Latino Immigrant Experiences in Accessing Healthcare in the Kansas City Area
Latino immigrants have many challenges in accessing healthcare, both nationally and in the Kansas City (Kansas and Missouri) area. Many struggle to acquire adequate insurance coverage while others, because of their immigration status, have been excluded from any type of healthcare coverage, public or private. Latino immigrants have high poverty rates and experience health inequities that put them at higher risk of poor health outcomes. Although access to quality healthcare is recognized as an essential factor in health and well-being, communities often fail to ensure access to healthcare for all residents.

This comprehensive report details Volume 1 of a two-volume project. This report has four major sections: 1) how Latino immigrants see (perceive) their need for healthcare and the availability of healthcare in the area, 2) barriers Latino immigrants face to access healthcare, 3) bridges in the community that can assist Latino immigrants in overcoming barriers to healthcare access, and 4) recommendations for action. The focus of this report is on Latino immigrants living in Wyandotte County and Johnson County in Kansas, and those in Jackson County, Missouri.

Volume 1, Latino Immigrant Experiences in Accessing Healthcare in the Kansas City Area, describes the experiences of Latino immigrants in seeking healthcare. It includes recommendations for action based on issues and concerns that were identified through surveys, focus groups, and interviews with Latino immigrants and healthcare professionals.

Volume 2, Health Insurance Coverage of Immigrants and Latinos in the Kansas City Metro Area, provides an overview of immigrant and Latino demographics in the Kansas City metropolitan area as well as a profile of trends in healthcare insurance coverage. This second part can be accessed at http://www.migrationpolicy.org/.

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1. The aim of this report

“
We have a duty to get to know one another, and to cultivate a concern and responsibility for all our neighbors in the global village.
”

- Karen Armstrong, author of Twelve Steps to a Compassionate Life

The growth of Latino and immigrant populations in the Kansas City area has increased steadily during the past 20 years. The three counties with the highest Latino and immigrant populations in the Kansas City area: Jackson, Missouri; Johnson, Kansas; and Wyandotte, Kansas, are home to approximately 150,000 Latinos and 115,000 immigrants. Almost half of the area’s immigrants (54,000) are Latinos, most of whom were born in Mexico, with a significant population from Central American countries.

Relatively young, Latinos and immigrants help offset the effects of an aging U.S.-born population and strengthen the local economy. With significant numbers of workers in the service, manufacturing, trade, and construction sectors, Latino immigrants contribute to the labor force, and therefore their health is essential to productivity and economic growth in the area.

This report aims to better describe healthcare access among Latino immigrants, both insured and uninsured, living in the aforementioned counties and communicate their experiences in trying to secure healthcare. The report also offers a voice for Kansas City area healthcare professionals who work with Latino immigrants to share their challenges serving this population.

The authors seek to inform community stakeholders and support environmental and organizational changes to improve healthcare access for traditionally underserved Latino immigrants in the area. Thus, this report has two primary aims:

1) To use research methods to discover and communicate the experiences of Kansas City Latino immigrants in trying to secure needed healthcare.

2) To cultivate a concern and responsibility for Latino immigrants’ experiences through recommended actions.
We encourage community stakeholders, many of who are identified in the Recommendations for Action section, to use this information to act to ensure more equitable conditions for healthcare.

2. Methods and limitations

Methods

The findings described in this report are based on qualitative data collection by health services researchers from the University of Kansas Medical Center. Over the past 8 years, JUNTOS has engaged Latino communities throughout the state of Kansas by providing preventive healthcare outreach programs and linking these communities to research activities in collaboration with an extensive network of community partners. The trust and reputation that JUNTOS has built within the Latino immigrant communities have enabled researchers to engage Latino immigrants, regardless of their immigration status or healthcare insurance coverage, and collect the data for this study.

The main topics assessed in this study include healthcare access and cost, insurance coverage, perceived immigration effects on healthcare use, satisfaction with available healthcare resources, and language barriers. This study used a mixed methods approach—including surveys, focus groups, and interviews—to gather information about Latino immigrant access to healthcare services. The study sought to understand the personal and environmental factors associated with Latino immigrants of different types of immigration status and their experiences securing needed healthcare services.

We conducted surveys, focus groups, and key informant interviews to answer the study questions. Based on a conceptual framework of access to healthcare (see Figure 1), this report describes how Latino immigrants engage in several aspects of healthcare access, including: 1) how Latino immigrants see (perceive) their need for healthcare and the availability of healthcare in the area, 2) how they seek and reach needed healthcare, 3) how they pay for healthcare, and 4) how they engage healthcare services.

The study questions used in focus groups with Latino immigrants and interviews with healthcare professionals were developed based on the conceptual framework shown in Figure 1.[1]
To learn about the demand side of healthcare access, including awareness of services and the ability to obtain them, Latino immigrants completed a survey and participated in focus groups. JUNTOS staff conducted community-based recruitment with the assistance of partnering community and healthcare organizations. Using convenience sampling, JUNTOS staff identified Latino immigrants in the three counties with the most significant number of Latino immigrants within the metropolitan Kansas City service area of REACH Healthcare Foundation: Johnson and Wyandotte in Kansas, and Jackson in Missouri.

To qualify for the study, participants had to be 18 years or older and identify as a Latino immigrant willing to share their experiences using healthcare services. Bilingual, bicultural-trained staff conducted 6 focus groups at community-based locations and a healthcare setting using a discussion guide with 13 questions. Focus group discussions were 60–90 minutes long, scripted in Spanish, and recorded. To protect the confidentiality of participants, we did not collect any identifying information.

In all, 55 focus group participants completed the survey; they were equally drawn from Wyandotte (20) and Johnson (22) counties in Kansas, with a smaller number (13) from Jackson County, Missouri (Figure 2). We refer to them collectively in this report as “Latino immigrant participants.” We also conducted 14 individual or group semistructured interviews with 18 key informants (e.g., doctors, nurses, community health workers [CHWs], healthcare navigators, and administrators at health and social service community-based organizations, clinics, and schools); we refer to them collectively as “healthcare professionals” or “providers” in this report (see Appendix D).

Figure 2. Social demographics of the Latino immigrant participants.
We developed and administered a 55-item survey in Spanish to focus group participants. The survey was organized in seven main sections: 1) healthcare access, 2) healthcare coverage, 3) health status and health behaviors, 4) mental health, 5) social demographics, 6) social support, and 7) discrimination and community concerns. The survey included standard questions used in the Behavioral Risk Factor Surveillance System (BRFSS), Wyandotte Community Health Assessment, the U.S. Census, The Colorado Health Assessment, as well as measures widely used with Latino populations such as acculturation, discrimination, and immigration concerns (see Appendix A).

Using JUNTOS’ network of partners, the research team and the REACH program officer identified key informants from healthcare and social service settings based on their experience working with Latino immigrant populations in Wyandotte, Jackson, and Johnson counties. Through interviews with key healthcare informants, we collected information primarily about the supply side of healthcare services. Using the conceptual framework for healthcare access described earlier, the 18-question interview asked about healthcare service approachability, acceptability, availability, affordability, and appropriateness. Interviews were conducted in English or Spanish based on preference of the interviewee.

We used an integrative approach to analyze the qualitative information gained from the focus groups and key healthcare informant interviews. This approach uses both grounded theory [2] and framework analysis [3] to capture themes. We used qualitative analysis software Atlas.ti to analyze the data. Coding of themes used a 4-step protocol: 1) reviewing the data, 2) initial coding, 3) secondary coding and comparisons for agreement between two independent researchers, and 4) applying the finalized coding structure to the information from focus groups and interviews. From there, we generated the results by developing themes that were interwoven with the information collected in the surveys. Surveys were analyzed using descriptive statistics and statistical testing using SPSS statistical software.

**Limitations**

Like many studies, this project encountered some challenges. Due to the small sample size and convenience sampling method used to recruit participants, this project might not be representative of the entire Latino immigrant community in the Kansas City area. Despite the relatively small sample size, this project reached theoretical saturation, indicating that the data collected were sufficient for analysis. Although this project attempted to recruit participants of all backgrounds to represent a sample of the Latino immigrant community living in the Kansas City area, only 18% of the focus group participants were men; therefore, Latino men’s healthcare engagement needs to be further studied to better understand specific health-related factors that might affect only Latino men. In addition, the proportion of participants of Mexican origin in the study (81%) was higher than the proportion of that population in the three counties (71%). The rest of the participants uniformly represented the countries of Chile, Colombia, El Salvador, Honduras, United States, and Venezuela.

We used three forms of data to cross-validate the results that involved the focus groups with Latino participants, interviews with healthcare professionals, and the survey of Latino immigrants. We also used respondent validation by working with healthcare professionals and community organizations to
share the initial results and develop study implications. Yet we recommend future studies incorporate Latino community members in the various aspects of respondent validation processes. Despite these challenges, this study has successfully explored healthcare barriers and bridges associated with Latino immigrants in Kansas City.
Findings and discussion

In this section, we discuss issues that Latino immigrants raised regarding how they perceive their health and health services available to them. We also discuss some of the financial and systemic barriers that Latino immigrants face in receiving services. Moreover, we report on the concerns shared by healthcare professionals who have to work around the limitations of their patients and who at the same time experience challenges to continue funding their services. Finally, we describe some of the “bridges” that facilitate access to healthcare for Latino immigrants. Below are the emergent themes of these conversations.

Latino Immigrants’ Views on Health and Health Services

1. How Latino immigrants see their health

Four in 10 Latino immigrant participants perceive their health as either fair or poor.

Many of the Latino immigrants in this study, 42%, reported experiencing fair or poor health. By contrast, only 18% of Kansans [4] and 19% of Missourians [5] reported fair or poor health. Only 18% of the Latino immigrant participants reported very good or excellent health, compared with over 50% of all Kansans reporting very good or excellent health. [4]

The social position of Latino immigrants in the United States, as well as vital social determinants such as income and education, can affect their health. [6] In this study, we found that among those who had completed 4 years of college education, none rated their health as fair or poor, whereas 64% of those who had completed 1–8 years of elementary education rated their health as poor or fair; and 62% of those who reported fair or poor health did not speak English at all (see Figure 3).

2. How Latino immigrants perceive healthcare in their community

Only one third of Latino immigrant participants think quality healthcare is accessible and affordable in their community.

Researchers asked the Latino immigrant participants to rate their community healthcare concerns (see Appendix B). For the issue “quality healthcare is accessible and affordable for all,” 94% reported that it was very or somewhat important. Only 33% indicated that they were very or somewhat satisfied that their healthcare was accessible and affordable.

These same concerns were echoed in the focus group sessions: Many Latino immigrant participants reported that they were not receiving the best quality of healthcare and that their concerns were not being heard.
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Figure 3. Quality of health in relation to (top) level of education and (bottom) English proficiency. Notes: *Question is part of the health-related quality of life (HRQOL) assessment. It is used by CDC’s surveillance system to measure an individual’s or a group’s perceived physical and mental health over time. [4] ** “How well do you speak English?” is used by the U.S. Census Bureau to assess the English-speaking ability of the foreign-born population who speaks a language other than English at home. [7]
Maria, a Latina immigrant from Mexico was not aware of prenatal care services available in her community and arrived at an emergency room (E.R.) with bloody vaginal discharge. She recalls it was a busy day at the E.R. and she had to wait longer because she did not have any health records on file.

If they’d had my [medical] history, if I’d had a doctor, I wouldn’t have had to wait those three hours when my baby miscarried. . . . Those are things that do hurt.

Seven in 10 Latino immigrant participants with a place to go when sick go to a community health center.

Access to comprehensive, quality healthcare is needed to maintain the health of individuals and to prevent and manage diseases. People with a regular source of healthcare achieve better health outcomes and have lower healthcare costs. [8] In our sample, 70% of Latino immigrants reported that they have a place to go when they are sick or need medical advice. This is a higher rate than that of Hispanic adults in Kansas (56%) and Missouri (35%). [9] This high rate might be associated with the fact that we recruited participants through safety-net clinics and engaged participants from counties with relatively robust safety-net networks (compared with the counties considered in the Consumer Health Access in Kansas and Missouri 2017 report).

The majority of Latino immigrant participants with a place to go when sick (68%) go to a community health center that offers discounted fees. They do so because of the affordability of services, Spanish language capacity, and ability to connect with other services they need such as access to discounted medicines.

Figure 4. Latino immigrant participants’ regular place of care. Question adapted from the Colorado Health Access Survey 2017, Colorado Health Institute. [10]

Almost half of Latino immigrant participants without a place of care (43%) reported they would go to an E.R. if they got sick or needed medical attention. In focus group discussions, we learned some participants would also go to the E.R. due to lack of knowledge of existing resources. Others, however, considered going to the E.R. only when they were not able to get an appointment but felt healthcare was needed.
For instance, Rubi struggled to get her daughter seen during an episode of fever and vomiting. “The child has a fever and vomiting. I go, and there aren’t any appointments, and ‘we are going to call you later,’ then they didn’t call me. I returned to the clinic, and they don’t have any space. I just stopped by so someone would tell me if, with my child like this, I go to the emergency department, or what do I do? I went to another clinic to find [healthcare] as well, and there wasn’t any there.”

Several participants reported repeated use of the E.R. because of poorly managed chronic diseases. One of the participants had chronic kidney disease and an ongoing need for dialysis. Patients with chronic diseases who let their symptoms worsen until they must be seen in an E.R. put their lives at unnecessary risk. Emergency care is far less cost-effective for the healthcare system than managing the disease with standard healthcare. Unfortunately, for patients without access to standard healthcare, the E.R. is the only healthcare option they have.

A comprehensive healthcare center is ideal but not available to everyone.

Participants shared that they would like to have access to the services they need—including dental, lab work, ophthalmology, and other specialty services—all in one place. But comprehensive healthcare, a kind of one-stop-shop in one location, is rare. Latino immigrant participants talked about the hurdles they need to jump to access healthcare services in different locations.

Some Latino participants who are parents mentioned they use hospitals with pediatric services for their insured children because hospitals have a more extensive array of needed specialty healthcare available. By contrast, uninsured parents typically get their healthcare at community clinics that are more affordable due to sliding scale fee systems. One of the mothers who participated in a focus group shared how mixed-status families led to a divide in their healthcare.

