it is a public hospital, private hospital, private practice, or community center. The most promising organizations for providing much-needed

primary care services are community health centers, but they are increasingly strained by the rising number of uninsured patients and a lack of federal funding (DuBard and Massing). Non-profit hospitals face the same dilemma of providing uncompensated care, but unlike smaller community health centers, they are more likely to have resources to fund primary care clinics and community outreach programs, through which they can assist immigrants with untreated hypertension, high cholesterol, diabetes, and mental illness (Light).

Even public hospitals, which receive more federal support, differ in how they respond to immigrant health policies. One public hospital apparently established inclusion rules based on the perceived moral worth of different immigrant groups, seeing Cubans as being more deserving of benefits than Mexicans. Researchers attributed this differential treatment to state policies, which recognized Cuban immigrants as refugees and provided them with a variety of health, welfare, education, occupational, and legal benefits. Meanwhile, Mexican immigrants were excluded from these benefits, treated instead as a “silent invasion” that was draining the state’s resources (Horton). This is an interesting example of how bias can be held by an entire group and can promote unethical medical practice.

Provider-to-Provider Variation

All remaining ambiguities that trickle past federal, state, and clinical policies are left to the individual provider to resolve. The two primary influences on how a provider responds to immigrant patients are personal bias and financial compensation. Providers can be influenced by their personal bias for or against certain immigrant groups. There is

especially great potential for bias in safety-net hospitals, which see a large number of diverse vulnerable patients, such as immigrants, the poor, the illiterate, and the mentally ill (Berlinger and Raghavan). A provider may disregard the hospital's allocation rules because they want to do everything they can for a certain patient. They may attempt to "game the system" by finding a loophole in eligibility criteria that allows them to provide more compensated care. However, this is an arbitrary process, entirely dependent on whether the provider feels that a patient is deserving of scarce benefits.

Even if a provider has no personal bias toward a patient due to their foreign origin or immigration status, they may determine care on the basis of financial compensation. Undocumented immigrants and lawfully present immigrants who immigrated in the past five years are more likely to receive uncompensated care than those who arrived legally more than five years ago. Very few are able to pay the provider directly out of pocket. Uncompensated care places considerable financial burden on providers. One study showed that uncompensated care declined after 1999 because healthcare providers became less likely to receive compensation (Stimpson, Wilson, and Eschbach). As mentioned previously, a 2004 attempt by the federal government to reimburse for uncompensated care failed. Thus, whether an immigrant patient is treated or not treated may be individually decided by a provider based on the financial risk involved.

The Debate on Restrictive Policies

Whether or not the policy restrictions on immigrant access to U.S. health services are necessary is debated, with evidence to support either side. On the one hand, the data indicate that in 2005, immigrants accounted for \$39.5 billion in healthcare spending.

However, only 30% of these expenses were paid by the government; 63% were paid by private insurers and 7% were paid out of pocket. Even then, the per capita health spending for immigrants was 55% lower than that of U.S. natives (Mohanty et al.). Still, it is impossible to ignore that in 2005, hospitals dealt with \$2 billion in unpaid medical bills for treating undocumented immigrants. In California alone, up to \$750 million, or 10%, of the annual cost of uncompensated care may be attributed to undocumented immigrants (Mohanty et al.).

On the other hand, immigrants cost significantly fewer health dollars than native U.S. citizens. A RAND Corporation Study found that although undocumented immigrants constitute around 3.2% of the U.S. population, they account for only around 1.5% of all medical spending (Okie). Even in North Carolina, a “new growth state” with rising immigrant numbers, the Emergency Medicaid system only treated an estimated 5% of all undocumented immigrants and cost less than 1% of the state Medicaid budget (DuBard and Massing). A 2006 estimate stated that noncitizens spend roughly 50% less than U.S. natives; even in states that extend Medicaid coverage beyond emergency situations, noncitizens still have much lower healthcare spending. For example, states in the northeast that extend coverage beyond Emergency Medicaid reported that public health expenditures were, on average, \$780 for noncitizens and \$1,200 for native citizens (Stimpson, Wilson, and Eschbach). Another study found no correlation between a state’s percentage of noncitizens and its burden of uncompensated care (Mohanty et al.). In fact, a higher number of native health expenses (28%) are publicly-funded compared to those of undocumented immigrants (23%) (Footracer). A 2003 Medical Expenditure Panel Survey (MEPS) found that more recent immigrants have lower health spending than more

established immigrants, yet both groups still have 14-20% lower spending than U.S. natives (Stimpson, Wilson, and Eschbach).

Immigrants even financially contribute to U.S. healthcare. According to the Social Security Administration, those without Social Security numbers, primarily immigrants, contribute an estimated \$8.5 billion annually to Social Security and Medicare. The National Research Council estimates that immigrants add up to \$10 billion annually to the U.S. economy and pay \$80,000 more in taxes per capita than they use in government services in a lifetime (Mohanty et al.).

Despite ambiguous evidence on whether immigrants burden our healthcare system or not, there is clear evidence that restrictive policies are harmful to immigrants. The complicated and frequently changing eligibility requirements have created a lack of awareness of eligibility for public programs (Mohanty et al.). Moreover, many immigrants do not utilize programs for which they are eligible, such as state-funded programs for undocumented immigrants, because they are worried that their lack of documentation will put them at risk for detention or deportation. One study found that lack of documentation, fear of deportation, fear of interaction with law enforcement, and racial profiling were associated with reduced utilization of medical services and worse health among immigrants (Rhodes et al.). Other studies have confirmed the negative psychological effects of restrictive policies. Some experts have observed what they term the “chilling effect” or “voluntary withdrawal,” a phenomenon in which eligible immigrants avoided using health services due to feeling “undeserving” of them after the 1996 PRWORA healthcare reform (Viladrich).

Consequences of Variations in Care

Inconsistent federal, state, local, and individual responses to the immigrant healthcare dilemma bring about problematic financial, medical, and ethical consequences that must be addressed. There are two ways in which the current gaps in immigrant healthcare will have negative financial consequences in the future. First of all, the states, healthcare organizations, and providers who extend coverage beyond Emergency Medicaid bear the burden of financing that coverage. They may also attract immigrants from other areas of the country that do not provide extended coverage, and thereby face a greater financial burden. At the same time, areas that do not provide extended coverage but have high immigrant populations, mainly “new growth communities,” may instead see immigrants utilizing emergency departments for non-emergency needs, which is costlier than providing treatment in a primary care setting. Consequently, areas that do not provide extended coverage must weigh the costs saved from not funding extended coverage against costs spent on non-emergency ED visits.

The restrictive policies on immigrant health care are also concerning because they prevent immigrants from receiving much-needed preventive services. These services are crucial for Hispanic immigrants in particular. Numerous studies have shown that length of residence in the U.S. for Hispanic immigrants is negatively associated with health (Williams and Sternthal). As Hispanic immigrants acculturate to U.S. society, they are exposed to chronic disease risk factors such as a high-fat diet, sedentary lifestyle, stressful work environment, greater alcohol consumption, and greater tobacco use. These negative health contributors can lead to obesity, diabetes, heart disease, and cancers of various kinds. The prevalence of such preventable conditions can be lowered through

greater access to primary care, regular check-ups, screenings, and education programs. This issue is especially concerning in light of the five-year waiting period, which only serves to delay much-needed preventive services during a time when Hispanic immigrants are already rapidly acculturating to the U.S. lifestyle. In the first five years, the BMIs of immigrants already demonstrate considerable convergence toward the higher BMIs of native U.S. citizens (Antecol and Bedard).

The future of U.S. healthcare will see a tremendous increase in the number of Hispanic immigrants who have lived in the U.S. for many years and are suffering from chronic conditions. Concurrently, studies show that immigrants access health services more and more with length of residence (Stepler and Brown). The result is a perfect storm: long-term Hispanic immigrants will suffer from high rates of chronic disease and also increasingly access health services, a combination which will place a considerable burden on the U.S. healthcare system in terms of both finances and provider workload. Not only will there be a large number of individuals with chronic conditions needing treatment, but chronic conditions are costlier to treat because they are incurable and require continuous treatment for the rest of the patient's life. As a result, it will be more cost-effective to provide preventive services now than to pay for expensive treatments for incurable chronic diseases later on.

Finally, the restrictive healthcare policies are concerning for ethical reasons. Emergency Medicaid denies an individual healthcare until they are in a health crisis, at which point it is more difficult or perhaps impossible to save their life or prevent them from suffering irreparable damage that will result in a lifetime of suffering. Moreover, public coverage programs grant complete eligibility to children born on U.S. soil, while

denying eligibility to the immigrant parents. Studies have shown that immigrant parents of U.S.-born children may avoid taking their children to see a U.S. provider out of fear of being detained or deported (Rhodes et al.).

On a similar note, many are concerned that requiring immigrants to show providers proof of documentation encourages the medical field to “criminalize” undocumented immigrants and deny them desperately-needed care. Many health organizations adamantly oppose such criminalization as an offense to the high standards of the medical profession (Footracer). It is also concerning that providers and even entire organizations have included or excluded certain Hispanic immigrants on the basis of their nationality, a discriminatory practice motivated solely by prejudice.

Recent healthcare developments have brought additional ethical questions to light. Under the 2010 ACA, undocumented immigrants cannot even purchase private insurance out of pocket through the Health Insurance Exchange; meanwhile, uninsured U.S. natives who cannot afford to purchase a plan from the Exchange are dealt a financial penalty. Such a system intrinsically forces all U.S. citizens into a universal health system and forces all non-citizens out; thus, only citizens are deemed worthy of receiving healthcare, while all outsiders are prohibited from receiving care. Finally, the DACA policy is concerning in that it incentivizes non-citizens to stay in the U.S. by renewing a temporary two-year status while barring them from accessing nearly every publicly-funded health service. Such a system only works if all individuals remain healthy for the duration of their DACA status, which is an impossible assumption. Moreover, those who have DACA status are relatively young and represent an age group exposed to acculturating factors such as high-fat diet, tobacco, and alcohol, which are habit-forming and can

predispose them to chronic conditions later on in life. Thus, preventive services are especially crucial for DACA recipients.

CHAPTER THREE

Barriers to Preventive Services

Introduction

Hispanic immigrants face numerous barriers to accessing preventive services in the United States. As seen in Chapter Two's review of healthcare policies, the discussion on immigrant health disparities has mainly focused on insurance eligibility. However, lack of insurance is only one of numerous obstacles Hispanic immigrants experience when seeking care. This chapter reviews two categories of barriers faced by Hispanic immigrants: barriers to accessing care and barriers to receiving quality care.

Access Barriers

Barriers to accessing care prevent Hispanic immigrants from having any contact with health services. Some of these access barriers are caused by the nature of the U.S. healthcare system, such as the high costs of services, complex insurance systems, policies that encourage discrimination or deportation, and lack of transparency and guidance for prospective patients. Other access barriers originate from the cultural background of the immigrants, including the health beliefs, social norms, and community relations unique to the Hispanic culture. Thus, there are barriers on both sides preventing Hispanic immigrants from accessing care.

Access Barriers Originating from the U.S. Healthcare System

Cost. Barriers originating from the U.S. healthcare system involve cost, insurance, discrimination, and transparency of information. These barriers are interrelated and synergistic in impeding access to care. In the literature, cost and insurance are most frequently cited. The high cost of basic preventive services is especially prohibitive to Hispanic immigrants, 23.7% of whom are in poverty compared to 15.8% of all U.S. residents (Stepler and Brown). In one study of a Long Island immigrant community, 31% of Hispanic immigrants mentioned cost as the primary barrier to getting medical care, compared to 17% of Blacks and 10% of Whites (Goodman et al.).

There are several reasons why cost is one of the largest barriers to care-seeking. One reason is that most immigrants consider food, school, and rent higher financial priorities than health services. As one example, a glucose tolerance test to screen for diabetes can cost several hundred dollars, a week's worth of wages for some immigrants. For the nearly one in four Hispanic immigrants living in poverty, the future possibility of diabetes is not as imminent of a threat compared to the close reality of homelessness and hunger. From the perspective of an immigrant in poverty, the screening test is pointless regardless of its result: a negative result provides reassurance but may then feel like a waste of money, while a positive result will require treatment more costly than the screening test. There are numerous health fairs and campaigns that offer free screening, yet the follow-up visits and treatments are costly or unavailable.

Cost acts as an access barrier in other ways. Many immigrants do not want to sacrifice time at a doctor's appointment that could be spent earning money. As a result, they wait until after work when the only open places of care are emergency departments, which are also the most expensive places of care. Others fear unexpectedly receiving a large medical bill after treatment. There are literature reports of immigrants who were not informed of costs up front and later received large bills for basic treatments; for example, one woman received a \$99 bill for a bottle of ear drops (Ayón). Moreover, bills are typically sent in English, so immigrants with limited English proficiency will have difficulty understanding the bill and how to settle it (Page-Reeves et al.). On the other hand, those who are informed of costs up front may choose to delay care. One report describes a Hispanic immigrant woman who was diagnosed with a breast tumor, but after seeing the price for its removal, delayed surgery (Ayón). Immigrants are not simply concerned with the up-front costs, but also with the long-term financial consequences of seeking care. Some Deferred Action Childhood Arrival (DACA) recipients worry that medical debt will lower their chances of legally immigrating (Raymond-Flesch et al.).

