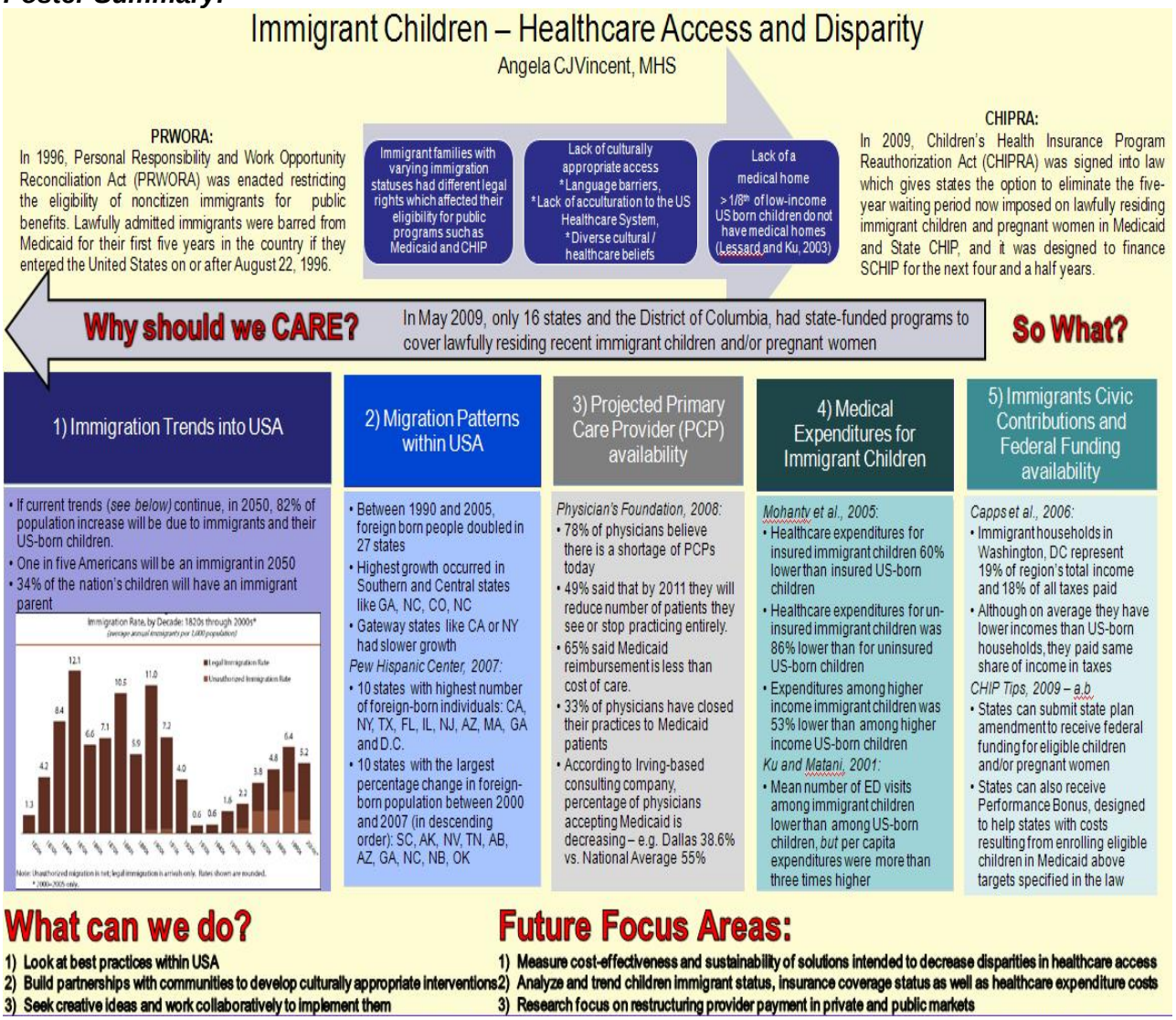
Immigrant Children – Healthcare Access and Disparity
Angela CJVincent, MHS

Essay Summary:

Immigrant children who entered the U.S. after August 22, 1996 faced many legal and cultural barriers in accessing healthcare. The recent Children's Health Insurance Program Reauthorization Act (CHIPRA) gives states the option to provide Medicaid and CHIP coverage to eligible lawfully residing immigrant children and pregnant women regardless of their date of entry into the U.S.