Yes, to the children, yes. As adults, we are going to a [community] clinic. One, because we do not have medical insurance and therefore, we are not going to a private hospital or a private clinic, so we go to the [community health] center.

Splitting the healthcare of families based on healthcare coverage status can have a negative impact on the financial ability of clinics to sustain uninsured patients.

Two crucial services that are difficult to reach are dental and mental health.

Dental and mental health services at community clinics are more common now than a few years ago. Yet Latino immigrants are still struggling to access these services. Cost and schedule availability seem to be the main barriers.

Ester, a Latina immigrant, shared this while receiving services at an FQHC, “But dental is more different. Just for the medical consultation, it’s $35, and then the dentist is more. It’s a different price, and depending on the insurance, it comes out to be $150 plus the consultation.”

Several staff echoed Ester’s view. A healthcare navigator said that even though patients may be able to go to a setting that offers physical, mental, and dental care, they might receive only the physical component because the other two have higher costs or a long wait list. Moreover, a clinic
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The administrator shared that there are a limited number of dental providers who accept Medicaid in Johnson County, Kansas, so patients oftentimes need to go to the Kansas City area, including Kansas City, Missouri.

The healthcare navigator commented that there is a similar situation for mental health and pediatric services. Although there are a large number of healthcare professionals across the spectrum of specialties and primary care in Johnson County, “Only a few [healthcare providers take patients with Medicaid, and even a smaller number sees individuals who self-pay."

Mental health is important to Latino immigrants.

a. Many are not satisfied with access to mental health treatment in their communities

A whopping 98% of the Latino immigrant participants reported that it was very or somewhat important that people with mental health needs can access and receive treatment. However, 49% indicated that they were not satisfied with how people with mental health needs can access and receive treatment (see Appendix B).

Latino immigrants reported experiencing more days when their mental health was “not good” each month than others in Kansas and Missouri. Latino immigrant participants reported an average of 6 days of poor mental health, and **22% of participants reported that their mental health was not good 14 or more days during the past 30 days.** By contrast, 11% of Kansans [4] and 12% of Missourians [11] reported that their mental health was not good for 14 or more days in the last 30 days. The majority of Latino immigrant participants, however, did not see or talk about their mental health issues to a primary care provider (66%) or a mental health professional (82%).

Some of the participants who did talk to a provider perceived that their concerns regarding their mental health and well-being were underestimated. For instance, Marisa shared her experience.

> I was telling [the healthcare provider], 'I don't sleep. I can't sleep. I am dead tired and can't sleep. I never get deep sleep. This has given [me] a lot of anxiety and has caused me to eat.' And, the [healthcare provider] told me, 'Munch on carrots.' So, this was like a slap [on the face], like he couldn't begin to understand what I was saying. I am telling him that it's my level of depression, anxiety. . . . He lost all of this.

b. Despite acknowledging the importance of mental health, stigma prevents the use of mental health services

Perceived stigma related to seeking mental health services was common among Latino immigrants. Participants reported shame about seeking mental help. Latino immigrants’ unauthorized status makes them increasingly vulnerable. As focus group discussions showed, participants feared that a mental health diagnosis would lead to them being labeled “crazy” or could result in their children being taken away. Given the existing sociopolitical context, with a growing rate of forced family separation among Latinos due to deportations, these fears are widespread within Latino communities.
For instance, Fernando, a focus group participant shared, “I had a young man who was violent towards his wife, he had problems, and I would tell him, ‘Look for help.’ ‘I am not crazy,’ he would say.”

A Latina immigrant spoke about her fears of talking about her postpartum depression. “[If] I say that I feel like that, like I don’t want my baby. Well, how am I going to tell my doctor that? She will want to take her [the baby] away.”

3. Latino immigrants and their primary care provider

Over one third of Latino immigrant participants did not have a personal doctor.

Lacking access to a regular doctor creates difficulties in building trust between patients and healthcare providers, which can complicate situations when a patient attempts to follow after-care instructions.

In Kansas, 38% of adult Hispanics reported not having a personal doctor or healthcare provider. [4] Similarly, 39% of Latino immigrant participants in this study did not have a personal doctor or healthcare provider. There is a marked disparity when compared with the overall population in Kansas and Missouri, where 23% of Kansans and 24% of Missourians do not have a personal doctor or healthcare provider. [4, 12]

Of the Latino immigrant participants who did not have a personal doctor, 71% had limited English proficiency (reported speaking English “not well” or “not at all”) and 40% had inadequate or marginal health literacy.

Figure 5. Personal doctor. Note: Question adapted from the CDC’s Behavioral Risk Factor Surveillance System (BRFSS) questionnaire. [4]
Having to see multiple primary care providers affects Latino immigrants’ trust.

Having a primary care provider (PCP) as a regular source of healthcare is crucial for the development of a sustained, meaningful relationship between patients and their PCP. [8] In addition, having a regular PCP is associated with lower mortality, increased likelihood of patients receiving appropriate care, greater patient trust, and improved patient–provider communication. [8]

We found that 24% of Latino immigrant participants had more than one personal doctor or healthcare provider. This rate is higher than that of the overall population in Kansas (5%) and Missouri (7%) who have more than one personal doctor. [12]

In a focus group, several participants exchanged their views about having multiple providers. They agreed that it generates mistrust.

“If you go with different [providers]...”

“...there is distrust.”

“And then, I also think that another thing is that one doctor, for example, prescribes one thing, and then you go with the other doctor for the same thing, and he prescribes something else.”

Having consistency with the same healthcare provider improved patient experience for many study participants, and they associated it with higher healthcare quality. Participants appreciated having a doctor who was familiar with their care and with whom they already had established rapport.

Latino immigrants and their views about medical students.

Another focus group participant, Viviana, expressed that she felt it was important to support the learning of students and that students should be given the opportunity to practice in clinics where the need is greatest. She also wondered where the medical students she had seen are now, and she hoped they would serve their communities.

“I see there are many [medical] students. They should be given the opportunity [to practice] because I think that the student in the future will be a doctor, but those who were students and are now doctors, where are they? They are needed.”

Some participants, however, reported disappointment when they were expecting to see their doctor and instead were assigned to see a medical student without previous notification, or without a clear understanding of what was happening. Rubi shared she was surprised when she saw a large number of people getting in the delivery room as she was about to deliver. “At least for me, [they told me about the students] that moment when all the people [students and providers] arrived. Supposedly they need to get authorization from you.”
4. Unheard concerns

Latino immigrant participants feel their health concerns are often not heard.

Latino immigrants in all the focus groups reported that their health concerns were often not addressed during their medical visits—regardless of where they accessed healthcare.

Mayra from El Salvador shared, “I feel very sick, and I go to the doctor, and I never come out with anything [diagnosis]. And [I feel] sick, sick, and [yet] ‘I am always fine.'”

Some Latino immigrant participants shared that when they feel sick, healthcare professionals recommend they go home without a diagnosis or medicine and come back if their symptoms do not improve. Others reported that they are asked to schedule multiple appointments because the medical visit can focus on only one presenting problem, even if patients are experiencing several at the same time. Some participants in the focus group wondered if these tactics were a way for healthcare practices to increase their profits, given that each medical visit has an associated cost to the patient.

Several participants shared that underestimation of their symptoms had resulted in severe complications. Lina, an immigrant with healthcare coverage, reported how a provider at an E.R. dismissed her after a brief consult. She was brought back and admitted to the hospital a few hours later in a worsened state.
1. Latino immigrants’ experiences paying for healthcare

**Lucero’s story about affordability of healthcare:**

Lucero is an expectant mom, originally from Mexico, who has a management role at her workplace. She is proactive about educating herself regarding health-related topics and programs. Lucero had Medicaid during her first pregnancy, and her care went smoothly. In her current pregnancy, she is covered by an employer-sponsored plan through her job; however, she is struggling to access the services she needs to ensure her health and that of her baby.

She said the plan is helpful to pay for general check-ups, but it does not cover the specialty care she needs. Finding providers who take her insurance, paying out-of-network services, and covering a co-pay for each consult has made her healthcare difficult to navigate and afford. At her last appointment, she presented symptoms of anxiety along with other irregularities and abdominal pain. Her doctor referred her to the E.R., but Lucero was concerned about the cost. “So there are times that you need [medical] things and you cannot have them because of the money or the [lack of] medical coverage.”

**Several factors affect Latino immigrants’ lack of healthcare coverage.**

a. Seven in 10 Latino immigrant participants were uninsured

In this study, 78% of Latino immigrants reported not having healthcare coverage. Of these, 69% said they had never had any type of healthcare coverage and 17% said they had been without healthcare coverage for more than 3 years.

Focus group discussions reflected this reality. Silvia, a Latina immigrant from Mexico, shared how lack of health insurance has affected her ability to take care of her health. “It has been over 5 years, I think, that I don’t go to the doctor because I don’t have health insurance.”
Uninsured adults are more likely to receive poorer quality of healthcare, acquire a severe illness, lack preventive care, and experience worse health outcomes compared with insured adults. [13, 14] Latinos have the highest uninsured levels of any racial or ethnic group in the United States [15]. In 2014, 26% of Latinos in Kansas were uninsured; of those uninsured Latinos, 49% were foreign-born. [16] Similar patterns were seen for Latinos in Missouri. [17]

![Figure 6. Lack of healthcare coverage. Question adapted from the CDC's BRFSS questionnaire. [18]](image)

b. Cost is one of the main reasons for the lack of healthcare coverage among Latino immigrant participants

In our study, Latino immigrants reported different barriers to accessing health insurance. Many (58%) reported cost as one of the reasons that they did not have health insurance. During focus groups, several participants shared that health insurance was very expensive.

For example, Camilo, an immigrant from Mexico, told us that his wife lacks health insurance because he cannot afford to add her to his employment-sponsored policy. He recognized a gender disparity given that the cost of his monthly premium would have a 5-fold increase if he added his wife or daughter, but not if he added his son. In Camilo’s words,

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*I pay $97 a month; if I include my wife, it’s $500, for the fact of being my wife.*

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c. Lack of a Social Security number prevents unauthorized Latino immigrants from getting private coverage

Unauthorized immigrants are eligible for an Individual Taxpayer Identification Number (ITIN) to pay taxes, but they are not able to get a Social Security number (SSN), which is a requirement to get health insurance. CHWs who participated in this study explained that at least one health insurance vendor in the Kansas City metropolitan area used to accept the ITIN in place of an SSN for patients to enroll in coverage. They added, however, that the vendor had restructured its eligibility policy and no longer accepts the ITIN—leaving many patients without coverage.

d. One in three Latino immigrant participants without health insurance did not know how to obtain healthcare coverage

During focus group discussions, many participants expressed a lack of clarity regarding the types of health insurance available to them and where to get that information. In the survey, 34% of Latino immigrant participants who did not have health insurance reported not knowing how to get it. Furthermore, 18% of Latino immigrant participants reported that in the past 2 years they tried to buy health insurance directly, not through an employer. Of those, 60% received assistance from a healthcare navigator. The majority (67%) who received help from a healthcare navigator were able to get health insurance. Yet, in 2017, only 36% of uninsured adults in Kansas and 12% of uninsured adults in Missouri reported receiving assistance from a healthcare navigator within the past 2 years. [9]

e. Employment-sponsored coverage is often unavailable or unaffordable

Of the participants without health insurance, 20% reported that one of the reasons for the lack of coverage was because of restrictions of a family member’s employer coverage. Reasons for this included either the employer did not offer coverage or they were not eligible for their employer's coverage.

In 2017 in the United States, 71% of uninsured workers who were not old enough to be eligible for Medicare (i.e., <65 years old) had an employer that did not offer health benefits to employees. Between 2008 and 2018, the total cost of premiums for family coverage increased by 55%, far surpassing wage growth rates. Cost is the main reason why 90% of uninsured workers decline an offer for employer-based coverage. [13]

Although more than one half (55%) of Latino immigrant participants in this study reported being currently employed, only 17% of them had health insurance through a current or former employer or union.

During focus groups, participants who had access to health insurance through their job reported that the high cost made it difficult to maintain. For instance, José shared that he had to pay almost $400 per week for health insurance, and that he had had to terminate his coverage because that
amount was unaffordable for him.

A clinic administrator thought that many Latino immigrants work for businesses that contract with smaller health insurance vendors and the price of their higher premiums made it harder for Latino immigrant families to enroll. The administrator noted, “I think for a lot for families in the Latino community, having to make . . . that choice from a budgeting perspective of having to pay a premium on a plan is very difficult. Especially with a lot of our families potentially working in places where it’s a smaller [insurance] group, it’s not a large corporation to where the plans are going to be affordable.”

It can be a struggle to find affordable options that provide needed care.

Javier’s story:

Javier is an immigrant from Mexico who volunteers and teaches evening classes at his parish. His classes fill up quickly because he explains things so well. During the day, he works in construction to be able to provide for his children so they can pursue a college education. He reports that his health is very poor. “I live with pain,” he says. He has suffered from chronic back pain for the last few years, which has affected his life. He has never been to the doctor since he moved to the U.S. over 15 years ago. “I just don’t know where to go. I do not have health insurance.”