The high costs of health care ultimately force immigrants to delay care-seeking until their symptoms become intolerable. Ironically, the longer treatment is delayed, the more likely the patient will require initial treatment in the emergency department followed by long-term, intensive treatment. Consequently, immigrants who cannot afford preventive services will probably be unable to afford the costs of chronic disease management later.

Insurance. In light of the high costs of health care, researchers are considering insurance expansion as a promising solution. Having insurance is associated with increased awareness and diagnosis of hypertension and diabetes in Hispanic immigrants (Barcellos, Goldman, and Smith), as well as a higher HPV vaccination rate in low-income, ethnic minority girls (Tsui et al.).

However, access to insurance is largely dependent on citizenship status. As previously discussed, eligibility rules for Medicaid, CHIP, and the Health Insurance Exchange are different for naturalized citizens, qualified non-citizens, H-2A agricultural workers, DACA recipients, and undocumented immigrants. The results of this civic stratification are clear. In 2014, four years after the ACA was passed into law, 14% of the total U.S. population was uninsured. Among Hispanics, 17% of the U.S.-born were uninsured compared to 39% of the foreign-born. Among foreign-born Hispanics, 21% of those who gained U.S. citizenship were uninsured compared to 49% of noncitizens (Krogstad and Lopez).

The most recent migrants are least likely to have insurance. In one study, 23% of Mexican immigrants who had migrated within the past five years had insurance compared to 77% of Mexican-origin U.S. citizens (Barcellos, Goldman, and Smith). Generally, more recent immigrants are more likely to be undocumented, have limited English proficiency, have a low income, and lack sources of reliable health information, all of which impede access to health insurance (Pigoga et al.) (Reyes and Hardy) (Goodman et al.).

For naturalized citizens and lawful permanent residents (LPRs), the ACA has substantially expanded coverage. A survey of Latino communities in Rhode Island found

that the health insurance rate increased from 5% in 2010 to 52% in 2014 (Pigoga et al.). Another survey found that, less than one year after the Health Insurance Exchange opened for enrollment, the national uninsured rate among Hispanics dropped from 36% to 23% (Doty, Rasmussen, and Collins).

Much of the increased insurance rate can be attributed to the ACA's expansion of Medicaid. In 2014, a larger portion of the insured were covered through Medicaid, Medicare, and other subsidized programs (Pigoga et al.). However, some states chose not to expand their Medicaid programs. Two examples – Texas and Florida – have an estimated 2 million uninsured Hispanics with Medicaid-eligible incomes. In states that did expand Medicaid, the percent of Hispanics who are uninsured dropped from 35% to 17%; in those that did not, the percent uninsured remained statistically unchanged at 33% (Doty, Rasmussen, and Collins).

For immigrants newly insured through the ACA, preventive health services should be readily available. The ACA mandates that all private Marketplace plans, Medicare, and Medicaid cover the full cost of certain preventive services, including: screenings for cancer, cardiovascular diseases, and type 2 diabetes; immunizations; obesity screening and management; alcohol and tobacco screening and counseling; and STI/HIV screening and counseling (*Preventive Services Covered*).

Though some immigrants are currently ineligible for health insurance coverage due to their citizenship status, there are many who are eligible yet remain uninsured. One study estimated that 44% of uninsured Hispanics were eligible to apply through the Exchange (Pigoga et al.). There are several potential reasons for this coverage gap, including cost, lack of awareness of available options, and lack of access to or skills for

using the online application. In one Hispanic community survey, 32% lacked computer access and 27% lacked the skills to use one (Pigoga et al.). Additionally, there were problems with launching the Spanish version of the Health Insurance Exchange website, CuidadoDeSalud.gov, including a delayed launch and translation malfunctions in the first few months. Individual states also had issues with the Spanish website for their state-run exchange (Doty, Rasmussen, and Collins). These technology issues have placed Spanish-speaking individuals at a greater disadvantage in obtaining health insurance.

Nevertheless, enrolling in an insurance plan is only half of the battle. Many immigrants find that they are still unable to afford the high cost of deductibles, copayments, and additional procedures that are not fully covered (Martens et al.) (Raymond-Flesch et al.). Hispanic immigrants are also more likely to experience insurance instability as a consequence of low socioeconomic status, citizenship status, and limited English proficiency (Reyes and Hardy). Shorter periods of coverage cause a pattern of discontinuous care that can result in negative health outcomes (Lopez and Gonzalez-Barrera).

Like high costs, lack of insurance can cause delayed care-seeking. In a study on breast cancer screening, Hispanic women felt prohibited from accessing health services because lack of documentation prevented them from obtaining insurance (Ramos et al.). A similar study found that lack of insurance was the biggest barrier to mammography screening for 49% of Hispanic women (Dang et al.). The uninsured who do seek care rely on emergency rooms (Pigoga et al.), either because they delay care until it becomes an emergency or because they have nowhere else to go for a non-emergent problem.

With time, many immigrants become eligible for public services and eventually obtain insurance; however, this long-awaited care often catches conditions that could have been detected and treated earlier in life. One study found that Medicare-funded screenings for the previously uninsured found later-stage diseases that required more aggressive and more costly treatment (McWilliams et al., 2007). The same research team then determined that Medicare spending for the previously uninsured is higher than Medicare spending for the continuously insured (McWilliams et al., 2009). Again, this is likely the result of treating health issues that were unaddressed for years.

Discrimination and deportation. Another major access barrier is fear of discrimination or deportation as a consequence of seeking medical care. Due to anti-immigrant sentiment and policies, immigrants are concerned that providers will discriminate against them, disclose their health and legal information, or even charge them more for the same services that U.S. citizens receive (Dolwick Grieb et al.) (Harvey et al.). According to one survey, DACA recipients fear that U.S. physicians are solely motivated by money and lack sensitivity about issues like immigration status; they also fear deportation and being treated differently on account of their skin color, legal status, and income (Raymond-Flesch et al.).

Several federal and state anti-immigrant policies have deterred care-seeking among Hispanic immigrants. On a national level, section 287(g) of the 1996 Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA) – which allows law enforcement agencies to enforce federal immigration laws during daily law enforcement

activities – caused immigrants to distrust staff at government agencies and avoid health services, even if eligible, for fear of detention and deportation (Rhodes et al.).

State-level anti-immigrant policies have had similar results. After the passage of Proposition 187 in California – a statute denying public services such as health care to illegal immigrants – providers in both California and Texas saw a decline in visits from undocumented Hispanic immigrants (Berk and Schur), even though the proposition was struck down by a federal district court before it took effect. In one survey, 32% of undocumented immigrants presenting to an emergency department had heard of Proposition 187. Furthermore, 13% believed healthcare personnel reported undocumented immigrants to immigration authorities, and 53% of these individuals feared going to the emergency department (Maldonado), even though they eventually decided to go. Since this survey did not capture the immigrants whose fear prevented them from going to the emergency department, it likely underestimates the proportion of immigrants who avoided healthcare services for fear of deportation.

Arizona, a state known for its strong anti-immigrant policies, passed a law requiring patients to provide proof of documentation when accessing care. As a consequence, immigrants reported avoiding care until their pain became unbearable. This policy was especially problematic for mixed immigrant families, in which the parents are undocumented and the children are U.S.-born citizens. Though the children are eligible for medical care, immigrant parents reported being asked for identification or documentation when seeking care for their child. Some children were even denied care due to the undocumented status of their parents. Such procedures are perceived by immigrants as “scare tactics” and are a strong deterrent to care-seeking (Ayón).

Lack of information. The aforementioned barriers – cost, lack of insurance, and fear of discrimination or deportation – have a common thread: lack of information. In numerous studies, Hispanic immigrants report lack of transparency about costs, insurance options, and patient rights as barriers to accessing health services. For example, Hispanic immigrant women reported that one barrier to mammography screening was not having reliable information on it (P. M. Wallace et al.). Another study found that many immigrants do not try to seek out information because they assume that no such information is available to them (Wagoner et al.). The first step to addressing access barriers may be improving the availability of information on U.S. healthcare services for Hispanic immigrants. Specifically, information is lacking in regards to navigating the complex U.S. healthcare system, and to the aforementioned topics of cost, insurance, and patient rights.

Upon immigrating to the U.S., Hispanics find that the healthcare system is difficult to understand. Numerous studies report that immigrants simply do not know where to go when they need medical care (Martens et al.) (Ramos et al.) (Documèt et al.) (Raymond-Flesch et al.) (Harvey et al.). In some cases, immigrants are searching specifically for care centers they can afford and trust without fear of discrimination or deportation; in other cases, they do not even know the physical locations of local health resources. At minimum, immigrants are usually aware of the nearest emergency department, but may not know how to determine if their condition is severe enough to merit a visit (Documèt et al.). This ambivalence and the ease of locating hospitals contribute to Hispanic immigrants' higher use of emergency departments for non-urgent conditions.

Information is also lacking on how to access clinical-based care. Free public screening events have been proposed as a way of connecting Hispanic immigrants to long-term primary care, but many participants who test positive do not get adequate information on how to find follow-up care. One study found that, of those who screened positive but did not seek further medical care, 75% were unable to identify a primary care provider (Siddaiah et al.). Many immigrants have trouble making an initial appointment, in some cases because they are not aware of the necessity of appointments in U.S. clinics. In one study, participants did not know if appointments were necessary, and one man even reported being told to “Just go home,” when he tried to see a doctor without an appointment (Dolwick Grieb et al.). Making an appointment is often difficult because most secretaries do not speak Spanish (Brown), and may not have access to a translator.

Hispanic immigrants are also frustrated by the lack of transparency about costs. As mentioned earlier, some avoid care for fear of receiving a large bill after the fact. Understandably, Hispanic immigrants – many of whom are financially strained – want to know the costs involved in seeking care beforehand so that they can make an informed decision. Though there are places that offer free or low-cost care, many immigrants do not know that they exist or where to find them (Ramos, Correa, and Trinidad). Federally Qualified Health Centers (FQHCs) are designed to offer low-cost care, including preventive services, regardless of insurance and citizenship status. In 2013, there were 1,173 FQHCs in all 50 states and the District of Columbia (“Key Health Center Data”), making them widely accessible throughout the United States. In areas without FQHCs, faith-based organizations are stepping in to fill the void and provide free or low-cost care

(Devi). Thus, there are options for obtaining affordable health care, yet Hispanic immigrants are uninformed about them.

Greater transparency is also needed with respect to insurance. A significant portion of uninsured immigrants are eligible to apply for insurance, yet do not know their eligibility status, how to apply, and other necessary information. In a survey of Latino communities in Rhode Island, 44% of the uninsured were eligible to apply for insurance in the Health Insurance Exchange (Pigoga et al.). By the end of the open enrollment period, however, only 50% of eligible Latinos were aware of the Exchange compared to 75% of non-Hispanic Whites. Furthermore, only 35% of Spanish-language dominant Hispanics knew about the Exchange compared to 65% of English-language dominant Hispanics (Doty, Rasmussen, and Collins). Even after obtaining insurance, many do not understand what services are covered under their plan (Raymond-Flesch et al.). Thus, both the insured and the uninsured are in need of accessible healthcare information.

Hispanic immigrants also lack information on their rights as patients, resulting in fear of being discriminated against or reported to immigration authorities. Some DACA recipients fear seeking care because they believe a diagnosis could cause them to be denied citizenship (Raymond-Flesch et al.). However, all lawful U.S. medical practices are held to strict patient confidentiality rules that prohibit providers from sharing patient health information with anyone not essential to that patient's care. Many health organizations, including the American Medical Association, are strongly opposed to reporting undocumented patients to the authorities. Immigrants should be informed that they can seek medical care knowing that their health and legal information will remain confidential.

Access Barriers Originating from Immigrant Backgrounds

Health Beliefs. Immigrants bring in a set of predetermined beliefs regarding health, prevention, and treatment. These beliefs are sometimes at odds with common U.S. beliefs. Researchers have discovered that, in general, Hispanic immigrants are less concerned with the future possibility of chronic disease, uninformed on preventive practices, fatalistic, and partial to self-treatment with home remedies.