This essay identifies the existing system of access, outlines the obstacles faced by immigrant children, and encourages healthcare leaders to correlate trends analyzing immigration rates, migration patterns internally and primary care provider availability to their impact on access and disparity issues among immigrant children. This essay discusses medical expenditure profiles, civic contributions by immigrants and federal funding options as reasons for healthcare leaders to invest resources in resolving this situation. Finally, this essay makes recommendations to healthcare leaders about the key steps to successfully implement CHIPRA and reduce disparities in access for immigrant children.

Poster Summary:



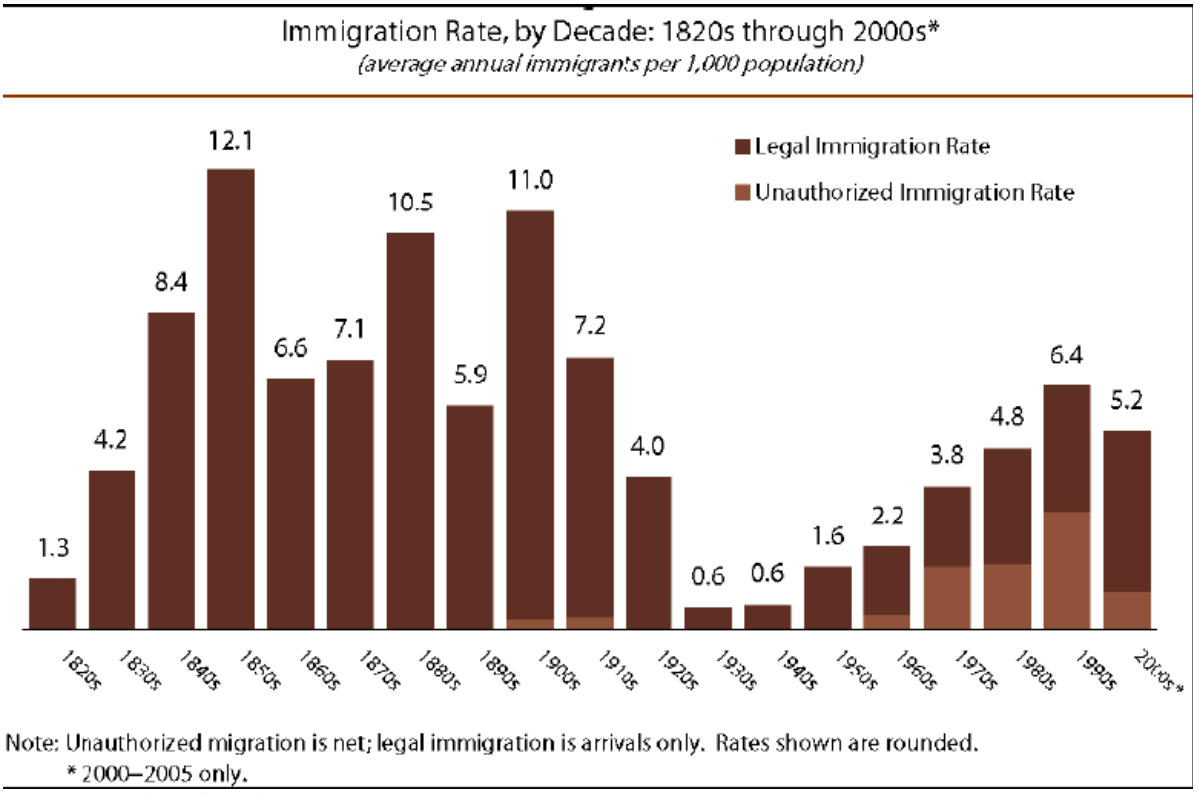
Key Data:

Table 1

Simplified Guide to Immigration Status and Federal Eligibility for Medicaid and SCHIP

Immigration Status	Definition	Program Eligibility Status
Native citizen	Born in the United States	Eligible
Naturalized citizen	Foreign-born, but became a U.S. citizen through naturalization	Eligible
Lawful permanent resident	Noncitizen with permission to live and work permanently in the United States; has a "green card"	Under 1996 welfare law, those admitted after August 22, 1996, are ineligible during their first five years in the United States, but may receive emergency medical treatment during this period. Other immigrant-specific eligibility rules may pertain even after the five-year period expires.
Refugee/asylee	Admitted to the United States because of fear of persecution in the home country	Eligible for at least first seven years in the United States, under 1996 welfare law
Undocumented alien	Either entered the United States without permission or violated the terms of his or her visa	Not eligible, but may receive emergency medical care
Other lawfully present immigrants	Includes foreign-born people with temporary visas (for example, students, work visas, tourists), persons granted temporary protected status, applicants for asylum, and others with pending immigration status	Not eligible, but some may receive emergency medical care

Source: Lessard and Ku, 2003



Source: Passel and Cohn, 2008

Recommendations:
Healthcare executives at all levels must be bold in their outlook and outreach to improve access for the pediatric immigrant subpopulation, but also actively integrate other subpopulations not mentioned in this essay.

First, Look Within:
The U.S. Health System, for all the criticism it has been receiving recently, is still renowned for best practices, great quality and excellent outcomes. Healthcare leaders must look within their peer group, as well as beyond, to identify those best practices and implement them wherever applicable. Some potential practices have already been identified by CHIPRA and included as part of its performance bonus option. However, there are many other such unique ideas that have been implemented successfully all over the country (Cousineau and Farias, 2009; Flores *et al.*, 2005; Marx *et al.,* 2009; Reid *et al.*, 2009). For example, the Department of San Francisco Public Health Department defined patient panels and automatic patient assignment for their community primary care clinics and have seen an increase in physician satisfaction and improved access (Marx *et al*, 2009). As other states analyze the trends for influx in migrant populations, it would be highly desirable to study those states that previously were havens for immigrants to study possible solutions as well as prevent potential mistakes.

Second, Community Partnerships:
Any attempt to improve access or decrease disparities must focus on culturally appropriate interventions. America is considered a land of immigrants, and the population mix is projected to be increasingly diverse in the coming years. Therefore, efforts to integrate them into society, especially healthcare, must be culturally appropriate as well. As healthcare leaders, it becomes imperative that a focus on culturally appropriate practices be developed at an outreach level as well as at the level of care provision. Identifying culturally appropriate solutions requires a partnership with the specific community in question. For example, Lessard and Ku (2003) recommend partnering with trusted community-based organizations (CBO) or community health outreach workers. One example of such a partnership is the collaboration between the Illinois Coalition for Immigrant and Refugee Rights and the state's Department of Human Services. The two organizations work together to improve CBOs' capacity to promote immigrant access to public health coverage and other services. Similarly, many Latino communities are served by community health outreach workers called promotoras. Promotoras are typically immigrant community volunteers who provide health education and outreach in homes and at farm labor camps (Lessard and Ku, 2003).

Third, Creativity is the Key:
Healthcare leaders should proactively seek creative ideas and work collaboratively to implement them. As described in this essay, language was a significant barrier for the immigrant pediatric population in accessing services as well as receiving appropriate care. The solution may need to be unconventional and creative to be successful. An option for outreach could be to focus on the teen pediatric population who are avid social media users. Healthcare leaders at the local level could collaborate to create a facebook page, in multiple languages if necessary, to raise awareness of Medicaid, CHIP, safety net clinics, and so on. If Disney can target its ads to children and thereby induce parents to bring their kids to Florida, is it wrong for healthcare leaders to use media to educate the public about health services? Another creative solution could involve creating a web-conference interpreter services by the State which could be accessed by any participating primary care physician.