Financial barriers prevent Latino immigrants from accessing different types of healthcare services.

a. Usual care

For the Latino immigrant participants in this study, cost was the main reason for not having a usual place of care. Of the 30% of participants without a usual place of healthcare, 44% reported it was due to their inability to afford the cost. Over one quarter (26%) of Latino immigrant participants did not get care from a doctor when they needed it due to cost. This rate was higher than the 15% of adults in Kansas and Missouri who needed healthcare but could not get it due to cost or lack of coverage. [9]

The expense of healthcare often pushed Latinos to delay care or to discontinue it altogether. For instance, Marisol, an immigrant from Mexico, delayed going to the dentist, even when experiencing a severe toothache, because of the high cost. Given the increasing pain, Marisol eventually went to a dentist. The delay harmed her health and resulted in expensive bills in the end.

b. Prescription medicines

Financial costs also affected the ability of Latino immigrants to follow up with healthcare recommendations. In particular, access to affordable medicines was a barrier. In this study, 32% of participants reported not filling a prescription for medicine due to cost in the past 12 months. In the focus groups, Latino immigrants, shared some of the challenges of paying for medicines.
Fernanda shared that now she must pay more for her monthly medicine to treat hypertension after losing a medical discount at her community clinic. Unable to pay for the medicine, Fernanda discontinued her treatment. “So before, yes, I was taking my medication because I am hypertensive, I have high blood pressure. But now, I haven’t been taking my high blood pressure medicine, and I am feeling awful . . . they used to charge me $35, and right now they are charging me $50 for each time I come. The medicine, my medicine that I used to take for my blood pressure, they would give it to me for $15; right now, it costs me $90. And no, and I have not been taking it because I do not have any [money] to buy it with.”

c. Specialty care

For this category, 28% of the Latino immigrant participants reported not getting the specialist care they needed due to cost. In the survey and focus group discussions, participants reported needing to see specialists in dental, eye, asthma, and allergy care. In addition, they mentioned the need for hemodialysis, cancer treatment, surgeries and screening procedures such as colonoscopies.

Access to specialty services was particularly challenging for patients who lacked legal status, given that unauthorized immigrants are less likely to have health insurance and do not qualify for federally funded programs.

Silvia, a Latina immigrant, talked about her friends being denied cancer treatment. “I’ve had two friends who have gone through cancer and have died because they did not have [health] insurance and because they did not have those [healthcare] services. Since she [one friend] did not have Social Security or health insurance, they denied care for her everywhere. When she was able to receive care, it was too late, and her cancer had already metastasized, and she died. And, too, the same for the other [friend]. They took too long to respond. We couldn’t do much. You feel powerless when they tell you that a loved one of yours has that and, as much as you want, there is no way to help them because they are very expensive diseases.”

Debbie, a clinic administrator with vast experience working with the unauthorized immigrant population, discussed the need for cancer treatment in the Kansas City area. “Undocumented women who have breast cancer do not have [access to] chemotherapy and radiation. There is nowhere here in the metro area that they can get that done.”

Similarly, Kristine, a healthcare professional who has worked with Latino immigrants for 11 years, shared,

_If they [uninsured Latino immigrants] needed to go for a neurology appointment or a dermatology appointment, if they don’t have the cash, then they probably won’t be seen._

Although several types of specialty healthcare are available through a foundation’s charitable programs for low-income, uninsured patients regardless of their immigration status, patients might have to wait weeks or months to be seen depending on the type of care they need.
d. Medical bills

In this study, 44% of participants reported that they were having problems paying or were unable to pay any of their medical bills in the past 12 months. By comparison, 28% of adults in Kansas and 34% in Missouri reported problems paying medical bills in the past 12 months. [9]

Micaela, an immigrant from Colombia, has health insurance, but it does not cover all the testing she needs for her chronic condition. So she makes scheduled payments at her healthcare setting. “Then, there was a time when I could not pay it all [at] once, and I told them, ‘I cannot pay for all of that, if you want I pay you little by a little bit, but I'll pay it back.’”

Healthcare professionals are aware of Latino immigrants’ financial barriers.

a. Community clinics make care more affordable

Healthcare professionals we interviewed were aware of cost as a barrier to healthcare—not only for initial appointments, but also for follow-up care recommendations or additional procedures. In order to alleviate financial barriers, community clinics provide a sliding scale fee, depending on a patient’s income.

Access to care at health systems presents different challenges. Even when financial assistance is available, Latino immigrants are not always able to meet the requirements for financial aid programs because they lack documentation. Financial assistance for services provided to adult patients at hospitals generally requires proof of an SSN.

As Jordan, a doctor who works in a hospital shared, “If you're looking for primary care . . . this place if you are uninsured you have to pay $140 or something like that over the counter to get in the door. The safety-net clinics mostly charge a sliding scale fee, which is cheaper for people who don’t have insurance. So, the places that have a sliding scale fee, I think more people come to them if they're uninsured. And of course, if you have insurance, it doesn't matter. But if you are uninsured, you wouldn't want to come here. It would be too expensive.”
One healthcare professional reported that uninsured Latino immigrants might be steered away from hospitals to local safety-net clinics. “They [hospitals] give them [patients] a list of safety nets or clinics they can go to, and they kind of circle the safety net and they'll circle [name of clinic] . . . and that's because they [hospitals] know they [patients] might not have health insurance, they might not have a Social [Security number].”

b. Some private practices target Latinos to charge patients at higher costs

We interviewed one healthcare professional who said that the lack of providers taking self-pay patients, combined with a lack of awareness about community clinics, sets the stage for private practices offering Spanish-based services for self-pay to charge patients at higher costs. According to this health professional, several private practices in the area (including one in Kansas City, Kansas, and another in Olathe, Kansas) run TV ads on Latino channels. These private practices, although aware of low-cost community clinics, do not let their patients know about the community clinics unless patients are unable to cover the cost of their services or need additional specialty care or laboratory services.

The healthcare professional at the community clinic noted, “They know we are here, but at the same time, if [their patients] reach a certain point and they feel like they cannot pay or need other types of care, because of the costs, then they kind of dump them on us.”

c. Medical professionals rejected negative stereotypes of Latino immigrants as freeloaders who want to use the welfare state

One healthcare professional said, “There’s this [false] perception that they want everything free, that there's a sense of entitlement, and that's not true at all.”

During the focus groups, participants echoed their willingness to pay for health insurance. Participants expressed their willingness to enroll in some type of clinic- or hospital-based health insurance or program where they could make regular payments to receive healthcare for their family when they needed it.

As Juana, an immigrant from Mexico shared, if health insurance were more affordable, she would rather purchase insurance than rely on other means to access healthcare.

“If they gave us that [opportunity] to have an [health] insurance, we would also make the effort to pay for the [health] insurance for the well-being of our health.”

Not having access to health insurance deters Latino immigrants from receiving the healthcare they need. Uninsured adults are more likely to experience economic hardship due to medical bills, including spending savings, struggling to cover necessities, borrowing money, or incurring debts sent to collections. [19]
d. Healthcare professionals express concern about their own funding

Some healthcare professionals shared that it is challenging to keep a mix of payers that allows them to serve the uninsured without going bankrupt. A clinic administrator explained that maintaining diverse funding is crucial for the operations of the clinic to serve the underserved. She also highlighted the importance of serving family units, where potentially the insured children will offset the cost of healthcare of their self-pay parents.

The clinic administrator said, “You basically have to have like a 60% insured rate to about 40% noninsured payer mix. So, a 60–40, that would be ideal for community health centers to be able to maintain. We have grants; we have additional funding both from the federal level, the state level, and local agencies, and it helps to offset that 40%. So, when we lose an entire family unit like that with the insured part, and then we keep the self-payer parents, it’s not sustainable long term for us.”

Below we discuss the impact of healthcare policies on Latino immigrant health.

a. The Affordable Care Act helps many but excludes others

Immigrants who are lawfully present and under 400% FPL qualify for federal health insurance Marketplace tax credits through the Affordable Care Act (ACA). However, they have to wait 5 years after receiving qualified immigration status to apply for Medicaid. [13] Although the ACA has increased health insurance levels among Latinos around the country [20] and in our region [21], the ACA systematically excluded unauthorized immigrants from getting healthcare coverage. [22–23]

Yet many unauthorized immigrants are not foreigners in our Kansas City metropolitan area communities. They have contributed to the labor force for years, largely employed in service sector occupations. After being a part of our community in so many ways, it is unjust to prevent them from getting the healthcare they need when they are sick.

We interviewed one healthcare professional who shared that there is a threat to funding for uncompensated services to care for the uninsured regardless of their immigration status, that would have been a given before implementation of the ACA. He explained that the idea behind the ACA was that the population without insurance would shrink down as they got coverage through the Marketplace, but unauthorized individuals were not factored into the equation.

As he explained it,

And so your documented population or citizen population without insurance is shrinking. So, our money we get to take care of uninsured patients is shrinking a lot to the point where the idea was not to have it anymore, but you still have all these immigrant patients who have no insurance, and they never got to get insurance. So, there is always a worry that this could actually harm our ability to take care of unauthorized, uninsured individuals as we improve everybody else’s life. Because everything’s been upside down with the ACA.

A health navigator talked about the challenges he faces explaining to Deferred Action for Childhood Arrivals (DACA) holders that even though they have an SSN, they do not qualify for the Marketplace. “[For] DACA students, they have determined they’re able to work, they’re able to study, but that’s
it—they’re not able to apply for anything else.”

He added that expanding KanCare (Kansas’ statewide mandatory Medicaid managed care program) would offer an opportunity to get coverage to the Latino immigrant families who are in the gap of eligibility. A representative from a community-based organization agreed that KanCare expansion would help lawfully present families but would do nothing for uninsured, unauthorized immigrants.

b. The impact of the ACA on low-income families who enrolled in health insurance plans they cannot afford

In general, health professionals in this study reported that the ACA benefited immigrant families who qualified for subsidies, but felt that the ACA economically hurt very low-income families who had to enroll in expensive plans.

For example, when talking about how the ACA is playing out for Latino immigrant families who did qualify for it, a healthcare administrator at a federally qualified health center (FQHC) shared that meeting high deductibles still makes it difficult for Latinos to benefit from their health insurance.

I think overall the deductible is really high for some families, making it hard. Even if they do have the health insurance, meeting that deductible can be tricky, so then they’re kind of in the same place.

Latino immigrant participants also shared some of the challenges they have faced using the health insurance they got through the ACA. Raquel, who has osteoporosis, said that every year when she enrolls in the Marketplace, the plans have changed, and she needs to look for a new one. She also expressed frustration with her high deductible, which means she can’t get all her testing done despite paying her premium. “So why pay for insurance all year long if I do not manage to get all the exams I need anyway.”

Another Latina immigrant participant, Lina, is a self-employed business owner who shared her disappointment at having few vendor options to choose from within the Marketplace. She explained that in her experience, all options are low quality and provide minimal provider networks, specialty services, and healthcare settings, while having very high deductibles. In her words: “It’s crap. It does not cover anything. I cannot go to the doctor I want; if I have something bad, well it’s too bad because I have to go where they [the health insurance vendors] say.”
c. Medicare gaps

One of the clinic administrators we interviewed shared that her clinic receives funding to care for medically indigent populations, which includes uninsured people living below 200% of the federal poverty level (FPL). She explained that when medically indigent patients turn 65 and get Medicare, they no longer qualify as medically indigent, so they cannot continue to receive healthcare at her setting. She said the problem is that even with Medicare coverage, many of these patients cannot afford to go to the doctor because they can’t pay the Medicare Supplemental Insurance plan or pay for prescribed medicines, resulting in them neglecting their care. She said that if the state changed the definition of medically underserved to include those who are on Medicare but still below 200% FPL, the 65-and-older population could still get healthcare services through her clinic.

2. Practical barriers to access healthcare

Rubi’s story:

Rubi is a Latina immigrant who has used healthcare services for herself and her children. The main thing that she wished she could change about the healthcare system would be appointment availability and flexibility. She used to suffer from severe migraines; when she was seen at a clinic, the provider told her to come back when the migraine returned. However, when the migraines returned, she was never able to see her provider due to the lack of available appointments. She was only able to schedule an appointment weeks later, and Rubi eventually paid a private physician $300 to be seen.

Wait time to schedule a healthcare appointment is a main barrier to healthcare access.

After cost, wait time to schedule an appointment was the main barrier Latino immigrant participants reported that impeded their access to healthcare services. In our survey, 26% of participants reported they experienced delayed medical care in the last 12 months due to the failure to get an appointment at the doctor’s office or clinic when it was needed. During focus groups, several Latino immigrant participants mentioned that when they needed medical care due to severe health symptoms, they tried to schedule an appointment. Yet often, the earliest availability was weeks later, after their symptoms improved or had worsened enough that they had to seek urgent or emergency healthcare.

Helena, an immigrant from Mexico and the mother of two children, told us that healthcare staff have suggested that she go to the E.R. when they do not have appointments available. “The problem is that like [someone] was saying, when one needs it [the appointment], they say, ‘No. Come back in 2, 3 weeks.’ But I have an infection and a headache too, what should I do? ‘Go to the E.R.’"
Besides cost, have you delayed healthcare in the last 12 months due to...

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<td>Not accepting patients with your type of health insurance</td>
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<td>Not accepting new patients</td>
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<td>Inability to get an appointment as soon as needed</td>
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<td>Inability to take off from work</td>
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<td>Language</td>
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<td>Inability to find child care</td>
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<td>Don’t know</td>
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<td>Other</td>
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Figure 7. Delayed healthcare. Question adapted from the CDC's BRFSS questionnaire. [18]

Wait time at the doctor’s office is another barrier to healthcare access.

Latino immigrant participants mentioned the long wait times for routine visits. Antonio shared, “I have not returned there [the healthcare setting] because it’s very slow. The last time I went, I was [waiting] for about 4 hours.”

In other instances, Latino immigrants reported being turned away from healthcare if they were late for an appointment. One shared, “What frustrates me is, for example, if you have the appointment at 9 in the morning and you arrive at 9, they take you inside at 9:30. Then they leave you in the room, another hour waiting. And if you come even 5 or 10 minutes late it’s, ‘Oh no, it’s canceled,’ and I’m like, ‘So what about the time you’re left in the room waiting?’”

Taking time off work is problematic for many Latino immigrants.

Healthcare professionals were aware of immigrants’ challenges in taking time off from work to access medical care. Time is a barrier of particular importance for immigrants, who often have limited availability to go to an appointment. Contributing factors to this issue include powerlessness to request time off from work, as well as limited access to childcare and reliable transportation.