U.S. health experts are constantly stressing the importance of preventing disease, not only through healthy lifestyle practices, but also through regular doctor appointments and screenings. Many immigrants, especially more recent ones, are foreign to the idea of visiting a doctor and getting tested while feeling healthy (Tanner et al.). In a study on STI and HIV testing in Hispanic men, about 67% felt that they did not need testing and were certain of not having an STI because they had no symptoms and felt good (Harvey et al.). Another study described a group distributing AIDS information brochures to day laborers at a market; the day laborers thought the group was crazy because they were certain that they did not have AIDS (Dolwick Grieb et al.), signifying that the U.S. concept of prevention is foreign to Hispanic immigrants.

In other cases, immigrants lack essential information on preventive health. In one study, only about half of immigrant women had heard of a breast self-exam, and many did not know how to do one or what to look for. Many also did not know the age and frequency at which women should get mammograms (Ramos, Correa, and Trinidad). Another study found that immigrant women understood how breast exams are performed, but did not know many of the signs and symptoms of breast cancer (P. M. Wallace et al.).

Though U.S. natives may be similarly uninformed, they are less likely than immigrants to lack a primary care provider who can provide information and help connect them to preventive services.

A cultural concept related to lack of information is *fatalismo*, the belief that one's fate is unchangeable and beyond one's control. Studies have associated *fatalismo* with deterred care-seeking behaviors for HIV and cancer (Abraído-Lanza et al.). Many Hispanics see diagnosis of these two conditions as a swift and unpreventable death sentence. Consequently, they avoid testing because they would prefer to remain ignorant (Dolwick Grieb et al.) (Ramos, Correa, and Trinidad). Hispanic men in one study saw HIV infection as an inescapable, predestined form of punishment, especially if they were homosexual and dealing with feelings of guilt (Mann et al.). Hispanic women in another study stated that breast cancer is "God's will" and beyond their control (P. M. Wallace et al.). Hispanic immigrants with fatalistic ideas need information on how preventive services can help them prevent or manage diagnoses at an early stage and, thus, take some measure of control over their health.

The use of home remedies is also strongly associated with delayed care-seeking. Home remedies are typically passed down each generation and practiced by female relatives or community healers. Their use commonly replaces or precedes a visit to the doctor, thus preventing or delaying professional care. Many immigrants consider home remedies more effective, more trustworthy, and gentler to the body than prescription medications. Hispanics may also feel socially obligated to try a remedy if it is recommended by a relative or friend (Page-Reeves et al.). Furthermore, some immigrants believe that certain illnesses have non-biomedical causes that cannot be

treated in a clinic. These illnesses are unique to the Hispanic culture and often have psychological or spiritual origins. Two common examples of “culture-bound syndromes” are *empacho*, which is indigestion or gastrointestinal obstruction, and *susto*, which is fright caused by a traumatic experience. In these cases, medical advice is sought from relatives, friends, and occasionally a *curandero* (folk healer) or *sobador* (massage specialist). One study found that when Hispanics associate illness with psychological or spiritual etiologies, they see biomedical treatment as inadequate; when they associate illness with viruses or bacteria, they see biomedical treatment as appropriate (Andrews, Ybarra, and Matthews). However, other studies show that Hispanics are also using home remedies to treat conditions such as diabetes, gastritis, hyperlipidemia, hypertension, and pain. For example, *ajo* (garlic) and *sábila* (aloe vera) are two common home remedies for hypertension (Kiefer, Tellez-Girón, and Bradbury). These chronic conditions should be managed professionally to prevent further complications.

In many cases, Hispanic immigrants will try home remedies before attempting to see a doctor. In one study, Hispanic women reported using home remedies such as tea for health problems that seem manageable but visiting a medical provider if problems are more serious or long-lasting (P. M. Wallace et al.). Another study found that immigrants will first seek medical advice from relatives and friends, followed by a *curandero* or *sobador*, and then a biomedical professional as the last resort. If one source of care is ineffective, it may be perceived as “God’s will” that treatment be sought elsewhere (Andrews, Ybarra, and Matthews). This practice puts immigrants at risk of delaying professional care for too long.

The preference for self-treatment with home remedies may originate not only from tradition, but also from a difference in the extent that physicians are relied upon in other countries. For example, antibiotics that require a doctor's prescription in the U.S. are commonly available over the counter in Mexico (Andrews, Ybarra, and Matthews). Thus, Hispanic immigrants may see professional medical consultation as less important compared to U.S. natives.

Social norms. Social norms in the Hispanic culture pose potential barriers to care-seeking in the United States. Three prominent cultural concepts found in the literature are *machismo*, *marianismo*, and *modestia*. *Machismo* refers to the social norms dictating masculinity or manhood. Most studies focus on its negative connotations – violence, aggression, dominance, and oppression – but it can also have positive connotations such as self-respect, and protecting and providing for one's family (Torres). The negative effects of *machismo* culture can hinder care-seeking in Hispanic men. One negative effect is the pressure for Hispanic men to prove their masculinity by having multiple sexual partners, often without using protection. Despite the risks of this behavior, many Hispanic men fear getting tested for sexually transmitted infections (STIs) because they do not want women to perceive them as unclean, and therefore undesirable (Harvey et al.). In other cases, Hispanic men who are experiencing pain may justify delaying care-seeking and enduring the pain as a validation of their masculinity (Documèt et al.).

Marianismo refers to the social norms involving femininity. As a word originating from the Virgin Mary, it idealizes women who are pure, nurturing, suffering, and religious. Women are expected to put their family's needs before their own, which

may cause them to neglect their own health concerns until they become serious or even unbearable (Garcés, Scarinci, and Harrison).

Modestia, or modesty, is a social norm that extends to both genders. In healthcare settings, Hispanic patients may feel uncomfortable or embarrassed about being examined, especially during more intrusive exams performed by a provider with whom they have not established familiarity and trust. In one survey, Hispanic men reported embarrassment as a barrier to getting screened for colorectal cancer (Martens et al.). Similarly, Hispanic women reported not wanting others to see their body as a barrier to getting a mammogram (P. M. Wallace et al.). Another study found that Hispanic women are also uncomfortable with the idea of performing a self-breast exam based on the cultural belief that it is wrong to touch oneself (Ramos, Correa, and Trinidad), which may originate from *marianismo* as well as *modestia*.

Lack of social support. The immigration process disrupts a strong social network of family and friends that Hispanics had in their home country. This network plays an essential role in maintaining psychological, social, and physical well-being. Mothers, grandmothers, and other female relatives are caregivers and educators, teaching the family how to stay healthy and how to treat illnesses with herbal remedies passed down for generations (Sanchez-Birkhead et al.). Health advice and support is sought from family and friends, who may encourage a visit to a doctor and often accompany the patient to the appointment. In some cases, the *curandero* is a well-known and trusted community member and is consulted for a variety of health concerns.

Upon immigrating to the U.S., these supportive ties are severed. Many immigrants, already in a state of legal, financial, linguistic, and social vulnerability, are reluctant to place their trust in an U.S. provider they have never met. Over time, immigrants may have increased access to community folk healers as they reestablish their social network (Andrews, Ybarra, and Matthews). These folk healers are often more affordable and trusted, and as a consequence, may be preferred to U.S. biomedical professionals.

For many immigrants, reestablishing a social network in the U.S. is a slow and challenging process. Though there are opportunities to connect with other Hispanic immigrants, especially in well-established immigrant communities, it may be difficult to develop social ties, especially between immigrants in different stages of settlement and adaptation. Studies indicate that some financially successful immigrants are unwilling to help other immigrants and even want to see them struggle (Wagoner et al.). More established immigrants may feel the need to distance themselves from more recent or struggling ones in order to establish their identity as immigrants who “made it” in the United States (Lo and Bahar). Hispanic men in particular perceive lack of compassion and assistance from other Hispanic men, whereas Hispanic women seem more willing to help each other, both emotionally and financially (Wagoner et al.). Thus, researchers warn against romanticizing the Hispanic community as an immediate and inclusive network bound by shared identities and values (Lo and Bahar). Nevertheless, recent immigrants still report relying on more established immigrants for assistance with “getting on their feet” (Wagoner et al.) and accessing health services (Documét et al.). This may be more difficult for immigrants in new growth communities, where social

networks are not as established. The ability to reconstruct their social network may greatly determine whether and how they will seek U.S. medical services.

Quality Barriers

Inability to access medical care is only part of the problem. Having access to care does not automatically entail that one receives quality care. In 2001, the Institute of Medicine identified six key areas in which healthcare quality could be improved: safety, effectiveness, patient-centeredness, timeliness, efficiency, and equitability (*Crossing the Quality Chasm*). Throughout the literature, there are indications that each of these areas is compromised in the care of Hispanic immigrant patients due to language barriers, discrimination, poor patient-provider relationships, and provider limitations. Whereas access barriers are primary barriers to obtaining care, quality barriers are secondary barriers that can just as easily prevent immigrants from receiving necessary health services.

Language

Several federal government policies and guidelines are in place to assist individuals who are “limited English proficient” (LEP) in the utilization of federally-funded services. Title VI of the Civil Rights Act of 1964 prohibits discrimination based on nationality, and Executive Order 13166, “Improving Access to Services for Persons with Limited English Proficiency,” of 2000 mandates that federal agencies provide LEP individuals with “meaningful access” to their services (“Commonly Asked Questions”).

Also in 2000, the Office of Minority Health, a division of the U.S. Department of Health and Human Services, published the *National Standards for Culturally and Linguistically Appropriate Services in Health Care (National CLAS Standards)*, which were revised in 2010 (“CLAS & the CLAS Standards”). There are fifteen standards, four of which are language specific: 1) offering linguistic assistance to LEP individuals at no cost to facilitate timely access to care, 2) informing individuals of the availability of linguistic services, 3) ensuring the competence of translators, and 4) providing translated print and multimedia materials that are easy to understand (“National Standards for Culturally and Linguistically Appropriate Services”). Failure to follow these standards may cost hospitals their Joint Commission accreditation. Moreover, the standards are based on Title VI of the Civil Rights Act of 1964 (*National Standards for Culturally and Linguistically Appropriate Services*), which can result in fines and lawsuits if violated. Despite these strong accountability measures, there appears to be little reinforcement of the standards. In 2010, only 13% of hospitals satisfied all four standards and 19% satisfied none (Diamond, Wilson-Stronks, and Jacobs).

As alluded to in the third linguistic CLAS standard, one of the foremost concerns with LEP patients is ensuring the quality of translation services. The Office of Minority Health and numerous researchers strongly discourage providers from using *ad hoc* interpreters such as a family member of the patient or a staff member with no interpreter training. Though these individuals are typically more accessible than professional interpreters, *ad hoc* interpreters make more errors of potential clinical consequence (Flores et al.).

In 2004, use of *ad hoc* interpreters was high: one survey found that they were used by nearly 70% of U.S. pediatricians (Kuo et al.). From 2004 to 2010, pediatricians reported increased contact with LEP patients. In the same period, the number of bilingual pediatricians decreased (DeCamp et al.). However, the use of family members as interpreters did not increase as expected, but decreased significantly. Instead, rates of formal interpreter use increased, primarily due to greater use of telephone interpreters. Rates of telephone interpreter use are higher in Alabama, Arkansas, Delaware, Georgia, Kentucky, Maryland, Mississippi, North Carolina, South Carolina, South Dakota, and Tennessee (DeCamp et al.), which are all states with a high Hispanic population growth rate (see page 6).

The use of a formal interpreter, whether in-person or over-the-phone, is determined by cost, setting, and the provider. Each state has the option to include reimbursement for language services in their Medicaid and CHIP programs. As of 2009, however, only the District of Columbia and thirteen states had this option; six other states were discussing or planning to implement it (Youdelman). None of the high Hispanic growth states are among the thirteen currently providing reimbursement. North Carolina is the only high Hispanic growth state planning to provide reimbursement after establishing a system for credentialing interpreters (Youdelman). Research shows that reimbursement policies encourage greater use of professional interpreters. Pediatricians in reimbursement states are twice as likely to use a professional interpreter versus pediatricians in non-reimbursing states (DeCamp et al.). Still, these reimbursement policies only apply to patients enrolled in Medicaid or CHIP. There is little information

on the reimbursement policies of private insurers, but it appears that they rarely reimburse for language services (Ku and Flores).

Studies have found that providers underuse language services even when they are available. In one such study, medical residents tended to rely on family members or their own second language skills instead of calling a professional interpreter, a practice they called “getting by,” in an effort to save time. The residents admittedly recognized that this practice lowers the quality of care for LEP patients (Diamond et al.). As a result, medical education programs are beginning to instruct students on the proper use and value of language services (DeCamp et al.). However, the efficacy of this instruction has not yet been evaluated.

