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## Health Care Delivery and the Hispanic Community in Knox County

Sean C. Barton

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# Health Care Delivery and the Hispanic Community in Knox County

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The University of Tennessee Knoxville

Chancellor's Honors Program: Senior Thesis

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**Purpose:** The purpose of this paper is to summarize the history of health care reform and how the health care system is operating today, to summarize key findings on disparities and access-barriers to health care for Hispanic immigrants, and to present findings on what initiatives are being taken in Knox County, Tennessee, with regards to health care delivery for the Hispanic population.

**Preface:**

In the midst of the dynamic and busy world of the health care industry new knowledge and policy changes are always emerging. In many hospitals, research institutes, and Universities around the country, scientists and physicians are constantly working on finding new cures for diseases and designing new, cutting edge technology to advance the capabilities of medicine further. These initiatives and efforts are without a doubt vital characteristics that allow medicine to progress. One aspect that will always be present within the health care industry is the increasing number of patients whose quality of life is often bettered thanks to these efforts. People will always need to be cared for, and they will always bring with them new challenges to the field of health care. However, within the complex and advanced problems of medicine, there is another a problem. It is the increasing number of uninsured Hispanic immigrants in the United States who cannot access or often afford health care due to many barriers within the health care industry. In order to demonstrate the pervasiveness and reality of this issue, I would like to present the thoughts, ideas, and personal accounts of some physicians and nurses who deal with this growing minority population in health care on a regular basis. These responses and personal testimonies from real interviews lend a more tangible and human perspective in addition to the data analysis that is also a part of this paper. The fictional and theatrical setting that follows has been created in order to provide a background that will allow the issues that this paper attempts to address to be brought to light.

## “A not so Imaginary Conversation”

Characters (\*the physicians and nurses will remain anonymous in the following account, but their places of work are listed along with the character’s pseudonym):

Interviewer: played by myself

Physician #1 (Vanderbilt Medical Center, Nashville, TN)

Physician #2 (Vanderbilt Medical Center, Nashville, TN)

Physician #3 (Community Health Systems and Private Practice organization, Clarksville, TN)

Physician #4 (Inova Fairfax Hospital, non-profit organization – Washington, D.C.)

Nurse #1 (Jennie Stuart Medical Center, non-profit organization- Hopkinsville, KY)

Nurse #2 (for-profit hospital – Southern California)

Nurse #3 (East Tennessee Children’s Hospital, non-profit organization – Knoxville, TN)

Setting: A hospital conference room. 8:00 am.

The physicians and nurses have agreed to meet to have an open discussion about the access barriers to health care for the Hispanic population as well as the difficulties that come with providing care in the presence of a language barrier. These health care professionals are from various cities and health care organizations.

All are seated around a wooden conference table; some indulge in the coffee and light breakfast provided. The atmosphere is relaxed but professional.

Interviewer: Hello, everyone. I’d like to first and foremost thank everyone for coming today. I know that you all are very busy and have patients to see, so we will try to be brief. As I mentioned on the phone or in person with some of you, I am investigating the barriers to access and delivery when serving the Hispanic population in health care. I hope to simply stimulate conversation amongst you in order to observe your personal interactions and testimonies, so as I ask the questions please feel free to comment by any means necessary. Are we all ready to begin?

[All nod or give some form of acknowledgement]

Interviewer: Very well then, let’s begin. First, is there anyone here who has not at some point found himself treating someone from the Hispanic population? Let’s start by going around the table. Physician #1 would you care to start?

Physician #1: Of course not. As a neonatologist, we actually see patients from a complete spectrum of race and ethnicity.

Physician #3: Yes that is very true. Seeing as Vanderbilt is in downtown Nashville, we deal with many non-English speakers. Everyone has babies, so we see everyone.

Nurse #1: Yes, we often see Hispanic patients in the labor and delivery department; our area is rural but it is growing; it has attracted a large volume of the Hispanic population due to jobs in construction and farming.

Physician #2: It's the same way for us. Even outside of the hospital in our clinic, I probably see several Hispanic patients each month who do not speak English.

Nurse #2: Being a Southern California native the majority of our patients, clients or community members tend to be of Hispanic descent.

Nurse #3: We see many Hispanic patients each day at East Tennessee Children's Hospital. Being in downtown Knoxville and the only Children's Hospital in East Tennessee, we are the region's destination for child care.

Physician #4: At Inova in D.C. we serve a large volume of the Hispanic population as well.

Interviewer: So, it is evident that you all are serving the Hispanic population in your places of work. In order to communicate, your employers would have to offer some services that bridge this language barrier such as interpreters, would they not?

Nurse #2: Well, actually all health care organizations, whether or not they are health departments, hospitals, or clinics, are required under federal law to provide interpreter and translator services if they are participating or affiliated with Medicare or Medicaid. It has been my experience that there are not personal translators in the hospital in California because most employees speak fluent Spanish.

Physician #1: Yes, that is very much true. However, many providers skirt around this requirement by having Spanish speakers "on staff."

Physician #2: Yes, this is the case at our hospital. There are no certified medical interpreters employed by the hospital. If interpretive services are needed, sometimes there is a house cleaning lady on staff who can communicate for us. In the hospital's labor and delivery department we have a nurse practitioner who is fluent, but she isn't always working or isn't always available. It's all very frustrating.

Physician #3: Wow, I could not imagine that. At Vanderbilt, we have daytime access to in-person translators who are staff; there is 24 hour access via a two-way phone translator for after hours.

Physician #1: Also, we have many NICU staff that are fluent in Spanish.

Nurse #1: Our hospital did not offer services. I work in L&D and the physician's office coordinated a Spanish speaking volunteer to be available to these patients for all appointments and hospital registration. The interpreter would leave her contact information for emergencies and would usually visit at least once daily during hospitalization to assist with any needed tasks.

The rest of the time the nursing staff would communicate with broken Spanish using Spanish/English translators.

Nurse #3: That sounds so frustrating. We have access to in-person Spanish interpreters 24 hours every day.

Physician #4: I agree, we have interpreters during the day time, but we have to use the phone line at night if there is an emergency. Some of our staff is bilingual, but for those not trained with medical terminology in Spanish, it is often very difficult to describe symptoms or a diagnosis. Even fluent speakers can have trouble explaining this to the patient.

Interviewer: Wow, I can only imagine how difficult it is to care for a patient when you aren't able to communicate. It would seem that since the Hispanic population is the fastest growing minority population in the U.S. that the law which requires medical interpretive services would be enforced more strictly.

Nurse #1: I very much agree. Especially when this is such a large population who is not getting health care attention. I have had the opportunity over the years to care for multiple patients that did not speak English. I found providing care to these people very rewarding. There were moments of frustration for both the patient and myself, but working together the language barrier was usually overcome. I found the gratitude exhibited by these patients to be a tremendous reward when the extra effort to ease fears and make sure all needs were met was given. I believe these patients should be treated with the same standards of care all patients are given.

Physician #4: That is very true. But, what if you can't get through to them or bridge that language barrier? To give my honest opinion, when my nurse tells me I have a Spanish speaking patient waiting in the next room, I'm already rolling my eyes. It's not that I don't want to or desire to provide the same standard of care to this patient, but you just can't most of the time. Even if it's during the day time and we have an in-person interpreter, things are lost in translation. I don't feel that my emotions or connotation are always conveyed appropriately. Even more so, a good bit of the time doctors are running behind schedule because you wait in each patient's room giving them as much time as they need regardless of the schedule. However, with Spanish speaking patients I already know when I walk in that I am not going to be able to deliver my highest standard of care. It takes twice as long to communicate through an interpreter.

Physician #1: This is very true. It is frustrating and time consuming, but I cannot imagine functioning without the interpreters. When I have felt barriers to full communication, they have usually been relieved by the use of a readily available interpreter. I wish I had language skills of my own. The best solution has been to have an NICU staff member who speaks Spanish, since that relieves the "medical language" barrier, too. This way you don't have to wait for an interpreter to come up to the floor, and you are able to communicate effectively.

Nurse #2: It may be difficult at times, but if the situation needs extra time to communicate then that is what I am going to do. As a health care professional, I always strive to treat every patient at the same standard of care regardless of their background or language.

Physician #2: Yes, it is frustrating to try and diagnose someone who can't communicate, but you still do your best for that patient. You all are very fortunate to have interpreters on staff. The board at our hospital would not even consider staffing interpreters at their own expense.

Interviewer: So money is a factor for the hospital sometimes? Would you say that your hospitals often are worried about making a profit before considering taking care of the patient?

Physician #2: Well it is not that money is a problem; it's the fact that it would cost them money to provide interpretive services to the patients. If they can get away with not having anyone but a few random staff members then this is more profitable to them. They're a business.

Nurse #3: That's very unfortunate. I haven't encountered that sort of attitude at Children's Hospital. Our hospital was founded on the basis of providing excellent, patient-centered care that doesn't discriminate based on ability to pay, race, or gender.

Interviewer: That is very interesting. Well while on the subject of improving access to care, I would like to ask the following. Is it a possibility that Hispanic immigrants may be undocumented or illegal residents and still receive treatment? Do any of your hospitals refuse to provide care to undocumented patients?

Physician #4: That's never an issue at our hospital. As a non-profit organization we are here to provide care to the patients. We are not here to enforce the law.

Nurse #3: That is very much the case at Children's as well. We do not deny care to anyone even if they have no documentation. Our goal is to take care of the patient and provide health care to anyone who comes through the door. We do not even think twice about delivering care to a patient; whether they have documentation or money, they can be served here.

Physician #2: I suppose I could say that is the case at our hospital; however, it is not because the board's aim is to provide accessible or affordable health care. At our hospital when a patient arrives, they only care about one thing, and it is not a matter of whether you have legal documentation. They want to know if you have money; they want to know if you are going to be able to pay them for the services.

Interviewer: Well that is rather disappointing, but I suppose it's a sad truth. I see that we have been here slightly longer than an hour, and I promised we'd be done in less than one. Unless anyone else has anything they would like to discuss, I suppose we shall end on this note. I can't thank you all enough for your time and the opportunity to gain this unique perspective on a rather difficult topic to address in health care. In the mean time I look forward to hearing from all of you again soon.

[All say their goodbyes and begin to depart].