Conclusion:

Healthcare reform is advancing upon all of us like the proverbial tsunami, relentless in its approach and unknowing in the depth of change that it will bring. Healthcare leaders and organizations seem to be braced for its arrival with bated breath, yet the approach seems quintessentially wrong. Like the palm tree, health services at the local, state and federal level, payors and providers alike, need to bend to the force of the tsunami's will. In its aftermath, like the same palm tree that will straighten to calm waters or destruction, healthcare leaders need to analyze policies, trend future issues and restructure the existing framework to implement policies effectively and efficiently, ensuring the health of all Americans – current and future. In this essay, CHIPRA was analyzed through a similar lens and a few recommendations have been made.

One of the major challenges in writing this essay and presenting this poster was the lack of comprehensive data on the population of children who are legal immigrants, the group that is targeted by both PRWORA and CHIPRA. Future research in this arena could focus on clearly indicating the three categories of immigrant children and their insurance coverage status – those who are recent legal immigrants, US born children with immigrant parents (authorized and not authorized), and unauthorized children. This would enable healthcare leaders to focus their resources in identifying and implementing policies aimed at addressing the issues faced by those specific subpopulations. Additional areas for research could also include a focus on restructuring provider payment in private and public markets and measuring the cost-effectiveness and sustainability of solutions intended to decrease disparities in accessing healthcare for low-income, immigrant populations.

This poster presentation has been made possible by funding and support from Children's Medical Center's Dallas Emergency Services Department as well as the Johns Hopkins Bloomberg School of Public Health's Student Assembly.

I would like to thank my preceptors and colleagues at Children's, my mentors at Hopkins, and my family for their contributions in making this a cohesive research paper. Their content matter expertise, support and feedback have been an invaluable resource as I learnt about CHIPRA and the challenges that legal immigrant children faced.

Thank you!

References:

1) Capps, Randy. (2001). Hardship among Children of Immigrants: Findings from the 1999 National Survey of America's Families. *Urban Institute 'Assessing the New Federalism' project,* B (B-29): 1-8

2) Capps, Randy, Henderson, Everett, Passel, Jeffrey S., and Fix, Michael. (2006). Civic Contributions: Taxes Paid by Immigrants in the Washington, DC, Metropolitan Area. *The Community Foundation for the National Capital Region,* The Urban Institute website: http://www.urban.org

3) CHIP TIPS. (2009). Medicaid Performance Bonus "5 of 8" Requirements. *The Kaiser Commission on Medicaid and Uninsured*, Kaiser Family Foundation website: http://www.kff.org

4) CHIP TIPS. (2009). New Federal Funding Available to Cover Immigrant Children and Pregnant Women. *The Kaiser Commission on Medicaid and Uninsured and Georgetown University Health Policy Institute Center for Children and Families*, Kaiser Family Foundation website: http://www.kff.org

5) CHIP TIPS. (2009). New Option for States to Provide Federally Funded Medicaid and CHIP Coverage to Additional Immigrant Children and Pregnant Women. *The Kaiser Commission on Medicaid and Uninsured*, Kaiser Family Foundation website: http://www.kff.org

6) Cousineau, Michael R. and Farias, Albert J. (2009). Changes in Uncompensated Pediatric