Even when professional translators are available, there are still reports of poor interpretation. One study gave an example of how an interpreter mistakenly used the Spanish word for constipated instead of concentrated; as a result, the patient reported that they were not constipated, although it turns out that they were having trouble concentrating. Errors such as these can seem careless and lead patients to think that interpreters are disinterested or not fully invested in ensuring the quality of their care (Page-Reeves et al.). For this reason, one of the CLAS Standards aims to “ensure the competence of individuals providing language assistance” (“National Standards for Culturally and Linguistically Appropriate Services”). While professional interpreters are required to go through a credentialing process, bilingual providers do not typically undergo any type of language proficiency assessment (DeCamp et al.). This is especially concerning for providers who consider themselves bilingual, but still have gaps in their Spanish proficiency that a professional interpreter would not have. According to one

study, providers are becoming more aware of the hazards of interpreting on their own if they are not highly proficient in Spanish (DeCamp et al.), a realization that may encourage greater utilization of professional interpreters.

One drawback to using a professional interpreter rather than a bilingual physician is that many patients do not like having an interpreter. They may feel guilty about needing this additional service (Page-Reeves et al.), as if it justifies anti-immigrant rhetoric on the burden that immigrants place on public U.S. systems. They may also feel that having a translator diminishes privacy and trust-building with the provider (Lo and Bahar). Hispanic immigrant men in one study mentioned feeling embarrassed when telling a translator private health details, especially if the translator was a female (Harvey et al.). Embarrassment and concerns about privacy can lead patients to avoid disclosing certain information that may be vital to their care.

As mentioned in the CLAS Standards, appropriate language services must be provided not only in speaking, but also in writing. Written materials are often translated into Spanish assuming a high level of literacy. However, the 2013 National Assessment of Adult Literacy (NAAL) found that Hispanics have among the lowest levels of health literacy in the U.S. population (Mas et al.). Hispanic immigrants in one study reported that brochures are easy to find, but hard to understand because they contain “odd” language that is never spoken conversationally (Moreno et al.). Thus, written materials should not be translated word-for-word, but adapted to accommodate the reading level of the target audience.

Discrimination

Discrimination is a major barrier to accessing care, as previously discussed, but it can also diminish the quality of care. Hispanic immigrants are discriminated against in clinics primarily based on two factors: language and citizenship status. Language is significant because the first step in securing a medical appointment requires speaking with a receptionist, who may or may not speak Spanish. Immigrants in one study recounted being told by receptionists to speak English because “you’re in America now” (Page-Reeves et al.). This led them to feel ashamed of their limited English proficiency and validated a construction of immigrants as burdens to the healthcare system. Experiencing discrimination at the first point of contact with U.S. health care may cause some immigrants to give up on seeking care.

Also common is discrimination based on citizenship status. Anti-immigrant rhetoric describing immigrants as burdens to public systems, using up valuable taxpayer resources that they do not deserve, can lead to a perceived or actual reduction in the quality of care. As mentioned previously, the passage of section 287(g) of the 1996 IIRIRA led immigrants to perceive discrimination from providers, interpreters, and other healthcare staff, which they believed led to inadequate, inefficient, and low-quality care (Rhodes et al.). Some physicians will ask patients about their citizenship status and immigration process in an interrogation-style line of questioning, which immigrants perceive as intrusive and inappropriate (Page-Reeves et al.). Experiencing discrimination can lead immigrants to downplay their health needs in order to seem more deserving of care and less burdensome. Researchers term these behaviors “strategies of acquiescence”

(Page-Reeves et al.). Consequently, discriminatory environments may result in resolution of only superficial health needs, while more serious issues go unaddressed.

Patient-Provider Mismatch

The relationship between patient and provider is a key determinant of quality of care. In the case of Hispanic immigrants, this relationship is undermined by two types of problems: 1) different agendas or expectations of what the care will be like, and 2) different ethnic and cultural backgrounds. Research indicates that many Hispanic immigrants enter appointments with different concerns and expectations than those of their providers. They may be concerned with paying rent and feeding their families, social determinants which can influence health yet are often unacknowledged by the provider. Providers often enter an appointment with a predetermined agenda that is highly focused on the biomedical causes and solutions of the patient's symptoms. Though their physical needs are addressed, immigrants tend to feel that their emotional needs are overlooked. They feel like a disease being processed through an impersonal system rather than a human being (Lo and Bahar). Furthermore, the power dynamics of the encounter tend to favor the agenda of the provider, leaving little time for the immigrant to voice his or her concerns. This is especially problematic with the packed schedules and rushed appointments of many primary care physicians; immigrants leave these encounters feeling that they were not listened to and that their concerns were not addressed (Clochesy et al.). The imbalance of agendas between patient and provider impedes the development of a trusting, personal relationship.

The common factor that many immigrants desire from their medical care is a personal and sustained relationship with their provider. This desire relates to *personalismo*, or “closeness and empathy in personal relationships” (Jay et al.). Immigrants want a provider who treats them respectfully by demonstrating kindness, sincerity, and honesty, and who treats them equally regardless of their color, race, or income. Dialogue is especially important to immigrant patients, who value when a provider initiates friendly conversation, listens to their concerns, and offers multiple options in an honest manner (Harvey et al.). Immigrants also desire more guidance and support from their providers through a sustained relationship. Hispanic women in one study were frustrated when providers suggested losing weight without giving specific advice or following up with and encouraging them over time (Jay et al.).

Discord between patient and provider may also arise from intrinsic differences in ethnicity, language, culture, gender, and health beliefs. Several studies have tested the idea that Hispanic immigrants would be more comfortable seeing a provider who is similar to them in demographics, background, and values. Some results indicated that Hispanic patients prefer an “ethnic-concordant” provider (P. M. Wallace et al.), that these encounters are more communicative and satisfying, and that they increase the quality of care and the use of healthcare services (Lo and Bahar).

Other results indicated that ethnic concordance does not correlate with (Lo and Bahar) or may even decrease the quality of care. Despite the assumption that ethnic concordance will quickly foster a strong bond between the provider and the patient, Hispanic immigrants have described some co-ethnic providers and staff as disrespectful, mean, uncaring or rude (Blanchard, Nayar, and Lurie). Some even perceived that co-

ethnic case workers deliberately tried to make care unavailable to them. Researchers term this phenomenon “boundary work,” in which more established Hispanics create a boundary between themselves and more recent or struggling immigrants to emphasize their identity as one who “made it” in U.S. society. In addition, they attempt to diminish the boundary between themselves and successful U.S. natives, such as doctors. Hispanic immigrant patients indeed sense that co-ethnic staff put them down in order to feel superior and are more likely than non-coethnic staff to emphasize their social distance from the patient (Lo and Bahar).

Interestingly, one study indicated that Hispanic immigrant patients have more satisfying healthcare encounters with ethnically discordant providers. More important than sharing cultural values is being listened to and treated with respect and compassion. In fact, not a single immigrant in the study considered ethnic concordance more important than patient-centered care (Lo and Bahar). Essentially, immigrants want a provider who understands *el calor humano*, a term referring to warm human affection or friendliness. For some immigrants, this factor is even more important than having a bilingual provider (Harvey et al.).

Nevertheless, cultural differences can still interfere with the patient-provider relationship. Many immigrants do not disclose their use of home remedies with their U.S. provider due to anticipation of the provider’s lack of understanding or respect (Andrews, Ybarra, and Matthews) (Kiefer, Tellez-Girón, and Bradbury) (Page-Reeves et al.). In fact, providers receive little training on culture-based remedies and how to respectfully treat a patient who uses them. Some providers have stated that their medical training taught them to simply avoid discussing such practices during appointments. At

best, training programs may emphasize home remedies that are potentially harmful such as *greta* and *azarcón*, two lead-containing substances, to cure *empacho*. However, such remedies are rarely encountered, making the training irrelevant and insufficient.

Perhaps because of this lack of training, providers have been known to scold or ridicule patients for using home remedies. As a result, patients may feel that their use of home remedies is irrational or wrong, leading them to hide these practices from providers (Page-Reeves et al.). This situation harms the patient-provider relationship by stifling communication and trust, which can have physical ramifications. In some cases, herbal remedies can react with prescribed medications and produce an unintended effect; for example, cinnamon – a common remedy used in Hispanic homes – can amplify the effects of diabetic medications and cause hypoglycemia (Kiefer, Tellez-Girón, and Bradbury).

Provider Limitations

The quality of health care available to Hispanic immigrants is also impacted by the limitations of providers and clinics. With regard to provider limitations, three themes emerged in the literature: inadequate training, burnout, and a looming shortage. As mentioned earlier, providers often receive little to no training on using professional language services and respectfully caring for patients who use home remedies. However, these are just two examples of a larger problem: providers are not receiving sufficient training to understand Hispanic cultures, values, and beliefs. It is even less likely that they will learn about the social determinants of Hispanic immigrant health and best practices for delivering patient-centered care to this vulnerable population. Failure to

understand the patient beyond a physical condition can limit the efficacy of treatment; for example, a physician may tell a low-income patient with high blood pressure to cut salt out of his or her diet, an impractical suggestion if the patient relies on the food pantry, which distributes high-sodium preserved food (Stempniak). Immigrants also look to providers as trusted sources of information on healthcare options for immigrants, only to realize that many providers have little to no background in immigrant health policy (Raymond-Flesch et al.).

Though improving cultural competency programs for providers is necessary, these programs are often seen as lower funding priorities compared to other healthcare expenses. Furthermore, the busy schedules of providers mean that training sessions only last a few hours to a few days. As a result, such sessions are criticized for being generalized and superficial, and for bolstering providers with false confidence when treating patients from different cultural backgrounds (Andrews, Ybarra, and Matthews). Most professional schools now include cultural competency in their curricula and the Accreditation Council for Graduate Medical Education (ACGME) expects residency programs to train residents to understand the unique social determinants of each patient's health (Maldonado).

Providers in safety-net clinics are likely to experience burnout. Due to lack of insurance and access to specialty care, patients often present to safety-net providers with complex chronic diseases that are typically beyond the scope of primary care (Maldonado). Furthermore, many patients are limited English proficient, have low health literacy, and are dealing with issues such as unemployment, homelessness, violence, and substance abuse. Appointments with these patients are rarely long enough; a typical

length is 40 minutes for a new patient or 20 minutes for a follow-up. As one physician working at a Federally Qualified Health Center (FQHC) points out, “One could spend hours with these patients before getting to the bottom of their symptoms” (Maldonado). After examining the patient and making a diagnosis, there is little time left for patient education, which involves teaching the patient how to take charge of their health and improve their quality of life. Patient education is especially difficult if the patient is limited English proficient and has low health literacy.

Bilingual providers may be especially burdened in clinics that serve large Spanish-speaking communities. One physician noted that, as one of only a few bilingual providers, he spends some days exclusively seeing Spanish-speaking patients. Each appointment takes more time and effort, and the time between appointments is often used to fill out extra forms or help patients schedule appointments. Moreover, discharge instructions stored as English templates do not have a Spanish version, so the physician must translate them himself. Bilingual physicians may also face the unanticipated burden of assisting immigrant patients outside of the appointment with navigating the healthcare system and advocating for them at state agencies or nonprofit organizations (Brown).

Unfortunately, the extra effort required may cause safety-net providers to become less empathetic toward Hispanic immigrant patients, which can lower the quality of care they provide and entrench existing health disparities. Residents are especially vulnerable to burnout because they comprise a large portion of the safety-net workforce and work longer hours for shorter pay. Consequently, many choose to specialize, exacerbating the growing shortage of primary care physicians (Maldonado).

The primary care workforce is not keeping pace with the growing number of patients accessing safety-net clinics. In 2006, the American College of Physicians estimated that 35% of U.S. physicians are within ten years of retirement and less than 50% of new physicians are entering primary care (*The Impending Collapse of Primary Care*). This shortage will continue to increase the burden on providers and potentially cause delays in patient care. In one study, physician shortages were a barrier to Hispanic immigrant women receiving a mammogram (P. M. Wallace et al.). Rural health centers are hit especially hard by this shortage, experiencing a greater proportion of physician vacancies than urban centers (Frank et al.).

In response to the growing shortage of providers, section 5508 of the 2010 Affordable Care Act introduced the Teaching Health Center Graduate Medical Education program, which trains primary care residents in safety-net clinics serving medically-underserved areas. However, establishing a Teaching Health Center is a long process (Maldonado) and funding is only secured through 2017 (see page 88).

Other limitations of clinics and hospitals stem from a shortage of funding. In 2009, the Migrant Health Program – started in 1962 to provide care to migrant seasonal workers and their families – received only 8.2% of funding appropriated for FQHCs, despite serving roughly 865,000 individuals (Frank et al.). Additionally, the Affordable Care Act reduced compensation for hospitals providing uncompensated care based on the assumption that the law's national expansion of healthcare coverage would reduce the number of uninsured patients showing up to hospitals. However, the ACA did not take into account the fact that non-citizens may not benefit from the insurance expansion depending on citizenship status (S. Wallace et al.). As a consequence, some academic

health centers (hospitals affiliated with a medical school) are now closing their doors to uninsured individuals seeking non-urgent care (Acosta and Aguilar-Gaxiola).