THE END

It is evident that there are barriers to delivering health care to the Hispanic population. Physicians and nurses are the health care providers who are facing these access barriers in addition to the Hispanic population themselves. There is a language barrier present, but it is not necessarily this factor that makes treating these patients so difficult; there is a lack of interpretive services in hospitals that would be able to facilitate communication with this population. Patients as well as the providers become frustrated because they are not able to care for the patient. Some hospitals are taking the initiative to provide interpretive services, and these are often the non-profit hospitals in the community. This paper will address these disparities and barriers in access to health care for the Hispanic population in the midst of the major health care reforms in the United States today.

**Introduction:**

In an article titled “Left Out: Immigrants’ Access to Health Care and Insurance” published in the *Journal of Health Affairs* (2001) , the author sheds light on the fact that recent policy changes have limited immigrants’ access to health care and insurance. The federal welfare reform law of 1996, the Personal Responsibility and Work Opportunity Act (PRWORA), restricted eligibility for Medicaid by immigrants. It states that immigrants who arrive after August 1996 cannot receive coverage from the Medicaid program, except for emergencies, during their first five years in the country<sup>1</sup> . Prior to this law people legally admitted into the United States were eligible to apply for and receive the same benefits from the Medicaid program as legal citizens. The article then proceeds to say that non-citizen immigrants are less likely to have job-based insurance. Without insurance, people are going to be less likely to seek

care from private practices or health care organizations such as hospitals. This leaves the community clinics and emergency rooms for outpatient treatments as the main source of care. In addition, these conclusions do not take into account how being an immigrant in a foreign country affects the people's comprehension of these health care systems and laws in the United States. Even if someone was a legal immigrant he or she might be deterred from enrolling in Medicaid or even looking into getting insurance coverage; it would seem that lack of communication, knowledge, and the presence of language barriers could very much deter someone from enrolling in government programs even if they were eligible. In a country where the white/ Caucasian population has retained power for the majority of its history, it is not unlikely that there is a fear factor present among these immigrants who may often feel stereotyped as illegal or even unwelcomed in general; this mindset must certainly be detrimental when trying to get someone to take the initiative to then engage with a government program or private health maintenance organization directly. If these immigrants are not eligible for the government programs and are not receiving coverage through their employers, then how are they expected to access health care? How are they supposed to provide a usual source of care for their children?

According to the Pew Hispanic Center, approximately thirteen percent of the roughly three hundred and sixty six million people in the United States is Hispanic. Over the past two decades the percent of uninsured Hispanics has doubled to thirty seven percent<sup>5</sup>. *The Journal of the National Medical Association* also notes that even when noncitizens and children are insured they have less access to health care in comparison to non-Hispanic civilians of the United States. All of this information is ironic. When immigrants come to the United States to

improve their quality of life, it would seem that having access to health care would go hand in hand with such a big move. I was intrigued by all of this information when I was doing some research for a service learning class that I was participating in here at the University of Tennessee. The service learning opportunity consisted of shadowing and working with the medical interpreters at East Tennessee Children's Hospital each week. It was during this experience that I was able to observe the interactions between the medical staff as well as the quality of care that the hospital was providing. The interpreters are full-time workers, and the hospital staffs at least one of these interpreters seven days a week. I observed the interpreters regularly varying from instances such as patient registration, in-patient checkups, radiology, and surgery preparation. I saw the nurses, secretaries, and doctors all in a variety of situations. I was attending the hospital so often that what I was observing became the norm for how a hospital or health care organization operated. I never thought about this quality of care being out of the ordinary; I believed while I was there that every hospital operated with standards set this high when it came to patient care. It was towards the end of the semester when this service learning practicum was ending that I remembered that East Tennessee Children's Hospital is not the norm when it comes to patient care. It occurred to me that their quality of care was above and beyond what I had observed in comparison to various other hospitals where I had shadowed the summer before. They were setting the bar as high as I had seen.

With these observations and experiences I had the desire to investigate what initiatives were being taken to accommodate the United States' fastest growing minority population in terms of access to health care and its delivery methods in Knox County health maintenance organizations. The purpose of this paper is to summarize the history of health care reform and

how the health care system is operating today, to summarize key findings on disparities and access-barriers to health care for Hispanic immigrants, and to present findings on what initiatives are being taken in Knox County, Tennessee, with regards to health care delivery for the Hispanic population. This exploration of health care delivery, barriers to access, and a history of health care reform in the United States will be organized as follows. In part one, the history of health care reform will be presented to demonstrate how the health care system in the country has changed and progressed over time. This will show the buildup and actions that have led the health care system to its operating platform of today. Given that the government is in the midst of the most comprehensive reform of health care since 1965, a summary of the major provisions of the Patient Protection and Affordable Health Care Act of 2010 will be given next. After laying the ground work of the history and current operation of our health care system in the United States, part two will consist of a literature review and key findings of how the Hispanic population is being accommodated into this health care system; the barriers to access, disparities, health status, health communication, the degree to which other institutions are prepared to provide care to the immigrants, and attitudes towards the system will be included. Part three will discuss the initiatives being taken in Knox County that aim to accommodate the Hispanic population with respect to health services and delivery.

## **Part 1: Health Care Reform in the United States**

### **A. A History of Health Care Reform**

Since President Barrack Obama was elected for his first term of service in the White House in 2008, the country has heard about an increased push for national health care reform. Before long it was not only a possibility that the health care reform was going to take place, but it was also becoming a reality. Then on March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (PPACA) into law. The bill was designed to implement its effects over a time frame of years; the changes would be gradual and not immediate. Needless to say this did not mean that some changes would not be perceived as drastic. Before attempting to unpack the patient protection and affordable care act, it is important to note that health care reform initiatives have occurred multiple times throughout history. Because of this it is important to observe how the United States has arrived at its current health care system that it is using today.

Health care reform is not a recent subject, controversy, or initiative in the United States. The matter of health care reform has cropped up in legislation and presidential campaign platforms over the last century. Advocacy for health care reform has existed on many levels throughout history. According to a not-for-profit research organization called Physicians for a National Health Program (PNHP), the first health insurance proposals in the United States did not evolve from the government as was the case in Europe. In the late 1800's in contrast to the United States, many European countries had already experienced a type of socialized insurance<sup>37</sup>. The United States had begun its Progressive Era in the 1890's but there was not a powerful initiative arising from the working class to support broad social insurance programs as was the case in Europe. Despite the reformers of the Progressive Era advocating for improved social conditions for the working class, the first president to support health insurance reform in a

campaign platform did not arrive until Theodore Roosevelt. Roosevelt took this initiative during his progressive “bull moose” campaign in the election of 1912; it was his goal to increase the welfare of the citizens and increase federal regulation. However, no success was seen here because William H. Taft won the election and the conservatives moved into office. Also arising out of the Progressive Era was the American Association of Labor Legislation (AALL); they drafted a preliminary bill in 1915 that proposed to cover the working class and people earning less than twelve thousand dollars per year. The AALL wanted to have the costs of physicians, nurses, and hospitals covered as well as sick pay and maternity leave. This national health care push was supported by the American Medical Association (AMA) but opposed by the American Federation of Labor (AFL) and the private insurance agencies.

After the progressives’ attempts at reform the focus of legislation was shifted towards financing and accessing health care as opposed to stabilizing people’s incomes. During the 1920’s hospital costs started to rise mostly due to the increased use in hospital services by the middle class<sup>32</sup>. Then, during the Great Depression (1929-1939) the unemployment rate rocketed above 20%; medical costs continued to rise and illness was a leading factor of poverty<sup>32</sup>. At the end of the 1920’s the Committee on the Cost of Medical Care (CCMC) was formed and made up of some fifty economists, physicians, public health workers, and interest groups<sup>32</sup>. Privately funded by philanthropists such as Rockefeller and Millbank, they published twenty six research volumes full of reports that determined and brought light to the fact that there was a need for more medical care for everyone. Their report was treated as a radical document by the American Medical Association (AMA)<sup>37</sup>.

Next, there was President Franklin D. Roosevelt who served from 1933-1945 while he attempted to tackle the Great Depression and WWII; his plans for this included the New Deal and its relief programs which were enacted between 1933 and 1938. During this time President Roosevelt had the option to include health care reform with the Social Securities Act of 1935; however, with unemployment insurance taking the front seat during the Great Depression along with old age benefits, in addition to opposition by the American Medical Association, FDR's committee on economic security concluded that the Social Securities Act of 1935 might have been compromised and never disclosed their findings to the public<sup>37</sup>. After the Social Security Act was passed, another group of federal representatives called the Technical Committee on Medical Care was assembled in 1937<sup>32</sup>. This committee also suggested a compulsory health insurance and payroll tax system that the states would choose whether to adopt or not; the committee tried to organize a national health convention in 1938 but with continued opposition from the AMA and therefore no success. The last push for national health insurance during the FDR tenure was the Wagner-Murray-Dingell bill of 1943 which grew from the initiatives brought about by the Technical Committee on Medical Care; this effort had been thwarted however by the arrival of a conservative congress in 1938 and the arrival of World War II<sup>32</sup>. Universal Health Care failed, but FDR did sign the Public Health Service act of 1944 into law. The law included revisions to existing laws and public health service reforms such as elimination of outdated regulations, authorization to make grants which aid research institutions for study of disease, and creation of the Office of the Surgeon General and the National Institute of Health to name a few<sup>31</sup>.

When President Roosevelt died in 1945 Vice President Harry Truman came into office; it was during this same year that WWII ended. President Truman soon proposed his Fair Deal programs. The Fair Deal consisted of plans for a national health insurance program, education reform, civil rights initiatives, and labor/welfare programs<sup>40</sup>; Truman's plan proposed a single egalitarian system that included all classes of society, not just the working class<sup>37</sup>. Furthermore, reformers had shifted away from the state-administered health insurance initiatives implemented by the Technical Committee on Medical Care and were now in favor of the national health insurance program which had been presented by the Wagner-Murray-Dingell bill of 1943<sup>32</sup>. Even though Truman was reelected to serve a second term in 1948, his national health insurance program was losing support. The American Medical Association fought fiercely to sell the plan to the public and congress as socialized medicine. In the end Truman's universal health insurance failed, but many other health initiatives were successful such as the Hill Burton Act of 1946 which created financial assistance from the federal government to modernize and update hospital facilities<sup>31 37</sup>. With the audacious initiatives of national health insurance stopped yet again, reformists would next turn to attempts at insurance for the elderly and the beginnings of Medicare.

In 1953 President Dwight D. Eisenhower took office and presided until 1961. Under his term of service the Kerr-Mills Act of 1960 created a program called Medical Assistance for the Aged. Prior to 1965, this was how states received federal assistance for medical expenses; this grant program gave the states the option to cover the elderly people who were deemed medically in need with income levels above those needed to qualify for public assistance<sup>41</sup>.