A CHW best described this situation. “It’s like most of the families that we see, they have kids, they work. You know they have their schedule, their routine. So, it’s really hard for them to say, ‘OK if I have to go to the doctor, I have to ask off for my work. If I ask off for my work, I might not get paid. How am I going to feed the kids? Or who am I going to leave the kids with?’ Most of them don’t have transportation. So, for them to go to the bus stop, they have to walk, and then from the bus to an appointment, maybe it is going to take them an hour to get there. Then they’re seen another hour, maybe an hour and a half, and especially if they need interpretation. So it’s like the whole day just to go to an appointment.”
Some healthcare professionals try to accommodate the schedules of working Latino immigrants by extending clinic hours into the evening. Time also becomes an issue, though, for providers who rely on interpreters. As healthcare professionals explained, reliance on interpreters takes additional time, making appointments longer than they are for patients who do not need interpreters.

**Limited transportation affects Latino immigrants’ ability to get to healthcare appointments.**

In Kansas, 8% of adults did not have a usual place for healthcare due to difficulties accessing transportation. In Missouri, this is true for 10% of adults. [9] Similarly, 8% of Latino immigrant participants in this study reported transportation as a reason they have delayed their medical services in the past 12 months.

Juana, a self-employed Latina immigrant with a chronic condition that requires frequent visits to the doctor, shared her need for transportation to and from medical settings. “I do not drive, so it would be great if there were a bus with a route that would take you to the hospital.”

**Negative first contact interactions with healthcare services and its affect on Latino immigrants.**

When discussing first-contact interactions in medical settings, Latino immigrants reported hopes that staff members could be friendlier and more patient. Echoing the voices of Latino immigrants, CHWs revealed that Latino immigrant patients are not always treated in a kind or friendly manner.

For instance, CHWs shared that often Latino immigrants are ignored in waiting rooms. One explained, “People that are out front should be more aware and see ‘oh that person has been sitting for a long time, let me go check on them . . . do you need an interpreter?’ You know, just to be more aware of the situation. Because I went to a clinic where there is a sign saying, ‘If you have been sitting here for more than 15 minutes, come to the front desk’—but it was only in English. If I don’t speak English, I’m not going to understand. I think they should be trained more.”

**Other factors related to underutilization of healthcare services by Latino immigrants.**

a. Some healthcare professionals are concerned that Latinos might have lower use of preventive services

Some healthcare professionals reported that they are linking Latino immigrant patients to preventive care only after they seek curative care. A healthcare administrator shared,

> I think we try to loop them [Latino immigrant patients] into prevent [disease] once they cross the barrier, the threshold into the clinic.

Some Latino immigrant participants cited a lack of information about preventive care services as well as limited access. Others reported that preventive care is not something they are used to in their country of origin. One CHW pointed out that Latino immigrants prioritize their job over their own health because they need to provide for their families. He said, “They [Latino immigrants] did not come to the U.S. to see the doctor; they came here to work.”
b. Engagement of male Latino immigrants in healthcare might be falling under the radar

A healthcare provider with over 20 years of experience expressed concern that the young-adult Latino male population is underutilizing healthcare services, especially preventive care. Her experience is that men see the need for healthcare only when they sustain work-related injuries. Lower availability of male-specific services at her clinic is another barrier.

*I can screen ladies for diabetes, but the only male exams other than STDs [sexually transmitted diseases] at this moment that I can do is a physical exam... I think the male Latino population is falling under the radar as far as routine preventative care.*

**Lengthy and complex requirements for documentation and its impact on healthcare utilization.**

Participants reported that filling out complex forms to enroll in healthcare services or apply for discounted fees can be a daunting process that scares potential patients away. This is particularly hard for unauthorized individuals who might lack proof of income, even though they are employed. When Latino immigrants are paid in cash at their workplace or work under a different name (to avoid being identified and potentially deported), it makes it hard to prove their financial status. Sometimes there are alternative mechanisms to verify income, such as getting a letter from an employer. Overall, however, this process is particularly challenging for Latino immigrants, especially when disclosing this type of information can leave them at risk of deportation.

Request for an SSN is another concern, especially among participants who lack legal status. A Latino immigrant participant in a focus group shared that it becomes anxiety-provoking when so many questions are asked. “Many people don’t feel confident about going to a place to get help, to look for a social worker. Many people don’t try because the first thing they are going to ask you is ‘And your Social Security number?’ and ‘Do you have Medicaid?’ So, that is when you start getting a stomachache.”

**3. Fear of current anti-immigration environment**

**Fernando’s story:**

Fernando, an immigrant from Mexico, has been living in the Kansas City area for over 15 years and is a small business owner. He said the anti-immigrant climate and related policies have added stress at work. His Latino immigrant employees are concerned about seeking any type of federal assistance or services for their families because they fear being denied permanent residency or naturalization if they do so. As a result, the children of his employees are not getting the healthcare services they need to be healthy.
The current anti-immigration environment affects the willingness of Latino immigrants to seek care.

In recent years, the anti-immigrant discourse in the United States has become increasingly harsh. In this study, 87% of participants reported that life is more difficult for Latinos in the United States due to changes in recent immigration policy and the failure of Congress to enact an immigration reform bill.

Latino immigrant participants reported ongoing fear related to using healthcare and social services because of immigration-related concerns. In this study, 64% were concerned that using public healthcare services could impact their or their families’ immigration status and 60% reported concerns that healthcare professionals might share their or their families’ personal information with immigration officials.

Edgar, an immigrant of Mexican origin, shared his frustration and fears about using healthcare services.

_“Will I lose my rights to apply for residency or citizenship? And under the threat that they can take away my [permanent] residency if I already have it, [or] even [my] citizenship, there’s a lot of uncertainty. And that includes the healthcare system too, because do I use it? Or do I not use it?”_  

In interviews, healthcare professionals also reported that Latino immigrants are experiencing fear. Some healthcare professionals shared stories of individual patients who turned down programs such as Medicaid, WIC, and Early Detection Works specifically for this reason. Fear and similar factors likely lead to reduced use of needed healthcare services among Latino immigrants.

One healthcare professional at an FQHC reported how fear had an impact on the children and families seen at the clinic. “We also have certain children and youth that are eligible and have the right to these [healthcare] services, and because of the fear, they aren’t being enrolled in those programs. And so, that makes it difficult when we are trying to find sustainability and funding for the providers to give the quality services that are needed. . . . We could be getting reimbursed by Medicaid potentially, but if those families aren’t reapplying or applying, then that kind of diminishes that funding source.”

School administrators we interviewed reported seeing a significant decrease in their applications from Latino immigrants for free and reduced lunch and summer programming in 2018. They also reported reluctance by Latino immigrant families to fill out forms with personal information. One of the school administrators shared that Immigration and Customs Enforcement (ICE) officers went to the school looking for a student after they apprehended one of the student’s family members at the family’s home. The administrator reported the school had taken a strong position about protecting students and their families and guarding their personal information; therefore, no information was disclosed. That case provided the school leadership an opportunity to confirm that their protocols are protecting children and families. In addition to having rules to protect students, school administrators reported that schools have been working to reassure families that their information is confidential and used only for school and health-related purposes.

Latino immigrant participants are fearful that they, a family member, or a close friend could be deported.
Regardless of immigration status, there has been an increased number of Latinos in the United States worrying about deportation under the current administration. Of the Latino immigrant participants in our study, 85% reported being very worried about themselves, a family member, or a close friend being deported (see Figure 8). In our study, 49% of participants reported knowing someone who had been deported or detained by the federal government for immigration reasons in the last 12 months.

An administrator at a local FQHC shared that one of the main fears of Latino immigrants around deportation is losing their children. “Especially the fear that ‘If they deport me what will happen to my children who were born here?’ We work with . . . the Mexican consulate to assure to them, ‘Look, do this if something happens.’ But the level of stress is high for everyone, educated or uneducated. It does not matter.”

School administrators shared during interviews that they are seeing more cases of separated Latino families where the parents are now in Mexico and their U.S.-born children, who are citizens, remain in the U.S. Furthermore, children of Latino immigrants often are left with relatives, yet they do not have an official guardian who can take formal responsibility for their medical care. Other studies have shown that children in mixed-status families (i.e., families whose members do not have the same immigration status) suffer from constant fear of the possible detention or deportation of a family member. This chronic fear causes elevated risks of negative psychological, emotional, and behavioral effects among these children and their families. [25–27]

Fear of deportation and family separation is not new among Latino immigrants, according to some in the healthcare field. One healthcare professional reported hearing multiple stories of deportation during his 13 years of practice. “Mom disappeared, and they couldn’t find her. And so, they find out later that she was picked up by ICE. But I mean, she’s just gone for days, and they’re trying to figure out what’s happened.”

These fears are not unfounded: the number of immigrants who have been apprehended inside the United States increased by more than 40% in 2017 compared to 2016. [28]
Worry that you, a family member, or a close friend could be deported?*

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Regardless of your own immigration or citizenship status, how much do you...?

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You have been concerned that healthcare practices share your or your family’s personal information with immigration officials**

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You have been concerned that using public healthcare services may impact you or your family’s immigration status**

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Figure 8. Immigration-related concerns among Latino immigrants. Questions adapted from Pew Research Center* [30] and the Immigration Law Concerns Scale**. [29]

**Healthcare professionals face challenges related to the fears Latino immigrants are experiencing.**

We interviewed health and social service professionals who identified specific challenges they face due to the fears their Latino immigrant clients are experiencing. For example, they reported that some Latino immigrant patients are using different names across healthcare and social services systems to avoid being identified and deported, which complicates following and coordinating their care. They also said that they lack clear information to provide patients regarding what services they can safely use without affecting their immigration status. Frequently, patients are unsure whether the assistance they receive is funded by private or federal funds, so they decide to turn down all services.

Latino immigrant patients who forego seeking care can complicate their health. One healthcare professional shared the case of a minor who was unable to get the treatment she needed because of her parents’ fear.

_There was this girl who came in who had a knee injury and needed intervention on her knee. She was uninsured without Medicaid, but she was eligible [for care because] she had been born here. [When asked] 'Why have your parents not gotten you on Medicaid, she said ‘Well, we have an uncle who is not legal, and my parents are not willing to sign me up [for Medicaid] because of the concern about him.' They didn’t want to take a chance on registering anywhere or [accepting] any public services even though she was entitled to them._

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32

Latino Immigrant Experiences in Accessing Healthcare in the Kansas City Area
Healthcare professionals also shared that Latino immigrant patients are reaching out to them to seek advice about the potential effects of the changes to the Public Charge rule¹. Patients want to know whether enrolling in health programs and using healthcare services can affect their immigration status.

Healthcare professionals, in general, expressed the need for accurate information to be available to patients so that they can make informed decisions about their healthcare.

“Now it’s harder for us as providers to give that reassurance [that there won’t be any consequences for patients if they apply for healthcare services], and so that’s a much tougher conversation to have with families when they’re asking for suggestions on if they should or they shouldn’t.”

All healthcare professionals, whether from school or healthcare organizations, reported making extra efforts to reassure Latino immigrants they are safe and their information is confidential. The justifiable fear remains, however, and it affects both patients and providers.

4. Latino immigrants face discrimination while accessing healthcare

Latino immigrants shared their experiences with discrimination.

Besides enduring challenges related to anti-immigrant policies, Latino immigrants experience discrimination. In 2016, approximately half (52%) Latinos in the United States reported discrimination based on their ethnicity. [31] In the greater Kansas City metropolitan area, the 2012 Hispanic Needs Assessment found that one in two (50%) Latinos reported discrimination based on their ethnicity, most often at work or from law enforcement and the criminal justice system. Some of these discrimination issues were linked to legal status in the United States, for instance, being denied a driver’s license or access to medical or dental care. [32]

In our study, 38% of participants reported having ever experienced discrimination on the street or a public setting, and 20% experienced discrimination at work. Additionally, 46% reported feeling treated with less respect than other people and 40% reported having been criticized based on their accent or the way they speak at least once in a while in their daily lives.

a. Discrimination by healthcare staff

We interviewed Latino immigrants and CHWs who reported instances when support staff at some healthcare systems have told uninsured immigrant patients to go back to their country of origin to receive the services they need, especially when those services represent substantial costs.

¹ U.S. Citizenship and Immigration Services defines “public charge” as an individual who is likely to become “primarily dependent on the government for subsistence, as demonstrated by either the receipt of public cash assistance for income maintenance, or institutionalization for long-term care at government expense.”
A Latina immigrant mom shared how she witnessed a close friend and her friend’s son being asked to leave the country.

I went to see a friend whose son was sick, and I witnessed a horrible experience because the finance [person] came and said, ‘If you are not from here, you do not have to be here . . . you have to go to your country. You are not from here, you have to go.’

CHWs reported that discrimination issues are more frequent in larger systems and hospitals and less common in safety-net clinics, where staff members are accustomed to serving immigrant patients.

b. Latino immigrant participants report insurance-based discrimination

Survey participants in this study reported relatively few experiences with discrimination based on race, ethnicity, or skin color when getting healthcare (11%). During the focus groups, however, many shared stories of discrimination due to lack of healthcare coverage, often associated with unauthorized status. Currently, unauthorized immigrants are not eligible to purchase Marketplace health coverage or apply for Medicaid under federal guidelines. [33, 34] This lack of healthcare coverage is compounded by a lack of commercial plans available for individuals without an SSN in the Kansas City metropolitan area; thereby, unauthorized individuals are left with few alternatives to pay for care.

Insurance-based discrimination is linked to delays in healthcare and suboptimal treatment. Latino immigrants who experience insurance-based discrimination are more likely to lack a regular source of healthcare, have diminished confidence in getting care, and do without care due to cost. [33]

During the focus group discussions, Latino immigrant participants shared that there are healthcare facilities in the Kansas City metropolitan area that have denied services, citing lack of health coverage, to other Latinos the participants personally knew. “They tell you, if you don’t have insurance, we cannot see you.”

Other uninsured Latino immigrant participants reported that they had been required to provide large down payments as a condition of receiving urgent healthcare services. For example, Fernando, a Mexican immigrant, was required to pay $3,700 up front to be scheduled for a surgery that he needed the next day. His perception was that he was required to pay the down payment because of his ethnicity.

Fernando said, “Let me tell you why, because ‘maybe [the Latino patient] does not have a way to pay us [hospital],’ ‘maybe he does not have this,’ ‘maybe.’”

Agencies identify funding vulnerability and racism as challenges related to serving Latino immigrants.