Reduced funding for safety-net providers will prevent the establishment of new FQHCs, which are especially needed in new growth and rural Hispanic communities. The more immediate consequence, however, is a reduction in the services that FQHCs are able to offer. Currently, the services available at each FQHC are based on its size and scope. More advanced services, such as x-ray screening, may not be available at smaller locations, forcing patients to travel to a larger clinic (Frank et al.). Patients who lack the transportation or time to travel may elect not to pursue the screening referral. Funding cuts threaten further restriction of advanced medical services.

Conclusion

Hispanic immigrants face numerous barriers to accessing medical care and then to receiving quality care. Access barriers are created by both the healthcare system and the immigrant's cultural and social background. The healthcare system produces access barriers such as high costs, complex insurance plans, discrimination, and lack of information to help guide Hispanic immigrants through healthcare options. Immigrants also face access barriers on account of their health beliefs, social norms, and lack of social support post-immigration. Even after accessing care, there are additional barriers producing disparities in the quality of care, including language, discrimination, discordant patient-provider relationships, and inadequate providers and clinics.

Each of these barriers alone is complex; together, they act synergistically to limit access to timely, effective care. Moreover, the barriers are not exclusively access barriers

or quality barriers; they often act as both. For example, limited English proficiency not only threatens the quality of care by hampering patient-provider communication; it also prevents Hispanic immigrants from obtaining information on which clinics they can access and how they will be able to afford treatment. Lack of insurance is primarily an access barrier, but even immigrants with insurance may lack quality care if their plan does not cover certain services recommended by their provider. Despite the complexity of these barriers, there are several solutions that the U.S. can pursue on the local, state, and national levels to improve access to and quality of health care for Hispanic immigrants.

CHAPTER FOUR

Solutions to Access and Quality Barriers

The previous chapters established that the U.S. Hispanic immigrant population faces unique chronic health problems, that they are not burdening the healthcare system, and that numerous barriers prevent them from accessing quality care. There are several strategies that the U.S. can pursue to diminish access and quality barriers. Three groups of key players are capable of carrying out these strategies: community health workers, healthcare providers and their educators, and government administrators. Collectively, these groups can make enormous strides toward eliminating the profound disparities in health care currently experienced by Hispanic immigrants.

Community Health Workers (CHWs)

Community health workers (CHWs) are arguably the most important key players in eliminating healthcare barriers for Hispanic immigrants. They act as advocates for the health of underserved and disadvantaged communities, providing education through both group and one-on-one settings. However, they are a relatively new and unfamiliar concept in the healthcare field. They go by a variety of titles: community health workers, lay health advisors, *promotores*, and *navegantes*. In Hispanic communities, they are predominantly referred to as *promotores*, while community health workers or lay health advisors are non-specific titles for professionals who work with various racial, ethnic, and

socioeconomic groups. In this chapter, the abbreviation CHW for community health worker will be used.

As discussed in Chapter Three, providers do not necessarily need to be ethnically, linguistically, or culturally concordant with their patients in order to provide quality care. CHWs on the other hand, are concordant in these areas, and for good reason. Typically, they are recruited from the community that they will be trained to serve. Moreover, there is evidence that sharing the same demographics and language allows Hispanic immigrants to feel comfortable discussing their struggles and sensitive health issues (Wagoner et al.). CHWs usually have the same gender and nationality of their target community as well.

CHWs and Access Barriers

CHWs are the most promising solution to one of the major access barriers: lack of information about the healthcare system. One study demonstrated this by successfully recruiting the captains of soccer teams to act as *navegantes* to their team members, all of whom were Hispanic immigrants. The researchers reported that the team captains were natural leaders and were willing to help other immigrants in their social network; very importantly, their familiarity made it easier for the team members to trust them with private health concerns. The *navegantes* successfully provided information and training sessions, distributed health educational materials, and referred men to health clinics. They also accompanied men to a clinic if they did not know where to go or were apprehensive about going alone (Wagoner et al.). Tapping into existing immigrant social

networks, as done in this study, appears to be an effective strategy for initiating CHW programs.

Another study examined the attitudes of Hispanic immigrants toward CHWs. The researchers found four roles that Hispanic immigrants expect CHWs to fulfill: 1) to develop familiarity and trust, 2) to alleviate their fears of the healthcare system, 3) to interpret, and 4) to connect them to both health services and the broader community (Documèt et al.). These expectations implicate several access barriers discussed in the previous chapter: distrust, fear, inability to navigate the healthcare system, limited English proficiency, and lack of social support. Hispanic immigrants look to CHWs as promising sources of assistance in getting past these barriers.

Various other studies suggested specific gaps in information that CHWs could fill. One gap is information on insurance plans, especially regarding co-payments and other costs (Martens et al.). CHWs could provide group training sessions on available insurance plans and the various costs involved, and also offer one-on-one advising to help individuals determine their eligibility. Education is especially needed on the enrollment plans offered through the Affordable Care Act's Health Insurance Exchange. Many Hispanic immigrants are unaware that they are eligible to enroll in the Exchange. As mentioned previously, a Rhode Island community survey found that 44% of uninsured Hispanic immigrants were eligible. The surveyors offered free assistance with the enrollment applications, resulting in the enrollment of over 100 survey participants (Pigoga et al.). CHWs can similarly be trained to identify eligible people in their community and assist them with the enrollment process. They can also fill the

information gap regarding immigrant rights in healthcare settings and safe sources of care for those who fear discrimination or deportation.

CHWs have another advantage when it comes to eliminating access barriers. They are members of the community and personally connect to the ethnic and cultural identities of its members; some are immigrants themselves. Thus, they are better able to understand the social and cultural forces that determine care-seeking behaviors in Hispanic immigrants. For example, they are in a better position to discuss the negative effects of *machismo* and *marianismo* on care-seeking with their community because they are also personally connected to these social concepts; such discussions are probably not as well-received when initiated by non-Hispanic health professionals. CHWs are also a resource to confront the social isolation that many recent immigrants face. As well-connected leaders and educators in the community, they have the means to foster social connections between immigrants. They are also a source of personal and trusted social support themselves, as seen by how they accompany others to clinic appointments. As discussed previously, social support is vital to maintaining health and encouraging care-seeking in Hispanic communities.

CHWs and Quality Barriers

CHWs will be equally instrumental in eliminating quality barriers. Not only can they initially connect immigrants to sources of care, but they can also provide post-appointment support by helping immigrants follow the physician's care plan in the context of complex social determinants. Chapter Three discusses how physicians can lack the time and training needed to address social determinants during appointments,

which can prevent patients from affording treatment or following take-home instructions. For example, the physician may tell the patient to follow a low-sodium diet, but the CHW may discover that the patient relies on the food pantry, which typically distributes high-sodium food. As a result, the CHW will be able to educate the patient on reasonable selections within the limits of the food pantry or to identify alternative healthy food sources.

Several programs are already using CHWs as “reinforcers” of professional care. One Hope Centro de Vida Health Center in Albuquerque, New Mexico, provides all patients with a “salida,” or an exit interview, in which a CHW reviews instructions and health information received from the provider in the patient’s native language. They also identify potential issues that may interfere with the care plan, such as financial hardship, lack of transportation, and cultural differences (“One Hope Clinic”). Another program sends CHWs to meet with patients as they are being discharged from the hospital. Just like the One Hope Clinic program, these CHWs ensure that the patient understands the discharge instructions and addresses social circumstances that will interfere with compliance (Stempniak).

The patient-CHW relationship can and should extend beyond a single post-care visit, especially to support long-term lifestyle changes. One 30-minute appointment in which a physician recommends weight loss to an obese patient cannot provide the sufficient education, support, and accountability needed to produce sustained changes in dietary habits. Hispanic immigrant women in one study stated a need for low-cost, group-based healthy lifestyle programs to support their weight-loss goals (Jay et al.). Diabetic programs would also help immigrants adapt cooking and eating habits without

completely sacrificing traditions and the social connectedness fostered through food in Hispanic cultures. CHWs can provide these long-term programs to fill the gap between physician recommendations and patient compliance.

Several studies have demonstrated the success of CHW-led intervention programs. Hispanic immigrants in one CHW-led weight-loss program significantly lowered their intake of calories, fat, and carbohydrates compared to those who received only printed educational materials and those who received no intervention (Elder et al.). In a similar program, Hispanic immigrant women demonstrated significant improvement in their dietary habits, waist circumference, physical activity, and knowledge of heart disease compared to a non-intervention control group; furthermore, the program's 6-month retention rate was nearly 90%, indicating that it was well-received. Those who had more contact with the CHW through both group classes and individual coaching made the greatest improvements (Koniak-Griffin et al.). These results indicate the great potential of CHWs for implementing long-term lifestyle changes that will prevent the onset of chronic health issues such as heart disease and diabetes.

The Rise of CHWs and Current Issues

The CHW occupation is fairly recent and still developing. The first federal funding for CHWs began under the Office of Economic Opportunity Act of 1964, but the position did not spark major national interest until the 1990s. In 1999, Texas became the first state to pass legislation describing CHW training and certification; the 2000s saw legislation in other states and recommendations for integrating CHWs into the healthcare team from national organizations, including the Institute of Medicine in 2003 and the

Federal Office of Minority Health and the Agency for Healthcare Research and Quality in 2004. The first major federal policy on CHWs, the Patient Navigator Bill, passed in 2005 (*Community Health Worker National Workforce Study*). Finally, CHWs were officially recognized as an occupation by the Bureau of Labor Statistics in 2010 (“Community Health Workers”).

Two foreseeable issues with the increased use of CHWs are funding and credentialing. The 2010 Affordable Care Act made several provisions that encouraged the funding of CHWs. Most notably, section 5313 authorized the Centers for Disease Control and Prevention (CDC) to award grants specifically for CHWs promoting the health of medically underserved communities (*Grants to Promote the Community Health Workforce*). Funding was authorized to come from Social Security through 2014, but the funds were never appropriated and the section expired (Redhead et al.).

Another section that indirectly supports the use of CHWs is section 3502, which calls for the Health and Human Services Secretary to provide grants for the establishment of “community-based interdisciplinary, interprofessional teams to support primary care practices.” The section stresses preventive, holistic, patient-centered care delivered through the medical home model and funded through capitated payments (*Establishing Community Health Teams*). Like Section 5313, funding was authorized to come from Social Security (with no specific expiration year) but the funds were never appropriated (Redhead et al.).

Nevertheless, the ACA has increased use of CHWs through more indirect means on the state level. First, to accommodate the increased preventive services mandated by the ACA’s expansion of state Medicaid programs, states are able to designate preventive

tasks to non-licensed providers, such as CHWs. Second, the ACA allows states to create “Health Homes” for Medicaid beneficiaries living with chronic conditions; several states have designed plans that include CHWs. Third, the ACA funds “State Innovation Models,” to encourage states to improve healthcare quality and outcomes while limiting the growth of healthcare costs; four out of six states with Models included CHWs (Katzen and Morgan).

Because the ACA has encouraged the integration of CHWs into the healthcare team but has failed to garner grants for their compensation, funding remains a critical issue. States that utilize CHWs must solve the compensation problem on their own. Minnesota and Alaska are two examples of states that provide reimbursement through their state Medicaid programs (Stempniak). Another option is using a bundled payment model, in which the entire care team – physicians, nurses, CHWs, etc. – are paid one sum and divide it amongst themselves.

Aside from funding, credentialing is another impending issue. CHWs are now expected to be experts on a vast amount of information regarding health and the U.S. healthcare system. As pre-access navigators, they must know where immigrants can safely access care, the costs involved, where and how to find information on insurance plans, and the rules of eligibility. As health advisors and members of the care team, they must know about preventive health, symptoms, screening procedures, chronic illness management, goal-setting, coaching, and, most importantly, the impact of social determinants on health. Despite this vast amount of complex knowledge, there are currently no standardized training or credentialing protocols for becoming a CHW (Stempniak). The states vary widely on this matter. Texas requires CHWs to be state-

certified and offers a Promotor(a) or Community Health Worker Training and Certification Program. Minnesota, Ohio, and Oregon also mandate state training or certification. Some states have community college programs and are moving toward offering state certification. Others only provide standards, curricula, and requirements for certification, but leave program development to academic or health institutions. Several provide non-mandatory programs. Still others are merely in the beginning phases of establishing programs and certification standards (“Community Health Workers Toolkit”). The standardization of CHW training and certification will become increasingly important as CHWs become more numerous and more integrated into the healthcare team.

It is difficult to estimate the current number of CHWs, with estimates as low as 48,000 (“Occupational Employment and Wages”) and as high as 120,000 (Stempniak). With their increased recognition and legislative funding, more CHWs are now being hired by hospitals as staff rather than serving as volunteers (Stempniak). However, some physicians are concerned that CHWs will begin to interfere with their work if their roles expand too much. On the other hand, CHWs worry about becoming too integrated into the healthcare setting, thus losing their outsider status and connections to the community. Researchers point out, however, that CHWs are not trained to diagnose or take over any of the physician’s task; they should instead be thought of as the physician’s “right arm” (Stempniak). In their post-care role, they essentially act as the component of the healthcare system that extends into the community and life of the patient, an area that most providers cannot enter themselves.