Unfortunately by 1963 only 28 states had enrolled in the Medical Assistance for the Aged program and funds were not being budgeted well <sup>32</sup>. In the following presidency, John F. Kennedy made health reform a large part of his campaign platform; he supported policy changes in favor of hospital coverage for seniors under the Social Security Act (this was the beginnings of Medicare) <sup>37</sup>. This legislation did not pass congress during JFK's term of service however. It was then in 1964 when Lyndon Johnson was elected president that he made Medicare a top priority. By this point in time labor unions along with civil rights organizations supported coverage for the elderly, the National Council of Senior Citizens was created to campaign in favor of Medicare, and even the American Hospital Association along with health insurance companies acknowledged that it was costly to insure the elderly. By this point the Medicare bill had evolved into part A (coverage for hospital care, nursing, and home health care), part B (coverage paid partly by premiums for physician care), and Medicaid (assistance to the states for coverage of long-term care for the poor as well as for certain classes of the poor and the disabled) <sup>32</sup>. In July of 1965 President Johnson signed the Social Security Amendments of 1965 into law which included the Medicare and Medicaid programs. Additionally, title VI of the Civil Rights Act of 1964 declared that any organization that receives federal funding is required to provide language access to its services so as to not create discrimination on the basis of race <sup>42</sup>.

The Social Security Amendments of 1965 were the last major health care reforms signed into law that pertained to "socialized medicine." Following Lyndon Johnson's term, there were national health insurance proposals under Richard Nixon as well. President Nixon proposed his Comprehensive Health Insurance Plan (CHIP) which included universal coverage that would be

paid for by employers as well as federal subsidies to aid people in acquiring private insurance<sup>43</sup>. This proposal eventually lost support as the Watergate Scandal became the primary subject during that time. Then, during President Carter's term in office, a national health insurance plan proposed that employers provide a benefits package for health coverage and that public coverage for the poor and aged be expanded under the Social Security Act<sup>32</sup>. This plan was stopped by a growing conservative congress. During President Reagan's time in office Congress did expand Medicare by providing a prescription drug benefit and coverage for catastrophic events; however, this legislation was repealed the following year<sup>44</sup>. The clause for prescription drug coverage would later be reinstated under President Bush in 2003<sup>44</sup>.

The last major health reform plan proposed before 2010 was President Clinton's plan, the Health Security Act; this plan proposed universal coverage, employer and individual mandates, and planned to keep insurance costs down by encouraging competition between private insurers and providers which would be handled by the government<sup>30</sup>. The managed competition approach as well as individual mandates were ideas that would remain prominent in the Patient Protection and Affordable Care Act in the future. Although the Health Security Act did not gain enough support to pass through Congress under Clinton, the Clinton administration did achieve some health care reform. The State Children's Health Insurance Program (SCHIP) was signed into law expanding upon Medicaid in 1997; it was designed to cover the uninsured children of families whose incomes are too high to qualify for Medicaid but are still in need of assistance with medical expenses ([chipmedicaid.org](http://chipmedicaid.org)). Also, in August of 2000 President Clinton signed executive order 13166 which required federal agencies to provide guidance to recipients of their funds so that they would know how to comply with Title VI from 1964<sup>42</sup>. In short, this

order reminded everyone including health care providers that interpretive services had to be provided by those organizations who encountered language barriers in health care delivery; the order required that all organizations produce a plan and updated information on how they were providing language access in their own services <sup>42</sup>.

## **B. The Patient Protection and Affordable Care Act**

President Barrack Obama was elected president of the United States in 2009. By March 23, 2010, the Patient Protection and Affordable Care Act was signed into law. This bill is the largest and most significant health care reform law that has been passed since the Social Security Amendments were signed into law in 1965. As outlined above, since 1965 there have been multiple initiatives proposed for national health care reform or national health insurance programs that were not successful. The Patient Protection and Affordable Care Act (PPACA) has become a landmark piece of legislation.

According to the U.S. Department of Health and Human Services, the overall goals of the PPACA (also known as ObamaCare) are to increase the quality of health insurance, expand the availability of coverage, control the rising costs of health care, and improve health care delivery. The reform of the health care industry has been put into effect through numerous provisions over the last four years. One of the largest targets of this bill is the 50.7 million people who do not have health insurance in the United States <sup>1</sup>. This law will reform private and public health insurers who often have taken advantage of consumers. The PPACA's main provisions include actions to eliminate pre-existing condition discrimination and denial for coverage based on health status, expand the Medicaid program to all people with incomes below 133 percent of the poverty line <sup>7</sup>, permit young adults to remain on their parent's plans until age 26, and create health insurance marketplaces for each state (obamacarefacts.com). These "exchanges" are where low or middle income people can purchase

discounted or even free health insurance. The entire program is expected to extend coverage to 30 million people by 2020<sup>36</sup>. In order to achieve these goals the bill will utilize government subsidies, taxes, and individual and employer mandates.

Under the new PPACA, many people will now have access to health care insurance who did not before. Changes will even take place for those people who will retain the insurance plan they already have; employers, employees and individuals become affected under the employer and individual mandates. Those making more money in the country can expect tax increases to pay for the expansion of these government programs. During June of 2012, the Supreme Court ruled that the PPACA mandate requirement was constitutional within the bounds of Congress's power to levy taxes<sup>46</sup>. With all these changes coming it is important to know when they will be enacted and what is going to change. Between research and information acquired from the Henry J. Kaiser Foundation and the U.S. Department of Health and Human Services the following chronological summary of the PPACA provisions has been constructed.

One of the goals of the PPACA was to strengthen insurance coverage and reliability even for those who were already able to afford it. In 2010 the first provisions to be enacted under the PPACA focused on consumer protection from the abuses of the insurance companies, improving quality and lowering costs, and increasing access to affordable care.

Beginning July 1, 2010, consumers were able to begin comparing information on insurance coverage options online. Then, on September 23, 2010 insurance companies were prohibited from denying coverage to children under the age of 19 based on pre-existing conditions, revoking coverage, and imposing lifetime limits on essential needs like hospital stays. In addition the law has provided a way for consumers to appeal coverage decisions through an external review process provided by assistance programs in the states. In order to improve quality and lower costs, small businesses were provided with

health insurance tax credits, relief was offered to seniors who recently fell into the Medicare prescription drug “donut hole”, free preventive care benefits were added, a new Prevention and Public Health Fund was created, and new screening efforts to crack down on health care fraud are being implemented. In 2010 four million senior citizens were expected to eventually exhaust their Medicare Prescription drug coverage and fall into the “donut hole” of coverage. Those who reach this gap in drug coverage will receive a rebate check and will automatically get a 50% discount on covered brand-name drugs<sup>41</sup>. The free preventive care benefits include health services such as mammograms and colonoscopies without charging a deductible or co-pay. As far as increasing access to affordable care, in 2010 new coverage options were made available to those uninsured due to pre-existing conditions, young adults are permitted to remain on their parents’ plan until age 26, coverage has been expanded to early retirees who don’t qualify for Medicare yet, incentives have been provided to expand the number of primary care doctors and nurses, states are implementing measures that require insurance companies to justify premium increases, states can receive funds to cover some low-income individuals and families that previously were not allotted for, rural health care providers receive increased payment as incentive to practice, and funding for construction of new services at community health centers is being provided. By rebuilding the rural and primary care work force the health care reform law aims to strengthen care in underserved areas where often professionals do not desire to work. Together with the increasing capabilities of community health centers this initiative should be able to successfully provide greater access and affordability to care.

In 2011 the PPACA retained focus on improving quality and lowering costs as well as increasing access and affordability. In addition the insurance companies also began to be held accountable for taking advantage of consumers. During 2011 it was officially determined that all seniors who reach the coverage gap will receive a 50% discount when purchasing Medicare Part D name brand prescription drugs; additionally, free preventive care services like annual wellness visits began to be provided for.

This allowed prevention plans to be established and improved care for seniors once they leave the hospitals so that readmissions can be avoided. Also, the law established a new Center for Medicare and Medicaid Innovation that tests new ways of delivering care to patients and submits annual reports intended to reflect on how efficiency and quality can be improved. Effective beginning in October 2011, the "Community First Choice Option" began allowing states to offer home and community based services to individuals through Medicaid rather than only care in nursing homes. Concerning the health insurance companies' accountability, as of January 1, 2011, cracking down on health care premiums became stricter. The law now requires that 80% of the costs of premiums be spent on health care services and health care quality improvement; if they are not then rebates are to be issued to the consumers.

The provisions in 2012 continued to focus on lowering costs, improving quality, and increasing access and affordability. Beginning January 1, 2012, the law provided incentives for physicians who would join together and form "Accountable Care Organizations." The goal is to encourage physicians to facilitate a better quality of patient care and then reduce unnecessary hospital admissions. One of the long standing debates with hospital companies is the unnecessary amount of services or tests that are suggested so as to generate larger hospital bills. These integrated health groups will provide incentives in hopes that physicians and hospital staff will work while keeping what is the best for the patient in mind. Further as of March 2012 federal health programs are required to submit racial, ethnic, and language data to the Secretary of Health and Human Services; this initiative will hopefully help to understand and fight health care disparities. Also as of October 2012 changes were implemented that require health care providers to use electronic health records to an extent in order to reduce paperwork, reduce medical errors, and improve efficiency and equality.

In 2013 more funding was provided to Medicaid programs of the states that choose to cover preventive services for patients at discounted or no cost. This will hopefully increase the number of

people who are receiving some sort of a regular preventive care. Additionally, the law intends to coordinate with hospitals, doctors, and providers to bundle payments; by bundling payments a flat rate is paid for a care instance and consumers do not have to make multiple claims to multiple providers. Prior to this law if a patient had to have surgery whether it be in a hospital or private surgery center it was likely that claims would have to be made for the doctor's services as well as the facility's; this stipulation will hopefully streamline care and efficiency as well. In preparation for the implementations that were coming in 2014, beginning in 2013 states are required to pay primary care physicians no less than one hundred percent of Medicare payment rates in 2013 and 2014 for primary care services. This increase acted as an incentive for primary care physicians as the Medicaid program prepared to cover the increased volume of eligible citizens in 2014. It was also as of October 1, 2013, that the Health Insurance Marketplace was open for business. Consumers were allowed to begin purchasing plans at this time that would go into effect on January 1, 2014.