Healthcare professionals discussed the challenges they face with their non-Latino patients, funders, and leadership as it pertains to marketing their services to Latino immigrants. In some cases, they are concerned they could lose resources if funding entities found out they were serving Latino immigrants who might be unauthorized. For instance, an administrator of a clinic serving Latinos noted, “We like to keep what we do under the radar . . . because, politically, it’s just better that we do it that way.”
A provider at an FQHC clinic explained that her site has bilingual staff and materials to meet the needs of Spanish-speaking clients, who are almost half of the clinic’s patient population. This accommodation, though, has brought complaints from some non-Spanish speaking patients. “[Some] non-Hispanic patients see this clinic as the Mexican clinic. . . . So right, I’ve escorted patients out the building because of their racist remarks toward the front desk. I mean, there are some very interesting voicemails that have been left and interactions that our front desk has had because of their . . . accent, because their name is Maria, because whatever.”

5. Language barriers impacting healthcare quality

Latino immigrants look for quality and affordable healthcare in their native language.

Latino immigrants look for the possibility of talking directly with their healthcare providers in their native language without the need for an interpreter.

Aarón, a focus group participant, shared that Latino immigrants seek healthcare services in Spanish because they feel more confident asking all of their questions.

“Yes, very good care. More than anything the language, it was in Spanish. You could ask questions, and you receive answers for everything.”

Healthcare professionals agreed that language is one of the most important attributes Latino immigrants look for in healthcare provision. A bilingual healthcare provider who has been working for 13 years in the Kansas City community shared that the provider’s language proficiency increases patient confidence. “But then what surprises people most, you see it in their eyes when you first walk in and talk with them—if they’ve never seen you before—is that ‘a white doctor is speaking Spanish to me.’ When everybody you talk to, it doesn’t matter what they look like, who they are, continues to talk to you . . . I think that makes people feel a little bit more comfortable and confident, too.”

a. Nine in 10 Latino immigrant participants speak Spanish at home

English language acquisition among immigrants is related to the length of time living in the United States, with youth acquiring English faster than adults. In this study, 95% of the Latino immigrant participants spoke mainly Spanish at home. Nationally, 72% of Latinos spoke Spanish at home in 2016. [35]

We spoke with Latino immigrants who have been living in the United States for 15 years on average, with 76% of them having lived in the United States for 10 years or more. However, their level of acculturation—a measure indicating how much they have adapted to the U.S. culture—based on language was very low (see Figure 9).

Immigrants who speak a language other than English at home and have a lower level of education are
more likely to have limited English skills. [36] In this study, 7% reported speaking English “very well.” In contrast, 80% reported speaking Spanish “very well.” Therefore, language accommodations in Spanish are crucial to ensure the quality of healthcare for this population of Latino immigrants.

Figure 9. Acculturation based on language use. Source: Brief Acculturation Scale for Hispanics. [37]

a. Almost half of the Latino immigrant participants have low health literacy skills

Health literacy refers to “the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.” [38] Health literacy affects the ability of people to understand health information and follow medical instructions. Health literacy and language impact the way Latino immigrants obtain and make sense of medical information. Among the project’s participants, 43% of Latino immigrants had low (inadequate to marginal) health literacy compared with 12% of the general population in Kansas [4] and 4.2% in Missouri. [39]

Researchers heard from healthcare professionals about different communication issues they face when interacting with immigrant families. They reported concerns regarding patients’ inability to follow up with instructions once they are at home. Follow-up care is more complicated when health information is not in the patient’s language or when there is a mix of languages, which is often the case.

Daniel, a CHW, shared an example of a miscommunication that arises when healthcare professionals
are unable to communicate with patients in a language that the patient can understand. “[Healthcare professionals] are going to be talking a technical language that maybe for them it doesn’t sound like it’s a technical language, but it is. And so, the patients go to the appointment, and when they get out of the appointment, they say, ‘I didn’t understand anything.’ And that prevents them from coming back.”

Similarly, David, a healthcare professional, shared that language access is of particular concern when patients are outside of his clinic.

“The surrounding system still isn’t in their language. The paperwork I hand out may be mixed English and Spanish, right? One handout is [in Spanish]; and, the other one, we don’t have it in Spanish. I do worry about medication information being understandable for families once they’re beyond our clinic. There’s a little bit of an uncertainty. Kind of like cross your fingers and hope.”

**Working through an interpreter and its challenges and benefits.**

a. Healthcare professionals’ experiences with interpretation services

Nearly 60% of Latinos in the United States have had a difficult time communicating with a healthcare provider due to language or cultural barriers, and this lack of communication can affect patients’ overall health. [40, 41] Using professional interpreters who serve as a liaison between the patient and healthcare professionals increases patient satisfaction, adherence, and outcomes. [42] The use of professional interpreters meets the legal requirements of Title VI of the Civil Rights Act of 1964. The Act mandates that health providers (as recipients of federal financial assistance from the Department of Health and Human Services) provide meaningful access to persons of limited English proficiency (LEP). Federal financial assistance includes resources such as grants, training, and use of equipment. Recipients include hospitals, managed care organizations, universities, entities with health or social service research programs as well as state, county, and local welfare agencies, among others.

Healthcare professionals in this study employ various forms of interpretation services. The first and most welcomed form of interpretation, according to both patients and healthcare professionals, is in-person interpreters. Less than half of the healthcare professionals we spoke with in this study had certified in-person interpreters.

The second and most readily available form of interpretation for the majority of healthcare professionals involves phone interpretation services, where the healthcare professionals use a third-party company that provides interpretation via phone during appointments. The third and less common form of interpretation was video interpretation services, where a person would provide interpretation via a video service hired through a third-party company.

Existing research has shown the importance of language in medical encounters and the possible dangers of inadequate interpreting. [43] We briefly describe the perceptions of healthcare professionals using interpretation service, followed by the experiences of Latino immigrant patients.
b. Phone-based interpretation is most common

Some healthcare professionals shared that their organizations are providing medical interpretation training for some of their staff. Nevertheless, most healthcare professionals reported relying on phone interpretation services due to cost. In one of the clinics, healthcare professionals use a mix of in-person, phone interpreter, and video interpreter services. Jordan, a healthcare provider who works with LEP patients, said video interpreting was almost as good as having an in-person interpreter. “In our clinic, we are mostly using . . . our department interpretation line by [third-party phone interpretation provider]. We are using that mostly because of cost; it’s about half the cost of in-person interpretation.”

While some clinics had access to certified interpreters, some clinics did not know if the interpreting services they used were certified. This lack of knowledge is not surprising given that—although federal law mandates medical agencies support LEP patients—the regulations outlining the type of interpretation used vary by state. For instance, Kansas does not have any competency requirements for healthcare interpreters. [44]

Funding is a significant challenge to providing competent interpretation, especially for community clinics serving considerable numbers of LEP patients.

c. Providing certified medical interpreters is crucial given the potential consequences to a patient’s health if information is not shared correctly

A health administrator at a healthcare setting that serves mostly Latino immigrants noted multiple challenges including communication barriers that originated from not having an in-person interpreter and the failure to use certified medical interpreters who are competent in their job. “I mean there’s always some struggles with interpretation. . . . You can’t convey everything through interpretation. Emotion. And there’s been some struggles. . . . The males don’t know the female anatomy and the female words that are used for female health, and so that sometimes becomes that barrier.”

Time is an additional problem encountered by clinics that serve a large number of Spanish-speaking patients. A healthcare administrator at one of these clinics reported that over 90% of their Latino participants require interpretation services. Therefore, they have a certified interpreter on-site at all times and have all their resources in Spanish. One of the challenges they face is that Spanish-speaking patients end up using larger blocks of time for scheduled appointments because everything must be said twice. For clinics to ensure adequate time for their patients to have a high-quality experience, they allow 30 minutes for follow-up appointments and 40 minutes for new patient appointments. This time allotment is necessary but becomes an issue with funders.

The healthcare administrator said, “It’s a challenge with funders who think maybe we should be seeing more people, that our volume may not be high enough. . . . If we were to look at other models to get revenue, we would have to close the gap of how long we spend with people, and so that is part of the challenge of trying to do the care the way we do and giving them space.”

d. Lost in translation: experiences of Latino immigrants with interpretation services
Several of the study participants reported that they did not trust interpreters because of previous negative experiences. One participant noted that there had been times when she noticed that interpreters shortened what she said.

Ester, an immigrant from Mexico, shared her frustration when she used an interpreter for the care of her daughter and how she decided to take action. “I was telling the interpreter everything that was occurring, and then when he translated, the little that I understood was not what I said. So, that bothered me, and I think ‘Well, I am telling them the seriousness of what my daughter has’ and . . . they were not telling [the provider] correctly what I was saying. So, I said to the doctor, I said: ‘I’m going to try to tell you—I feel like I would express myself better, and you would understand me better if I explain it to you.’”

Other issues reported by Latino immigrant participants were interpreters not knowing some of the medical terminology and asking the patient for assistance with terminology in Spanish. Overall, participants found phone-based interpretations to be less personable and found it harder to communicate compared with having the interpreter present in the room. That their health was dependent on the quality of interpreter and the phone call itself—some participants reported hearing background noises that interfered with communication—was one of their concerns for phone-based interpretation. “If they [interpreters] hear it poorly or they mistranslate it, then they tell them [the healthcare professional] something else.”

e. Nurse lines and telephone menus in English limit communication

We interviewed one healthcare navigator who said Latino immigrant patients are able to engage well during their medical encounter when they receive appropriate language assistance, but the patients have difficulties with follow-up care when language assistance is not available. He went on to describe that the nurse line, telephonic menu/automated instructions, and voicemail messages are usually in English, so Spanish-speaking patients are not always able to follow through with communication after the doctor visit. In his experience, Spanish-speaking patients are less likely to leave phone messages for their doctor when, to leave that message, all the automated instructions are in English. Therefore, communication between the patient and healthcare professional gets lost.
6. Immigrants seek alternative healthcare when formal healthcare is not available

Given the barriers to accessing healthcare in the United States, Latino immigrants reach for other options to take care of their health needs. Some Latino immigrants reported seeking care in their country of origin, either by supplementing the care they receive in the United States or by replacing it altogether. Given the high expenses associated with medicines, Latino immigrants often rely on self-medication or alternative medicines such as home remedies.

a. Latino immigrants reach for care in their country of origin when care is not available locally

Hilda is an immigrant originally from Colombia. After her husband died, she lost access to health insurance. Following recommendations from church friends, Hilda started going to a community clinic for her healthcare needs. Hilda has kidney-related diseases and the community clinic often has to refer her to other settings for her to get the specialized services she needs.

Hilda shared that because the treatment for her illness is so costly, the healthcare professional placed her on a wait list to receive the care she needs. “Over there in the clinic, they have me on the [wait] list. And because it’s so expensive, they have to wait for a clinic to approve it. They told me, ‘It can take a month, two months, a year.’” As she awaits treatment, Hilda has used the E.R. multiple times, in addition to having had emergency surgery.

Although she relies on Kansas clinics for routine care, Hilda also uses her ties to Colombia. “I have a doctor. The one that always saw me in Colombia.” Hilda consults with her doctor in Colombia via the telephone. In addition to providing suggestions on her physical health, Hilda’s doctor in Colombia treats her mental health needs as well. After losing her husband, Hilda received alternative medicines from the Colombian doctor to cope with depression. “With what happened with my husband, the doctor from Colombia, she is the one who keeps an eye on it. She even came [to see me]. She is a general practitioner, but she also works with alternative medicine. Then she sends me medicine for depression.”

b. Higher prescription medicine costs push Latino immigrants to get medicine from their country of origin or via social media connections

Like Hilda, other Latino immigrant participants shared that they accessed medicines from their home countries to address their treatment needs, particularly when they faced financial barriers to buy medicines in the United States. For example, Micaela, who is from Colombia, gets her medicines from other Colombian migrants. “Any person that comes from Colombia, from my country, well, I tell them to send it to me because it is absurd. It is absurd to buy medicine here; it is extremely expensive.”

Similarly, Silvia, who is originally from Mexico, gets her asthma inhalers from her mom in Mexico, as well as from other patients who resell their inhalers via social media. “Back then, I used my inhaler four or five times a day, and being left without it is difficult because an asthma attack is a straight visit to
the ER. . . . And it was very difficult for me [to get the inhaler]. The way to get it was through other people who had it [asthma] or posting my request to get an inhaler on Facebook. You might find people who sell it for at up to $70, but . . . there wasn’t another way for me.”

Other Latino immigrants reported accessing medicines at ethnic food stores rather than seeing a doctor. For instance, Latina women in a focus group shared that they buy medicine at a Mexican store that friends or acquaintances had recommended. However, medical advice from nonprofessionals has risks. Angela, who is originally from Mexico, shared experiencing an allergic reaction after self-medicating on advice from a Mexican store attendant.

“Like once, I took one [pill], and my lips were swollen. . . . I didn’t even look like myself. But [that is] because one doesn’t have a place [to go for care].”

c. Nonlicensed healthcare providers offer their services to Latino immigrants

When they are unable to obtain formal healthcare, Latino immigrants reported going to people who provide services without a professional license. Even though Latino immigrants are aware of the risks associated with this choice, it is the only practical solution for many given the high costs of professional, licensed care. Below is an example related to dental care.

Luz, a Latino immigrant in a focus group, shared, “Because I know a girl that hired a person, she [an informal provider] went to her house to pull out her husband’s tooth. . . . I mean, maybe [the informal provider] knows everything [the procedure] but she doesn’t have the tools, what if the anesthetics go wrong or something happens to the person? . . . [but] dental [services] are very expensive.” Fabiola, another focus group participant, added: “Yes, very expensive. That is why people, that is why Latinos, we opt for that type of people [informal providers].”

d. Home remedies are used mainly because many Latino immigrants cannot afford prescription medicines

Latino immigrants use home remedies (e.g., teas, herbal mixtures, homeopathy) mainly due to their inability to pay for medicines to tend to minor health issues, such as a cold or sore throat.