Healthcare Providers and Educators

Healthcare providers and those who train them can also make great strides toward eliminating access and quality barriers. Providers can help reduce access barriers by educating their communities through outreach programs, as well as improving screening and referral strategies. Educators can help reduce quality barriers by increasing the implementation and efficacy of training on cultural competency, linguistic competency, and inter-professional teamwork.

Healthcare Providers and Access Barriers

Like community health workers, healthcare providers can greatly improve Hispanic immigrants' exposure to information on preventive health and the U.S. healthcare system. There are pros and cons to programs organized by trained providers as opposed to CHWs: providers have greater expertise in health topics and can serve as a direct connection to accessing care; however, they are less connected to the community and are often busy with clinical duties. Community clinics and Federally Qualified Health Centers (FQHCs) – in which providers care daily for the underserved – are best-equipped to organize educational programs. One notable example is Puentes de Salud, a clinic serving Hispanic immigrants in Philadelphia. Puentes de Salud hosts weekly Health Education Workshops in the waiting area, which are open to patients and community members alike. These programs cover preventive health topics such as diabetes and hypertension, as well as health system topics on immigrants' legal rights, WIC and food stamp eligibility rules, and accessing dental care. The clinic also partners with various immigrant community organizations and academic institutions to facilitate

greater access to care (“Programs”). Such educational programs should also strive to increase transparency about the costs of care and insurance options.

Providers can also improve screening strategies. Because immigrants cannot access care, they have fewer opportunities to get screened and prevent conditions from occurring or worsening. Recently, North Carolina public health experts noticed that many HIV/AIDS testers diagnosed at a more advanced stage were Hispanic. In response, health departments and community clinics began offering free HIV testing. Knowing that access barriers would still hinder use of these sites, the state also organized nontraditional testing sites in community organizations, homeless shelters, public parks, street corners, nightclubs, and academic institutions (Sudha et al.).

Historically, many screening initiatives have successfully reached out to Hispanic immigrants, but failed to address the issue of how to help immigrants who screen positive. A mere recommendation to receive further testing or treatment is insufficient in light of the various access barriers that immigrants face. Immigrants who screen positive need to be linked to follow-up services and navigated through these access barriers. North Carolina addressed this issue by linking immigrants who tested positive for HIV/AIDS to a network of AIDS service organizations (ASOs) (Sudha et al.), which provide support and financial assistance regardless of documentation status (Poon et al.).

Healthcare Educators and Quality

Removing quality barriers begins with educators, including those who train physicians, nurses, translators, and receptionists – essentially, everyone who interacts with immigrant patients. All members of the health care team must be trained in

culturally and linguistically competent care, which addresses many of the quality barriers discussed in Chapter Three: translation issues, discrimination, cultural differences, and patient-provider mismatch due to different agendas or expectations.

Nearly every health professions school now has cultural competence as part of its curriculum. Numerous studies have found an association between cultural competence training and patient satisfaction. A systematic review found that cultural competence training improves providers' knowledge, attitudes, and skills, and boosts patient satisfaction, though no studies indicated whether patient health outcomes actually improve (Beach et al.). In another study, hospitals with better cultural competence practices had higher scores for doctor communication, hospital rating, and hospital recommendation on patient surveys; among minority patients, scores were higher for nurse communication, staff responsiveness, and pain control (Weech-Maldonado et al.).

If cultural competence training is so common now, why are so many Hispanic immigrant patients reporting dissatisfying encounters with providers due to cultural differences and perceived or actual discrimination? One explanation could be that cultural competence training was introduced fairly recently into medical training. The Liaison Committee on Medical Education (LCME) – which governs the American Association of Medical Colleges (AAMC) and the American Medical Association (AMA) – introduced a standard for cultural competence in 2000:

The faculty and students must demonstrate an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments. Medical students should learn to recognize and appropriately address gender and cultural biases in health care delivery, while considering first the health of the patient.

Thus, older physicians did not have cultural competence courses during their training.

Moreover, the LCME's one standard is fairly brief and does not provide schools with

much direction as to how they should develop their curricula. The AAMC published more detailed guidelines for medical schools in 2005. The Accreditation Council for Graduate Medical Education (ACGME), the accreditation board for residency programs, introduced six cultural competence domains in 2011 (*Cultural Competence Education*). Two years later, however, a review of all residency programs in the U.S. found high variability in their cultural competence requirements (Ambrose, Lin, and Chun). There are no studies comparing patient care outcomes between different curricula. Such studies are needed to determine best practices for cultural competence training and establish greater standardization and accountability among medical educators.

For providers who have already attained their professional degree, cultural competence training is being introduced through continuing medical education (CME), which is required for providers to keep their license to practice. However, CME courses in cultural competence have been slow to take effect, and attempts to legally mandate such courses have met resistance. Currently, only seven states legally mandate or strongly recommend cultural competence training. Legislation is currently under consideration in eight states, and failed to pass or was vetoed in six states. The remaining twenty-nine states have not yet considered such legislation (“CLAS Legislation Map”). Opposition comes from physicians and administrators concerned about adding more courses to those already required for CME. An alternative is to make such training voluntary but provide physicians with an incentive. In New York, physicians can earn a 5% discount on their medical liability premiums by completing a course. Despite their initial skepticism of these courses, many physicians find them informative for understanding the health risks and needs of their Hispanic patients (Landers). One study

found that an online breast cancer cultural competence course significantly increased provider knowledge; after completing the course, 95% of participants agreed it was an appropriate tool for training providers on cultural competence and health disparities (Palmer et al.).

Going forward, there are more innovative and effective approaches to increasing cultural competence beyond coursework. One nursing program found that real-life experiences with Hispanic patients, including social interaction and cultural immersion, were significant predictors of better knowledge, cultural competence, and comfort with Hispanic patients. These real-life experiences were more associated with positive outcomes compared to traditional coursework methods (Mayo et al.). Similarly, the Physician Assistant Program at Emory University provides an intensive two-week immersion experience through the Farm Worker Project, in which students provide free care to migrant and seasonal farmworkers in rural communities (Smith-Thym). Introducing similar immersion experiences into other training programs will be a more effective method of teaching cultural competence to future providers.

Providers must also be trained in linguistically-competent care. Primarily, this entails knowing when and how to access translators, as well as how to communicate with patients through translators. As discussed in Chapter Three, studies have shown that providers tend to underutilize professional language services in favor of *ad hoc* interpreters, such as family members and untrained staff, even when such services are available. Cultural competence curricula can effectively integrate training on linguistic competence, as demonstrated in a curriculum designed for pediatric clerkships (Mihalic et al.).

As the Hispanic population continues to grow, it will be especially helpful to have providers who are at least proficient in the Spanish language. All professional schools should provide their students with the opportunity to learn conversational Spanish skills for the medical field. A survey of U.S. medical schools, however, found that only 40% offer a medical Spanish course; furthermore, only 35% of schools in the top ten Hispanic growth states currently offer a course (“How All 175 Medical Schools Teach Medical Spanish”). Given that most medical schools want their students to practice eventually in the same state, it is crucial that they provide opportunities for the acquisition of second language skills.

Educators should not expect providers to shoulder the entire burden of ensuring patient satisfaction, compliance, and improved health by integrating their biomedical knowledge with the patient’s social and cultural background. Instead, they should train providers to collaborate with community health workers (CHWs). In the last decade, medical schools began to recognize the importance of Inter-professional Education (IPE), which focuses on improving collaboration between members of the healthcare team to reduce medical errors and improve care quality. A clinical trial demonstrated that inter-professional team care improved the care quality for patients with type 2 diabetes (Janson et al.). Current IPE curricula, however, does not include community health workers (CHWs) in their framework. As mentioned previously, CHWs can serve as vital members to the care team by understanding and addressing the patient’s social determinants of health through sustained education and support between clinical appointments. Care quality will improve if providers communicate with CHWs to ensure that they are appropriately coordinating care for their shared patients.

Administrators

Government administrators are the third group of key players in the effort to eliminate access and quality barriers to health care for Hispanic immigrants. They can reduce access barriers through increasing immigrant knowledge about health care and reconsidering the viability of current exclusionary policies. They are also capable of reducing quality barriers through their power to create new programs and control funding.

Administrators and Access Barriers

Lack of Knowledge. One of the biggest access barriers – lack of knowledge about the U.S. healthcare system – is a barrier that administrators can address immediately, unlike the barriers of insurance and cost, complex and controversial issues that will take more time to address. Strategies for increasing immigrant knowledge differ for legal versus illegal immigrants.

There is little information on how much assistance legal immigrants receive in finding health services during the immigration process. The United States Citizenship and Immigration Services (USCIS) office has an online guidebook in Spanish for new immigrants, which includes information on how to find medical care (“Bienvenido a Los Estados Unidos”). It includes basic information on employer-based insurance, the Health Insurance Exchange, Medicare, Medicaid, CHIP, and low-cost health centers. It then directs readers to various websites for additional information, including healthfinder.gov for general information, healthcare.gov for information on the Exchange, and

findahealthcenter.hrsa.gov for information on FQHCs. Though it does mention the 5-year waiting period for Medicaid eligibility and the caveats for pregnant women, children, and the disabled, it does not mention that lawful permanent residents will face the ACA tax penalty for failing to find health insurance. These guidebooks are only free online or they are available for purchase in U.S. Government Bookstores (“Welcome to the United States”). In this approach, administrators are faultily assuming that immigrants will have access to a computer and printer and that they will be able to find this guidebook online, or that they will locate and purchase it in a government bookstore. Moreover, it assumes that immigrants will have the literacy skills to understand it. Understandably, providing this guidebook to every immigrant or immigrant family who lawfully enters the country would be expensive, and most likely, wasteful; many would likely not read it or be unable to read it. Instead, in-person counseling sessions in which a Spanish-speaking government-trained worker explains how to access health services would be a more effective approach.

Unfortunately, this approach would only apply to immigrants who come here legally, when the majority of Hispanic immigrants come to the U.S. illegally. This reality demands a different kind of strategy that involves a combination of mass social marketing and community partnerships. Numerous social marketing campaigns have effectively targeted Spanish-speaking communities to boost screening and insurance enrollment rates. For example, one HIV campaign utilized Spanish-language print materials, radio advertisements, and community outreach; after seven months, researchers reported increased perception of HIV risk, increased knowledge of testing locations, and decreased HIV risk behaviors (Martínez-Donate et al.). Spanish TV and radio are

especially promising avenues for disseminating health information to immigrants (Ramos, Correa, and Trinidad), and should be combined with the distribution of print materials in places immigrants frequent: workplaces, churches, grocery stores, marketplaces, schools, and community centers.

However, administrators cannot rely on mass social marketing alone to boost immigrant health knowledge. Personal outreach is perhaps more effective; state and federal agencies can train and support such local efforts through partnerships with community organizations. Several agencies have already utilized this strategy with great success. For example, the Baltimore City Public Health Department began using street outreach strategies to find HIV-positive individuals who were not receiving treatment. Only 6% of those contacted had a source of primary care; the health department was able to re-connect 69% to primary care services (*CQM Outreach Report*).

With the Affordable Care Act, government-directed community campaigns became more common in an effort to inform Hispanics about their eligibility and how to enroll. One example is National Latino Week of Action, which took place in January of 2016 to boost enrollment before the January 31 deadline to obtain coverage for 2016. The campaign launched digital tools to estimate the costs of coverage and to schedule appointments with community assisters, as well as community events where Hispanic families could get free health checkups and enroll in coverage (Plaza). In previous years, the U.S. Department of Health and Human Services Latino Affairs Liaison also hosted webinars to share best practices for educating and assisting Hispanics with enrollment, and granted \$3.2 million to community organizations working to enroll minority populations in healthcare plans (Doty, Rasmussen, and Collins). States are also

conducting their own campaigns; when the ACA open enrollment period began, the Illinois Coalition for Immigrant and Refugee Rights launched a campaign to educate immigrants about enrollment (Olivo). Cities such as Houston opened telephone hotlines with Spanish-speaking Exchange enrollment counselors (Doty, Rasmussen, and Collins).

Though these strategies are effective and necessary, they are not comprehensive because they only apply to legal permanent residents and are no longer useful now that the Marketplace open enrollment period has passed. Immigrants would still greatly benefit from information on Medicaid, which is always open for enrollment, and on FQHCs, which provide care regardless of insurance or legal status. Administrators can continue to use mass media and community partnership strategies to disseminate information on these health resources. They should pay particular attention to community health workers (CHWs), who can be trained to counsel immigrants in their community on accessing healthcare. For example, in Washington, D.C., the Centers for Medicare and Medicaid Services began a partnership with the Cameroon American Council to train faith and community leaders about the ACA and other health services available to Cameroonian immigrants (Serafini). The government can establish similar partnerships with Hispanic community organizations around the country.