As of January 1, 2014 new measures for consumer protection went into effect. Just as had occurred with children under the age of 19 in 2010, now the law declared that it had officially implemented all reforms prohibiting anyone from being sold insurance or denied coverage due to pre-existing conditions or gender; renewals can no longer be denied for these reasons either. In accordance with this, companies cannot charge higher rates due to gender or health status. The law also prohibits plans from limiting the yearly amount of coverage an individual may receive, and insurers are now no longer permitted to drop or limit coverage to a person participating in a clinical trial. As of 2014 the major implementations went into effect that are going to elicit noticeable change for those people who are uninsured. Now the tax credits are available to those with income between 100% and 400% of the poverty line; the department of health and human services states that in 2013 400% of the poverty line was \$45,960 for an individual and \$94,200 for a family of four<sup>19</sup>. The law also implemented the second phase of tax credits for small businesses, and people can purchase insurance in the marketplace if their

employer doesn't provide it. Additionally, access to Medicaid was expanded and the individual mandate was put into effect. It was during this year that eligibility for Medicaid was expanded to those who earn less than 133% of the federal poverty level. As for the individual mandate, for those who do not acquire health insurance, do not qualify for subsidies and are not exempt, there will be a one percent tax imposed on the individual's income; this tax will increase to two and a half percent by 2016. The government will intend to enforce this tax penalty on tax returns. Further, in order to help finance the law, taxes will now be implemented on pharmaceutical companies, medical devices, and the insurance companies.

By the end of 2014 most of the major provisions of the PPACA have been put into effect. In 2015 the U.S. Department of Health states that physicians will see payments for their services adjusted according to the value of care they provide. The Kaiser Family Foundation includes that the State Children's Health Insurance Program will increase eligibility by October of the same year. It is also during 2015 that businesses with more than 50 employees will have to offer health insurance. By 2018 all health care plans must offer preventive coverage (this includes the plans held before any preventive care was required). During this time an excise tax will also be put into place on insurers who provide coverage for employer provided health plans; this tax on high-cost insurance is being referred to as the "Cadillac tax." The tax is a non-deductible excise tax of 40 percent on insurance that costs more than \$10,200 for individuals and \$27,500 for a family in 2018. And finally as the law works with the elderly over the next six years, by 2020 ObamaCare hopes to eliminate the Medicare gap or "donut hole" explained previously.

The Patient Protection and Affordable Care Act looks great on paper. It has expanded the Medicaid program to include those whose income is below 133 percent of the federal poverty line, federal subsidies are available for those who make less than 400 percent of the poverty level. The Congressional Budget Office (CBO) projected in 2010 that the Affordable Care Act will provide health

insurance coverage to 32 million people by 2019<sup>7</sup>; as of 2009, 50.6 million people were uninsured in the United States. The PPACA will even raise revenues and reduce spending so efficiently that the bill is projected to reduce the overall federal budget deficit by \$100 billion in the first ten years and then by \$1 trillion by 2030; given that the United States spends 17 percent of its gross domestic product on health care, any reduction of the budget can only be a positive effect<sup>7</sup>.

## **Part 2: The United States Health Care System and the Immigrant Population**

### **A. Immigrants' Access to Health Care Coverage**

John Gruber of the *National Tax Journal* cites the two major sources of public insurance coverage for the United States as the Medicare program for the elderly and the Medicaid program for many of the poor and the children. Because of the qualifying credentials required to be eligible for these two programs, it turns out that most of the uninsured are not the poorest of Americans as the Kaiser Family Foundation also states. Most of the uninsured are in fact those referred to as the “working poor”; these people are those whose income and age leave them ineligible for public insurance coverage and who are not receiving employer based insurance<sup>7</sup>. A significant amount of the immigrant population in the United States falls into the classification of the working poor.

According to the Pew Hispanic Center, in 2011 there were approximately 11 million undocumented immigrants living in the United States; 1 million of these 11 million were children. Of these undocumented immigrants 76% were Latinos<sup>15</sup>. From these statistics it is

clear that a significant portion of these immigrants are of Hispanic origin. However, these statistics can be misleading by suggesting the stereotype that many Hispanic immigrants are illegally living in the U.S. This is not necessarily the case. Thirteen percent of the total U.S. population is Hispanic (roughly 41 million people), and only one quarter of all these people are undocumented. It is clear that a large majority of immigrants and namely Hispanics are legally present in the United States, yet they are at a disadvantage when it comes to access to health care and coverage. With the increases in immigration and dispersal of immigrants around the United States, it is no surprise that Hispanic health issues have become an increasingly important concern. Although immigrants arrive with the initiative to acquire a job and do in fact work, one of the largest problems is that they are not provided employer based insurance, nor can they afford to buy private insurance. In response to the restrictions placed on the Medicaid and State Children's Health Insurance Program (SCHIP) in 1996, some states are attempting to help where permitted. For example, as of 2004, 25 states offered state-funded coverage or used SCHIP funding to provide prenatal care to immigrants without regard to their immigration status<sup>23</sup>. Regardless of some states taking the initiative to provide health care, there is still a large amount of people who are underserved or not served at all.

In comparison to native citizens, statistics show that immigrants in the United States are much more likely to be uninsured. Fifty two percent of immigrants in 2003 were uninsured in comparison to fifteen percent of native citizens<sup>23</sup>. Adding further strength to the claim that this lack of access to health care is not a matter of work ethic or effort, a Kaiser Family Foundation study found that over eighty percent of immigrants have a full-time laborer in the family. The same study found that low income immigrant families are also more likely to have a full-time

worker in the household in comparison to low income native families. Further, the Kaiser Family Foundation reported that approximately one third of noncitizens who had lived legally in the U.S. for 0-6 years had employer based coverage. In contrast nearly two thirds of citizens had employer based coverage<sup>23</sup>. In an additional study in 2009 it was found that nearly two thirds (fifty seven percent) of the citizen population in the United States had employment-based insurance<sup>7</sup>. Employer-based insurance is the leading provider for health insurance plans of citizens in the United States. It is this lack of employer based insurance that puts the working poor population at a disadvantage.

In general noncitizen immigrants are less likely to have insurance coverage when compared to native-born or naturalized citizens; in 2006 immigrants accounted for twenty one percent of the nation's 46 million people who were without insurance. This may be a general trend that noncitizen immigrants are less likely to have health insurance in comparison to citizens; however, since the passage of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) in 1996, uninsured levels have risen even more<sup>26</sup>. In 1996 the PRWORA changed immigrants' eligibility requirements making it more difficult for them to obtain health care coverage. This law tied the immigrants' eligibility for Medicaid and then SCHIP in 1997 to their length of residency in the United States. The eligibility rules for immigrants in terms of the Medicaid and SCHIP programs are described below. The eligibility for these programs is discussed here because these programs are usually the only way in which it is possible to obtain affordable health insurance for the majority of Hispanics, immigrants, or native-born persons who fit into the "working poor" category.

In general most immigrants cannot be eligible for the program during their first five years living in the country. Then it is only after this five year bar that legal, permanent residents are eligible for the Medicaid and SCHIP programs under the normal stipulations that apply to citizens<sup>13</sup>. There are a few immigrants who merit exemption from this five year bar regardless of how long they have been in the U.S. These exceptions include refugees, humanitarian immigrants, and active duty members or veterans of the U.S. Armed Forces as well as their families<sup>26</sup>. (The U.S. Citizenship and Immigration Services website refers to humanitarian immigrant cases as those of battered spouses, children and parents, childhood arrivals, humanitarian parole, refugees and asylum, special situations, temporary protected status, and victims of human trafficking and other crimes.) Also, undocumented and temporary immigrants such as those with temporary work or student visas are still ineligible for Medicaid and SCHIP; this is regardless of the length of time present in the U.S. and was a restriction prior to 1996. As mentioned above, some states utilize the option to use SCHIP funding to provide prenatal care to immigrants regardless of immigration status. In 2002, the Centers for Medicare and Medicaid Services amended the State Children's Health Insurance Program to permit states to provide this prenatal care without an immigration test<sup>26</sup>. Just as for citizens who cannot afford to pay hospital or insurance bills, legal and undocumented immigrants are eligible for emergency Medicaid. All hospitals are required to treat situations that have been assessed and deemed emergencies. Furthermore, legal immigrants can become ineligible for Medicaid who would otherwise qualify; this may occur if they have been given a "sponsor" who pledged to support them upon arrival in the U.S. This may disqualify them from program eligibility because the sponsor's income can be included when determining Medicaid income and this may render the

applicants income too high to qualify<sup>26</sup>. States can also choose to not lift the five year bar on a person until they become a naturalized citizen; however, these restrictions are also prohibited from being enforced on refugees and people seeking asylum (<http://www.uscis.gov/humanitarian>).

As of late immigration reform seems to be heading in a positive direction. During President Obama's administration there has been a strong push for immigration reform during the last two years. On January 29, 2013, President Obama gave a speech unveiling the key points of his and the Senate's immigration reform bills. This bill has come to be known as "a roadmap to citizenship" (<http://www.nilc.org/immreform2013.html>). Put simply, under this reform a "Provisional legal status" can be acquired and then U.S. individuals with this status would be allowed to work lawfully in the country; after five years and once immigration visa backlogs are cleared, these people with provisional status would be eligible to apply for lawful permanent residence (<http://www.nilc.org/immreform2013.html>). However, while these aspiring citizens are engaging in this immigration reform will they be able to access affordable health care or coverage?

Under the new immigration reform proposals of 2013 and 2014, even for those immigrants who would be granted the provisional lawful status under the law, the proposals do not aim to permit these immigrants to engage in the federal benefits programs, including those of health care coverage<sup>24</sup>. The same eligibility requirements reported above including the five year bar will remain in effect before being eligible to apply for the Medicaid or SCHIP programs. This same ruling was determined when deciding whether or not those immigrants who were permitted to remain in the country under the Deferred Action for Childhood Arrivals program

would be eligible for Medicaid or SCHIP <sup>24</sup>. On June 15, 2012, the Department of Homeland Security determined that people who came to the United States as children and meet several guidelines are able to request consideration of deferred action for a period of two years, subject to renewal, and would then be eligible for work authorization; deferred action is a determination to defer removal of an individual from the country (<https://www.dhs.gov/deferred-action-childhood-arrivals>). These youths like immigrants who have not lived in the United States for five years are also excluded from health coverage options even though there are options available to other lawfully present immigrants. This leaves these people facing the same restrictions for health care coverage as those who are unlawfully present in the United States.