A mom in one of the focus groups shared her frustration with not being able to afford prescription medicines for her child. “I try to take care of myself, try to take care of my children, but it is very concerning. . . . It’s a lot of stress. Suddenly, your child gets sick and you cannot give to him the basic things, you can only give him home remedies or buy [over-the-counter] medicines at Walmart. It is very frustrating not having access [to prescription medicine].”

Other participants used home remedies due to their distrust of prescription medicines, or because home remedies are rooted practices that they have from their home country. Self-treatment, alternative medicines, and home remedies can result in delayed conventional treatment, however, which sometimes increases harm. [45, 46]
Bridges to Healthcare

1. Available services for the Latino community

Latino immigrants have access to a strong primary care network.

A wide variety of services are potentially available to Latino immigrant communities, especially within primary care. According to healthcare administrators, the main services that Latino immigrants use in community clinics are pediatrics and chronic disease management, particularly for controlling diabetes and hypertension.

Several healthcare professionals reported that local health departments also contribute significantly to meeting the needs of Latina immigrants. These services include women’s health needs such as wellness exams, prenatal care, family planning, testing for sexually transmitted diseases, and immunizations.

a. Interagency collaborations extend the reach of available healthcare services

We also heard about several successful interagency collaborations that increase access to different resources for healthcare and social services. For example, Spanish-speaking patients at Vibrant Health Clinic and at Health Partnership Clinic (HPC) have access to diabetes prevention programming through JUNTOS. Duchesne Clinic provides patients with bilingual diabetes management education through a collaboration with the nonprofit Riverview Health Services; several safety net clinics refer their clients to the latter for medication assistance.
Health departments in Johnson and Wyandotte counties partner with the KU Health System to offer prenatal services to their patients, especially at delivery. One of the prenatal care providers mentioned she refers many of her patients to El Centro Inc. when they need help to access other types of care. Schools partner with healthcare organizations to bring primary care to their students. Examples include the HPC school-based clinic at Merriam Park Elementary School in the Shawnee Mission School District, the KU-BullDoc school-based clinic at Wyandotte, and Harmon High Schools in the Kansas City Kansas Public Schools. Some school-based clinics partner with other organizations to provide mental health services such as PACES, Mattie Rhodes Center, and Vibrant Health.

There are innovative partnerships with agencies outside the healthcare world, too. For instance, Samuel U. Rodgers FQHC has partnered with the professional soccer club Sporting KC to implement soccer clinics and promote physical activity. And as a final example, the school districts partner with agencies that provide community services, to bring them closer to the families of their students on a regular basis and address some of the social determinants of health that can negatively affect students' health (e.g., access to electricity in homes).

Meeting Latino immigrants where they are, whether at a church or a soccer game, facilitates their connection with healthcare services. According to a healthcare administrator at an FQHC, having a presence in different sectors of the patients’ lives—where they live, work, and play—helps establish the setting as their medical home.

Several successful programs can be accessed by Latino immigrants.

Other important efforts and programs highlighted by Latino immigrants and healthcare professionals included The Special Supplemental Nutritional Program for Women, Infants, and Children (WIC), Early Detection Works (EDW), on-site pharmacies, and pediatric weight management programs with information available to Spanish-speaking patients, such as those offered by Vibrant Health Clinics and Children’s Mercy Hospital (CMH). CMH in Kansas City, Missouri, also has a clinic specially equipped to serve children in Spanish-speaking families. At its Clínica Hispana de Cuidados de Salud (CHICOS Clinic), all the staff members are bilingual, including nurses, care assistants, admissions staff, physicians, nurse practitioners, and medical residents. Duchesne Clinic offers longer blocks of time to accommodate language interpretation services for their patients.

Home-visiting programs and assistance with transportation helped alleviate some of the access barriers experienced by Latino immigrant participants, and on-site lab services were valued highly. Some healthcare professionals reported that patients go to specific clinics because they are connected to more extensive healthcare systems that offer secondary care. A community clinic administrator shared, “JayDoc seems to be a resource [for patients] to access KU for services when they need resources that we don’t have here.”

a. Some services are underused in community clinics

Healthcare professionals reported that some available services are underutilized, including
colposcopy (a procedure recommended after an abnormal Pap-test result), LEEP procedures (loop electrosurgical excision procedure, a treatment for abnormal cervical cells and cancer of the cervix), and long-acting reversible contraceptives.

2. Cultural competence

Healthcare professionals are implementing cultural competency practices to improve the experience of their Latino immigrant patients.

a. Being open and curious about the culture is a path to cultural competence

David, one of the healthcare professionals we interviewed, shared his experiences working with Latino immigrant populations and his ideas to enhance the cultural competence of doctors. David said there are barriers from both the Latino immigrant patient’s and the doctor’s side, giving an example of a family who brings in their baby to the medical consult with a red bracelet with little dangly beads on it to prevent “mal de ojo,” a culture-bound folk illness of the “evil eye” in traditional Mexican and Central American culture. [47]

According to David, patients often feel uncomfortable sharing their beliefs and might assume the doctor will think they are silly. On the other hand, the doctor might hesitate to talk about the bracelet and its meaning in part due to time constraints (especially working through an interpreter) but also because of “not feeling comfortable addressing things that are clearly cultural,” or just not knowing about them.

David said patients who come from countries where antibiotics are commonly administered go through a similar situation. “To not give antibiotics for a child who has a fever and is sick can be really confusing to a family; but doctors may not know that culturally, getting medicine is the family’s expectation coming in the medical encounter. Without a cultural understanding of the situation, providers may address this situation inadequately. Although providers are following a clinical protocol and are confident they took good care of their patient, without reassuring the family that is the best course of action for the child, the family may leave feeling disappointed, thinking the doctor did not have the time or did not value them enough.”

When talking about the barriers to increasing cultural competency among healthcare professionals, David said,

“The barrier for me isn’t that you don’t know everything. It’s that you’re not in the mindset to be curious and confident about asking and understanding more about the family.”

David also said it is also important to teach physicians how to ask patients of different backgrounds to clarify things the physician does not understand, how to open the discussion for patients to express their concerns related to their culture, and to do this in a short amount of time.

b. Community health workers can enhance patient engagement
A CHW is a “frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.” [48]

In the Kansas City metropolitan area, CHWs are fulfilling different roles and approaching community members in a culturally and linguistically appropriate way. They conduct health outreach and education for some organizations. Depending on their skill set, other CHWs facilitate group or individual preventive health programming. Others provide navigation for patients to access and use healthcare. While CHWs have been working in some healthcare settings for years, other settings have not integrated CHWs yet for a variety of reasons.

One of the providers talked about the effectiveness of CHWs to help patients manage chronic diseases. He emphasized the need to embed CHWs in the clinics to complement the skills of the medical teams and maximize the impact of the team on the patient’s health. “We have to let [CHWs] in the door in the first place. We need to have the community health workers working with us in the clinic, not just out in the community. . . . [Having CHWs just out in the community] keeps them at arm’s length from the healthcare professional community: the nurses, the doctors that are seeing the patients in the clinic. If they [CHWs] are clinic-based, we are much more likely to work in close contact and close communication.”

We interviewed CHWs who talked about their role as cultural interpreters between Latino immigrants and their providers, facilitating a greater understanding of both beyond language. They also talked about their role advocating for patients and empowering patients to advocate for themselves. One of the CHWs shared a story of a client whom he taught how to request generic prescriptions instead of brand medicines. He said once patients learn they can advocate for themselves, they do it. “Once you [patient] get that knowledge, you [the patient] don’t let it go, you know how to use it.”

c. Healthcare settings as welcoming spaces

Healthcare and social service professionals told us that they create welcoming spaces for Latino immigrants by setting up a visually appealing environment, having amiable bilingual staff, providing access to interpretation services, and having immigrant-friendly cultural competency practices in place.

For instance, Laura, who works at a community-based organization and has served the Kansas City community for over 15 years, shared that her organization hires staff who care about their clients and provide kind treatment. “Simply, it is clear that when we hire someone, we look for people that love the community, and it is very clear to us that human treatment and connecting with people is the main thing.”

Healthcare administrators also made significant efforts to create welcoming spaces inside their clinics. This effort entailed limiting the physical barriers between patients. The clinic staff also
placed symbols and signs in a variety of languages as decorations around their lobby area. They linked bilingual symbols to ideas of belonging, in an attempt to make their clinics welcoming to patients from different cultures. “[If] they do see it ‘my language is on there, it means I’m welcomed here too.’”

d. Bilingual healthcare professionals increase Latino immigrants’ trust

Several Latino immigrant participants treated by a bilingual healthcare professional report increased levels of trust and satisfaction. Yet healthcare administrators described a shortage of bilingual professionals, including doctors and mental health professionals, in our area.

“They (bilingual therapists) understand the needs of our communities. I feel like it’s just more of the supply and demand that bilingual therapists or bilingual social workers, you know, they aren’t readily available for us, but they do an excellent job of meeting the families where they are.”

Growing health disparities have an impact on the availability of Latino physicians who can help provide care for Latino immigrants. Latino healthcare professionals are more likely to speak Spanish and practice medicine in underserved areas [49] than non-Latino healthcare professionals. Nationally, the rates of Latino physicians in practice have worsened over time compared with non-Latino physicians. From 1980–2010, the non-Latino physician rate increased from 211–315 per 100,000 people. By contrast, the Latino physician rate decreased from 135–105 per 100,000 people in the same period of time. [50]

3. Latino immigrants use their social networks to learn about healthcare services

Friends and family are acting as healthcare navigators for Latino immigrants.

Support from social networks, such as family and friends, has been linked to positive health outcomes among Latinos [51] and those living in disadvantaged neighborhoods. [52] Forms of support include instrumental (e.g., getting a ride to a doctor’s appointment) and emotional (e.g., cheering someone up after a loss). Social support networks act as a protective factor in buffering the harmful effects of exposure to stress and discrimination. [53]

Social cohesion refers to “the strength of relationships and the sense of solidarity among members of a community.” [53] Social cohesion can affect the health of individuals and groups. Latino immigrants and healthcare professionals reported during the focus groups that Latino immigrants have strong social cohesion and a willingness to share their knowledge about healthcare with others. Latino immigrants rely heavily on their social networks—including other Latino immigrants—to get information about the availability and quality of healthcare services. Family and friends frequently act as healthcare navigators, providing information that enables Latino immigrants to make healthcare choices and receive medical care with an improved sense of confidence. [54]
When Latino immigrant participants faced specific health issues, the majority (69%) sought advice from doctors or other healthcare professionals. In addition, nearly half of them (48%) reached out to their personal networks.

Healthcare and social service professionals described Latino immigrants' sense of familialism (also called familismo) as a key strength. This reliance on family ties is seen as a vital asset in overcoming the healthcare barriers encountered by Latino immigrants. Healthcare and social service professionals reported that Latinos rely on their families for many critical services, including health education, transportation, financial support, and even translation services.

One healthcare professional put it this way, “Strengths . . . family. I would say family is huge. It is a strength, because if you’re able to talk to more than one person in the family about someone who has a condition, or provide education for more than just one person, it makes it easier for them to remember that information and act on it—being able to go to appointments. That’s the transportation piece. That’s the cost piece. We see families that might not be able to afford their cancer treatment, but they’ve talked to their family, and then they started raising money or [are] able to borrow money.”

An administrator at a local FQHC that serves a large Latino population shared, 

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So that sense of community, I think is so crucial, I think for their own well-being. They’re always willing to share. Not only share, but they say, ‘This is what you do,’ so they break it down into steps for their other friends and family. They tell each other ‘No, it’s easy, just call and ask for this,’ and so that way their community members feel more comfortable accessing those services.

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Latino immigrants and healthcare professionals emphasized that navigation of the healthcare system based on social networks is particularly important for recent immigrants accessing services for the first time. That first encounter is crucial because it can lead to establishing a medical home for the patient and their family. Receiving immunizations, family planning, and prenatal care seem to be working as effective bridges to engaging Latino immigrants in seeking additional healthcare when needed.

**Latino immigrants use social media on their cellphones to learn about healthcare resources.**

Healthcare administrators and healthcare professionals shared that they have limited resources to market their services and that most of their Latino immigrant clients know about their services through word-of-mouth referrals from other Latino immigrants.

The majority of Latino immigrant participants reported using social media—Facebook, in particular—to learn about different types of services, including low-cost healthcare in the area.

Also, focus group participants shared that Latinos have their cellphones with them “all the time” and that checking Facebook on their cellphones “has turned into a habit.” In 2015, according to the Pew Research Institute, 94% of Latino Internet users in the U.S. have used a mobile device to navigate the
the Internet. For some Latinos, their smartphone is their primary source of access to the Internet. [55]

Three quarters of participants looked online for health information in the past 12 months

Latinos are high Internet users and adopters of mobile technology. [56] Nationally in 2015, 73% of Latino adults smartphone owners reported using the Internet in their phone to research a health condition. [55] Among our Latino immigrant participants, 75% turned to the Internet to obtain health information in the past 12 months. The majority (85%) went online for health information regarding a condition or disease. Other common searches involve learning about a medicine or treatment (59%) and learning about health insurance (17%). (see Figure 10)

![Figure 10. Health topics searched online by Latino immigrants. Question adapted from the Pew Internet & American Life Project. [57]](image)

Furthermore, 15% of Latino immigrant participants used the Internet to clarify information obtained from a medical encounter. During focus group discussions, some patients reported looking up information online or seeking other sources when they didn’t feel entirely comfortable asking their healthcare provider about specific issues.

a. The majority of health searches involved Google or YouTube

When we asked participants what websites they use to find health information, 93% of their responses included search engines such as Google, YouTube, or both. The majority of respondents were unable to state a specific website they go to after using Google or YouTube and explained they compare information across multiple sites to validate the content.
Only 8% of the responses named an online patient portal for services such as appointments and viewing lab results. Participants named three portals: KU Health System’s MyChart, Samuel U. Rodgers Health Center, and Quest Diagnostics. Other responses included health-related websites from health organizations or programs (5%) such as Shawnee Mission Health Center and Davita, and other pages websites (5%) such as Salud.com and Wikipedia.