Administrators and Quality Barriers

As policymakers, government administrators have considerable power to improve the quality of health care for Hispanic immigrants. Their attention should focus on three components of healthcare delivery: improving the use of language services, developing the healthcare team, and supporting community health centers.

Language. Chapter Three discussed how, despite the existence of laws and standards for the proper provision of language services to limited English proficient (LEP) patients, providers are still using *ad hoc* interpreters or trying to “get by” on their own limited second language skills. It turns out that many hospitals and clinics do not meet the *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS Standards)* issued by the Office of Minority Health in the U.S. Department of Health and Human Services. Some administrators want to address this non-compliance by making it punishable by law. For example, the Connecticut Commission on Health Equity drafted the Connecticut Culturally and Linguistically Appropriate Services Standards Accountability (CCLASA) Bill, which would subject non-compliant organizations to fines and loss of federal funding (“CCLASA Fact Sheet”). The bill has not been formally proposed.

Nonetheless, the reason for non-compliance with CLAS Standards is likely a result of not only lack of accountability, but also the cost of reimbursing translators. As healthcare costs continue to rise and health organizations look for ways to save money, translators may be seen as less essential than other expenses. Consequently, government administrators should also consider improving reimbursement for language services, which has been shown to encourage greater use of professional interpreters (DeCamp et al.). In 2009, only thirteen states and the District of Columbia had Medicaid reimbursement for language services (Youdelman). Still, even if all states provide Medicaid reimbursement for language services, those covered by a Marketplace or other private plan will not have reimbursed language services. As more health organizations move toward a capitation payment system, in which the patient pays a bundled fee to the

entire healthcare team instead of paying for each individual service, the organizations may consider covering translators through this bundled fee.

The Healthcare Team. Administrators are the key players most capable of addressing the looming shortage and burnout of primary care physicians. One of their current priorities should be continuing to secure funding for the Teaching Health Center Graduate Medical Education program established by section 5508 of the 2010 Affordable Care Act, which redirects federal funds from traditional hospital residency programs to new residency programs in community health centers. These programs train residents to deliver culturally-competent care to diverse populations in the safety-net setting. There are currently 59 Teaching Health Center GME programs in 24 states training nearly 690 residents (“Teaching Health Center”). A survey of the program’s 2014 graduates demonstrated its success: 76% were practicing in underserved areas and 21% were practicing in rural areas, compared to 26% and 8% of their peers, respectively (Robeznieks, “Federal Primary-Care Program”). The program nearly expired in 2015 but was reauthorized by the Medicare and CHIP Reauthorization Act, which provided \$120 in funding through the end of the 2017 Fiscal Year. However, the program costs \$132 million annually, so the funding is barely sufficient to cover the program through the end of the 2016 Fiscal Year (Robeznieks, “Teaching Health Center Program”).

Primary care physicians in underserved settings also need to be protected from burnout. One way to do this is to expand funding for community health workers (CHWs). As mentioned previously, the 2010 ACA has made provisions for greater integration of CHWs into the healthcare team, but Congress has not acquired the

appropriate funds. It is practically impossible for providers to address the social determinants of an immigrant patient's health, educate the patient on health topics, and carry out the routine duties of performing a physical, making a diagnosis, and determining a care plan, all through a translator, within a 20-40 minute appointment slot. CHWs can help ease this burden because they have more time, a better understanding of the patient's social and cultural background, and can speak the patient's native language. Thus, the provider can rely on the CHW to continue educating the patient and assisting them with following the physician's treatment plan, in the context of social determinants, after the appointment is over. However, funding is necessary to reimburse health organizations for the integration of CHWs into the care team.

Community Health Centers. Health centers are important delivery sites of health care for Hispanic immigrants, and are the only major source of care for immigrants who are undocumented or uninsured. As federally-funded entities, they must comply with four requirements: 1) care for a medically underserved population, 2) work on a sliding-fee scale, 3) demonstrate sound clinical and financial management, and 4) have a governing board with a majority composed of health center patients. There are currently about 1,400 health centers serving 23 million patients ("What Is a Health Center?"), of which 35% are Hispanic, 23% are limited English proficient, 71% are at or below poverty level, 28% are uninsured, and 47% are on Medicaid or CHIP ("2014 Health Center Data"). The total nationwide operating cost was \$17 billion in 2014, or about \$760 per patient. Grants cover 18% of funding; the rest is covered by Medicaid, Medicare, private insurance, patient payments, and other sources ("What Is a Health Center?"). Health

centers save the U.S. healthcare system an estimated \$24 billion by preventing expensive emergency, hospital, and specialty care (“About Our Health Centers”).

What makes health centers desirable is not just their lower operating cost or mission to care for underserved populations, but also their delivery of comprehensive and continuous care. The care is comprehensive in that all health centers are required to provide certain medical, pharmaceutical, dental, and mental health services. Moreover, the majority offer preventive services such as cancer screening, weight screening and follow-up, tobacco screening and intervention, and HIV/STD testing. In 2013, health centers performed roughly 1.8 million pap smear tests, 1.1 million HIV tests, 600,000 hepatitis B and C tests, and 400,000 mammograms (“About Our Health Centers”). Moreover, health centers are effectively managing chronic conditions before they get worse; in 2014, two-thirds of hypertensive patients and two-thirds of diabetic patients were receiving treatment to control their conditions, and three-fourths of HIV-positive patients were linked to long-term care (“2014 Health Center Data”). Beyond medical services, three-fourths of health centers provide eligibility assistance and engage in community outreach, half provide health education, and one-fourth provide language services (“About Our Health Centers”). The reason for the low use of language services is not known, but is something that should be improved going forward.

Health centers are also providing continuous care by switching to the patient-centered medical home (PCMH) model, in which an integrated inter-professional healthcare team serves each patient, as opposed to the traditional model of each health professional individually providing services to the patient. The PCMH model is designed to improve quality and patient outcomes while reducing healthcare costs. In 2008, the

Commonwealth Fund began the Safety Net Medical Home Initiative to transform 65 health centers into PCMHs. The Initiative successfully created a framework for other health centers to adopt the PCMH model (“Patient-Centered Care”). As of 2014, two-thirds of health centers were operating under this model (“What Is a Health Center?”).

Though there are almost 2,000 health centers across all 50 states and the District of Columbia, there is still an overwhelming number of Hispanic immigrants who lack healthcare access. Administrators are looking to establish new health centers in order to reach Hispanic immigrants and other medically underserved populations. The Health Resources and Services Administration (HRSA) offers a data-driven approach to identifying promising areas for expansion. HRSA has compiled a list of Medically Underserved Areas (MUAs) and Primary Care Professional Shortage Areas (PPSAs). The criteria for determining MUAs include a shortage of primary care providers, high infant mortality, high poverty, and a high elderly population. PPSAs are areas with a shortage of primary care providers (“MUA Find”).

Texas and California have by far the most MUAs, with 316 and 212, respectively. In general, the Midwestern and Southeastern states have higher numbers of MUAs. The Northeastern states (minus Pennsylvania and New York) and the entire western half of the U.S. (minus Texas and California) have lower numbers of MUAs.

Medically Underserved Areas (MUAs) by State

HRSA Data Warehouse, 2016

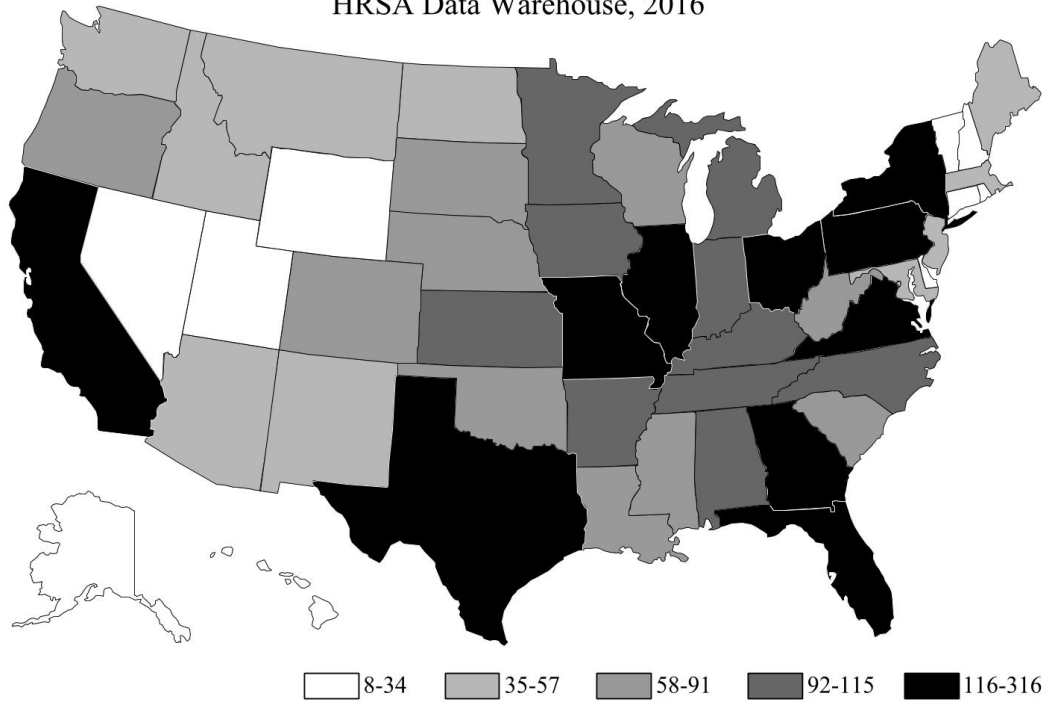


Figure 7: A density map comparing the number of medically underserved areas (MUAs) between states (“HRSA Data Warehouse”).

The distribution of PPSAs follows a fairly similar trend to that of MUAs.

California and Texas again have the largest number, with 575 and 386, respectively.

Florida, Georgia, Illinois, Missouri, and New York are also states with a large number of MUAs and PPSAs. Once again, the Western and Northeastern states tend to have fewer PPSAs.

Primary Care Professional Shortage Areas (PPSAs) by State

HRSA Data Warehouse, 2016

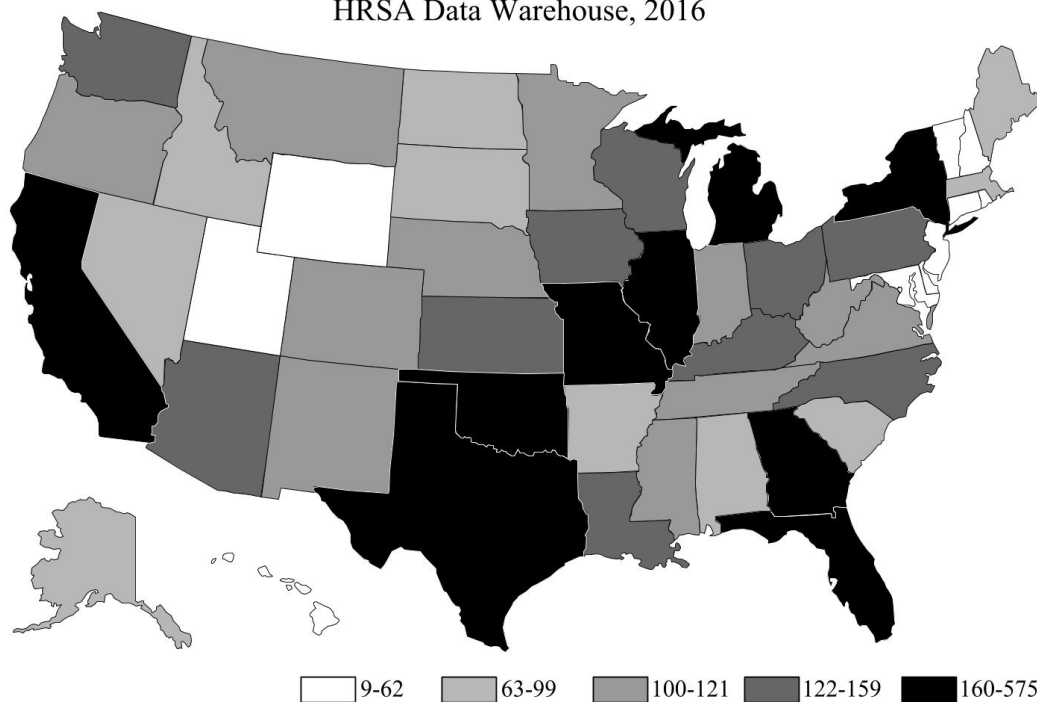


Figure 8: A density map comparing the number of primary care professional shortage areas (PPSAs) between states (“HRSA Data Warehouse”).