Additionally, immigrants who have not become citizens will continue to face restrictions under the ACA health care coverage expansions. The whole idea of the Affordable Care Act is to lower the number of uninsured individuals by expanding Medicaid and creating health insurance exchange marketplaces that will also have premium tax credits to help individuals whose incomes are too high (those with incomes between 100-400% of the poverty level) to qualify for Medicaid. It has already been shown that immigrants are barred from the Medicaid and SCHIP programs. This raises the question of whether or not these individuals qualify for the tax credits. According to a Kaiser Family Foundation issue brief, immigrants who are lawfully present are allowed to purchase coverage in this exchange marketplace, and they are eligible to receive tax credits regardless of how long they have lived in the country. Undocumented immigrants will remain ineligible for tax credits and are also not permitted to purchase coverage in the exchange marketplace even at full cost <sup>24</sup>.

In summary, immigrants are permitted to purchase insurance in the exchange if they are lawfully present regardless of how long they have lived in the United States. After five years of legal residence they may apply for Medicaid or the SCHIP. Lastly, the possible “roadmap to citizenship” immigration reform proposals to be implemented in the near future will not provide any new options that make health care coverage more accessible or affordable for immigrants. With purchasing health coverage at a possible discount in the exchange marketplace as the only option for health coverage, it does not seem likely that uninsured rates among immigrants will decline drastically in the near future. If access to coverage was extended for lawfully present immigrants these individuals would have a more regular access to needed care; they would then not have to delay seeing a health care provider until having to go to the emergency room. If coverage were extended to this group of people they would have access to preventive care which the ACA is requiring insurance companies to eventually include in policy plans; this encourages earlier diagnosis and reduced risk of serious long term health problems. Also with health coverage people can remain healthier, retain job security, and focus on providing for their families.

#### **B. Are Immigrants Enrolling Under the Affordable Care Act:**

Lastly, the question of whether or not Hispanics are enrolling in the Affordable Care Act will be addressed in this section. In early March of 2014, a little over six million people had reportedly signed up for a health care plan through a state or federal exchange marketplace<sup>47</sup>. Earlier the Pew Hispanic Center reported that only one fourth of the Hispanics living in the United States were undocumented; this leaves a significant number of this population who should be eligible to sign up for health coverage under the Affordable Care Act. Before looking

at the enrollment updates from the Department of Health and Human Services as of March 2014, some public opinions of the opening of the exchange market will be presented.

As of October 2013 the ACA's health insurance exchange marketplace opened to the general public. However, the Hispanic language version of the website ([cuidadodesalud.gov](http://cuidadodesalud.gov)) reportedly was not up and running until two months after the opening of the English version. According to an article in *USA Today* the website was presented more so in "Spanglish" than in Spanish. Many pages seem to have been directly translated into English which often leads to misunderstandings or the inability to understand what was supposed to be said. With the broken and unavailable website starting things off in October of 2013, the Hispanic population lost much of the incentive to register. Another CNN article reported that in January 2014 the website was still often returning pages ending in dead ends or linking to pages in English while people were trying to sign up.

La Clínica del Pueblo in Washington D.C. is one such place that is having trouble; this clinic is a non-profit, federally qualified health center that serves the Latino and immigrant populations of the Washington, DC, area <sup>48</sup>. One of the staff members at the clinic stated that it often requires multiple visits each several hours in length to get a Hispanic family signed up for Obamacare on the Spanish version website because of the technical difficulties; while this reporter was interviewing staff at La Clínica he observed the program crash an hour into the process while he was helping a family enroll. The staff member reported that this was a regular occurrence that the Spanish population is facing all over the country; needless to say they had to start the process from the beginning. Things are not going smoothly to say the least. The Department of Health and Human Safety has pointed out that Spanish speakers can enroll on

the phone with bilingual staff members through [cuidadodesalud.gov](http://cuidadodesalud.gov); they can also fill out a paper application <sup>39</sup>. This however places the responsibility of community organizations, libraries, and local health centers to get these people signed up.

Additionally, at least part of the Hispanic community is voicing concern that the Affordable Care Act may actually be making coverage even more costly for the Hispanic population. A writer for the Libre Initiative (a 501(c)4 non-partisan, non-profit grassroots organization) goes as far to say that the ACA is encouraging Hispanics to forgo health insurance because it is prohibitively expensive <sup>38</sup>. In an article from the Libre Initiative the executive director reports that the ACA has overlooked what the increased price in premiums is doing to the population as well as the choices patients have for doctors now. The median age of the Hispanic population is 27 which is much lower than that of the American population in the United States; that of the U.S. population is approximately 37 <sup>1</sup>. The executive director states that according to *Forbes* magazine, the average 27-year-old's health care premium has increased by 41 percent; in New Mexico (the state with the highest percentage of Hispanics) the premiums for this age group have increased by 160% for men and 146% for women <sup>45</sup>. Further, the ACA is reported to have made it more difficult for Hispanic Americans to find doctors; *Forbes* magazine reports that only 5% of the physicians in the U.S. are Hispanic <sup>49</sup>. Because the law has reorganized which plans include certain physicians, many are finding that the most affordable health care plan is not the one that provides access to the best choice of <sup>45</sup>.

With that being said, these clinics and other institutions do report that enrollment is occurring; however, worries are present. La Raza's Institute for Hispanic Health (the largest national Hispanic civil rights and advocacy organization in the United States) states that in

addition to the technical problems with the website, people are worried about information being used for deportation purposes, problems verifying income, and not having access to a computer<sup>39</sup>. Despite these problems, delays and misunderstandings, the Department of Health decided not to extend the deadline (March 31, 2014) by which people had to have signed up for health insurance according to the individual mandate that went into effect on January 1, 2014. According to the Department of Health and Human Services' March Enrollment Report, as of March 11, 2014, more than 4.2 million people have selected a "Marketplace" plan. As mentioned earlier, enrollment was projected to reach over six million by late March. Unfortunately, the U.S. department has only reported enrollment data according to age and gender, but not race. As of February 11, 2014 the department did issue a research brief on eligible uninsured Latinos. They report that more than half of all Latinos living in the United States live in California, Texas, Florida, New York, and Arizona, so many generalizations are made from statistics based on these states. In short, as of right now the department has reported that under the Affordable Care Act, 10.2 million eligible uninsured Latinos have gained access to new options for health care coverage as of January 1, 2014. They have determined that 8.1 million of these people may qualify for the tax credits to purchase health insurance, Medicaid, or SCHIP. As for the other 2.1 million they may simply purchase insurance from the exchange marketplace if they can afford it.

### **C. Caring for Immigrants: Initiatives in the United States**

So far immigrants' access to health care coverage has been assessed as well the obstacles the population faces in terms of enrollment in the health coverage programs due to federal law. This section will now look at what disparities and access barriers are common in

access to health care for Hispanic immigrants. Then, it will look at where the Hispanic population is receiving health care if they are not covered by health insurance plans or federal programs and what initiatives are being taken in some select cities to provide health care.

### **I. Access Barriers to Health Care and Coverage**

Since the implementation of the State Children's Health Insurance Program (SCHIP) in 1996 many policy assessments began to take place around the beginning of the 21<sup>st</sup> century in order to begin analyzing whether or not health insurance coverage and health access had improved for children. In particular many studies began to look at the access barriers to health care for the Latino population and its children. The findings of several studies are reported here to show the commonalities that have been found in terms of what are the access barriers to health care for the Hispanic population.

First, a summary of data collected from studies performed during the 1980's and early 1990's will be presented. Showing these statistics followed by more recent data will demonstrate what has changed in the last twenty to thirty years; whether or not disparities and access to health care for Hispanic immigrants have been addressed during this time should become clear. This information was collected from *Hispanics in the United States* by Pastora San Juan Cafferty and David W. Engstrom. To begin, in these studies occupational status was determined to be a common predisposing characteristic for the Hispanic population in terms of access to health care. In 1994 the U.S. census reported that the majority of all Hispanic subgroups in the U.S. who are older than 25 have no college education. Lower levels of education correlate with increased health risks as well as lower levels of health insurance

coverage. Today the world is becoming full of jobs that require greater education; these higher paying jobs are the ones providing benefits like health insurance to their employees. A study by the National Council of La Raza found that 63 percent of 328,064 families sampled were uninsured even though they had at least one full time worker. Concentration of the Hispanic population in low income jobs will leave them without health insurance coverage as well as money to buy it independently. Limited use of health care by the Hispanic population also correlated to limited language skills and a shortage of health care professionals who spoke Spanish; these studies found that the Hispanic population was experiencing language barriers that prevented access to care in the emergency room and deterred some from seeking care at all. At this time, executive order 13166 (signed in 2000) which required health care organizations to provide interpretive services was not enacted. Culture was found to be a significant factor affecting whether or not a Hispanic family seeks health care. It was found in a survey of families from the Southwestern United States that many immigrants reported that they would seek medicine, herbs, or consultation with folk healers before considering consulting a health care professional.

In addition to these predisposing characteristics, several barriers to access that were described as enabling characteristics in terms of health care access were identified. Health maintenance organizations (HMO) were projected to negatively affect Hispanics' access to health care. One of the major concerns is that HMO's will not include Spanish speaking physicians on their list of covered primary care services; this deters Hispanics from seeking health care services. Another concern is that Hispanics will be denied coverage by HMO's because they are deemed more likely to be poor and therefore less healthy. With regards to

insurance coverage, the *Journal of Health and Social Behavior* found that in 1976 more than 33 percent of Hispanics were uninsured; twenty years later the uninsured rate remained unchanged. During this period Hispanics were also the least likely of all populations in federal reports to have a regular source of care; having a regular source of care correlates with receiving timely treatment and preventative care as opposed to when utilizing outpatient services or emergency rooms. Lastly, this book cited the implementation of Personal Responsibility and Work Opportunity Act of 1996 as a barrier to access health care for immigrants.