We hypothesize that the higher use of search engines, which have translation capabilities, and the lower use of patient portals, which do not, is related to lower English proficiency and health literacy levels among the Latino immigrant participants. Some healthcare professionals also noted limited access to health information resources in Spanish as a barrier. Alex, who is a healthcare navigator, noted, “It’s information that is more available in English, so having a website that is in Spanish and is user-friendly, you don’t really see a lot of those. There’s a lot of old medical vocabulary on those websites that people just don’t understand.”

Figure II. Websites used by participants for health-related purposes in the past 12 months. Question adapted from the Pew Internet & American Life Project. [57]
Conclusions: Recommendations for Action

This closing section outlines several recommended action areas to address Latino immigrants’ barriers to healthcare.

1. Addressing Latino immigrants’ views on health and health services

Healthcare professionals should ensure that health information is in a language and form that all clients can understand and act upon.

We used the results of this study to complement the language recommendations from the Health Resources and Services Administration (HRSA) Special Educational Guide Quality Health Services for Hispanics: The Cultural Competency Component. Below is a list of recommended practices. [58]

a. Bilingual/bicultural professional staff

Healthcare organizations should recruit bilingual/bicultural staff at all levels of the organization and provide additional compensation based on their language skills.

b. Interpreters
Healthcare professionals should use trained medical interpreters. Medical interpreters generally complete a number of hours of instructional curriculum on medical vocabulary, ethics, interpretation techniques, and cultural aspects of interpretation. They also complete hours of shadowing or supervised interpretation and pass certification testing.

Health agencies should establish standards for quality, training, and continuing education efforts. The organizations must have a way to assess the competency and ongoing performance of
interpreters and bilingual staff, especially if the people hiring or supervising staff do not speak the language assessed. The facilities should have an adequate ratio of interpreters to healthcare professionals to allow preparation time for the interpreter and avoid unnecessary wait time for medical staff and patients. Additionally, facilities should train healthcare professionals and medical students on how to work with interpreters.

A publication by the American Academy of Family Physicians offers strategies to reduce the financial impact of interpretation services to practices including coding visits based on time, treating cost of interpreter services as an overhead expense for tax purposes, and collaborating with other practices to negotiate discounted rates for language services.[59]

c. Language skills training for existing staff

Healthcare organizations need to support the development of bilingual skills for all staff and use training programs to increase the bilingual level of services. For example, the language coaching program at Children’s Mercy Hospital has shown promising results in a clinical setting and is being pilot tested with mental health professionals.

d. Bilingual materials

Healthcare organizations need to have as many materials as possible available in print, especially essential documents such as consent forms, discharge instructions, and follow-up instructions. A good way to approach this need for printed materials is to create a shared bank of bilingual educational materials for healthcare settings in your area. Use official sites with evidence-based information in Spanish such as the Centers for Disease Control and Prevention. Similar to the recommendations for interpretation services, work with professional translators who provide high-quality, certified work.

e. Healthcare professionals should use a cultural mediator to interpret the cultural and social circumstances of patients

For example, a CHW can be embedded in the healthcare team to provide the team with insights and a greater understanding of patients' needs and culture, resulting in increased trust and ability to negotiate culturally appropriate plans of care.

It must be noted that some well-meaning approaches inadvertently result in detrimental patient–provider communication. For instance, healthcare organizations should not use staff or patient's relatives (especially children) who are not formally trained to translate. Providers with basic (i.e., limited) Spanish proficiency should not attempt to communicate with a Spanish-speaking patient without the assistance of a trained interpreter.

**Healthcare professionals need to ensure welcoming spaces for the diverse communities they serve.**

The U.S. Department of Health and Human Services' Office of Minority Health issued a set of standards for Culturally and Linguistically Appropriate Services in Health and Health Care.[60]
Standard 8 specifically addresses signage and materials and recommends to “provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.” [61]

Creating a space where immigrants have access to information in their native language sends a welcoming message of belonging.

**Elected officials in Kansas and Missouri need to adopt policies to have health insurers pay for certified interpretation services**

State legislators in Kansas and Missouri need to develop legislation to have health insurers contract and provide medical interpreters to their enrollees rather than having healthcare professionals or clinics pay for interpretation services. A model of this approach is California, which requires all health plans and health insurers to provide their enrollees with translated materials and interpreting services when seeking care under Senate Bill 853, the Health Care Language Assistance Act.

Along with 14 states and the District of Columbia, Kansas provides reimbursement for interpreter services related to Medicaid managed care. [62, 63] The state of Missouri, however, does not provide Medicaid/CHIP reimbursement for interpretation services. [62] State legislators in Missouri need to develop legislation to provide language services as a Medicaid-covered benefit.

**Kansas needs to have competency requirements in place for its interpretation services**

At the current time, Kansas does not have any competency requirements for healthcare interpreters. [44] Legislators in Kansas need to establish requirements that ensure the quality of interpreters. For example, in Wyoming, interpreters must meet the national standards set by the National Council on Interpreting in Healthcare (NCIHC). These standards ensure accuracy, professionalism, and role boundaries for interpreters who are to be reimbursed by Medicaid. [64]

**Healthcare professionals, government agencies, professional societies, and funders should educate Latino families about preventive and primary care services available in their communities.**

To implement a unified, coordinated, and culturally tailored communications campaign for Latino families in their catchment area, healthcare organizations should collaborate with other organizations serving Latino immigrants. Potential partners include social service agencies, faith-based organizations, government agencies, professional societies, schools, places of employment, community centers, and Latino markets. **Messaging of the campaign should always have specific directions on where to go and who to contact** to arrange for care, and emphasize that clinics and hospitals will keep patient health information confidential and not share any patient information with ICE. The communications guide in Reaching and Engaging with Hispanic Communities includes effective recommendations on how to engage Latino audiences (see 2016-51LatinoCommunicationsGuide.pdf).

**Healthcare professionals and policy makers should find ways to reduce barriers to dental and mental health care**

Policy makers and advocates need to support policies that expand the availability of dental health services by increasing the number of dental professionals and advancing the dental hygienists’
Participation of dental hygienists and dental assistants for maintenance and preventive services allows for higher productivity of dentists. Moreover, dental hygienists in alternative practices (e.g., schools, living facilities) aim to increase access to dental services where patients live while lowering costs. [66]

Mental health services are underutilized by the Latino community. Besides addressing high costs, healthcare professionals need to provide Latino immigrants with culturally relevant information about the mental health services available and where to go to access such services. [67] The fear and stigma associated with mental health issues and seeking mental health care could be reduced by implementing collaborations between medical and mental health facilities, such as FQHCs and working with social service organizations.

The following recommendations, adapted from the report Community-Defined Solutions for Latino Mental Health Care Disparities [68], are aimed at reducing mental health disparities among Latinos.

a. Increase collaborations among social service organizations, schools, and clinics

Involve faith-based organizations and other organizations in the community to promote mental wellness. Encourage peer-to-peer networks, and increase social engagement.

b. Use social media, news, and different forms of communication to disseminate mental health awareness

Coordinate with radio stations and local television stations to promote educational programming about mental health.

c. Encourage the development of cultural and linguistic competency for mental health professionals

Implement bicultural and bilingual mental health training and offer compensation (loan forgiveness) for individuals who pursue careers in the mental health field to work with the Latino community. Expand training in mental health for CHWs.

d. Develop partnerships to implement strategies to increase Latino's use of mental health services

Identify leaders in the Latino community to serve as strong advocates, and disseminate information about mental health care services. Strong community leaders could change attitudes and reduce the stigma that lingers unnecessarily around mental health.
2. Addressing Latino immigrants’ barriers to healthcare

There are several actions that could be taken to address the ability of Latino immigrants to pay for healthcare services.

a. Health advocates should work with state legislators in Kansas and Missouri to expand Medicaid coverage to include people in the income gap, including Latino immigrants.

Medicaid expansion would provide health coverage for people who make less than 138% of the FPL, which would mean covering an additional 150,000 people in Kansas and 300,000 in Missouri, including eligible Latinos. This expanded coverage would help those who are older, low-income, and/or disabled.

Unauthorized immigrants could benefit indirectly through an improved payer mix at safety-net clinics. A 2014 research brief from the U.S. Department of Health and Human Services’ Office of the Assistant Secretary for Planning and Evaluation [69] indicated that of the 10.2 million ACA-eligible uninsured Latinos in the United States, 5.7 million were at or below 138% of the FPL, the threshold for qualifying for Medicaid in expansion states. The same brief reported that there were 52,000 ACA-eligible uninsured Latinos in Kansas and 43,000 in Missouri.

With Medicaid expansion in both states and assuming that same national eligibility rate (57%), 95,000 Latinos could be eligible to access health coverage through Medicaid in Kansas and Missouri. Medicaid expansion also has the potential to improve the coverage of U.S.-born children in families with members who have different immigration statuses. Mixed-status families may apply for the federal Medicaid expansion program in expansion states, providing a premium subsidy tax credit or subsidized out-of-pocket expenses for a Marketplace plan for eligible dependent family members. [70] The impact of Medicaid expansion would be even greater if it included documented immigrants who have been resident in the United States for fewer than 5 years. Currently, the ACA excludes such documented immigrants from Medicaid eligibility.

b. Health professionals and state legislators in Kansas and Missouri should advocate for the development of programs to cover high-cost specialty care.

Washington, Illinois, California, and New York provide nonfederal funding to cover standard hemodialysis for unauthorized patients with end-stage renal disease (ESRD). Along with improving patients’ quality of life, the savings of standard care are considerable compared with the cost of emergency-only hemodialysis, which has higher death rates and is almost 4 times more expensive. [70, 71]

Illinois went a step further by funding kidney transplantation for their unauthorized residents, resulting in cost savings as soon as 1.5 years after its implementation. California has also been able to provide kidney transplants to their unauthorized patients through Medi-Cal after patients are
approved for Permanent Residence Under Color of Law (PRUCOL). PRUCOL is a public benefits eligibility category that applies to Supplemental Security Income (SSI) benefit applicants or recipients, including some unauthorized patients.

Currently, the charitable arm of the nonprofit Kansas City Medical Society Foundation coordinates specialty care donated by hospitals and health systems to bridge the gap for many patients needing specialty care. Healthcare systems in the Kansas City metropolitan area need to continue supporting this program and identify additional mechanisms to fund services not currently covered, such as cancer treatment. As a healthcare community, healthcare systems share the responsibility of serving all people in their catchment areas who are in need of healthcare. Screening and preventive care services are necessary, but insufficient without linkage to care. [58]

c. Employers should be encouraged to implement strategies that reduce the risk of high out-of-pocket costs for their employees

Strategies to reduce high out-of-pocket costs might include efforts to reduce deductibles or contribute to HSAs to reduce the impact of high deductibles. Unauthorized Latino immigrants are able to work and pay taxes, but they are ineligible to buy health insurance through the Marketplace, even without subsidies. Nor do they qualify for federal Medicaid. [34] Therefore, employer-based health insurance is one of the few avenues available to unauthorized Latino immigrants. In Jackson County, Missouri, and Johnson County, Kansas, approximately 50% of Latino immigrants have private health coverage, suggesting that they are more likely to have jobs with health coverage than those in Wyandotte County and nationwide. If the employer-based health coverage is unaffordable, however, Latino immigrants end up declining it for themselves or their family members.

d. County governments in Kansas and Missouri should explore and test county-level access models that have been implemented successfully in other states

County governments should adopt and test model programs used in other states to improve access to health services for uninsured, low-income residents in their counties, including Latino immigrants. For instance, Healthy San Francisco and My Health LA in California have comprehensive, coordinated models of care that increase the efficiency of their safety nets while ensuring healthcare access to uninsured residents. Their respective county health departments administer both programs and use capitation payment models (every month, the health department pays each medical home a set amount per person enrolled, regardless of whether they use any services), which improve the timeliness of payments to healthcare professionals.

Having one regular medical home as opposed to visiting multiple locations for primary care in a year improves efficiency of the safety-net clinic and patient care and allows for monitoring safety-net capacity. Having a designated site for emergency care streamlines access and facilitates referral of follow-up care.

In California, two primary revenue sources fund the safety-net services: the state realignment funds (through portions of vehicle licensing fees and sales tax revenues) and federal funds for
uncompensated care (under the Global Payment Program through California's Medi-Cal Demonstration waiver). Healthy San Francisco was established and continues to be funded with funds provided by employers under the Health Care Security Ordinance. [72]

**There are several actions that could help Latino immigrants overcome practical barriers to reach healthcare.**

a. Healthcare professionals should improve access for patients who have difficulty leaving work

There is a high concentration of the Latino immigrant workforce in service occupations that do not allow for adequate sick leave. Therefore, it is imperative that medical services are available to serve this part of the workforce promptly and efficiently.

b. Healthcare professionals need to have appointments available within a reasonable time

We recommend that community clinics build time slots for urgent walk-ins and train their staff to identify and prioritize urgent cases. Offering hours on weekends and evenings is key, especially for patients with limited time off of work and limited transportation options.

c. Healthcare organizations should minimize wait times for all patients

We recommend that community clinics evaluate innovative flow models (e.g., staggered appointments) to minimize the wait time of patients in the waiting and exam rooms. Wait time can be used as an opportunity to provide printed and multimedia educational materials to patients about their presenting problem or newer health programs in the clinic.

d. Healthcare organizations should coordinate services to minimize the number of visits and appointments required for patients

We recommend that community clinics coordinate, as much as possible, paperwork and appointments to minimize the number of visits patients need to make to the clinic. This saves time and transportation costs for patients.

**There are many ways in which healthcare professionals can address immigration concerns.**

Starting in 2011, ICE implemented an informal policy under a memorandum of agreement (MOA) that immigration enforcement will not conduct “enforcement actions” in “sensitive locations.” [73] In the MOA, hospitals, doctors' offices, accredited healthcare clinics, and emergent or urgent healthcare facilities are considered sensitive locations where immigration enforcement by ICE and Customs and Border Protection (CBP) is to be avoided in general.