Interestingly, there is a fairly strong correlation between a state’s Hispanic immigrant population and its number of MUAs or PPSAs. The correlation coefficient between the Hispanic immigrant population and number of MUAs is 0.63. The correlation coefficient between the Hispanic immigrant population and number of PPSAs is even stronger at 0.82. These data indicate that Hispanic immigrants tend to live in areas with lower availability of health care compared to other areas of the country. Administrators should partly base the location of new health centers on measures such as MUAs and PPSAs, as these seem to be powerful indicators of regions where low-cost primary care services are greatly needed by Hispanic immigrants.

However, administrators should take caution when using indicators such as MUAs and PPSAs. These indicators are not representative of the future need that states will experience in terms of healthcare resources. Since 2000, states that are not traditionally immigrant destinations have grown more rapidly than traditional destination states like California, Texas, New York, Florida, and Illinois. These “new growth states” are heavily concentrated in the Southeast, but there are other surprising states such as the Dakotas, Nebraska, Oklahoma, Iowa, Indiana, West Virginia, and Maine. Currently, there is no correlation between the percent growth of a state’s Hispanic population and that state’s number of MUAs or PPSAs. This may be because these immigrant populations are likely more recent, younger, and healthier. However, as the immigrant populations in these states continue to grow rapidly, age, and develop more chronic illness, there will be a greater burden on their healthcare resources. Thus, administrators must consider changes in the geographical distribution of the Hispanic population when establishing new health centers. Supporting health care in new growth states will provide more access to primary care and preventive services for more recent immigrants, thereby reducing the chronic illness burden that those states will face in the future. Though current areas of need are a priority, neglecting future areas of need will ultimately hurt U.S. healthcare and continue to place the health of Hispanic immigrants at a disadvantage.

Conclusion

Removing access and quality barriers to improve preventive health care for Hispanic immigrants will require efforts from community health workers, providers,

medical educators, and government administrators. These key players will serve the same purpose of removing access barriers by educating Hispanic immigrants on preventive health and the U.S. healthcare system. Their roles in removing quality barriers will be more variable. Community health workers will have the initial function of connecting immigrants to health services, and the subsequent function of ensuring patient compliance with the provider's recommendations despite interfering social factors. Medical educators will have the role of equipping health professionals to provide high-quality care through curricula on cultural and linguistic competency, as well as interprofessional teamwork. Administrators must determine appropriate funding measures for language services, primary care residency programs, community health workers, and community health centers. Collectively, the efforts of these key players will effectively address obstacles to health care and gradually reduce the prevalence of chronic disease in the U.S. Hispanic immigrant population.

CHAPTER FIVE

Conclusion

There are currently over 20 million Hispanic immigrants living in the United States. Though they represent a rich diversity of cultures and social circumstances, there are certain observable trends in the Hispanic immigrant population. The most popular immigrant destination states are California, Texas, Florida, and New York. About two-thirds of Hispanic immigrants are limited English proficient, and may or may not improve their English language skills over time. Despite language limitations and low rates of education, Hispanic immigrants have a lower unemployment rate than that of U.S. natives. More than half come to the U.S. for economic reasons and about one-fourth come for family reasons. Traditionally, the U.S. is seen as a place to achieve one's goals, have a better life, and be more prosperous.

Current statistics show a changing immigrant population. Immigrants are settling in non-traditional destinations such as the Southeast, the Dakotas, Nebraska, Oklahoma, Iowa, Indiana, West Virginia, and Maine; these states experienced a growth rate above 90% from 2000 to 2014. Recent growth is occurring in communities that are historically less than 20% Hispanic. In recent years, the immigration rate has slowed, especially from Mexico, in part due to trouble in the U.S. economy. While the Hispanic immigrant population has typically been a young population, the average age will increase as the current population ages and fewer new immigrants cross the border. It is time to start looking at how this aging community will affect U.S. healthcare.

The health trends of Hispanic immigrants are very paradoxical. Despite their lower socioeconomic status, Hispanic immigrants are healthier than U.S. natives upon first immigrating. Studies of recent immigrants report a lower BMI, longer life expectancy, and better self-rated health. As they rise in socioeconomic status, their health does not actually improve as expected; in fact, overall health worsens. This trend is attributed to acculturation, which exposes immigrants to disease risk factors such as unhealthy eating habits, as well as limited access to preventive health services. Over time, they develop chronic conditions such as diabetes, heart disease, and cancer. The preventive health resources used to combat these health issues in the native U.S. population are not as effective for the Hispanic immigrant population, which faces unique barriers to accessing quality health services.

Policymakers have been predominantly concerned with the financial burden that the Hispanic immigrant population will place on the U.S. healthcare system. Between 1985 and 2012, twelve national and state policies dealt with insurance eligibility rules for Hispanics of various citizenship statuses:

1985 *Emergency Medical Treatment and Active Labor Act (EMTALA)*

All hospitals receiving Medicare payments must treat anyone in a medical emergency, including labor, until he or she is ready for discharge or stable transfer, regardless of ability to pay or citizenship status.

1996 *Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA)*

Shifted the financial burden of meeting immigrant health needs to the states. Immigrants must be lawfully present for five years in order to become eligible for public benefit programs such as Medicaid.

- 1996 *Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA)*
- Placed additional restrictions on immigrant eligibility for public benefit programs. Section 287(g) allowed law enforcement agencies to enforce federal immigration laws during daily law enforcement activities and caused immigrants to avoid health services.
- 1997 *State Children's Health Insurance Program (CHIP)*
- Provides health insurance to children with family incomes above the Medicaid eligibility ceiling but below the 200% federal poverty level. The PRWORA five-year waiting period still applies, but some states chose to remove it for children and pregnant women.
- 2002 *CHIP prenatal care rule*
- Extended CHIP eligibility to unborn children of low-income immigrant women, regardless of documentation status.
- 2002 *Guidance following CHIP prenatal care rule*
- Authorized states to continue reimbursing providers for comprehensive pregnancy care for immigrant women beyond care covered by the CHIP.
- 2004 *Emergency uncompensated care reimbursement program*
- Allocated \$1 billion over four years to reimburse hospitals for uncompensated emergency treatment of undocumented immigrants. Less than one-third of the funds were dispersed before the program was withdrawn due to concerns regarding providers inquiring about documentation status.
- 2005 *Deficit Reduction Act (DRA)*
- Mandated that those applying for or renewing their Medicaid coverage provide proof of citizenship. Led to declines in enrollment and prevented or delayed care for some immigrants.
- 2005-06 *Criminalization of medical care for Hispanic immigrants*
- Several bills proposed making it a felony to provide medical care to undocumented immigrants. The bills were met with strong opposition and did not pass.

- 2009 *Children's Health Insurance Program Reauthorization Act (CHIPRA)*
- Allowed states to remove the five-year waiting period for pregnant women and children.
- 2010 *Patient Protection and Affordable Care Act (ACA)*
- Lawfully present immigrants must wait five years before applying for federally-funded programs such as Medicaid, though they can purchase private insurance through the Health Insurance Exchange during this waiting period. Agricultural workers are not eligible for Medicaid; as lawfully present immigrants, they must still purchase insurance or pay the tax penalty. Undocumented immigrants are not eligible for federally-funded programs or the Exchange.
- 2012 *Deferred Action for Children Arrivals (DACA)*
- DACA recipients are prohibited from any type of insurance coverage, including Medicaid, CHIP, and private insurance in the Health Insurance Exchange. Years spent in DACA status do not apply to the five-year waiting period.

These policies were contradictory and controversial. Some placed greater restrictions on insurance eligibility while others removed them. Since many policies were simply insurance expansion options that the states could choose to offer or not, considerable state-to-state variation in eligibility rules arose. Regardless of their choice, all states face potential financial implications. States that extend insurance coverage risk bearing a greater burden for providing health care to Hispanic immigrants. States that do not extend insurance coverage risk increasing immigrants' reliance on emergency departments, which treat patients at a higher cost compared to the clinical setting.

Besides financial implications, there are also ethical implications to these policies. It seems unreasonable to deny individuals medical attention until their problems are urgent enough to require emergency treatment, which is more expensive and less

effective at treating advanced chronic disease. For example, an immigrant with high cholesterol would likely live a long life with minimal issues if started early on a regimen of medication, diet, exercise, and regular appointments with a primary care provider. In reality, many immigrants with high cholesterol are unaware of it because they have never been screened, and thus are not taking precautionary measures to prevent future heart disease or a heart attack. Furthermore, the only place they can access care is the local emergency department, which will only treat them after their heart has suffered major, irreparable damage.

By focusing solely on financial matters, lawmakers are missing other issues involved in health care for Hispanic immigrants. Undoubtedly, healthcare costs and insurance eligibility rules are two primary obstacles to accessing preventive services, but they are not the only barriers. Another common barrier that receives less attention is lack of information about and guidance through the U.S. healthcare system. Immigrants sense a lack of transparency regarding locations, costs, qualifications, and patient rights for U.S. health services. Many purposefully avoid health services for fear of discrimination or deportation. There are also factors that U.S. healthcare leaders cannot control, such as cultural health practices, social norms, and community dynamics, all of which can dissuade use of U.S. health services.

Even when immigrants are able to access care, the quality of the care is often diminished by the language barrier, discrimination, discordant patient-provider relationships, and inadequate providers and clinics. Though access to interpreters is increasing with the use of phone interpreters, many providers are still using *ad hoc* interpreters, such as family members of the patient or untrained staff. Providers who

consider themselves proficient in Spanish may try to get by on their own. When providers prioritize convenience over accuracy while treating a limited English proficient patient, they compromise the patient's well-being and satisfaction. Immigrants also report being discriminated against by providers and staff, primarily based on their language skills and citizenship status. After experiencing discrimination, immigrants may neglect further treatment or conceal more problematic health concerns with superficial ones in an effort to appear more deserving of care. Even if the provider is not discriminatory, their agenda and interpersonal skills may fail to satisfy the expectations of immigrant patients. Immigrants feel that U.S. providers treat patients more as diseases than people, do not listen to their concerns, and lack personable qualities such as empathy, kindness, and sincerity. Finally, the quality of care is threatened by a shortage of primary care providers in safety-net settings and health centers in medically-underserved areas of the country. All of the aforementioned barriers act synergistically to impede access to quality preventive services.

There are numerous solutions that the U.S. should pursue to make quality preventive services more available to the Hispanic immigrant population. Three groups of people can contribute most to effecting these changes: community health workers (CHWs), healthcare providers/educators, and government administrators. CHWs are fairly new figures in the healthcare field. They rose in prominence in the 1990s, but were not recognized as an official occupation until 2010. Many CHWs are simply volunteers, but the position is becoming more occupation-based. CHWs are in a great position to remove both access barriers and quality barriers. With their connections to the healthcare system on one side and the community on the other, CHWs can help initially connect

immigrants to care and provide education programs on preventive health in a culturally and linguistically appropriate manner. They can also improve the quality of care by helping immigrants follow the provider's care plan in the context of social determinants. Directly after the appointment, they can help translate instructions and discuss potential barriers to following them such as financial hardship, work or family obligations, lack of transportation, and cultural differences. Between appointments, they can provide one-on-one and group programs to educate and coach immigrants to meet long-term health goals, such as losing weight, controlling blood glucose, and quitting smoking. In order for CHWs to fulfill these roles, administrators must continue to develop CHW training programs and organize funding for CHW reimbursement.

Healthcare providers and educators will also play a crucial role in reducing barriers to preventive services. Providers can specifically address immigrants' lack of information about the U.S. healthcare system and preventive health by offering educational outreach programs in their communities. They can also improve current screening procedures by ensuring that immigrants who test positive are connected to long-term, affordable sources of further testing and treatment. Healthcare educators can target quality barriers by improving curricula on cultural competency and linguistic competency. They should also update curricula on inter-professional teamwork to include CHWs.

Reducing barriers to health care will also require the authority and resources of government administrators. Like healthcare providers, they can disseminate information on accessing health services and preventing chronic disease to communities, though they can do so on a larger scale through mass social marketing in addition to small-scale

community partnerships. They can improve the quality of health care for immigrants by providing funds for interpreters, residency programs, CHWs, and Federally Qualified Health Centers (FQHCs).

Hispanic immigrants have a significant presence in the U.S. population and constitute one of the most medically underserved demographics in the country. They are uniquely at risk of developing chronic conditions and simultaneously lacking preventive care. The combination of these factors results in a high burden of chronic disease in the aging Hispanic immigrant population, which will be detrimental to the fiscal and workforce capacities of the U.S. healthcare system. Fortunately, the incidence of chronic disease in the Hispanic immigrant population can be reduced through targeted efforts from community health workers, providers, medical educators, and government administrators. Eventually, these efforts will improve the quality of life of Hispanic immigrants. The U.S. as a whole will benefit from all residents, regardless of background, enjoying better long-term health.

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