It has been over more than a decade since the studies above were completed; since then the SCHIP (1997) and the ACA (2010-2014) have been put into effect. However, noncitizen immigrants and their children are still much more likely to be uninsured and to have access to health care, even when the children are citizens<sup>13</sup>. Language problems were found to be a leading barrier to child health care according to a 2001 national survey; it was found that language barriers led to increased medical errors and missed diagnosis<sup>13</sup>. Federal law states that providers must provide interpreter services to patients with limited English proficiency under executive order 13166, but problems and lack of services are entirely too common<sup>13</sup>. Further, many Latinos have a low level of employer provided insurance and cannot afford private insurance; in 2004 only 43% of Latinos received coverage through their employer compared to the national rate of 64%<sup>5</sup>. Lack of awareness of eligibility for federal programs like Medicaid or SCHIP, the complexity of the application process, the financial costs of paying for insurance or medical bills, and fear and mistrust of the government or providers have all been found as barriers to access<sup>5</sup>. In 2001 a California study found that from a survey of mothers,

83% of 500 Latino children surveyed were eligible for subsidized medical insurance; however, families with non-enrolled children reported barriers to the enrollment process such as problems providing documents, problems understanding the Spanish forms, inconvenient enrollment hours, and confusing paperwork<sup>21</sup>. Additionally, a study performed by the American Medical Association of children coming to a pediatric Latino clinic at an inner city hospital found that parents identified language barriers, cultural differences, poverty, lack of health insurance, transportation difficulties, difficulty paying medical bills, and long waiting times as the major barriers to access health care for their children<sup>20</sup>.

## **II. Health Care Experiences**

In addition to experiences with access barriers in health care reported previously, this section will show some reports on interaction experiences between the Hispanic population as patients and their health care providers. One study as well as a few others found that some cultural values have been identified among Latinos as affecting clinical care; it was found that a value is placed on sympathy in the face of distress and many Latinos expect physicians to share this positive attitude<sup>20</sup>. Latinos were also found to believe that authority figures merit respect, which in the clinical setting means respect for the physician as well as for the concerned parent<sup>20</sup>. Relatively neutral attitudes from physicians and failure to elicit the parent's concerns could therefore be associated with decreased satisfaction in care. It is important not to neglect bedside manner when there is a language barrier in place; when there is a language barrier

present the only way a patient can feel such emotions as compassion, politeness, and empathy is from bodily actions and mannerisms.

A separate study completed by the Pew Hispanic Center in 2009 evaluated experiences in the health care system as well. Their nationwide survey reported that 76% of Latino adults who are neither citizens nor legal permanent residents said that the quality of medical care they received in the past two years was excellent or good; similarly 78% of Latino citizens and legal permanent residents were satisfied with the quality of medical care they received<sup>15</sup>. Some Latinos (46% from those surveyed) reported in the last 5 years that they believed they received poor medical treatment because of their insufficient ability to speak English or their inability to pay for care<sup>15</sup>.

Similar to the study of cultural values in the health care environment above, one study by the *International Journal for Quality in Health Care* investigated the effectiveness of cultural competence programs in ethnic minority patient-centered health care. In this study they aimed to determine whether or not the patients' health experiences were improved if the physician, nurse or health care staff member held some perspective on the Hispanic culture (or cultural competence) of the patient he or she was treating. As expected, the research demonstrated that by operating with a more patient-centered focus, as opposed to a more paternalistic style of care, increased communication between the provider and the patient as well as understanding and sympathy. These findings may seem obvious or trivial, but it is not uncommon that a physician's standard of care is lowered when facing a language or cultural barrier. Whether this is due to frustration, attitude, or the inability to convey emotions effectively, it is important to remember that the objective is to care for the patient.

### III. Delivering Health Care: Who is taking the Initiative?

As of 1996 the restrictions on Medicaid and SCHIP limited immigrants' access to health care. This contributed to the increased number of uninsured people. Then, the arrival of the Affordable Care Act did not change any of the restrictions that limit immigrants' eligibility in applying for federal programs or engaging in the health insurance marketplace. The withdrawal of this federal support for immigrant health coverage has not only placed the burden of caring for this population upon the states, but also upon organizations that have come to be known as local "safety net" providers.

Since the federal welfare reform law of 1996, Medicaid enrollment has dropped amongst the Hispanic population and other immigrants while uninsured rates have risen. This has placed the responsibility to provide care to these people upon the safety net providers such as locally owned public hospitals, not-for-profit hospitals, and community health clinics or organizations that offer free or reduced price health care. Since this welfare reform, the Kaiser Commission on Medicaid and the Uninsured has conducted an investigation of safety nets in Los Angeles, New York, Miami, and Houston. Results of initiatives taken in a separate study conducted in California by an organization called the Permanente Medical Group will be presented here along with the Kaiser research. These two studies will demonstrate the initiatives being taken by four diverse and large cities across the United State that are trying to make health care more accessible for the growing immigrant population.

First, the Permanente Medical Group's objectives were to improve access to medical insurance and understand why Latino children who were eligible for state subsidized insurance

in a California community were not enrolled. Of the 464 children surveyed, 83% were eligible for subsidized medical insurance, yet 28% of those eligible were not enrolled. They discovered that barriers to the enrollment process were due to difficulties with providing documents, understanding Spanish forms, and inconvenient waiting times. This research found that a neighborhood social service and advocacy organization called the Canal Community Alliance (CCA) was playing a large role in bridging the barriers to access. The CCA had formed a partnership with the County Department of Health and Human Services. It was through this partnership that the CCA conducted outreach to provide Medi-Cal/ Healthy Families enrollment assistance (these are California's state funded public health care programs in California). Targeting the Latino population was achieved by distributing bimonthly newsletters that explain the options for children's subsidized insurance, broadcasting public service announcements twice weekly over the radio, distributing informational flyers with emergency food packages, hosting informational booths at the local farmer's market, and passing out information at children's soccer league games. Now that the initiatives being taken by a small community in the Southwest have been presented, the next paragraph will begin looking at the actions being taken in Los Angeles, New York City, Miami and Houston.

In the four urban areas of Los Angeles, New York City, Miami, and Houston it was found that all large health care safety nets were supported by locally owned public hospitals and clinics. Following the welfare reform of 1996, the state governments tried to make up for the loss of insurance coverage for children by creating supplemental, state-funded add on programs in addition to the federally-funded programs. California created the most inclusive state funded programs in addition to its Medicaid and SCHIP programs<sup>22</sup>. In Los Angeles the

Public Private Partnership program was created to help nonprofit clinics pay for care of uninsured patients under a subsection of their Medicaid program; the private clinics receive funds from the county to provide outpatient services for uninsured low income people <sup>22</sup>. The largest safety net provider in Los Angeles is the county's Department of Health which also administers public hospitals, public clinics and the public health system <sup>22</sup>. Many of the county or city facilities utilized the sliding scale payment system which can result in free care; however, one Los Angeles County Health Department had a system where a person could receive care for only \$35 <sup>22</sup>. The county also has a number of for-profit clinics called "clnicas" that provide care to uninsured immigrants who can pay in cash or with credit. Additionally, some providers avoid Medicaid restrictions on prenatal care for undocumented women by registering them with "presumptive eligibility" status that can last for as long as six months or until childbirth; this avoids the federal limitations as of 1996 which said immigrants could no longer receive prenatal care under Medicaid <sup>22</sup>.

In New York City the NYC Health and Hospitals Corporation runs multiple public hospitals and clinics; there were also found to be many community health centers and nonprofit hospitals acting as safety-nets <sup>22</sup>. New York was one of the states to expand its SCHIP program which is called Child Health Plus in order to ensure immigrant children were still covered under the state after 1996. The state also provides prenatal care to women despite immigration status whereas many states only cover emergency services under Medicaid which include child birth only <sup>22</sup>.

In Miami the key safety net provider was cited as Jackson Memorial Hospital; it administers the Public Health Trust which is a health care revenue source derived from

property taxes<sup>22</sup>. There are also several active health departments, nonprofit community centers and nonprofit hospitals. The city like New York has not implemented any state funded programs to make up for the loss of Medicaid eligibility of noncitizens. It was reported that these two larger immigrant groups weren't seen as a major concern because Cubans and Haitians receive exemptions as refugees under the welfare reform law<sup>22</sup>. The state of Florida has a child health insurance plan called Healthy Kids that is not affiliated with Medicaid; however, in 2000 they stopped offering eligibility to noncitizen children who arrived in the U.S. after 1996.

In Houston, TX, the Harris County Hospital district runs three public hospitals and several community health centers; these hospitals also receive funding from a local property tax<sup>22</sup>. Health department clinics offer primarily maternal and child health and preventative services. There are also some nonprofit hospitals and nonprofit clinics cited as safety net providers. In Houston it was found that public and nonprofit clinics provide prenatal care for undocumented immigrant women until their last three weeks of pregnancy; during the last three weeks of pregnancy they are able to enroll under emergency Medicaid<sup>22</sup>. Another initiative being taken is a mobile health van that is funded by a Catholic community clinic; the van screens people for health problems in the neighborhoods and reports a large volume of immigrant patients<sup>22</sup>.

There were also efforts by these cities to increase language access. In Miami, clinics were integrating Creole interpreters, and Houston clinics were found implementing Vietnamese interpreters. Houston and Los Angeles had nonprofit immigrant organizations that were working with health care providers to supply interpretive services for particular Asian and

African languages. New York has included explicit requirements in its state Medicaid program for providers to obtain translation capabilities. Many outfitted their organizations with the AT&T Language Line; this language line was reportedly being used in all cities and uses a speaker phone as the third party in the room to translate in up to thirty languages<sup>22</sup>. In one instance, a Los Angeles group of hospitals displayed pictures of the primary care physicians on their walls and underneath listed what languages they spoke. Other signs of innovative community initiatives like Houston's mobile health van were found as well. In Los Angeles a small insurance network for low income immigrants was established by a legal rights group in the San Fernando Valley. Lastly, in Brooklyn, NY, a Caribbean American Family Health Center was established thanks to the partnership between a local nonprofit organization and a Lutheran Hospital system.

### **Part 3: Initiatives Being Taken in Knox County to Facilitate Access to Health Care**

It has become apparent that since the number of uninsured immigrants continues to increase, many responses have been generated throughout the United States. Even though the federal government has not increased access to health care for these people, there are many initiatives around the country. Many organizations are making it their goal to provide affordable health care to the less fortunate minority populations. It is clear that the local health care safety net providers like local public hospitals (government funded hospital), not-for-profit hospitals, health departments, and community clinics are the ones who are taking action. The previous section has reviewed some of these initiatives in cities with large immigrant

populations across the United States. In this section, the initiatives being taken by health care providers in Knox County will be presented.