Ambulatory Care Visits for Uninsured Children Among Safety Net Providers After Implementing a Health Insurance Program for Children of Low-Income Families. *J Public Health Management Practice*, 15(4), E1–E6
7) Flores, Glenn, Abreu, Milagros, Chaisson, Christine E., Meyers, Alan, Sachdeva, Ramesh C., Fernandez, Harriet, Francisco, Patricia, Diaz, Beatriz, Diaz, Ana Milena and Santos-Guerrero, Iris. (2005). A Randomized, Controlled Trial of the Effectiveness of Community-Based Case Management in Insuring Uninsured Latino Children. *Pediatrics,* 116: 1433-1441
8) Flores, Glenn and Tomany-Korman, Sandra C. (2008). The Language Spoken at Home and Disparities in Medical and Dental Health, Access to Care, and use of Services in U.S. Children. *Pediatrics,* 121: e1703-e1714
9) Guendelman, Sylvia, Schauffler, Helen Halpin and Pearl, Michelle. (2001). Unfriendly Shores: How Immigrant Children Fare In The U.S. Health System. *Health Affairs*, 20(1): 257-266
10) Huang, Zhihuan Jennifer, Yu, Stella M., and Ledsky, Rebecca. (2006). Health Status and Health Service Access and use Among Children in U.S. Immigrant Families. *American Journal of Public Health*, 96: 634–640
11) Ku, Leighton. (2007). Improving Health Insurance and Access to Care for Children in Immigrant Families. *Ambulatory Pediatrics*, 7: 412–420
12) Ku, Leighton and Blaney, Shannon. (2000). Health Coverage for Legal Immigrant Children: New Census Data Highlight Importance of Restoring Medicaid and SCHIP Coverage. *Center on Budget and Policy Priorities website*: http://www.cbpp.org
13) Ku, Leighton and Matani, Sheetal. (2001). Left Out: Immigrants' Access To Health Care And Insurance. *Health Affairs*, 20(1): 247-256.
14) Lessard, Gabrielle and Ku, Leighton. (2003). Gaps in Coverage for Children in Immigrant Families. *The Future of Children - Health Insurance for Children,* 13(1): pp. 101-115
15) Marx, Rani, Drennan, Michael J., Johnson, Elizabeth C., Solnit, Stephen A., Hirozawa, Anne M. and Katz, Mitchell H. (2009). Creating a Medical Home in the San Francisco Department of Public Health: Establishing Patient Panels. *J Public Health Management Practice*, 15(4): 337–344
16) Mohanty, Sarita A., Woolhandler, Steffie, Himmelstein, David U., Pati, Susmita, Carrasquillo, Olveen, and Bor, David H. (2005). Health Care Expenditures of Immigrants in the United States: A Nationally Representative Analysis. *Am J Public Health,* 95: 1431–1438
17) Passel, Jeffrey S., and Cohn, D'Vera. (2008). U.S. Population Projections: 2005–2050. *Pew Research Center Social and Demographic Trends Report:* 1-49
18) Pew Hispanic Center. (2007). Tabulations of 2000 Census (5% IPUMS) and 2007 American Community Survey (1% IPUMS). *Pew Hispanic Center website*: http://pewhispanic.org/
19) Population Division, U.S. Census. Bureau. (2008).Table 15 - Projections of the Black Alone Population by Age and Sex for the United States: 2010 to 2050 (NP2008-T15); Table 17 - Projections of the Asian Alone Population by Age and Sex for the United States: 2010 to 2050 (NP2008-T17); Table 20 - Projections of the Hispanic Population (Any Race) by Age and Sex for the United States: 2010 to 2050 (NP2008-T20). U.S. Census Bureau website: http://www.census.gov/
20) Reid, Robert J., Fishman, Paul A., Yu, Onchee, Ross, Tyler R., Tufano, James T., Soman, Michael P., and Larson, Eric B. (2009). Patient-Centered Medical Home Demonstration: A Prospective, Quasi-Experimental, Before and After Evaluation. *American Journal of Managed Care,* 15(9): e71-e87
21) Roberson, Jason. (2009). Medicaid patients have trouble finding doctors in Dallas area. The Dallas Morning News website: http://www.dallasnews.com
22) The Physicians' Foundation. (2008). The Physicians' Perspective: Medical Practice Survey. Merritt Hawkins & Associates website: http://www.merritthawkins.com
23) Yu, Stella M., Huang, Zhihuan J., and Singh, Gopal K. (2004). Health Status and Health Services Utilization Among U.S. Chinese, Asian Indian, Filipino, and Other Asian/Pacific Islander Children. *Pediatrics*, 113: 101-107