Since 2016, however, with a change in the federal administration, immigrants across the country have been apprehended on their way into and inside hospitals, outside of schools, and near healthcare clinics. [74, 76] Given the fear related to recent immigration policies and enforcement activity, the American Medical Association (AMA) enacted new policies in 2017 to address the heightened enforcement strategies from these newer immigration policies. Healthcare professionals
should enhance the sense of safety for Latino immigrants seeking healthcare. The AMA [77] and the National Immigration Law Center [78] created recommendations for healthcare providers on how to establish a safe space in healthcare settings. Below is a summary of relevant recommendations:

- **Have a policy designating private areas available to patients and providers that are closed to the public.**

  Patients can be more vulnerable to immigration enforcement in areas open to the public. Provide a safe area that is private for waiting or conducting business.

- **Designate an authorized staff member to be responsible for handling contacts with law enforcement**

  A designated and a back-up person should be trained on how to interact with immigration officials. The rest of the staff should be trained to refer immigration officers to the designated person as the only contact able to review warrants or authorize entry into nonpublic areas of the clinic. Train staff to decline to answer questions about all patients.

- **Establish a relationship with a local immigration lawyer**

  A local immigration lawyer or member of the organization’s board of directors who is an attorney can be available in case of enforcement activity.

- **Provide “know your rights” cards and educational materials**

  Materials informing patients of their rights in case they need to interact with immigration authorities can be made available in a visible area in the clinic.

- **Reassure your patients that federal and state laws protect their health information**

  Healthcare professionals are not required to ask for or report any information about a patient’s immigration status to federal immigration authorities. The Health Insurance Portability and Accountability Act (HIPAA) privacy rule is a federal law that prohibits the use or disclosure of patient information without the patient’s consent, except when required by law.

- **Protect medical records from immigration officials**

  Healthcare professionals are not required to report to federal immigration authorities any information about a person who lacks legal status. Healthcare professionals are protected under the First Amendment of the constitution and therefore can choose not to speak. Staff at community clinics and social service agencies should have information about relevant policies related to the use of healthcare services. For example, the website [Protecting Immigrant Families](#) provides updated information on healthcare services.
Legislators in Kansas and Missouri need to develop legislation to protect immigrants in healthcare settings.

Several states have introduced legislation to protect immigrants in healthcare facilities. For instance, California passed SB 54 in 2017, ensuring that state and local law enforcement agencies do not use their resources to facilitate ICE deportations. [79] This noncooperation policy also requires public healthcare professionals to structure policies that limit the assistance one has to give immigration enforcement.

Arizona has also suggested a bill to prevent police and immigration enforcement from questioning people in “safe locations.” [80] HR 1815, the Protecting Sensitive Locations Act, would amend the Immigration and Nationality Act to prevent immigration enforcement from taking place in a sensitive location, including inside medical facilities or during medical treatment. [81] This bill was introduced in 2017 and is yet to be debated.

Healthcare professionals should consistently implement antidiscrimination policies.

Healthcare professionals and staff at healthcare facilities need to be able to understand and control their own implicit biases. They also need to manage intolerant comments from patients. [82] Healthcare professionals need to identify instances of racism and discrimination where they work and address any instances that occur by following established policies. Healthcare staff and medical students should receive ongoing training related to identifying their own biases, advocating for their patients and themselves, and dealing with difficult situations.

As a society, we need to fight discrimination within and beyond the boundaries of healthcare organizations. Healthcare professionals, the communities they serve, community-based organizations, and academic institutions need to be united in declaring discrimination in healthcare unacceptable and take action to address discrimination. [83]

3. Strengthening bridges to healthcare

Healthcare organizations should have policies, organizational structures, and formal training to promote cultural competency and trauma-informed care.

Leadership in healthcare settings must value diversity and implement organizational policies and procedures to work effectively across cultures: organizational structures and staff change along with the demographics of communities. Therefore, there must be a commitment to maintain cultural competency through reassessments and adjustments of policies and outcomes. [84] Having a diverse committee overseeing the implementation of these policies and a budget line to cover their time increases accountability and sustainability of this effort to offer culturally competent care.
Latino immigrants bring their own cultural background—and many times, past traumatic experiences—into their healthcare interactions. Healthcare professionals need to be cognizant of this and ready to make Latino immigrants feel welcome and safe. This awareness includes being sensitive, patient, tolerant, and trauma-informed. For front desk staff, it may mean taking the extra time to explain unfamiliar forms to Latino immigrants. For healthcare professionals, it may mean being more curious about the cultural backgrounds of their patients and using cultural cues to make their communication more effective.

Cultural competence and cultural humility must be considered as quality improvement indicators, because the better organizations are able to engage diverse populations, the better the experience of their patients will be. Providing cultural competence training to staff might seem challenging due to the cost of the training and the number of billing hours that staff members invest in it. In the long run, however, providing high quality, culturally informed services will result in higher patient retention and satisfaction.

**Elected and appointed officials should authorize funding for community health workers in Kansas and Missouri.**

Nationwide, CHW programs have demonstrated success in improving patient outcomes and avoiding costly emergency department visits and hospitalizations. [85] New York, Oregon, Minnesota, and Massachusetts have used Medicaid waivers to fund CHWs. Also, CMS announced that states could be reimbursed for using CHWs who provide preventive care services.

Kansas and Missouri should follow the recommendations provided by the Regional CHW Collaborative in the Kansas City metro area, which outlined that 1) both Kansas and Missouri leverage the flexibilities afforded through the Medicaid-managed care contracts to reimburse for CHW services and that 2) Kansas also explore the use of its 1115 waiver to fund CHW activities.

**Healthcare settings using community health workers should follow successful integration models.**

The impact of CHWs is greater when they are fully embedded in multidisciplinary care teams, take part in case review meetings, have access to medical records, and participate in the development of care plans. [86] Because of their close connection to patients, CHWs can get valuable health information that wouldn't be available to healthcare professionals otherwise. Clinical settings adopting CHWs in the Kansas City metro area should look at successful models that exist already.

For example, in the Kansas City metropolitan area, KC Care Health Center partnered with community-based organizations and hospitals to employ 26 CHWs in clinical and community settings. The CHWs in emergency medicine and primary care departments provided patient care coordination along with medical teams. Integrated care teams with CHWs resulted in an 86% reduction of E.R. use and a high number of patients (85%) reporting improvement in their health. [87]

In New York, the Bronx–Lebanon Hospital Center has used CHWs since 2007. They use CHWs to help patients prepare for discharge, follow up with no-shows, and conduct home visits. The hospital trains clinical staff on how to work effectively with CHWs. Medical residents go with CHWs on
home visits to enhance their understanding of the social determinants of health that affect their patients' health and well-being. [88] Increased return on investment has resulted in the expansion of their CHW program. [89]

**Administrators at medical and health professional schools should promote and support community engagement by their students.**

This outreach activity will increase students' understanding and sense of responsibility for the diverse groups residing in their area. Moreover, we recommend that local healthcare systems and clinics create incentive mechanisms to increase retention of graduates from local medical and health professional schools (e.g., physical therapists, dental hygienists, medical assistants) who are interested in serving underserved communities in the Kansas City area.

**Healthcare professionals, social service agencies, and government organizations should continue to facilitate interagency collaborations and reach out to nontraditional partners.**

We recommend that funders support cross-sector collaboration at health coalitions and that coalitions are encouraged to serve as platforms where successful health programs share their “road to success” with other community partners. This opportunity to share lessons learned should include challenges faced by healthcare programs, which could be discussed and addressed collectively.

To address the underutilization of available services within community clinics, we recommend that clinics develop a referral network with other clinics that offer services related to those being underutilized. For example, if colposcopy services are underutilized in your clinic, talk to community clinics that provide women's health services so they can inform patients that they might get seen sooner at your clinic. We recommend the use of a Web-based communication tool such as IRIS, the Integrated Referral and Intake System in Kansas City, to improve interagency communication and referral of patients.

**Healthcare professionals should develop a bilingual online and social media presence to communicate with Latino immigrants, with online information available in Spanish.**

The growing use of the Internet among Latino immigrants for seeking health information offers an opportunity for wide dissemination of evidence-based resources aimed at meeting their health information needs.

On their websites, healthcare organizations should include bilingual information about conditions that are common in Latinos (e.g., diabetes and hypertension) and services offered at their facilities. To address low health literacy and English proficiency barriers, the websites of community clinics should have simple and consistent content organization and navigation menus to help users locate information quickly. [90] The Office of Disease Prevention and Health Promotion, part of the U.S. Department of Health and Human Services, has developed a guide to help health organizations create websites and digital tools that can be easily understood by all users (see https://health.gov/healthliteracyonline/).
Messaging in websites from community clinics should reassure Latino immigrants of the safety measures in place at the clinic related to immigration enforcement (e.g., patient health information will be kept confidential). For example, the New York City Health Insurance Link website lets potential patients know up front that their health insurance application will not affect their immigration status. It states on their website “Applying for health insurance won’t affect your immigration status or application for status” (see https://www1.nyc.gov/site/ochia/find-what-fits/immigrants.page).

**Healthcare professionals should make their websites culturally tailored and mobile friendly for viewing on cell phones.**

Clinics should include culturally tailored messaging to resonate with their clients. Website content also needs to be mobile-responsive, because for many Latinos, the cell phone is the primary way they access online health information and social media.

Clinic administrators could also use paid advertising and tools such as geotargeting on the online platforms used by Latino immigrants (i.e., Google, YouTube, and Facebook) to boost visits to their websites until they get a consistent base of users. Tracking the number of website visitors or “likes” would allow them to monitor use and allocate financial resources accordingly. Paid Facebook campaigns allow the messaging to reach specific demographics, and campaigns can be funded with as little as $5 per week or month depending on their desired reach.

**Healthcare funders and community clinics should develop a bilingual online directory of community clinics with ratings from patients.**

Similar to the websites Community Network of Kansas and United Way of Greater Kansas City available in Spanish that shows the location, types of services offered, office hours, language services, payment options, and user reviews would allow community members, including Latino immigrants, to identify the clinic that is most appropriate for them. Providing maps and infographics would make the information easier to understand.

**Healthcare professionals should offer assistance to Latino immigrant patients to register in online patient portals.**

Having staff at clinics introduce the idea to patients of a patient portal on a tablet (i.e., small screen) could improve use rates of patient portals. This approach addresses both technological and personal concerns by having a clinic staff member assist the patient with the portal setup and be available to answer any questions.

The patient portal should be bilingual and easy to navigate. Like websites, patient portals need to have a low reading level to be accessible to the most people.
Works Cited


how-people-use-mobile-technology/


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Appendix B: Community Satisfactions and Concerns

The research team presented participants with statements about health and healthcare to help assess the level of community concern about various issues affecting Latino immigrants (see table below). This assessment was adapted from the Community Concerns section of the 2017 Wyandotte County Community Health Assessment [97]. The assessment was included in the survey conducted with focus group participants. Each statement about an issue was rated for how important it was to the respondents and how satisfied they were with the community’s efforts in that area on a 0–4 rating scale, with 0 indicating not important or not satisfied. A rating of 4 indicated it was very important or they were very satisfied with the community effort in that area. The table below shows means of responses and is ordered by how important respondents rated the concern. It also includes the associated level of satisfaction with the community’s efforts to address the issue. The rating of importance for the concerns listed ranged from 3.7–3.9; this means that respondents found all of these issues important. The rating of satisfaction associated with the concerns ranged from 1.7–2.2. Overall, the respondents were only moderately satisfied with the community effort related to these issues. We discuss these issues in greater detail in relevant sections of this report.

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<tr>
<td>People are able to manage chronic diseases, such as diabetes, cardiovascular disease, and arthritis</td>
<td>n = 55</td>
<td>n = 55</td>
</tr>
<tr>
<td>People are treated fairly and without discrimination</td>
<td>n = 55</td>
<td>n = 55</td>
</tr>
<tr>
<td>Quality health care is accessible and affordable for all</td>
<td>n = 53</td>
<td>n = 54</td>
</tr>
<tr>
<td>People have meaningful opportunities to influence what happens in their community</td>
<td>n = 55</td>
<td>n = 54</td>
</tr>
<tr>
<td>People with mental health needs can access and receive treatment</td>
<td>n = 55</td>
<td>n = 54</td>
</tr>
<tr>
<td>People are free from the threat of physical and sexual violence</td>
<td>n = 55</td>
<td>n = 54</td>
</tr>
<tr>
<td>People receive the support they need in their lives</td>
<td>n = 55</td>
<td>n = 54</td>
</tr>
</tbody>
</table>
## Appendix C: Role and Number of Healthcare Professionals Participating in Individual or Group Key Informant Interviews

<table>
<thead>
<tr>
<th>CONSTRUCT</th>
<th>SCALE/SOURCE OF QUESTIONS</th>
<th>NUMBER OF INTERVIEWEES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare administrator</td>
<td>FQHC, health department, and community health center</td>
<td>5</td>
</tr>
<tr>
<td>Healthcare provider</td>
<td>Health department, hospital clinic, and community health center</td>
<td>5</td>
</tr>
<tr>
<td>Community health worker, healthcare navigator</td>
<td>FQHC and community-based organization</td>
<td>3</td>
</tr>
<tr>
<td>Social services and school administrator</td>
<td>Community-based organization and school district</td>
<td>5</td>
</tr>
</tbody>
</table>
Appendix D: Multidisciplinary Project Team

JUNTOS Center for Advancing Latino Health, University of Kansas Medical Center [https://www.jsuntosk.org/](https://www.jsuntosk.org/)

JUNTOS, the Spanish word for together, is a community–academic partnership dedicated to engaging Latino communities in health research with the goal of reducing health disparities experienced by Latinos and building healthier communities in Kansas. JUNTOS engages in community-based and academic collaborative efforts with local, regional, and Latin American partners to develop innovative, culturally appropriate interventions to meet the needs of diverse Latino populations.

Center for Community Health and Development, University of Kansas [http://communityhealth.ku.edu/](http://communityhealth.ku.edu/)

The KU Center supports community health and development through collaborative research and evaluation, teaching and training, and technical support and capacity building. The Center has developed widely used capabilities for community-based participatory research and building capacity for community work, including the Community Tool Box. Recognition of these capabilities led to its official designation in 2004 as a World Health Organization Collaborating Centre for Community Health and Development.
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