According to the United States Census Bureau, of the 6,495,978 people living in Tennessee in the year 2013, 4.8% (311,806) of these people were Hispanic or Latino. The population of Hispanic and Latino immigrants grows each year within the state. Looking at the initiatives being taken in Knox County where there are notable community outreach efforts involving the Hispanic population will provide a unique perspective on what a rather progressive county is doing for this minority population. Organizations investigated include four hospitals, the Knox County Health Department, three 501(c)(3) non-profit organizations (religious or charitable, tax-exempt organizations), and a philanthropic community health partnership in order to ascertain the degree to which these organizations were prepared to treat the Hispanic population with regards to health care.

First, three of the larger hospitals in the area, the University of Tennessee Medical Center, Fort Sanders Medical Center, and Parkwest Medical Center, will be analyzed. In general, investigation of these three hospitals did not uncover any actions that were attempting to go the extra mile for the Hispanic population. The University of Tennessee Medical Center (UT Medical) does not staff or provide foreign language interpreters. One physician reported that in the past the hospital and clinical office staff were going to be given an opportunity to vote on whether or not they thought it would be beneficial to hire full time Spanish interpreters; this proposal fell through. Instead the hospital has installed third party language lines in all the departments from the company CyraCom International. This phone line can be called twenty four hours a day; the patient and doctor communicate awkwardly with the

interpreter over the speaker phone. Some companies such as Language Line Solutions are providing face-to-face interpretive services via video chat; however, none of these hospitals have implemented this service. Also, the CyraCom phone service charges the hospital by the minute. In addition to the difficulties with communicating over a three-way phone call, two physicians reported that the hospital prefers that the phone line be used as a last resort. So, if these language lines are an impediment for the physician and the Hospital's budget, what is being done in order to avoid breaking the law under executive order 13166 described earlier? On paper the hospital has multiple Hispanic speakers on staff and the language line in order to comply with the federal law. For example, a nurse in the emergency room at UT Medical said that if Spanish speaking patients are not proficient in English, then they have a nurse on staff who they call to interpret sometimes. As for physicians, if a Hispanic patient would like to be referred to a Spanish speaking doctor, the UT Medical Center has two primary care physicians and a vascular/ transplant surgeon who speak the language.

The websites of each of these hospitals have also been investigated due to the fact that this is a very common source of information today. The UT Medical Center's website has only two documents (a Living Will/ Power of Attorney pdf file and a Patient's Rights page) that are translated in Spanish; they appear to be direct translations and are confusing due to grammatical errors. The documents entitled "general information" and "how to prepare for your stay" [in the hospital] are not available in Spanish. These few translated documents are only available if you can read, access a computer, navigate the internet, and think to type in "Spanish" in the search box on the UT Medical Center's home page. If the word "interpreter" is entered in the search box then results for "patient guide page 4" are returned in English; if the

patient is able to read this document then they can find the phone number that the document says to call if an interpreter is needed. Reading the document further will then elaborate on the fact that this phone number is only for hearing impairment interpreters and not for foreign language interpreters. Upon checking into the hospital a patient can request that all subsequent documents, forms, and information packets be provided in Spanish. The website also states that the in-room television "Patient Education System" that is sometimes utilized to play informational videos has subtitles in more than one language. Lastly, given that many Hispanics are categorized as the "working poor" and lack insurance, it is worth mentioning that patients without insurance will receive a discount on their bill. Also, they offer financial assistance to qualified, low-income, or uninsured patients. These matters are handled on a case by case basis with social services.

In addition to UT Medical Center, Fort Sanders Hospital and Parkwest Hospital are not doing much more to increase access to health care for the Hispanic population. Both of these hospitals along with Leconte Medical Center in Sevierville are a part of the company called Covenant Health Systems. There were not many differences between the hospitals as a result. When speaking with the emergency room departments of Fort Sanders and Parkwest they reported that they will sometimes use a Spanish speaking staff member to communicate if needed. These three Covenant Health Hospitals do not staff interpreters; they have installed a three way language line in the departments of the hospitals like the UT Medical Center. As for Spanish speaking physicians, Covenant Health does boast many more. Parkwest Medical Center has eight Spanish speaking physicians on staff; however, they are all surgeons, specialists, or internists except for one pediatrician. It is worth noting that generally it is the primary care

doctors who bridge the gap between health care delivery and language barriers due to the fact that they have more personal interactions with the patients. Many patients do not see their surgeon until their pre-operation appointment and then post-operation follow up appointments; by this time, the difficulties of navigating the hospital, communicating with staff, and becoming diagnosed have all been dealt with. Fort Sanders Medical Center has two physicians who are both specialists as does Leconte; neither had any registered primary care physicians.

The website for Covenant Health Systems does not facilitate access any more than that of UT Medical Center's. Once again, if the patient has access to a computer, they can access the health system's home page, yet they will not find anything to aid the Spanish speaker. If a person types in "Spanish" in the search box, the results return a "library of diseases and conditions" in Spanish. However, even this list leads to links ending in dead ends. If "interpreter" is entered in the search box the user may discover a patient information page of things to know when getting ready to stay at the hospital. There is not a Spanish version of the document, but it does say that "interpretive services for non-English speaking patients" is available. It does not mention however that this service is not an interpreter but in fact the language line mentioned above.

By looking at these three hospitals it does not appear that there is a large attempt to break down barriers to access in health care for Hispanics. However, there are a number of organizations that are taking it upon themselves in Knox County to make a significant difference. The first bit of information that alluded to someone facilitating access to health care for the Hispanic population in Tennessee happened to come from the state government itself.

Under federal law every state is required to provide a child health program as a part of Medicaid; this component of the Medicaid program is called the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. In Tennessee the program is called TENNdercare, and it helps finance pediatric services (<http://mchb.hrsa.gov/epsdt/>). The goal of this program is to identify and treat health conditions for children early and appropriately by providing regular, affordable check-ups and screenings. The rules of eligibility for the program are the same as under the Medicaid program; however, the small initiative came in the form of an informational brochure. The TennCare program has made the effort to print and distribute informational brochures in Spanish about itself as well as TENNdercare; these can be found in county Health Departments in Tennessee. In addition, there is a private, non-profit organization called the Legal Aid Society of Tennessee that is reaching out to the Hispanic population. They provide free legal services to people with low income. The closest office operates out of Oak Ridge, TN. In the midst of PPACA changes taking effect, the Legal Aid Society began distributing information and offering counseling for the PPACA individual mandate that took effect in January 2014. Once the marketplace opened in October 2013, they began organizing workshops and helping people sign up for insurance plans. They have distributed informational pamphlets on the Affordable Care Act in English and Spanish to local non-profit organizations and health departments. Their website's home page also has a large "En Español" link for their information in Spanish. The organization has reported that if a non-English speaking client calls their office, they use an interpretive language line like the hospitals have installed to communicate through a conference call. Additionally, there is an outreach program in Knoxville called Knoxville Area Project Access (KAPA); the program is made up of a network of volunteer

physicians whose goal is to provide access to health care to those who cannot afford to be insured privately or by the government. The program uses a sliding fee scale that is based on a person's income. It is a volunteer physician partnership with the Knox County Hospitals. KAPA has distributed pamphlets in English and Spanish that include the benefits and contact information of the program. The requirement is that the patient must be a resident of Knox County for 90 days; legal documentation is not required in order to obtain care. The organization has a fluent Spanish speaker on staff to specifically assist with the Hispanic population. One of the down sides to the program is the long list of documents that are needed to apply; approximately one third of the documents they request include a valid driver's license or photo identification, pay stubs for the last 90 days, income tax documents, and utility bills from the last 90 days. As mentioned earlier, it is often lengthy and confusing documents or forms which deter the immigrant population from looking into these types of programs. The program does its best to connect the Hispanic population with the Hispanic physicians in Knox County at Covenant Health Systems, the University of Tennessee Medical Center, East Tennessee Children's Hospital, and United Way of Greater Knoxville. Even though some of these actions are small like a simple brochure, these are the small initiatives that offer a helping hand to this population which may otherwise feel isolated from the health care community.

In addition to these organizations, there is a community health care clinic that is providing affordable medical care, dental care, mental health counseling, and prescription medications for the working uninsured. The clinic is called InterFaith Health Clinic; it is a non-profit health care ministry in Knoxville. Its goal is to provide affordable and accessible health care to the "working poor" population which often includes the Hispanic population as

mentioned previously. In order to become a patient at InterFaith, one person in the household must be employed, and the patient must have no form of health insurance including TennCare. These are the only two requirements; legal documentation is not required. Payment is based on a sliding fee scale according to household size and income; the payments range from 10% to 50% of the actual cost of care. The remaining costs are covered by donations. The clinic is staffed by a network of volunteer physicians, dentists, and nurses from the Knoxville area. The clinic does not have Spanish speaking interpreters. There is one Spanish speaking nurse practitioner who can help sometimes; however, they prefer that the patient bring someone who can translate. This clinic strives to provide services within their capacity and to serve patients regardless of race, creed, age, religion, or national origin <sup>50</sup>.

One of the larger organizations facilitating access in Knox County is the county health department. Knox County Health department clinical services require a fee for service that is based on income and eligibility. The department provides preventive clinic services such as communicable disease testing, physicals for children on TennCare under the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, women's health and family planning services, dental clinics and immunizations. What is noteworthy about the county health department is that the main lobby is split into two halls, one is for Spanish speaking patient information and the other is for English speaking patient information. The department has Spanish speaking staff at the informational desk. This is the greatest effort taken so far by the city that is attempting to target the Hispanic population directly. In addition to the clinical health services offered within the health department, the Community Health branch of the health department is targeting the underserved areas of the county including the immigrant

population. The mission statement of the county health department is to develop an active, healthy community, and it is doing just that by hosting informational workshops and after school activities in the community at local schools and non-profit organizations which often act as service hubs for the underserved. The Community Health department manages adolescent pregnancy prevention, the Car Seat program, health equity promotion, the public schools' Healthy Weight program, Safe Routes to School, Senior falls prevention, TENnderCare, and Worksite wellness. Many workshops and information sessions are often presented at Centro Hispano of East Tennessee; the sessions are presented by a Community Health staff member who is fluent in Spanish. One of the programs that has targeted and had success with the immigrant population specifically is the Safe Routes to School program. The organized "Walking School Bus" is the leading program and has specifically been taken to poorer neighborhoods in the community which include the Hispanic population and refugees from Burundi in southeast Africa. The aim of the program is to not only stimulate development of an active and healthy community, but to make known the fact that infrastructure such as sidewalks are necessary in parts of the community that are underserved. This may not be a clinical health initiative; however, health care does not simply include the services of doctors and nurses. Preventive care starts with nutrition and access to activity, and this is another great example of an organization in Knox County reaching out to all members of its community.

An organization that is whole heartedly reaching out to the Hispanic population in Knox County is another 501(c)3, non-profit organization called Centro Hispano of East Tennessee. Centro Hispano of East Tennessee serves as a source of information, meeting place, and advocacy group for the Hispanics in Knox County. In reality they do everything in their power to

facilitate the integration of the Hispanic community in East Tennessee and ultimately in the country as a whole. Some of the services offered include English classes, GED classes, individual tutoring sessions, financial advice and training, legal counseling, and child care during class times. All of the programs are run by volunteers. In terms of facilitating access to health care, the organization and staff are connected with the health department and the county; because of this, many of the informational workshops of the health department are brought to Centro by one of the Spanish speaking staff members. The center does not provide clinical care, but it does work to facilitate access to health care by connecting patients with Hispanic physicians if they desire. Additionally, this year the Centro Hispano Board of Directors has taken the initiative to establish contact with the nonprofit organization called Remote Area Medical (RAM); this organization sets up free health care clinics around the United States by using volunteer physicians, nurses, and staff in order to provide care to impoverished and/or isolated areas. Centro Hispano has recently been meeting with the RAM local chapter in order to organize a free clinic that will be available to the Hispanic community this September 2014, in Knoxville, TN. As of right now Centro Hispano is in the process of finalizing a location and raising funds. It is their hope that the clinic will become an annual event. To anyone who has worked with Centro Hispano, it is evident that it is more than a source of information and services; it is truly a representation of the Hispanic community. As an immigrant in a new country, having a community connection and advocacy group whom you can come to for aid is invaluable. An organization like this is another significant initiative that shows what is being done in Knox County in order to break down barriers that exist between two different cultures. Even though

the organization does not officially provide health care services, it acts as a vital connection for the Hispanic community.

These community outreach programs and non-profit organizations are providing invaluable services to the Hispanic population. It is without a doubt that they are making an impact every day in the lives of this growing minority. However, the most progressive and exceptional health care provider in Knox County is East Tennessee Children's Hospital (ETCH). East Tennessee Children's Hospital is Knox County's 501(c)(3) non-profit, private, independent pediatric medical center. The hospital opened in 1937 as Knox County Crippled Children's Hospital. The hospital has always pledged to never deny care to a child because of race, religion, or their parents' ability to pay their child's medical bill. In September of 2000 the Children's Hospital was designated as the region's Comprehensive Regional Pediatric Center certified by the state of Tennessee. Families and their children travel from Virginia and Kentucky to ETCH in order to receive exceptional family-centered care and compassion. The hospital received \$5,698,120 in donations in 2013. A major part of the Children's Hospital is the volunteer staff; it was reported that 52,784 volunteer hours were completed in 2013; this represents \$1,339,657 worth of cost-savings<sup>51</sup>. The hospital is the leader as far as facilitating access to health care for the Hispanic population in the area. This is the only hospital in Knoxville with interpreters on staff. In 2013 the Spanish interpreters had 12,573 translation requests according to the ETCH Annual Report. Not only is ETCH the only hospital to staff interpreters, but it also has them available 24 hours a day, seven days a week. Five interpreters are on staff Monday through Friday during the daytime. A PRN interpreter works after hours when a full time interpreter is not available. All of the interpreters have Certified Medical

Interpreter (CMI) training which is approved by the National Board of Medical Interpreters. This means that these people can communicate effectively and are able to use the proper terminology; this is in complete opposition to when using a family member or other hospital staff worker. The interpreters also work in every aspect of the hospital; they are there at the time of hospital registration all the way to pre and post operation. They are not only present when a physician or nurse needs assistance; they accompany the patients throughout the hospital to all services. In addition, for the rare case when an interpreter is not available, the hospital also has installed the Optimal Phone Interpreters (OPI) line; this service is also a three way phone line that can translate in 204 languages and dialects. Their website also has an informational page in Spanish that covers all the topics from a welcome letter, to the services provided at the hospital, patient responsibilities, and information on interpretive services.

#### **Part 4: Discussion/ Conclusion**

Health care has changed a great deal since the early 1900's. In 1915 when the American Association of Labor Legislation drafted a bill for national health care, the proposal did not have a large chance at success. When the Committee on the Cost of Medical Care was formed in the 1920's in response to the growing cost of health care and rising unemployment rates, their reports were treated as radical documents. Until 1965 and the passage of the Social Security amendments, it did not seem that a form of socialized medicine was ever going to make it through Congress in the United States. It was not until 1997 with the passage of the State Children's Health Insurance Program that another socialized health care initiative would

succeed. At the end of the 1920's when the Committee on the Cost of Medical Care (CCMC) published the twenty six research volumes shedding light on the fact that there was a dire need to increase access to health care for everyone, it did not seem that these calls for help would ever be addressed. Today, the Patient Protection and Affordable Care Act has been implemented since 2010. The bill aims to increase the quality of health insurance, expand the availability of coverage, control the rising costs of health care, and improve health care delivery. It will hopefully succeed in limiting how much public health insurers can take advantage of consumers. Under the PPACA many people should now have access to health care insurance who previously were not able to qualify for federal programs or purchase it privately. The PPACA is addressing the fact that the accessibility and the affordability of health care needed to be improved; 44 million people in the United States did not have access to health care prior to the passage of this bill. However, it is clear that the federal government has left out a large number of people in the United States, including the Hispanic and immigrant populations.

The Personal Responsibility and Work Opportunity Act and the Patient Protection and Affordable Care Act have either limited access to health care for the immigrant population of the U.S or have not addressed or eliminated the barriers in access to health care. Residence restrictions and legal status limit the availability of not only federal programs but also access to the health insurance "Marketplace." Additionally, it is clear that eligibility and enrollment in government programs are not the only barriers to access for the 11 million Hispanics in the U.S. The Hispanic population is more likely to be uninsured and therefore more prone to health problems. Barriers to health care coverage and access to care include a low level of employer sponsored insurance, lack of information about services, language problems, fear and mistrust

of government and providers, literacy limitations, immigrant status, cultural differences, poverty, transportation difficulties, and lengthy, confusing documentation and paperwork. All of these problems can result in poor medical care, misdiagnosis, and inappropriate or unnecessary medication and hospitalization.

Fortunately, the health care safety net providers have taken the initiative to provide care to this growing minority population. These providers include public hospitals, not-for-profit hospitals, and community health clinics or organizations that offer reduced price health care. In Knox County the major efforts being made are due to small non-profit organizations and clinics, the county health department, and East Tennessee Children's Hospital. These are the same types of organizations that are leading the way to facilitate access to health care in the four cities analyzed across the United States; in Los Angeles, New York City, Miami and Houston the major efforts were put forth by state funded programs, nonprofit clinics, county health departments, public hospitals, nonprofit community centers, and nonprofit hospitals. The differences between Knox County initiatives and those found in these major cities was the absence of public hospitals. Public hospitals are large safety net providers in these big cities. In the cities analyzed as well as in Knox County, the for-profit hospitals were not found to be taking extra initiatives to facilitate access to health care for the Hispanic or immigrant population.

In order to close the gap in health insurance coverage that occurs within the population of noncitizen immigrants and their children, there are several initiatives and policy implications that could take place. To begin, the government could lift legal restrictions. The Department of Immigration and Naturalization Services could declare that receiving Medicaid or enrolling in

any government program will not endanger an immigrant's legal status. It was mentioned that several states have expanded their Medicaid and SCHIP programs to cover children and pregnant women who are ineligible due to immigration status. Eligibility for public insurance programs could also be restored to immigrants by amending the restrictions put in place by the PRWORA. Also, if employers are going to employ working poor immigrants, then the government could subsidize these employers so that they could afford to provide health insurance coverage. Hopefully with the arrival of the new regulations in the PPACA, the government will be able to sufficiently monitor and enforce the fact that businesses of a certain size will be required to provide health insurance to its employees.

Finally, health care systems need to reduce access barriers. Language problems were often cited as the leading barrier to health care services. Federal policy states that providers must ensure that people with limited English proficiency have access to interpretive services; however, it is clear that the lack of these services remains common place. Distributing information amongst the community is a source of success in terms of facilitating access to health care. If all communities began with their county health departments and trained health educators to reach the entire community, then the absence of information and mistrust in organizations would not be as prominent. Distributing informational pamphlets and offering informational sessions or workshops in the communities have proved to be successful outreach methods. Also, the efforts with which a provider attempts to deliver care should not be lessened due to the presence of cultural or language barriers. When language barriers are present, emotions are conveyed through facial expressions and body language. In the midst of stressful and busy schedules at a hospital or clinic, it important as a provider to walk into every

appointment ready to convey empathy, compassion, and understanding in order to deliver exceptional, patient centered care.

Given the large increases in immigration into the United States, and the contribution these immigrants make to the national labor force, it is selfish and short-sighted to not extend the services of health care to the needs of this foreign born population. The large increase in the number of uninsured immigrants and disparities in access to health care is the result of not only governmental regulations, but also the health care providers who choose to ignore this minority group. Many health care providers or insurers have lost sight of the objective in health care which is to care for the patient. Unfortunately, many health care organizations are a business, and they are not concerned with the patient but with the profitable income that the patient brings. In Knox County the major hospitals of the region were not the organizations who were taking the initiative to break down these barriers in access to health care for the Hispanic population. It is not that these hospitals lack medical expertise in the least; both Fort Sanders and UT Medical Center offer a wide range of specialty services. The UT Medical Center is the region's destination for neurology, cardiology, transplant, and trauma cases. So, why do these organizations choose to not address these disparities? Fort Sanders, UT Medical Center, and East Tennessee Children's Hospital are situated close to downtown Knoxville and are less than three miles apart; Parkwest Medical Center is approximately eleven miles away from these three hospitals. However, East Tennessee Children's Hospital is the only hospital providing medical interpreters. It is the only not-for-profit hospital in Knox County, and it chooses to pay the extra expenses when attempting to go above and beyond caring for the patient. The providers who are facilitating access to health care are the ones whose only concern is the care

of the patient. It is an organization such as this that serves as a model for health care organizations in Knox County as well as in the U.S. Leading the way to a healthy society can be accomplished through comprehensive patient-centered care, wellness, and education. When embracing these objectives it is important as a provider and as a society to not forget about the growing minority populations that make up such a significant part of the communities that we live in.

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